Development of a Student Success Protocol for Undergraduate Nursing Program Students

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Abstract

Background: Nursing clinical instructors are tasked with the challenge of ensuring patient safety standards are upheld, while evaluating and supporting learners. The majority of undergraduate nursing students are successful in meeting clinical course outcomes. However, clinical nursing instructors and schools of nursing need tools to identify those students at risk of unsafe practice or underperformance, as well as resources to guide pedagogical practices in order to ensure continued patient safety. **Purpose:** The purpose of this project was to design a student success protocol to assist clinical nursing instructors in the early recognition and remediation of students who are at risk of clinical failure due to unsafe practices or clinical underperformance. **Methods:** A comprehensive literature review was conducted. Next, consultations with key stakeholders explored needs of the institution. Based on the findings of the literature review and the consultations, the student success protocol was developed, including a plan for implementation and evaluation. **Results:** Consultation meetings and the literature review identified the need for faculty development, in-situ remedial activities, clinical learning contracts and learner handover. The developed student success protocol includes an algorithm of student progression, an associated faculty guidebook with direction on feedback and in-situ remedial activities, and a plan for faculty development. Additional supportive documents, including a student performance plan and post-performance plan summary were also created. **Conclusion:** The student success protocol was developed from consultation and an investigation of the extant literature, and is intended to meet the needs of faculty members and students in schools of nursing.

Key Words: nursing student, student nurse, unsafe practice, underperformance, clinical practice, clinical failure

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Table of Contents

Introduction and Objectives

Undergraduate nursing programs are responsible for ensuring that graduate nurses are equipped with the knowledge, skills, and attitudes to provide safe and high-quality nursing care in complex practice settings. Clinical learning environments encourage the acquisition and application of nursing theoretical knowledge, and it is the role of the clinical nursing instructor to not only facilitate student learning, but also to evaluate learner outcomes while ensuring patient and organizational safety standards are upheld. Though the majority of students will be successful in meeting clinical course learning outcomes and providing safe, competent, ethical care, this may not be true of all learners. Schools of nursing and their clinical faculty members require transparent, supportive, and fair processes that identify and manage students at risk of clinical failure, with an overarching goal of facilitating student success where possible.

Student attrition continues to be of pressing concern to undergraduate programs in Canada. It is estimated that across Canada, nursing educational programs have approximately 25% attrition of students in entry-to-practice programs (Canadian Association of Schools of Nursing [CASN], 2019). The rate of nursing student attrition, whether voluntary or involuntary, affects overall program funding via loss of tuition, may jeopardize nursing program reputation and recruitment efforts, and is implicated in nursing profession destabilization (CASN, 2019; Craig, 2014). There is significant benefit for schools of nursing to address program retention and completion rates via internal processes designed to support learning, positive faculty-student interactions and provide high-quality instruction. As a result, measures need to be in place in nursing

programs that will address attrition rates, while ensuring that students demonstrate the necessary competencies as they move through their programs of study.

Red Deer College (RDC) is a medium sized community college, with both a four-year collaborative Bachelor of Science in Nursing (BScN) degree program and a two-year Practical Nurse (PN) diploma program (Red Deer College, n.d.). In total, RDC admits 184 students into nursing programs each year, with 104 seats allotted to the BScN program, and 80 to the PN program. Based upon feedback and concerning trends over the last three years, including increased rates of student appeals, increased clinical failure, and attrition occurring in the last year of the program, the need for a novel process related to addressing attrition while maintaining students' clinical safety was identified. Such a process needed to be grounded in evidence and based upon relevant andragogical theory. The goal of the project was to develop a student success protocol to meet the needs of RDC's BScN program. The outcomes of the project included:

1. Describe actions and behaviors of unsuccessful/underperforming and unsafe clinical nursing students
2. Identify evidence-informed strategies to support students at risk of clinical failure
3. Describe tools used in supporting students at risk of clinical failure
4. Develop a process to identify and support students at risk of clinical failure
5. Demonstrate advanced nursing practice competencies.

Overview of Methods

There were two key methods used in the development of the *Student success protocol*. First, a comprehensive literature review was undertaken, the findings of which

are detailed in a subsequent section. Secondly, consultations were used to identify the institutional needs, and consultations were undertaken with administrators, faculty members, and others. The methods and findings of the consultations are described in a subsequent section. Both the literature review and the consultations were necessary in understanding the scope of the issue, and determined the content needed for a responsive, transparent protocol to use for students who are struggling to meet clinical learning outcomes.

Development of the *Student success protocol* was a highly iterative process, based upon the findings from the literature review and consultations, and culminated in a protocol that includes five components: an algorithm for use by students and faculty members, two forms for documenting student progress, a faculty guidebook, and a faculty development plan to guide the implementation of the protocol. Detailed information about the developed materials will be presented below, with copies found in Appendix C.

Summary of Literature Review

The literature review was conducted in April and May of 2020 within the Current Index to Nursing and Allied Health (CINAHL), Google Scholar, ProQuest, and PubMed databases. The review was comprised of literature that was published after 2000, as there was limited relevant research published after 2009. Literature relevant to clinical students in nursing, medicine, and in the allied health fields was included if there was discussion about the attributes of underperformance or unsafe practice, including clinical teaching strategies to identify and support such students. Articles were retrieved,

reviewed, and analyzed for themes. Qualitative and quantitative studies and literature reviews were analyzed; the Public Health Agency of Canada (2014) critical appraisal tools was used to evaluate quantitative research, while the Critical Appraisal Skills Programme (2018) was used to critically evaluate qualitative research. The full literature review and associated evaluation of research is found in Appendix A. The key findings of the literature review included four key components that were used in the development of the *Student success protocol*.

The Student

Academically, students admitted into nursing programs are accustomed to success with little effort; the demands of undergraduate nursing programs are often underestimated and may cause feelings of overwhelm (Barton, 2011; Freeman & All, 2017; Jakubec et al., 2020). Most students will re-evaluate their study and preparation habits after a first failure and correct their trajectory, though this is not true of all (Barton, 2011; Jakubec et al., 2020). Those students who cannot, or do not, change their course may go into clinical practice with attributes associated with underperformance or unsafe practice. Often, attributes of unsafe practice or underperformance will have concerning characteristics or patterns in multiple domains of practice, including cognitive, affective, and psychomotor domains (Craven, 2015; Duffy, 2013; El Hussein & Fast, 2020; Lewallen & DeBrew, 2012; Scanlan & Chernomas, 2016). In general, students are noted to be successful when they attend clinical prepared, they have strong interpersonal communication skills, they seek, receive, and act on feedback given to them, and they display a positive attitude (Craven, 2015; Lewallen & Debrew, 2012).

The Faculty

Findings from the research identify that there are many challenges for faculty members when working with students who are underperforming or unsuccessful. Students at risk of clinical failure require more instructor time, and the experience is often identified as an emotionally challenging experience for faculty members (Bearman et al., 2012; Cassidy et al., 2017; Duffy, 2013; Elliot, 2016; MacLeod, 2005; Stoker, 2016). Due in part to the challenges in working with students at risk of clinical failure, the notion of "failing to fail" emerged in the literature in the 2000's, the definition of which is allocating passing grades to students who do not meet the threshold of passable practice (Hughes et al., 2016; Laroque & Luhanga, 2013). Though a complex phenomenon, the profession cannot rectify the failure to fail phenomenon without identifying the antecedent factors that contribute.

Instructors may inappropriately assign passing grades to students who do not meet the requirements of a passing grade for a number of reasons, though the more commonly cited factors include institutional factors, student factors, and individual faculty member factors. Institutional factors may include subjective clinical evaluation tools that fail to account for the various attributes of underperformance or unsafe practice (Cassidy et al., 2017; Elliot, 2016; Hall, 2013; Hughes et al., 2016; MacLeod, 2005). Of particular note is the challenge for faculty members to assign a failing grade based on deficiencies that are not psychomotor in nature using assessment tools (Elliot, 2016; Elliot, 2017; Hughes et al., 2019). Additionally, fears including appeals processes, grades being overturned, and litigation are factors in failing to fail (Boley & Whitney, 2003; Chasens et al., 2000;

Docherty & Dieckmann, 2015; Hughes et al., 2019; Laroque & Luhanga, 2013; Hunt et al., 2016; Smith et al., 2001). Failure to fail is also identified because of student responses to feedback, which may include anger, aggression, hostility, incivility, and intimidation (Hughes et al., 2016; Hughes et al., 2019; Hunt et al., 2016). As the profession of nursing is grounded in caring, assigning a failing grade to a clinical student has been identified as being at odds with caring values (Duffy, 2013; Hunt et al., 2016). Faculty members may also be inclined to give students the benefit of the doubt about their specific performance, and award inappropriate passing grades based solely on the timing in the course, the degree of remorse, and the student's previous reports of clinical practice (Docherty & Dieckmann, 2015; Duffy, 2013; Elliot, 2016; Hunt et al., 2016; Laroque & Luhanga, 2013; Luhanga et al., 2014; Pritchard & Ward-Smith, 2017).

Processes Relating to Student Underperformance

There is a significant paucity of literature that identifies the efficacy of practices commonly used by clinical faculty members or instructors when a student is at risk of clinical failure. However, it is widely recognized providing clear expectations to clinical students is thought to foster a shared understanding of what clinical safety and success consists of, as well as indices of clinical preparation required for success (Brown et al., 2007; Chunta, 2016; Lewallen & DeBrew, 2012; Luhanga et al., 2008).

In addition to transparent clinical expectations, early recognition of struggling students and early feedback are identified as helpful processes for the struggling clinical student. Estimates identify that approximately 10-15% of students will demonstrate

attributes of unsafe practice or underperformance, though only ~2-6% will self-identify (Boileau et al., 2017). Identification of unsafe practice and underperformance should occur in the first two to three weeks of a clinical course, and may be elicited via direct clinical observation and feedback from others (Craven, 2015; Duffy, 2013; El Hussein & Fast, 2020; Luhanga et al., 2008; Luhanga et al., 2014; MacLeod, 2005). Based on early concerns, frequent and clear feedback should be communicated using both verbal and written mediums (Boileau et al., 2017; Chunta, 2016; Luhanga et al., 2008; MacLeod, 2005; Teeter, 2005).

Lastly, when patterns of underperformance or unsafe practice exist, learning contracts or performance plans are recommended by the extant literature. Learning contracts are thought to evoke change in behavior, while improving student motivation and self-efficacy (Barrington, 2009; Frank & Scharff, 2013). Learning contracts clearly outline the steps needed from both faculty member and student that contribute to success, as well as the consequences if course expectations are not fully met (Brown et al., 2007; Craven, 2015; Chunta, 2016; Gallant et al., 2006; Kosta, 2012; Luhanga et al., 2014; Teeter, 2005; Zuzelo, 2000). Such plans are thought to act as a formula for student success; however, few studies have explored their efficacy empirically.

Remedial learning activities are also identified as a process to employ when working with students at risk of clinical failure, and these activities occur in addition to the normal curriculum to support course success (Boileau et al., 2017). Remedial activities have not been confirmed as an empirically beneficial intervention for struggling students, though many detail using additional human and institutional resources to

supplement student learning when success in a clinical course is in jeopardy (Chunta, 2016; Craven, 2015; Custer, 2015; Gallant et al., 2006; Luhanga et al., 2008; MacLeod, 2005). Learner handover, though not common in nursing education, is used in other clinical disciplines when students have failed a clinical course, or required a learning contract (Teeter, 2005). Learner handover has been identified as a tool to reduce the rates of failure to fail, while providing continuity of learner strategies and activities that have yielded success (Bearman et al., 2012; Brown et al., 2007; Chou et al., 2019).

Theoretical Framework

Both Deci and Ryan's (2008) self-determination theory and Knowles' theory of andragogy (1984) were heavily referenced in the literature related to processes for working with unsafe and underperforming students. Andragogic principles include using adult learners' previous experiences, readiness to learn, and intrinsic motivation; all addressed in the use of learning contracts and remedial activities (Frank & Scharff, 2013; Gallant et al., 2006; Knowles, 1984). Learner autonomy and competence, components of self-determination theory, are enhanced when providing feedback, remedial activities and using learning contracts (Deci & Ryan, 2008; Kosta, 2012; Orsini et al., 2015).

Based upon the extant literature, though largely anecdotal and of low-quality study design, the use of learning contracts, remedial activities, feedback mechanisms, and learner handover appear to be warranted for use by faculty members when working with unsafe or underperforming clinical nursing students. Significant gaps in the efficacy of processes related to working with struggling students exist, and no studies to evaluate

whether these mechanisms yield success in nursing programs and licensure exams, or as practicing nurses.

Summary of Consultations

Consultations with a variety of stakeholders were used to ensure that the designed protocols would meet the needs of the institution. A full consultation report is found in Appendix B.

Ethical Considerations

As the consultations involved human research, abiding by the Tri-Council policy was necessary for this project. Red Deer College Research and Ethics Board approval was sought and obtained prior to consultations taking place. All participants received an informed consent letter detailing the presumed benefits and risks of participation, as well as the voluntary nature of participation and the ability of all participants to withdraw at any time without prejudice. The principles of confidentiality and anonymity were maintained throughout the consultation process.

Methods

RDC employs approximately 60 full-time and part-time instructors within the nursing program. Convenience sampling methods were used to gain access to the faculty members-at-large, and nursing program students. Faculty members were asked to participate in the consultation process providing they had teaching experience of more than two years, and they had worked with students who had failed a clinical course, or who were at risk of failing a clinical course. Faculty members were invited to take part in

virtual focus groups, and there were four participants with a variety of experience in clinical instruction. Student participants were limited to those students in year's two to four of the BScN program, as students in the first year have scant clinical experiences to draw from. Only one student responded to the recruitment email; the student was subsequently interviewed using a virtual platform.

Purposive sampling was used to identify those key stakeholders who are routinely involved with students and faculty members when students are at risk of clinical failure. Such stakeholders included the Associate Dean of Nursing, the BScN chairperson, Faculty Navigators, and the Lab Instructor who leads the clinical remediation programs. All of the identified stakeholders agreed to participate in the consultation process, so semi-structured interviews took place in June and July 2020 using virtual and telephone platforms. No focus groups and interviews were recorded, though hand-written notes were used and then transcribed into a Word document that is stored securely.

Lastly, voluntary sampling was used to consult with other nursing programs in western Canada via email to describe what other institutions experience when working with underperforming or unsafe students. Of the 39 email invitations sent, two were returned for analysis.

Data Analysis

Analysis of the data from the various sources was an iterative process. Transcribed notes from the interviews were read, re-read, and deductively coded into

themes. All themes and findings were compared to the extant literature, which emerged from the literature review.

Results

Key stakeholders and Focus Groups

All participants identified that the current Faculty Navigator program was a necessary measure to support faculty members when working with students who were unsafe or underperforming through discussion, provision of resources, and validating instructors' concerns. Participants also noted that the collegiality amongst faculty and a commitment to a learner-centered culture was of benefit to the institution. All participants readily identified successes within the formal remediation course, taken by students who have failed a clinical course.

There were a number of challenges identified by participants when working with unsafe or underperforming students. Four key themes emerged from the consultations that are perceived as barriers when working with students at risk of clinical failure: student factors, faculty member factors, program factors, and institutional factors.

Student Factors. Consultation participants unanimously identified that students who are unsafe or underperforming often lack accurate insight and self-awareness to correct their own deficiencies in clinical practice, as well as to be able to act on feedback received. Participants also reported that unsafe and underperforming students often have multiple deficiencies across cognitive, affective, and psychomotor domains; these deficiencies are often repetitive, resulting in repeated learning contracts during clinical

courses. Such reports are largely found in the literature, and are reported to be compounded by external student factors that challenge clinical instructors' usual practices with clinical students to promote success.

Faculty Factors. Participants described faculty related factors that impede the use of current clinical student performance protocols. Faculty members reported feeling challenged to offer clear, meaningful feedback to students about their performance in a language the student understands. Further, there was a consensus that faculty development relevant to working with students at risk of failure is needed, as instructors have varying levels of comfort and skill. Though the use of learning contracts was seen as a helpful tool by some, concerns were raised that not all students will have sufficient in-situ remedial activities in place to support success while on contract.

Faculty members cited similar experiences to the literature when working with students who are at risk of clinical failure. Faculty members reported a sense of ownership over the student's failings, questioning their own practices and what more could be done to promote success. All participants reported an increase in workload when working with a struggling student; reporting that they lose presence and contact with other students in the clinical group as a result.

Program Factors. Consultation participants described significant limitations in the current use of learning contracts; many reported that students and faculty alike see contracts as being punitive and not a measure to support success, but rather, a formality prior to assigning a failing grade. Participants further detailed concern with the lack of

clarity and transparency for students and instructors about attributes of unsuccessful students, as well as the actions and behaviors that would warrant immediate clinical failure.

Institutional Factors. Participants readily discussed the institutional factors that affect their practice when working with students who are unsafe or underperforming. First, the appeals process requires faculty members to not only justify their assignment of a failing grade, but also teach the appeals board about the nursing programs and the profession of nursing. It was largely agreed upon by participants that the appeals process within the institution is grounded in mistrust towards nursing faculty members, and that the appeals process leave faculty members without sufficient support to navigate the process.

Recommendations. Participants were able to identify many recommendations to improve practice when working with underperforming or unsafe students. First, faculty development was a key need in order to support the early recognition of students who are unsafe or underperforming in the clinical setting. Participants reported that faculty development include evidence-informed practices that would support their ability to benchmark student performance early in the term, giving students effective feedback, and plan in-situ remedial learning activities to support student learning. Additionally, participants strongly recommended that processes be edited to be more transparent and easily understood for faculty and students alike, including delineating and clarifying student and faculty members' roles when concerns arise. Participants recommended that learning contracts contain in-situ remedial activities and that the language in a learning

contract reframe it as a tool to support student success. Further, participant recommended the nursing programs investigate the opportunity for an internal appeals process in order to reduce the number of student appeals that occur at the college-wide level.

Student Interview

The findings from the singular student interview included the pressures associated with clinical student learning, as well as a perceived lack of transparency in processes relating to student failure from the clinical setting. The interviewee described the internal and external pressures to do well in the clinical setting and recommended faculty development for more consistent practices for clinical teaching. The participant also discussed the negative affect that a lack of transparency has on the student experience. A reported lack of tangible expectations of instructors was reported to increase student fear, anxiety, and uncertainty. Furthermore, the participant recommended the need for all students to have clear and early feedback, including the "non-negotiables" in clinical learning that would warrant immediate failure.

Other Institutions

The few institutions that responded to the consultation request used very similar processes to those currently practiced at RDC, including learning contracts. Neither institution had a faculty navigator position; both reported having dedicated clinical coordinators for instructors to discuss student performance concerns. Both institutions reported similar challenges to RDC when students are at risk of clinical failure including

demands on instructor's time and energy, the perception of contracts as punitive, and identification of student concerns late in the term.

Conclusions from Consultations

The findings from the consultations overall validated the findings from the literature review. Based on the consultations, a newly designed student success protocol should be clear and transparent and support consistency, in language that will be easily understood by faculty members, students, and the college community-at-large. All participants recommended faculty development opportunities as a priority as in-situ remedial learning activities, feedback, and accurate assessment of student performance remain areas of concern. There was a high degree of agreement within the consultations and the findings from the literature review, which supported a clear direction for the development of the *Student success protocol*.

Summary of the Developed Protocol

The *Student success protocol* was developed based upon the key results of the literature review, as well as the findings from the consultations. The protocol contains five components, each designed for the ready implementation within the RDC nursing programs. The entire *Student success protocol* is found in Appendix C.

Performance Improvement Algorithm

As part of the *Student success protocol*, an algorithm was developed for use by faculty members to facilitate the decision-making processes related to student progression

within a course. Within the algorithm is a list of actions, behaviours, and attributes that constitute unsafe practice and underperformance, as well as a description of the actions by a student that would constitute immediate failure and removal from the clinical area. The algorithm outlines the required steps of the faculty member when a student is unsafe or performing unsatisfactorily in the clinical setting, including decision points to consult outside resources, including the Associate Dean and faculty navigators. The purpose of the algorithm is to promote consistent identification and practices related to managing underperforming students in a transparent manner. The language used in the algorithm is plain and descriptive, intended for use by novice and experienced faculty members alike, but also for students to be able to read and interpret. The algorithm can be used to identify the appropriate use of a learning contract, now referred to as a Performance Improvement Plan (PIP), as well as to make decisions around the discontinuation of a PIP, and student clinical failure. It is intended that the algorithm is available for faculty members to access in the faculty handbook, and that students have a copy of the algorithm in their clinical course syllabi.

Faculty Guidebook

While the student progress algorithm is a visual decision making tool for student progress, the associated faculty guidebook provides a comprehensive approach to facilitating student success in a clinical setting. The guidebook contains evidence-informed practices, including strategies to identify student knowledge early in the term, in-situ remedial activities to enhance student learning, and methods to providing clear student feedback. The guidebook builds upon the descriptions of unsafe practice and

underperformance detailed in the algorithm, and further details the possible etiology of concerning student behaviours. The guidebook contains samples of written feedback to students in order to give instructors ideas around the language to use when students have displayed underperformance in the clinical setting. Lastly, the guidebook contains a reference list for further reading for instructors. It is intended that the guidebook is available via the faculty handbook with the algorithm.

Performance Improvement Plan

Participants in the consultation process identified that though a learning contract was a beneficial tool when students are struggling in the clinical setting, there were challenges in its use, including the term "learning contract". To remove the legal undertones of the document, and to describe the document as a supportive measure, rather than a punitive measure, the contract was renamed as the Performance Improvement Plan. The PIP is intended for use when a student has a pattern of clinical deficiency, and should be initiated early in the clinical course, co-created by the instructor and the student. The PIP is grounded in andragogical and self-determination principles, wherein both the student and the faculty member have responsibilities for the outcome. The PIP is intended to foster transparency in the process, including making clear the actions of the instructor when a student is struggling, as one common theme in both literature and consultation was that struggling students might feel singled out when instructors increase observation or questioning to assess learning. Finally, the PIP contains statements that ensure students and faculty members discuss the mechanisms for

both success and clinical failure, and acknowledge the students right to withdraw from the clinical learning course.

Post-Improvement Plan Summary

Learner handover was identified by the literature as a measure to decrease the failure to fail phenomenon. The post-improvement plan summary (P-PIPS) is a learner handover tool to be placed on the student file following the use of a PIP, regardless of outcome, as well as if a student withdraws a clinical course following practice concerns. The P-PIPS would be a permanent document within the student file, based upon the literature on students with attributes of unsafe practice or underperformance. The P-PIPS provides a mechanism for faculty members to identify the efficacy of learning strategies in addressing clinical deficiencies for individual students. This document is intended to support student success in subsequent clinical learning settings by building off the strategies that have worked for the student in the past. Faculty members who are seeing attributes of underperformance or unsafe practice can request the Associate Dean to review this document and share back both previous clinical concerns, as well as the in-situ remedial activities previously used and the outcome of these strategies. A copy of the P-PIPS would also be given to the student following the use of a PIP, in order to promote student self-efficacy and awareness by articulating their own strengths, areas of growth, and strategies to support their success.

Faculty Development Plan

The last component of the Student success algorithm is the faculty development plan. This resource outlines the intended implementation of the student success algorithm through a workshop-style learning session. Following the workshop, participants should be able to: (1) describe the behaviours and attributes of an unsafe or underperforming student; (2) identify appropriate remedial activities for student performance concerns; (3) practice using the performance improvement algorithm; and (4) create a performance improvement plan and post-performance improvement summary for a fictional student case study. Learning actives, including individual reflection, small group learning activities, case studies, and lecture are described within the plan, as well as a plan for evaluating the learning outcomes following the workshop.

Discussion of Advanced Nursing Practice Competencies

One of the main outcomes of the project in its entirety was to demonstrate the advanced nursing practice (ANP) competencies as defined by the Canadian Nurses Association (CNA, 2019). Of the competencies, those associated with research, leadership, and education are of particular relevance to this project (CNA, 2019).

Research

The domain of research includes accessing, analyzing, and applying research into the practice setting (CNA, 2019). The comprehensive literature review, analysis, and evaluation using critical appraisal identified the deficits in the extant literature related to the empirical evidence to guide instructors' practices when working with students who

are unsafe or underperforming. The findings of the literature review informed the questions used in the consultation process, as validating the key findings within the context of the RDC program was deemed necessary.

Generating research, as identified within the evaluation plan for the *Student success protocol*, too is a key component of the research competencies (CNA, 2019). In addition, the ethical practices required in research with human subjects were demonstrated through obtaining research and ethics board approval for the consultation process. Dissemination of the *Student success protocol* and associated evaluation will contribute to the scant research specific to supporting student success in clinical learning once deficiencies are identified.

Leadership

Advanced practice nurses are considered agents of change, seeking novel and innovative solutions to problems in their practice settings (CNA, 2019). The *Student success protocol* was designed to be a responsive solution to a known problem within nursing education. Grounded in evidence, the *Student success protocol* will improve the experience of students and faculty alike, and if successful, will serve to strengthen the nursing program at RDC.

Education

The educational competencies for the ANP include planning educational activities, disseminating new knowledge, and contributing to a culture of learning (CNA, 2019). The faculty development plan and associated workshops will be the main vector

for disseminating the findings from the literature review, the consultations, as well as the direction for the *Student success protocol*. The careful development of the components of the *Student success protocol* was based upon the consultation of the members of RDC and considered the needs, recommendations, and suggestion of all in order to reflect and meet their learning needs. Further, the *Student success protocol* will contribute to learner success, while facilitating the professional growth of faculty members and nursing students alike (CNA, 2019).

Next Steps

As the *Student success protocol* is complete, the suggested next steps include implementing and evaluating the *Student success protocol*. The complete implementation and evaluation plan is included in Appendix D.

Implementation Plan

The completed components of the *Student success protocol* were introduced first to the Associate Dean of the nursing programs and the Chairperson for feedback. These two individuals were selected given their broad experiences working with faculty and students at the program level, but also their experiences with relevant policies and procedures at the institutional level, including appeals processes. The individuals were asked to identify if the protocol sufficiently detailed student, instructor, and administrative roles when a student is at risk of clinical failure; whether the protocol is easily understood; and if the protocol is likely to be understood by others outside of the nursing programs. Based on their feedback, there were minor process changes made to the algorithm and associated faculty guidebook. In addition, there was a suggestion for

faculty to engage in self-reflection about their clinical teaching prior to the faculty development workshops, thus a worksheet was added to the faculty development plan. As a result, the *Student success protocol* is ready to be introduced to the faculty at large.

Based upon the knowledge to action framework, the dissemination of the protocol will occur within the faculty development session (Graham et al., 2006). The overarching goal of the faculty development sessions is to change faculty members' knowledge, skills, and attitudes to improve student success outcomes in clinical learning (Thomas & Steinert, 2014). The expected barriers to faculty members' integration of the new protocol include a perceived lack of benefit over existing processes, varying levels of instructor experience, as well as a lack of time to take part in the faculty development process (Thomas & Stenert, 2014). With consideration of the aforementioned barriers, the faculty development plan was devised.

Faculty development is more likely to be successful when accompanied by interactive and experiential learning strategies, as well as opportunity for connection and informal mentorship, principles that informed the faculty development plan (Spencer, 2014). Implementing the *Student success protocol* will occur via an online workshop, as described in the Faculty development plan. The workshop will include interactive small and large group work, self-reflection, and a case-study scenario to apply the components of the *Student success protocol*. Implementation and faculty development are planned for December 2020, in advance of the winter academic term.

Evaluation

The conceptual use of the protocol, described as changing knowledge without a change in practice, will occur within and following the workshops via direct evaluation of the implementation activities (Graham et al., 2006; Thomas & Steinert, 2014). However, the evaluation of the conceptual use is of limited use, other than in planning subsequent faculty development activities related to unsafe or underperforming students.

The instrumental use of the *Student success protocol* is the actual practice change that occurs because of the new knowledge, in short assessing the efficacy of the new protocol (Graham et al., 2006). Identifying the instrumental use of the protocol will require a one-year timeline, in order for sufficient and consistent use by faculty members.

After one year of use, the evaluation of the *Student success protocol* will consist in part of faculty member satisfaction. This feedback will be collected via anonymous survey using a simple Likert scale and open-ended questions to describe faculty members' experiences and to what degree the *Student success protocol* supported faculty member work with unsafe or underperforming students.

Instrumental use of the protocol will also be assessed using quantitative data obtained from BScN student records. After one year of use, the frequencies of performance improvement plans initiated, clinical course withdrawals, and clinical failures will be compared to the frequencies in the two years immediately preceding implementation of the protocol. Of particular interest will be the frequencies of students who have had a performance improvement plan initiated and were ultimately successful

in meeting course outcomes compared to previous year. Frequency measures would be obtained through the Associate Deans, with no student identifiers or course related data attached. The comparisons in student outcomes under the new protocol will necessitate inferential statistical methods, including measures of variance (ANOVA) and t-test measures. Until such point where the *Student success protocol* becomes the integrated process for students with unsafe or underperformance, evaluation of outcomes may need to take place more frequently than after one year of use.

Conclusion

Nursing programs are obligated to ensure that graduates have the knowledge, skills, and attitudes to be safe, competent, and ethical practicing nurses. Clinical learning environments serve to shape students to be successful in future practice, and clinical instructors are responsible for ensuring that students meet the course specific requirements to move on. Though unsafe practice and underperformance occurs infrequently, nursing faculty members identify this to be a challenge. The *Student success protocol* was developed to assist faculty in the early identification and remediation of student clinical deficits to optimize the likelihood of student success in clinical learning settings, but also in their future practice. The student-centered and transparent processes incorporate self-determination theory and adult learning principles to improve the student experience, while the cohesive components of the protocol address faculty concerns identified in both the consultations and the extant literature. The components of the protocol address the needs of administrators, faculty members, and students in order to improve clinical learning outcomes in a novel, responsive manner.

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Appendix A

Literature Review

Student Success Protocol in Undergraduate Nursing Programs: An Integrative Review

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Student Success Protocol in Undergraduate Nursing Programs: An Integrative Review

Undergraduate nursing students are expected to meet specific educational competencies in order to move through courses and result in program completion. Demonstration of course-specific skills, knowledge, and attitudes support the acquisition of the skills needed for Registered Nursing practice upon graduation. It is essential that new graduate nurses exit their respective programs with the knowledge and skills required to deliver high quality nursing care in highly complex practice settings. Nurse educators require the skills and tools to fairly and accurately evaluate learners' meeting of outcomes, including the ability to identify underperforming or unsafe practice in nursing students, and to take the appropriate steps to support student success or award a failing grade (Heaslip & Scammell, 2012). The purpose of this literature review is to define and describe the issue of student underperformance or unsafe practice, including identifying and analyzing the evidence around managing unsafe practice and underperformance in nursing students, and identifying the resultant gaps for future research study.

Background

Red Deer College (RDC) is a mid-sized community college with a student population of 7,500 full-time and part-time students per year (Red Deer College, n.d.). The college offers certificate, diploma, apprenticeship programs, as well as collaborative degree opportunities (Red Deer College, n.d.). The Nursing program at Red Deer College (RDC) began in the 1960's, and became a collaborative degree program with the University of Alberta in 1990 (Red Deer College, n.d.). The current baccalaureate

program is a four-year program, with the first three years completed as a Red Deer College student, and the fourth year completed as a University of Alberta student while continuing at the Red Deer College campus. The baccalaureate program admits 96-104 students per year, with the goal of graduating 88 students per year. RDC also offers a two-year Practical Nurse diploma program, which admits 80 students per year.

Student attrition rates are of particular concern to nursing programs. Student attrition, whether voluntary or involuntary, affect the sustainability of the nursing profession. In Canada, there were approximately 16,000 students admitted into entry-to-practice nursing programs, but only approximately 12,000 graduate, which assumes 25% attrition (Canadian Association of Schools of Nursing [CASN], 2019). In Alberta, attrition in Baccalaureate degrees is somewhat higher at 27%, and this is a worrisome trend (CASN, 2019). The nursing profession is currently female dominated and aging, and saw a decrease of 2.4% of nurses in the workforce in 2018 alone (Canadian Institute for Health Information, 2020). As such, nursing programs need to be responsive to student attrition rates, while ensuring students are exiting nursing programs with the necessary knowledge, tools, and skills to be retained in the nursing profession.

Involuntary attrition, wherein students do not complete their program due to academic misconduct or failure, is of particular concern. Schools with high attrition rates may be viewed as substandard and difficulty recruiting into programs (Craig, 2014). Tuition losses conferred from vacant seats is also costly to postsecondary institutions, and this is especially true when involuntary attrition rates climb (Craig, 2014). Schools of Nursing need to ensure that their curricula adequately prepares nursing graduates for the

complexities of the profession, while concurrently ensuring there are appropriate student supports and resources for success. Finally, when students are not able to fulfill academic or practice expectations, the internal processes used for failure need to be clear and transparent. Nursing educators are responsible for ensuring student readiness for progression within the years of the program, and completion of the program and entry to practice. As such, the aim of this literature review is to determine what processes and activities should be used by clinical instructors when working with underperforming or unsafe students.

Search Strategies

Three key databases were accessed and used between April 30th, 2020 and May 27th, 2020, including Current Index to Nursing and Allied Health (CINAHL), ProQuest, and PubMed to find literature applicable to the processes used by nursing faculty and programs when students are unsuccessful or unsafe in clinical practice. Comprehensive searches were conducted using the following search queries or keywords: ("nursing student" OR "student nurse") AND ("fail*" OR "underperform*" OR "unsafe" OR "unsuccessful). In order to describe the process used by schools of nursing, the following search queries were also used in combination with the terms above: ("faculty" OR "mentor" OR "remediation), as well as ("learning contract" OR "practicum plan" OR "clinical contract" OR "performance plan"). Initially, results were limited to those published after 2009; however, the results yielded were less than expected with this limitation. As such, older literature was included. There is a paucity of literature specific to the processes used by faculty when students are unsafe or unsuccessful, and so the

search terms were broadened to include "clinical students" or "medical students" as well. All search terms were then used in Google Scholar, Theses Canada, and Open Access Theses and Dissertations databases to ensure relevant theses and dissertations were retrieved. Lastly, the reference lists of highly relevant articles were reviewed, and the primary resources were retrieved accordingly.

Articles were reviewed, and the most relevant literature was analyzed and evaluated. The Public Health Agency of Canada (2014) critical appraisal tool was accessed and used for both quantitative studies and literature reviews, while the Critical Appraisal Skills Programme (2018) tool was accessed and used to evaluate qualitative studies. The literature summary tables containing these analyses can be found in the appendix. Based upon the results of the literature search, resources can be themed by common foci: student, faculty, and learning supports and processes.

The Student

Students admitted into nursing programs are often academically strong, and accustomed to successes without substantial effort (Freeman & All, 2017; Jakubec et al., 2020; Killam et al., 2010a). Nursing students often underestimate the challenges of nursing school, and many will struggle with time management and critical thinking skills (Freeman & All, 2017). Though the coursework often feels overwhelming, students generally have a sense of strong optimism and recognize that such challenges are normal (Barton, 2011). When students begin to struggle to meet academic or clinical expectations, they rarely seek help from faculty or from peers (Jakubec et al., 2020). When nursing students experience their first failure, often in a quiz or test, there is a

pervasive feeling of discomfort, disbelief and incredulousness, as these students have rarely failed previously (Barton, 2011; Freeman & All, 2017; Handwerker, 2018; Jakubec et al., 2020).

Generally, after a first failure, students will engage in self-reflection and seek support in establishing better study habits (Barton, 2011; Jakubec et al., 2020). Students may consider reaching out to faculty members, joining study groups, and using formal institutional learning resources (Barton, 2011; Jakubec et al., 2020). However, this is noted not to be true of all nursing students. Jakubec et al., (2020) found that for some, the discomfort of a failing grade brought forward a sense of hopelessness and loss of motivation. When students experience involuntary attrition because of failure, especially because of unsafe practice, acceptance may be difficult (Barton, 2011, Handwerker, 2018).

Unsafe, Unsuccessful, or Underperforming characteristics

Students are identified as being unsafe or unsuccessful in the clinical setting for a variety of behaviors and characteristics. These behaviors are often identified in cognitive, affective, and psychomotor domains, and failing students are noted to have concerning characteristics in multiple domains (Craven, 2015; Duffy, 2013; Scanlan & Chernomas, 2016).

Cognitive. Cognitive deficits that hinder successful practice include poor interpersonal communication skills, failing to ask questions, and an inability to describe or demonstrate independent thinking and decision-making (El Hussein & Fast, 2020; Killam et al., 2010a; Lewallen & DeBrew, 2012; Luhanga et al., 2014; Scanlan &

Chernomas, 2016). Additionally, when students cannot connect theoretical knowledge to clinical practice, or have only weak theoretical knowledge to draw upon, they are at risk of being unsuccessful (Craven, 2015; Lewallen & DeBrew, 2012; Scanlan & Chernomas, 2016). Nursing students who struggle with the cognitive demands of practice can be described aptly as "like a passenger on a bus" (Lewallen & DeBrew, 2012, p. 7).

Affective. Affective attributes that contribute to unsafe or unsuccessful practice include being consistently flustered, anxious, or freezing while in practice (Craven, 2015; Killam et al., 2010a; Lewallen & DeBrew, 2012; Scanlan & Chernomas, 2016). Attitudinal concerns, including incivility, defensiveness, deflection, and blaming of others are also problematic attributes and are inherently unsafe in practice and indicate a lack of accountability (Killam et al., 2010a; Killam et al., 2010b; Scanlan & Chernomas, 2016). Compromised accountability, evidenced by covering up mistakes, falsifying assessment data, and failing to disclose mistakes also demonstrate unsafe and failing behaviors (Killam et al., 2010b). Both low levels of confidence and over-confidence have been found to be attributes of unsafe students, as the student with low confidence does not trust their own knowledge enough to act, while the over-confident student misses cues and may practice beyond their scope (Killam et al., 2010a; Scanlan & Chernomas, 2016). Finally, unsafe practice may occur when students lack insight and self-awareness into their own practice, and thus cannot use feedback to improve their practice (Killam et al., 2010a; Scanlan & Chernomas, 2016). Deficits in affective domains of practice demonstrate unprofessionalism and interfere with providing safe care.

Psychomotor. Psychomotor practice concerns include poor organizational skills and time-management skills in practice, and poor preparation for practice that is not improved despite feedback (Lewallen & DeBrew, 2012; Scanlan & Chernomas, 2016). Students who cannot demonstrate satisfactory documentation skills jeopardize patient safety, as do students with poor motor skills and incompetent math skills that repeatedly constitute error (Craven, 2015; Killam et al., 2010a; Lewallen & DeBrew, 2012). Though a single incidence of incompetence is of concern, it is repeated errors or inconsistency in practice that are particularly dangerous in the clinical setting (Duffy, 2013; Killam et al., 2010a).

The affective, psychomotor, and cognitive deficits in clinical practice must be considered with the year of study and timing in the clinical semester, as well as by examining the pattern and frequency of concerns and the level of risk for the patients, peers, or the clinical agency (Killam et al., 2010a). Students found to be unsuccessful in clinical settings are often noted to have a pattern of behavior and poor work that does not improve (El Hussein & Fast, 2020; Lewallen & DeBrew, 2012).

Faculty Experiences

Nursing faculty members have identified their role in supervising clinical practice as that as a gatekeeper, as a line of defense to ultimately protect patient safety (Hughes et al., 2016; Hunt et al., 2016; Stoker, 2016). Educators have a responsibility to ensure that patient safety is not jeopardized by supporting learning opportunities for student nurses, while being equally responsible in putting safe student nurses into practice (CNA, 2017; Stoker, 2016). In order to develop a process to support students in clinical practice, it is

important to describe the faculty experience both in working with failing students, and in failing to fail.

Faculty Experiences of Working with Failing Students

The experience of working with students who demonstrate failing characteristics in clinical has been explored extensively using qualitative methods. Working with students who have failing characteristics or who are underperforming in the clinical setting has been reported to be challenging for a variety of reasons over the last decade, yet identifying and managing such students remain an area of continued study (Elliot, 2016). Faculty report working with underperforming or unsafe students to be an emotionally challenging and time-consuming process (Bearman et al., 2012; Cassidy et al., 2017; Duffy, 2013; Elliot, 2016; MacLeod, 2015; Stoker, 2016). Conservative estimates identify that having a student who is struggling to meet clinical expectations, or who demonstrates unsafe practice to double the workload of the clinical instructor (Duffy, 2013).

Concerns with nursing student practice is often noted early in the term, with clinical instructors identifying that students with unsafe characteristics are readily seen as performing differently from the other clinical students (MacLeod, 2015). Clinical instructors may identify the presence of red flags or a gut feeling that a student is on track to being unsuccessful (El Hussein & Fast, 2020). When such concerns arise, clinical instructors weigh the risks and benefits of assigning a failing grade, which contributes to the emotional toll of working with underperforming students (MacLeod, 2015; Stoker, 2016). Educators may question their own abilities and see the students' lack of success a

result of their own deficiencies and may feel guilty as a result (Laroque & Luhanga, 2013; Pritchard & Ward-Smith, 2017; Stoker, 2016). A literature review conducted by Elliot (2016) noted that there is a preference to provide positive reinforcement as it is easier to provide, and students are more receptive to positive feedback than constructive. Student responses to feedback around failing characteristics can vary, and may range from devastation to incivility, outrage and anger, adding to the emotional load carried by clinical instructors (Hughes et al., 2016).

Lastly, when clinical instructors recognize that students are at risk of failure, there comes added stress as the instructor begins to gather evidence supporting student failure (MacLeod, 2015; McGregor, 2007, Pritchard & Ward-Smith, 2017). One researcher used the term "thereness" to describe this phenomenon (MacLeod, 2015). The notion of thereness, wherein the clinical instructor is gathering evidence of failure while still attempting to support student success is reported to be challenging (MacLeod, 2015). Instructors' emotional resilience is compromised when they are being encouraging to a student, while knowing the outcome is likely failure (Cassidy et al., 2017; McGregor, 2007). When nursing faculty work with students who have unsafe or underperforming characteristics, there is significant time and emotional demands. It is important that protocols and processes in place recognize, reflect, and are responsive to the experiences and demands on faculty.

Failing to Fail

The definition of "failing to fail" includes the allocation of passing grades to nursing students who do not meet the necessary satisfactory practice threshold (Hughes et

al., 2016). Evidence of failing to fail first emerged in the 2000's and the concept of failing to fail in nursing has been researched extensively, especially in the last five years (Laroque & Luhanga, 2013). One study found that though 88% of clinical instructors felt confident in their abilities to identify and determine practice competence, 66% had worked with a student who should not have passed their previous clinical experience (Docherty & Dieckmann, 2015). When students are not appropriately assigned failing grades, faculty members are doing harm to the student and to the profession (Hughes et al., 2019; Laroque & Luhanga, 2013). Students who carry on into later clinical courses, or into practice, without necessary clinical skills or knowledge will continue to be unsafe. The nursing profession cannot address failing to fail without first understanding the factors that contribute to the reluctance of clinical instructors to assign failing grades (Hughes et al., 2019; Prichard & Ward-Smith, 2017). In the literature focused on failing to fail, institutional factors, student factors, and educator factors influence the appropriate assignment of failing grades. Understanding and addressing failing to fail is necessary to ensure the continued integrity of both individual schools of nursing, but more importantly to the profession as a whole.

Institutional factors. The identified institutional factors that impede the appropriate assignment of failing grades include issues with subjective assessment tools, and fear of appeal processes.

The subjectivity of clinical assessment is problematic in assigning failing grades appropriately to failing students. Faculty can generally identify students at risk of failure, seeing red flags early and readily, but often competency frameworks and clinical

assessment tools fail to accommodate the variety of affective and cognitive behaviors that make for unsafe practice (Cassidy et al., 2017; Elliot, 2016; MacLeod, 2015). Additionally, clinical assessment is admittedly a subjective experience, and competence assessment documents can be open to interpretation (Cassidy et al., 2017; Hall, 2013; Hughes et al., 2016). Clinical instructors can be swayed to assign passing grades by viewing positive aspects of students' performance on a competency list, without considering the wider skills, behaviors and attitudes needed for safe, competent practice (Cassidy et al., 2017). Concerns with clinical practice that are attitudinal in nature may not align with assessment criteria, especially if assessment criteria are built around psychomotor and cognitive aspects of practice (Elliot, 2016; Elliot, 2017; Heaslip & Scammell, 2012). Faculty members are less prepared to assign failing grades for concerns other than psychomotor skills, with less than 50% of assessors surveyed believing a failing grade can be assigned based on affective and attitude concerns alone (Hughes et al., 2019). The subjective nature of clinical assessment, combined with clinical assessment documents that may not consider the affective domains of successful clinical practice may impede the appropriate assignment of a failing grade.

When a failing grade is assigned, students have a right for due process, which may include a formal appeal of the grade. Appeals processes vary significantly between postsecondary institutions, however universally the process includes hearing the perspectives of the nursing faculty member and the student within a panel, often including non-nursing faculty. The increased workload associated with preparing and compiling evidence of failing characteristics is a deterrent to assigning failing grades

(Duffy, 2013; Hughes et al., 2019; Laroque & Luhanga, 2013). Nursing instructors need to ensure that they have sufficient evidence of failing characteristics, and that their assignment of a failing grade will stand up to scrutiny. College and university policies may lead to fears of failing grades being overturned, which some faculty see as a deterrent to assigning a failing grade (Hunt et al., 2016). When institutions do override decisions to assign a failing grade, there may be subsequent reluctance to fail future underperforming or unsafe students (Hunt et al., 2016). As such, the desire to avoid an appeal may lead to reluctance to assign failing grades when warranted (Docherty & Dieckmann, 2015; Hughes et al., 2019; Laroque & Luhanga, 2013). There is also fear of litigation beyond the appeal level as well, as nursing faculty may fear being sued or accused of harassment or discrimination (Boley & Whitney, 2003; Chasens et al., 2000; Smith et al., 2001)

Student factors. Nursing students are typically accustomed to success, and many enter the nursing program with little experience with failure (Jakubec et al., 2020; Killam et al., 2010a). It is also important to reiterate that students with failing characteristics often lack insight into their own deficiencies (Duffy, 2013; Gallant et al., 2006). Researchers have identified that when confronted with feedback about failing characteristics, student responses may be less than positive (Hughes et al., 2019; Hunt et al., 2016). Student reactions to failing clinical grades have been found to evoke fear, as students may react angrily and aggressively (Hunt et al., 2016). Students may react to feedback about failing characteristics by displaying manipulation, coercion, and intimidation (Hughes et al., 2016; Hughes et al., 2019; Hunt et al., 2016). These

responses may in part be due to the notion that patient safety was prioritized over their own learning opportunities (Hunt et al., 2016). Such student responses may further deter clinical instructors in providing failing grades in the clinical setting.

Educator factors. There are multiple factors that may impede a nursing faculty member in assigning a failing grade appropriately. It is important to identify that assigning failing grades may not feel consistent with caring nursing values, as failing a student can be seen as an uncaring practice (Duffy, 2013; Hunt et al., 2016). Beyond a perceived incongruence of educator responsibilities and nursing value and ethics, nursing educator factors that may impact assigning failing grades include giving students the benefit of the doubt and perceived lack of support in the process.

Giving students the benefit of the doubt is one recurrent theme in nursing literature specific to failing to fail. Giving students the benefit of the doubt is less likely when there are overtly or clearly unsafe practice, such as if a student makes a series of medication errors (Laroque et al., 2013). However, for borderline or underperforming students, giving the benefit of the doubt is a common reaction, especially when students attempt to show remorse or make effort toward improving their practice (Duffy, 2013; Elliot, 2016; Laroque & Luhanga, 2013). Despite the efforts put forth by the students still not meeting course expectations, faculty may feel that because the issue was raised, students will self-identify deficits and continue to address these on their own, and in their own time (Duffy, 2013). Nursing faculty members may also give students the benefit of the doubt if the concerns in practice were not addressed early in the clinical term (Hunt et al., 2016). Passing grades may be awarded inappropriately if clinical instructors have felt

as if they had not spent sufficient time with the student over the term, which may be more common in clinical courses with a community component, or in final preceptorship models (Elliot, 2016; Elliot, 2017). Clinical instructors may also award passing grades inappropriately if a particular student has not received a failing grade previously, while instructors have identified they would be less likely to give underperforming students the benefit of the doubt had they known of the student's history with similar characteristics (Duffy, 2013; Pritchard & Ward-Smith, 2017). Docherty and Dieckmann's (2015) descriptive study found over 70% of nursing instructors had, at one point, given an underperforming student the benefit of the doubt and inappropriately awarded a passing grade.

If clinical instructors feel that they are not supported in awarding failing grades, they may be less inclined to do so (Laroque & Luhanga, 2013; Stoker, 2016). Support needs to be both academic, as well as emotional (Laroque & Luhanga, 2013). This is especially true for part-time or inexperienced faculty (Elliot, 2016). Inexperience as a clinical educator or inexperience in having unsafe or underperforming students contributes to failure to fail, as instructors doubt and question the legitimacy of their assessment (Duffy, 2013). Schools of nursing can support clinical instructors in failing a student appropriately by not overturning grading, by providing mentoring and having an environment of openness in discussing student performance (Duffy, 2013; Hunt et al., 2016; Laroque & Luhanga, 2013; Stoker, 2016). It is vital that policy and processes related to unsafe or underperforming nursing students take into account the faculty experiences and factors that play into failing to fail in order to be applied effectively.

Processes Relating to Student Performance

Though there are ample anecdotal resources detailing how nursing programs have worked with unsafe or underperforming students, there is a paucity of research that evaluates the efficacy of current practice. Exploration of current literature has identified that there are three mechanisms to implement when working with nursing students to support success: clear expectations, early recognition and feedback, and student remediation.

Clear Expectations

Several resources note the importance of establishing clear expectations at the outset of a clinical course, though none have studied the impact on providing clear expectations on student performance. One Canadian institution published their processes and guidelines related to unsafe clinical practice, developed from consultations with staff and students, and reported that clear guidelines fostered a shared understanding about clinical safety (Brown et al., 2007). Luhanga, Yonge, and Myrick (2008) found through phenomenological research that unsafe and underperforming students might be prevented when there are clear definitions, policies, and expectations for faculty and students. A small qualitative study of clinical evaluation processes recommended that clinical orientation includes discussion of the cognitive, affective, and psychomotor expectations expected in the clinical setting (Lewallen & DeBrew, 2012). It would benefit clinical instructors to be explicit about expectations of clinical preparation, and describe how students can effectively prepare for clinical learning (Lewallen & DeBrew, 2012). Chunta (2016) recommended descriptions of unsafe practice and underperformance in course

syllabi, as well as having students sign a document that they understand the expectations and are aware of possible repercussions if expectations are not met. Overall, the evidence for being transparent with clinical expectations is limited to credible qualitative reports and anecdotal records. Though the evidence for having clear expectations is not strong, when considered in light of the overall subjective nature of clinical assessment and the literature related to failure to fail, it is plausible to contend that clear and explicit expectations are needed when working with clinical students.

Early Recognition and Feedback

One common theme noted in the literature was that of the importance of early recognition and feedback when working with underperforming or unsafe student practice. Additionally, many resources detail the use of learning contracts or performance plans as a feedback and accountability tool once underperformance is identified in a clinical setting.

Early Identification. The importance of early identification of concerns cannot be overstated. Though concerning medical students, one review found that approximately 10-15% of students will struggle in the clinical setting, but only 2-6% of those students will self-identify (Boileau et al., 2017). Overwhelmingly, phenomenological studies specific to nursing students advocated for the early identification and labelling of unsafe or underperforming characteristics, and some studies noted this should happen in the first two to three weeks of the course (Craven, 2015; Duffy, 2013; El Hussein & Fast, 2020; Luhanga et al., 2008; Luhanga et al., 2014; MacLeod, 2015). Similar recommendations existed in other practical learning professions, including physiotherapy and medicine

(Bearman et al., 2012; Boileau et al., 2017; Chou et al., 2019). Concerns with clinical practice may be identified through direct observation, monitoring of practice, and feedback from patients, peers, and other practicing nurses (Luhanga et al., 2008). Once concerns are identified by clinical instructors, faculty recommend spending extra time with at-risk students, including increasing the time spent at the start of the shift to check their preparation, as well as more time in debriefing at the end of the shift (Craven, 2015). In this process of early identification, researchers identified that clinical instructors need to consider if this is a single incidence, or indicative of a pattern, even if the pattern is "consistently inconsistent" (El Hussein & Fast, 2020, p. 80; Luhanga et al., 2008). Based on the experiences of clinical instructors, it may be helpful to verify one's own perceptions of student practice with others, and having an objective instructor observe student performance (Craven, 2015; Luhanga et al., 2008).

Feedback. Feedback was identified as a necessary step when working with students who display unsafe, unsatisfactory, or underperforming characteristics. Nursing programs should aim to foster a culture of feedback, including feedback training for faculty (Chou et al., 2019). When concerns are identified in student practice, clinical instructors should be prepared to offer high-quality feedback, including strategies to improve what students have done poorly (Boileau et al., 2017; Luhanga et al., 2008; MacLeod, 2015). Feedback should be delivered in a private setting where possible, and preferably away from the clinical setting (Chunta, 2016; Teeter, 2005). Verbal feedback should be paired with written feedback and documented by the clinical instructor, including the student response to feedback (Cassidy et al., 2017; Chunta, 2016; Luhanga

et al., 2008). Concerns need to be communicated to the student clearly, and in a timely manner, in order for the student time to reflect and improve (Chunta, 2016; Luhanga et al., 2008; MacLeod, 2015). Should student performance demonstrate minimal change despite specific feedback, instructors may need to be prepared to initiate a formal performance contract (Chunta, 2016; Teeter, 2005)

Learning contracts

Learning contracts were commonly cited within clinical literature, though their use was not well documented prior to 1986 (Barrington, 2009). Learning contracts, sometimes called performance plans or action plans, are thought to evoke change in behaviors, improve motivation, and encourage student self-efficacy (Barrington, 2009; Frank & Scharff, 2013). The use of learning contracts aligns with adult learning principles, including incorporating motivation and self-efficacy (Frank & Scharff, 2013). Learning contracts serve as a feedback tool, while also ensuring due process for students who are struggling to meet clinical outcomes (Chunta, 2016; Frank & Scharff, 2013; Kosta, 2012; Luhanga et al., 2014; Zuzelo, 2000). However, current recommendations about learning contract use in nursing education are based on phenomenological studies and literature reviews.

A learning contract should be set up jointly between the clinical instructor and the student, and identify the concerning characteristics or actions, as well as the course objectives at risk of not being met if underperformance or unsafe practice is not addressed (Brown et al., 2007; Craven, 2015; Chunta, 2016; Gallant et al., 2006; Kosta, 2012; Luhanga et al., 2014; Teeter, 2005). A learning contract should clearly identify the

consequences to course progression, such as removal from the clinical setting, or receiving a failing grade, should the student breach the contents of the contract (Brown et al., 2007; Chunta, 2016; Gallant et al., 2006). It is recommended that learning contracts detail the steps needed to be taken by the student to meet expectations, as well as a timeframe for completion (Brown et al., 2007; Chunta, 2016; Craven, 2015; Luhanga et al., 2014; Teeter, 2015; Zuzelo, 2000). Lastly, when a student agrees to the terms of the learning contract, clinical instructors and students should plan to meet more frequently, in order to facilitate continued communication and feedback, as well as provide a mechanism for students to ask for specific help (Brown et al., 2007; Duffy, 2013; Gallant et al., 2006). It is important to frame the learning contract as a tool for student success, and not a punitive action for the student (Teeter, 2005; Zuzelo, 2000).

Few studies have evaluated the efficacy of learning contracts empirically, and this is especially true in the nursing discipline. Gallant, MacDonald, and Smith Higuci (2006) presented a case study of using learning contracts for nursing students at risk of failing in three schools of nursing in Canada. There was anecdotal feedback from faculty and administrators that the use of a standardized learning contract provided clear descriptions of what students needed to address to successfully meet course outcomes, and was well received by faculty members (Gallant et al., 2006). In this descriptive report, faculty noted that the learning contract process was time consuming, and was of limited use when clinical students did not have insight into deficiencies in their own practice (Gallant et al., 2006). Similar findings emerged in Hadenfelt's (2012) retrospective study, comparing outcomes in nursing students prior to and following implementation of

learning contracts when students were at risk of failure. Findings of this study indicated that students who were retained because of fulfilling learning contracts were capable of program completion, but that when contracts were initiated for affective and attitudinal concerns only a third of students were able to complete (Hadenfelt, 2012). Though this small, retrospective study was not empirically strong, the author recommended that learning contracts were effective, however faculty support and familiarity with the process was recommended (Hadenfelt, 2012).

Researchers in medical education too, have sought to identify the efficacy of learning contracts. Two literature reviews published in medical education journals identified learning contracts as common practice and recommended their use for students identified as underperforming or unsafe (Boileau et al., 2017; Chou et al., 2019). Physiotherapist students in clinical practice have also been an area of study. Bearman, Molloy, Ajjawi, and Keating (2012) sought to identify physiotherapy clinical instructors experiences with underperforming students, and found learning contracts helped to shift the responsibility of learning back to the student, though many underperforming students lacked the insight to comply with learning contracts. One empirical study explored the use of learning contracts in engineering courses (Frank & Scharff, 2013). Students were either part of a control, non-contract, group, or in the experimental group wherein learning contracts were initiated upon the first instance of underperformance (Frank & Scharff, 2013). There was overall grade improvement for students who were placed on a learning contract; however, this increase was not statistically significant (Frank & Scharff, 2013). Despite the lack of statistical significance, a modest grade improvement

came at a low cost and potentially solidified the commitment between intention and deliberate action for students (Frank & Scharff, 2013).

Student Remediation and Future Planning

Remediation is defined as offering additional instruction, beyond the planned curriculum, to meet individual learners' needs when the student is unlikely to meet the expectations of the course (Boileau et al., 2017). There are no standardized remediation processes, nor any empirical evidence supporting remedial strategies used when students are at risk of failure (Boileau et al., 2017; Craven, 2015; Custer, 2106). However, many educators identified remediation as a necessary component to student learning contracts (Custer, 2016). When a clinical instructor identifies a student does not have a solid grasp of foundational material, such as physiology, or when underperforming or unsafe characteristics are noted, remedial activities should be instituted alongside a clear learning contract (Custer, 2016; Gallant et al., 2006). However, far too often, remediation in nursing programs occurs after the failing grade has been given (Bearman et al., 2012). It has been reported in the extant literature that faculty members often lack the knowledge on effective remediation strategies, and may place more emphasis on the failing attributes than remediation (Chunta, 2016; Custer, 2016). Additionally, remedial activities contribute to an increased workload for a faculty member (Chunta, 2016; Gallant et al., 2006). This may lead to faculty members doing more of the same—more observation, more feedback, but little in the way of structured support or targeted learning activities (Bearman et al., 2012). Unfortunately, giving more of the same perpetuates the idea that

the instructor is the driver of the learning, and does not facilitate student self-awareness or insight (Bearman et al., 2012).

As there is a current lack of empirical evidence to support various remediation strategies, clinical instructors may use a number of learning resources, activities, and supports with varying levels of success. Within the qualitative studies to understand the experiences of nursing instructors working with students who are unsafe or underperforming, remedial activities were not clearly delineated. Clinical instructors identified using institutional resources as remediation, including tutoring, student study groups, advising, and counselling (Craven, 2015; Gallant et al., 2006). While others reported using in-program supports, such as additional skills lab time (Brown et al., 2007; Craven, 2015; Luhanga et al., 2008; MacLeod, 2015). Only one phenomenological study had participants identify simulation lab time as a remedial activity (Craven, 2015), though this was a common theme within resources for nursing educators (Chunta, 2016; Custer, 2015). Finally, clinical instructors reported taking on the work of remediation themselves by reviewing student preparation, reviewing student care plans, additional coaching, and one-to-one instruction (Brown et al., 2007). While others reported using questioning skills, reviewing and interpreting clinical data together, role-playing, and modifying patient assignments to lower acuity patients, or patients with a similar patient profile as the student has had previously (Craven, 2015; Luhanga et al., 2008). Remedial activities vary between clinical instructors, with little empirical data to support any particular interventions when working with underperforming or unsafe students.

Planning for Future Practice

Whether a student can achieve success while on a learning contract with remediation, or not, there needs to be considerations made for subsequent clinical courses. It is important for students to leave a clinical term, where there was evidence of underperformance of unsafe practice, with a plan for success to carry forward, especially if they received a failing grade (Teeter, 2005). A fragmented approach to clinical learning, where there is a lack of transparency of learners' previous challenges limits early identification of underperformance, and contributes to clinical instructors unduly giving students the benefit of the doubt (Bearman et al., 2012; Chou et al., 2019). As underperforming or unsafe students often lack insight, they often do not disclose previous challenges in clinical settings, or may place the responsibility of their struggles squarely on previous clinical instructors (Bearman et al., 2012). For many learners, underperformance and unsafe practice is a pattern over time, rather than an isolated finding (Bearman et al., 2012; Chou et al., 2019). An overall lack of continuity of relevant learner information hinders the ability of clinical instructors to implement remedial activities that may have previously supported student success (Brown et al., 2007; Chou et al., 2019). The process of learner handover is recommended for students who have been unsuccessful in a clinical setting, or who have been awarded a minimally passing grade after use of a learning contract and remedial activities (Bearman et al., 2012; Brown et al., 2007; Chou et al., 2019). As this process may be viewed as breaching privacy rules, the process of learner handover needs to be made transparent to students, and conducted using a formal mechanism (Bearman et al., 2012; Brown et al., 2007).

Theoretical Framework

Theory is integral within the research process, and a determinant framework identifies potential factors that influence success of implementation of research (Nilsen, 2015). When identifying factors that affect the efficacy of processes and activities used by clinical instructors when working with underperforming or unsafe clinical students, Deci and Ryan's (2008) self-determination theory, and Knowles' theory of andragogy (1984) compose an appropriate theoretical framework.

Knowles' Theory of Andragogy

Malcolm Knowles' theory of Andragogy (1984) recognizes the necessity to use adult-centered learning approaches in working with postsecondary students, as adults learners have fundamental differences compared to children. The assumptions Knowles put forward about adult learners are applicable to children and youth as they mature, making this theory appropriate to apply to nursing students (Knowles, 1984).

There are five assumptions within the theory of andragogy that inform adult learning, including self-concept, the role of experience, readiness to learn, orientation to learning, and motivation to learn (Knowles, 1984).

- Self-concept, described as moving from dependency to self-directedness is thought to denote adulthood (Knowles, 1984). Students who have begun professional schooling, including nursing students, see themselves as self-directed, and expect to be treated as such (Knowles, 1984). Knowles (1984) identified when students are not able to be self-directing they experience tension.

- Experience accumulates as an individual matures, and adult-learners have a reservoir of experience to build new learning upon (Knowles, 1984).
- Readiness to learn is an assumed a product of need and choice, whereby adult-learners require learning experiences that are relevant and applicable to individual roles (Knowles, 1984).
- Orientation to learning for adult learners includes the need for immediacy of application and a problem based approach (Knowles, 1984).
- Motivation moves from external motivation in pedagogy, to that of internal motivation for adult learners (Knowles, 1984). Internal motivators include performing in order to achieve satisfaction, self-esteem, curiosity, and control (Knowles, 1984).

The five assumptions that underpin andragogic approaches to learning inform the six principles of adult learning that (a) adult learners need to know why they are learning, (b) that they are independent and accountable for their actions, (c) they have previous experience to build new knowledge upon, (d) their readiness to learn impact the learning process, (e) they need learning to be orientated to their needs, and (f) they are motivated to learn by intrinsic motivation (Knowles, 1984).

Nursing students are seen as largely adult-learners, thus Knowles' theory aligns with nursing school curricula. It is expected that learners entering into nursing programs have some degree of self-directedness, due to their growth and developmental stage (O'Shea, 2003). Though this assertion may not be true of all learners, the assumption of the theory of andragogy fits when considered in context of clinical instruction (Gallant et

al., 2006; Knowles, 1984; O'Shea, 2003). The use of learning contracts allows students to learn in the context of their previous experiences and clarifies the orientation and relevance of knowledge into their practice (Barrington & Sweet, 2009). Learning contracts support student self-directedness and assist students in taking charge of their own learning and success (Frank & Scharff, 2013). Remediation processes too, align with the principles and assumptions of the theory of andragogy, as the student at risk of clinical failure is respected as an autonomous individual capable of managing learning situations (Gallant et al., 2006). An individually created learning contract, with remediation strategies attached, makes the expectations of the clinical course relevant to the students immediate challenges, the learning is context specific and immediately applicable (Gallant et al., 2006). The processes used by nursing faculty to address underperforming or unsafe students, identified in the literature as including feedback, learning contracts, and remedial activities, align well with Knowles' theory of andragogy. Further development of processes to support faculty when working with students at risk of clinical failure would benefit from inclusion of the assumptions and principles of Knowles' (1984) theory of andragogy.

Self-Determination Theory

Self-determination theory is a theory of human motivation, and addresses individual's self-regulation, goals, affect, and behavior (Deci & Ryan, 2008). Developed in the 1980's, Edward Deci and Richard Ryan's self-determination theory has been studied substantially in applied fields, including nursing (Deci & Ryan, 2008; Messineo et al., 2019). The central tenet of the theory is the distinction in motivation, including

autonomous and controlled motivation (Deci & Ryan, 2008). Autonomous motivation is inclusive of intrinsic motivation and the components of extrinsic motivation that has been ingrained in their sense of self (Deci & Ryan, 2008). When people are autonomously motivated, they pursue a goal because of the inherent satisfaction of achievement (Deci & Ryan, 2008; Messineo et al., 2019). Autonomously motivated individuals choose meaningful activities to take part in which will allow them to use their skills and competence (Deci & Ryan, 2008; Messineo et al., 2019). Controlled motivation, by contrast, consists primarily of external motivation and introjected regulation (Deci & Ryan, 2008). Both external and introjected regulation refer to motivation that is derived from outside forces, such as achieving rewards or avoiding negative consequences (Deci & Ryan, 2008; Messineo et al., 2019). Deci and Ryan's (2008) theory postulates that motivation runs on a continuum, and includes amotivation, whereby individuals are neither extrinsically nor intrinsically motivated.

Student motivation has an impact on study behaviors, which in turn affects academic performance (Deci & Ryan, 2008). Autonomously motivated students are generally more likely to achieve learning outcomes and success than their counterparts who have controlled motivation (Deci & Ryan, 2008; Messineo et al., 2019). Additionally, autonomously motivated learners are associated with long-term persistence, grit, and greater psychological health, all attributes that are necessary in the discipline of nursing (Deci & Ryan, 2008). Autonomous motivation is also linked to deeper learning and the ability to accurately self-reflect (Messineo et al., 2019). In short, it is

advantageous for learners, including nursing students, to possess autonomous motivation, especially when evaluative measures are made clear (Kosta, 2012).

Self-determination theory also identifies three fundamental psychological needs that need to be satisfied in order to achieve autonomous motivation: the need for autonomy, competence, and relatedness (Deci & Ryan, 2008; Orsini et al., 2015). Autonomy includes making decisions based on free will, needs, and desires (Deci & Ryan, 2008). The need for competence refers to the ability to feel capable and to taking on challenges, while relatedness refers to the ability to achieve connection and a sense of belonging with others (Deci & Ryan, 2008; Orsini et al., 2015). The clinical setting, with nursing students working with peers, is an ideal environment to foster the needs that are a precursor to autonomous motivation (Orsini et al., 2015). It is suggested that by fostering autonomy, competence, and relatedness in the clinical setting, students will be more accountable to their learning (Orsini et al., 2015).

In a systematic review, Orsini et al. (2015) identified how clinical instructors can encourage autonomy, competence, and relatedness. In order to support autonomy, instructors can provide choice, identify what students want, and give the learner responsibility (Orsini et al., 2015). Supporting competence can be achieved through providing the right amount of challenge, providing feedback—both constructive and positive, and providing guidance (Orsini et al., 2015). Lastly, they found that relatedness could be enhanced by clinical instructors providing respect and building rapport with students (Orsini et al., 2015).

When compared to processes currently used by clinical instructors when working with underperforming and unsafe clinical students, self-determination theory supports the use of feedback, learning contracts, and remedial activities to develop competence. Moreover, the use of learning contracts may support the prerequisite needs to achieving autonomous motivation through the ongoing connection with the instructor, frequent feedback mechanisms and setting clear expectations (Kosta, 2012). Further development of processes for use with underperforming or unsafe clinical students would benefit from integration of autonomy, competence, and relatedness, in order to build students toward a model of autonomous motivation.

Implications and Recommendations

There is a general paucity of empirical evidence to support current practices for nursing faculty working with clinical nursing students at risk of clinical failure. There has been extensive phenomenological exploration of the experiences of faculty when working with unsafe or underperforming students, yet little research has been conducted to evaluate the efficacy of recommended student success strategies in nursing. It may be surmised that an evidence-informed approach to supporting student success needs to incorporate the phenomenological and qualitative literature that exists, including faculty experiences, student experiences, and commonly used strategies. Based upon the available literature, though empirically weak, there appears to be support for the use of learning contracts, remediation strategies in situ, and learner handover for selected at-risk students.

Areas of continued research include empirical and analytical exploration of the efficacy of learning contracts and remediation approaches of nursing instructors. There remain significant gaps in the literature about whether these approaches actually yield passing grades, success in future clinical settings, passing of licensure exams, and safety in practice. As well, there is scant literature that explores students' perceptions and reported usefulness of learning contracts and remedial strategies employed by instructors. Finally, longitudinal studies that seek to ascertain the persistence of underperformance beyond nursing school would be beneficial in better understanding the true scope and consequences of the problem.

Conclusion

Nursing programs have an obligation to the profession of nursing to ensure graduates are well prepared to enter practice in increasingly complex settings. There are multiple factors to consider when working with unsafe or underperforming students, including the student experience, faculty experience, factors that affect appropriate assignment of failing grades, and how best to support student success—both in their current course and in the future. While many descriptive and anecdotal resources describe processes for nursing faculty members to employ, there remain significant deficits in the literature about the empirical efficacy of usually used processes. Relevant theories, including self-determination theory and adult-learning theory support current approaches detailed in the literature including feedback, clear expectations, and learning contracts, and do need to be taken into account when nursing programs investigate or design their own processes for managing the unsafe or unsuccessful student. Though the evidence is

not high-quality, the current approaches identified in the extant literature appears to be sufficient in providing direction to instructors when working with unsafe or underperforming clinical nursing students.

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Appendix A: Literature Summary Tables

Table 1: Qualitative literature summary

Author	Participants/Methods	Results	Comments
Bearman et al., 2012 **Qualitative; Grounded Theory** **Objectives:** To identify physiotherapy clinical educators' experiences when working with underperforming students in the clinical setting. To identify strategies used to support underperforming students	**Setting**: An entry-level physiotherapy program in Australia **Participants:** • Physiotherapy clinical educators affiliated with the University • N = 26 • Recruited via email • All were noted to be experienced **Methods:** Used Strauss and Corbin's Grounded Theory approach Three 60-90 minute focus groups took place, and all were audio-recorded and transcribed. Open coding of the data for themes was independently completed by three of the researchers. A single researcher triangulated the open codes and compared to the transcripts. All researchers discussed and adjusted the analysis. An audit trail was maintained.	Two key themes and multiple subthemes identified Experiences: • Multifaceted role o Competing responsibilities means juggling multiple priorities o Responsible to student, client, and profession • Demanding environment o See themselves as gatekeepers o Heavy workloads and isolation common • Stresses of working with underperforming students o Struggle with unacceptable behaviors and student mental health o Invest significant time and energy and feel responsible Strategies • Diagnosis o Use performance tools, document performance o Lack of transparency of previous placement	**Quality**: **High credibility** **Limitations**: Findings are indicative of one program in Australia and cannot be generalized Pre-existing relationship between 2 researchers and participants which may limited blame shifting to university Lack of student perspective to validate findings

Author	Participants/Methods	Results	Comments
		• More, more, more ○ Use more of the same, more feedback, manage autonomy ○ Spend more time, invest more energy • Lack of focused strategies ○ Some benefit shifting responsibility to student ○ Consider using patient-centred focus	
Craven, 2015 Qualitative; Grounded Theory **Objectives**: To explore how clinical faculty identify, assess, and evaluate underperforming clinical nursing students. To describe how clinical faculty remediate underperforming students and how faculty make decisions about the progression of nursing students	**Setting:** Clinical faculty in a baccalaureate nursing programs across the United States **Participants:** • BScN instructors with > 5 years teaching experience in acute care and/or medical-surgical clinical settings • Recruited through email via educator listserv across multiple institutions, all were self-selected • N = 28; 40-74 years old. 5-42 years of clinical teaching experience • Most were Caucasian, 26/28 were female	3 stages included in final framework from data Being Present • Noticing 'red flags' in students' practice, taking time to validate concerns • Working with students, side by side and greater observation. • Building relationships and connection common Setting a New Course • When underperformance observed, setting up meetings and formal feedback opportunities • Learning contracts or action plans used	**Quality**: **High credibilty** **Limitations**: Inclusion criteria may limit generalizability to students in other practice settings (ie. Community or mental health placements) Lack of student perspective in relation to performance issues

Author	Participants/Methods	Results	Comments
who are underperforming in the clinical area.	**Methods;** Interviews conducted with investigator, and were 30-80 minutes long Semi-structured interviews took place via Skype, all were recorded and data was transcribed. Data analyzed using procedures outlined by Charmaz. Constant comparative methods used for analysis and initial, focused, axial and theoretical coding completed by investigator. Memo writing used by the investigator. Audit trail maintained as well. The final findings were presented to three outside clinicians to validate findings. Six transcripts withheld from initial validation process to compare with final framework to establish resonance.	• Using additional supports, such as dyad teams, other instructors, lab skills • May need more opportunities for mastery, such as in simulation, using concept maps, questioning. • Sometimes students can turn the course around and succeed, but some will be unsuccessful. Being Objective • When success is not likely, many will become more objective to justify failing grade • Documenting problems needed • Consider using outside validation from other faculty members	Recall bias due to retrospective recollection Rich descriptions and attention to rigor make this study highly transferable.

Author	Participants/Methods	Results	Comments
El Husein & Fast, 2019 Qualitative; Grounded Theory Research Question: To explore the indicators and processes that clinical instructors use to place a student on a learning contract.	**Setting**: A baccalaureate nursing program in one university in Western Canada in 2016-2017. **Participants:** • N = 17 clinical instructors from convenience sampling • Following convenience sampling, theoretical sampling used to recruit • Inclusion criteria for instructors who have taught at least 2 years in a Bachelor of Nursing program in acute or medical-surgical units with students OR having supervised more than 5 different clinical groups. **Methods:** Semi-structured interviews conducted with all participants, and were recorded. The primary investigator kept memos of each interview in order to modify the interview guide for the next interview, Glaser's Grounded Theory approach used for analysis.	'Gut Feeling' emerged as key category with three subcategories. Brewing Trouble • Triggered instructor's gut feeling that something is amiss with student • Knowledge gaps, lack of critical thinking created safety concerns • Often lack of insight another trigger for concern Unpacking Thinking • Attempting to discover students' thought process a common evaluative technique • Often multiple areas of concern to unpack (thinking, preparation, professionalism) Benchmarking • Instructors compare student performance with program or year expectations • Deviation from benchmarks and tangential thinking led to tipping point requiring failure	**Quality: Medium credibility** **Limitations:** Recall bias possible due to retrospective data collection Convenience sampling method may increase the chance of bias Participants were known to primary investigator, which may influence participants' responses

Author	Participants/Methods	Results	Comments
	Reported to have met theoretical saturation threshold. Coding data took part in two stages: substantive and theoretical. Analysis took place line by line. Constant comparison methods used in coding. Detailed memo writing used, and audit trail maintained by the primary investigator. Fittingness, relevance, modifiability, and workability criteria addressed to support study's rigor.		
Luhanga et al., 2008 Qualitative; Grounded Theory	**Setting:** Acute care practice settings who had worked with students in the final clinical practicum in Western Canada. **Participants:** • N = 22 preceptors from acute care settings • 20 were female, 2 were male	Three subcategories reported: Strategies for prevention of unsafe practice • Preceptors need to be familiar with course expectations of the level of student • Setting clear expectations important • Consider reviewing student's own expectations	**Quality: Low credibility** **Limitations:** There was not a clear aim or question for the study Authors did not describe recruitment methods, cannot

Author	Participants/Methods	Results	Comments
	• Aged 26 – 62, most prepared at the diploma level. • Included in study if they had previous knowledge and experience in precepting unsafe nursing students. **Method:** Data collected through semi-structured interviews of 20-50 minutes. Researchers consulted guidelines for preceptorship and course outlines. Data analyzed using Glaser & Strauss approach. Constant comparative analysis and three levels of coding employed.	Early identification of unsafe practices • Unsafe practices identified through observation, monitoring of student, feedback from colleagues, and faculty input • When unsafe practice noticed, increased vigilance and observation ensued to protect safety • Verify the presence of patterns in other settings, other courses • Need to document findings Dealing with unsafe practice • Recommended to communicate the problem to the student. • Set up a detailed action plan; provide constructive and honest feedback • Communicate problems to faculty instructors • Increased observation with transition to gradual independence.	accurately assess for possibility of biases Poor description of analysis methods, no discussion of consideration for rigor. Findings are specific to preceptors, and cannot likely be transferred to educators

Author	Participants/Methods	Results	Comments
		• Maintain a high standard of practice	
Luhanga et al., 2014 Qualitative; Grounded Theory **Research Questions:** What are the perceptions of faculty regarding a final-year nursing student who displays unsafe practice in the preceptorship experience? How do faculty contend with the evaluation and follow-up of such a student? What challenges do faculty face in managing a student who displays unsafe practice in the final	**Setting:** Faculty of a BScN program in multiple universities and colleges in eastern Canada between June 2010 and September 2010. **Participants:** • N = 6 • All participants were female; 5 had a MN degree and 1 had a PhD • 22-40 years of nursing experience among participants, but 1.5-25 years of teaching experience • Included in study if able to speak English and taught in a final, preceptorship model clinical course **Method:** Glaser & Strauss grounded theory approach was used Data collected via semi-structured interviews of between 60-90 minutes. Interviews were conducted by a graduate research assistant both face-	Facilitating Student Success emerged as core variable, with 6 categories Recognizing red flags of unsafe practice Strategies for managing unsafe practice • Instructors use communication, feedback, and documentation when unsafe practice reported • Promoting self-reflection by student is key • Learning contracts or plans and remedial support necessary to giving due process and every opportunity for success Evaluation strategies for success • Safety is the critical factor in decision for pass/fail • Variability in evaluative techniques used Decision to fail a student • Decision to fail if a student does not meet performance criteria by end of placement	**Quality: Medium credibility** **Limitations:** Authors did not describe recruitment methods, cannot accurately assess for possibility of biases Very homogenous sample limits ability to transfer findings Recall bias a possibility due to retrospective design.

Author	Participants/Methods	Results	Comments
preceptorship experience?	to-face and over telephone. Interviews were audio-recorded. Researchers reviewed course materials, including course outlines. Reportedly met theoretical saturation threshold via interviews. Audit trail was maintained. Data analyzed using constant comparative methods, and completed independently by the first and second author. Memo writing used. Initially, open coding yielded 150 substantive codes, later collapsed into one core variable with six categories Credibility, fittingness, auditability and confirmability described and addressed by authors.	• Persistent, repetitive, or patter of unsafe behavior following remedial activities lead to failure • Decision to fail is a difficult one, may be pressure to pass Support and guidance for student and preceptor Support and guidance for faculty	

Table 2: Literature Review Summaries

Author	Method	Results	Comments
Boileau et al., 2017 **Narrative Literature Review** **Objective:** To review the evidence that may guide clinical teachers in supervising struggling medical students in practice.	**Method:** • Grant and Booth's approach to review was used. • Medical (Medline, Embase) and Educational (ERIC, Education Source) databases used. **Studies Included:** • 33 studies • Included if they addressed the issue of struggling learners • Search for resources from 1995-2015 • Limited to English or French	**Findings:** Perceptions that students who are struggling is noticed intuitively by instructors, but delays in formal identification common **Recommendations** Subjective: Detecting a problem • Concerns should indicate more observation and documentation, and occur early • Clinical instructors should trust their impressions, as they are reported to be reliable Objective: Gathering and documenting data • Data should come from a variety of resources (direct observation, feedback from others etc) • Benchmarks are useful to document discrepancies with expected performance • Informal meeting should be held Assessment: Making a diagnosis based on data	**Strength:** No Rating **Quality: Weak** **Limitations:** Authors did not describe how they accepted or rejected studies used Transferability of recommendations limited as this was a non-nursing study.

		• Must consider cognitive, affective, and mental health issues • Difficulties in clinical are often interrelated, start with issue having the most impact on clinical performance • When issues are cognitive, clinical judgement/reasoning and insufficient knowledge base should be considered Plan: Planning targeted remediation • Have standardized, clear remediation activities Integrate remedial activities into clinical rotation	
Elliot, 2016 Systematic Literature Review **Objective:** To examine the literature relating to effective management of underperforming nursing students	**Studies Included:** • Sources included in review if they were original research or robust review • Resources from published after 2003 from the UK, USA, Canada, and Australia included • 11 studies reviewed, all of	**Findings:** Early intervention and prompt, effective feedback necessary when working with underperforming students. Factors that impact mentors' failing clinical student includes subjective and unclear nature of assessment, balancing multiple commitments, and student-mentor relationship. Reviewed literature was coherent and convincing. **Recommendations:**	**Strength:** No rating **Quality:** Weak **Limitations:** The review did not consult grey literature. Reviewed evidence was entirely qualitative in nature The role of mentors does not translate into Canadian nursing education context, which may impede transferability.

	which were qualitative in design **Method:** Searches within the British Nursing Index, CINAHL for 129 total papers Of the initial 129, only 11 selected due to relevance to search terms and research question	Ensure there are clearly defined roles, including clear boundaries in the mentor-student relationship. Improve mentor confidence through appropriate supports, clear assessment criteria, and a positive student-mentor relationship. Focus on communication, feedback, documentation of concerns, and early identification of underperformance.	

Table 3: Quantitative Literature Summaries

Author	Methods	Results	Comments
Frank & Scharff, 2013 **NRCT** **Objective:** To study the effect of individualized, voluntary learning contacts (LC) for student who performed poorly in the first semester of engineering courses.	**Setting:** Four classes across 3 courses in undergraduate engineering courses in the United States Air Force Academy in 2011. **Participants:** • Each participating instructor (4) divided their students into experimental and control groups • If an instructor taught 2 sections of the same course, one was	**Results:** • Hypothesis I *Signing a contract would increase self-reported learning behavoirs* ○ Students on LC reported completing more of assigned work than those not on LC (p=.06) ○ LC students reported higher prioritization of course work than not on LC (p<.0001). • Hypothesis II	**Design: Moderate** **Quality: Low** **Conclusions:** LC demonstrated more self-motivating behaviors and were more willing to seek help LC showed grade improvement at 74% confidence interval. LC as a low-cost intervention demonstrated positive shift in learning-related behaviors

Author	Methods	Results	Comments
	control, the other experimental • N = 204, with 26 students offered a contract • *n* = 18 who signed a learning contract • Students in 1st, 2nd, and 3rd year engineering classes included **Method:** • All 204 students completed in-class feedback form to anonymously self-report learning behaviors (reading, completing assignments, attending office hours) • All students completed in-class feedback form at start of term, at mid-point, and end of semester. • Mid-point and end questionnaire also	*Students who signed a learning contract would attend office hours more than those who did not* Students on LC met with instructors more frequently (4.5 sessions/term) than not on LC (<1 session/term) • Hypothesis III *Students who signed a learning contract would show greater improvement in the course than those that did not* LC students saw avg. of +7.2% points, low performing control group +2.4% points. ANOVA of groups found significant effect ($p<.0001$). • Hypothesis IV *Those that declined a learning contract would show least amount of improvement in the course* No difference found.	LC thought to solidify commitment between intention and action. **Limitations:** Not all instructors administered the contracts in the same way, jeopardizing internal validity. Self-reported data vulnerable to social desirability bias Program demographics were not described, unlikely transferability to nursing programs. No description of ethical process used, insufficient details of ethical conduct.

Author	Methods	Results	Comments
	asked students to identify if they had been offered a LC • Contracts were offered to students in experimental groups if their course average was less than threshold of 75% after first exam • Instructors met with students at LC threshold to develop individualized contract (strategies included tutoring, office hour attendance, complete readings and assignments Students in control groups were not offered contracts.		
Hadenfelt, 2011 **Retrospective cohort** **Objective:** To determine the success of an intervention plan (IP) for nursing students at risk for failure in coursework compared	**Setting:** Practical nurse and associate degree nurse programs within a multi-campus community college in the United States. **Participants:** • N = 384; 95% female and 5% male	Results: • In 2 years there were 118 IP implemented Group A (Prior to IP) 51 students (26%) failed one or more courses 18% involuntarily withdrawn from program	**Design: Strong** **Quality: Medium** **Limitations:** Retrospective data is not immune from confounding variables. May be other factors that affected groups' success.

Author	Methods	Results	Comments
with previous cohorts without IP	• 193 Practical nurse students, 191 associate degree nurse students • Convenience sample accessed via student electronic record **Method:** • Retrospective comparisons conducted in nursing programs of course completion, program completion and NCLEX pass rates between the 2 years prior to IP (group A) and the 2 years following IP initiation (group B). • IP were a 1-page plan completed by faculty to identify objectives not met, resources for remediation, and a student-led plan about learning changes needed to pass course	NCLEX success = 91% <u>Group B</u> (Within IP) 40 students (21%) failed during IP years. 12% involuntarily withdrawn from program NCLEX success = 91% **Recommendations** IP's were effective in reducing involuntary withdraw Need faculty education and support to use IP effectively.	Author noted there was limited ethnic diversity, this limits generalizability to more diverse programs Not all students who failed a clinical course were placed on an IP.

Author	Methods	Results	Comments
	IP's initiated when exam scores less than 76% threshold, when deficiencies in clinical practice, or when behavioral concerns (tardiness/absences, unprofessional)		

Appendix B

Consultation Report

Consultation Report: Developing a Student Success Protocol for Undergraduate Nursing Students

Maggie L. Convey

Memorial University of Newfoundland

Consultation Report: Developing a Student Success Protocol for Undergraduate Nursing

Nursing student program completion is of particular concern for undergraduate nursing programs. Graduate nurses need to be equipped with the knowledge, skills, and attitudes to work in highly complex environments, and the responsibility of readying students lies squarely with educational institutions. Attrition within nursing programs carries many consequences; nursing programs may be viewed as subpar, affecting prospective student recruitment and funding (Craig, 2014). Fewer nursing graduates further compounds the problematic forecasted nursing shortage of 36,000 nurses over the 2019 to 2028 period (Government of Canada, 2017). However, it is necessary to ensure the quality of graduate nurses will meet the needs of the practice environment, and this means that programs have the responsibility of ensuring nursing students meet the appropriate outcomes of a course prior to moving into the next course. Clinical nurse educators are responsible for assessing students' knowledge, skills and, attitudes; and to intervene appropriately if or when a student is at risk of being unsuccessful.

A comprehensive literature review identified that there are many factors that affect a clinical instructors' decision to award a failing grade when students are not meeting course-specific requirements. Moreover, the "failure to fail" phenomenon can be viewed because of clinical educator discomfort in awarding a failing grade, institutional barriers to awarding a failing grade, and fear of the repercussions of assigning a failing grade (Boley & Whitney, 2003; Chasens et al., 2000; Duffy, 2013; Hughes et al., 2019). To assist educators in failing securely, nursing programs need to ensure they use have tools available for early identification of failing behaviors, expectations around student

feedback, and opportunities to support student success (Chunta, 2016; Luhanga et al., 2014; MacLeod, 2015). The use of early feedback mechanisms, learning contracts, and remedial activities are proposed to support student success when there are behaviors that are identified as unsafe or underperforming (Chunta, 2016; Custer. 2016; Luhanga et al., 2014). However, the mechanisms used in nursing programs to identify and assist students who are at risk of clinical failure must adequately address the needs of educators, administrators, and students in order avoid propagating failure to fail. The purpose of these consultations is to assess current practices at other nursing institutions, as well as to describe the contextual needs of the faculty, students, and administrative staff that a newly developed process would effect.

Methods

Sample and Setting

Red Deer College (RDC) is a mid-sized community college offering a four-year collaborative baccalaureate nursing degree program (BScN), as well as a two-year practical nurse (PN) diploma program. Combined, the institution has approximately 480 nursing students in an academic year. Both the practical nurse and BScN include clinical practicums in all years of the program with a final preceptorship clinical prior to the program completion. RDC employs approximately 60 full-time and part-time instructors, and instructors usually teach both theory and clinical courses. Convenience sampling was used to access nursing faculty members and nursing program students, while purposive sampling was used to identify key stakeholders and administrative personnel for the consultation.

Invitations to take part in virtual focus groups were sent to nursing faculty members and to nursing program students. Students were included if they were in years two to four of the baccalaureate program, as students in year one have limited clinical experiences, as well as different clinical assessment opportunities due to a new curriculum. Faculty focus group members could teach in either nursing program, as the processes, policies, and expectations are similar; however, the inclusion criteria included having taught for more than two years and have had worked with students who failed or were at risk of failing. Purposive sampling was used to determine those persons who would have greater interaction with both faculty members and students when failure did occur or was likely to occur. These key stakeholders included the Associate Dean of Nursing Programs and the BScN program chairperson, who are involved when students are at risk of clinical failure, as well as for tracking those students who have previously failed a course. The Faculty Navigators were approached for consultation, as their mandate is to counsel and support clinical instructors about student underperformance or unsafe practice. Finally, the Nursing Lab Instructors is the lead for clinical remediation courses, for which students enroll if they have been unsuccessful in the clinical setting.

Finally, voluntary sampling of other nursing programs in western Canada occurred via email in order to describe current processes and limitations that occur in other institutions. Contextually, the programs in Western Canada were thought to be more similar to that of RDC, than programs in the rest of the country. All consultations were deemed important in generating a well-rounded student success protocol that would meet the needs of faculty members, administrators, and students alike.

Data Collection

Emailed invitations for one-to-one interviews were sent to the Associate Dean, Chairperson, Faculty Navigators, and Nursing Lab Instructor. All individuals responded that they were willing to participate. Semi-structured interviews occurred using the WebEx platform, and for one over telephone. The questions used to introduce the topic and initiate discussion are found in Appendix A. An invitation to participate in virtual focus groups was sent to all faculty members in the RDC nursing programs by an administrative assistant, and ultimately four individuals took part. Experience amongst participants was varied, with participants having four to twenty years of nurse educator experience in clinical settings. All had previous experience with students at risk of clinical failure due to underperformance or unsafe behaviors, and most had assigned a failing grade to at least one student. Neither the focus groups nor interviews were recorded, rather notes were taken throughout, and hand-written notes were transcribed to a Word document, and saved in a password-protected folder, on a secure computer in a locked office.

As an educator in the institution, I have a dual role that required additional consideration in initiating consultation with students. As such, the recruitment email to students was shared via the nursing society social media platforms. Only one student emailed with interest to participate, and in light of this, the singular student was interviewed. Student participation in research regarding clinical failure, involuntary attrition, underperformance and feedback have all been identified as an under-researched population, so it was not a surprise to see little engagement from students.

Emails were sent to program leads, Associate Deans or Chairpersons to 39 institutions with baccalaureate nursing degree programs in western Canada. Emails contained a description of the practicum project, and a fillable document for voluntary completion. A return date of July 25th, 2020 was included in order to have sufficient time to analyze the results. A copy of the fillable form is found in Appendix B. Data was collected via the information returned by other institutions, and these results too were stored in a password-protected folder on a secure computer within a locked office.

Data Analysis

The analysis of data from faculty focus groups and interviews with key stakeholders was an iterative process. Responses to the questions asked was read, re-read, and deductively coded by themes. Similarly, the results obtained from other institutions were analyzed for similarities, both to other institutions, as well as similarities to the data obtained from faculty members and administrators at Red Deer College. Data was too, clustered by theme. Student interview data was read, re-read, and compared to the extant literature.

Ethical Considerations

The ethical principles as outlined by the Tri-Council policy research with human participants were upheld. Each focus group participant and one to one interview received an informed consent letter, detailing the voluntary nature of consent, the ability to withdraw consent without prejudice, and the risks and benefits of participation. Red Deer College Research and Ethics Board approval for the consultations was obtained, and the resultant certificate and informed consent letters are found in Appendix C. The principles

of confidentiality and anonymity were maintained, as no names or identifying statements or stories are presented within the results. Focus group members were asked to ensure the confidentiality of the concurrent members, and all focus group participants were reminded that though confidentiality is not guaranteed in a focus group setting, all reasonable efforts in ensuring confidentiality were taken.

For faculty and administrative participants there were no real risks in participating in consultations. There is only theoretical benefit that participating in the consultation process would support the development of a faculty and student friendly protocol. The role duality that is present when an instructor sets about to research students necessitates additional ethical considerations. The student participant was provided with additional clarification on the role of researcher, including explicit description that participation in consultation would not affect their current or future learning opportunities. There were only theoretical benefits that student participation would assist in developing a student-friendly success protocol. However, if a student participant had previously experienced clinical failure—either directly or indirectly, there is the risk that discussing such experiences may trigger negative emotions. The student was encouraged to remove them self from the consultation process if this occurred and they were directed to on-campus counselling resources.

The consultations with the other institutions were not subject to research and ethics board approval, per the ethical approval checklist in Appendix D deemed this a quality assurance project. I ensured that the emails generated for the additional

institutions originated from my own student email, to distance myself from the RDC institution and my role as faculty member there.

Results

The results of the faculty focus groups and one-to-one meetings with faculty and administrators are presented within the questions asked, as both groups had three of the same questions. Finally, the additional findings of focus groups, student interview, and other institutions are presented by emergent theme.

Question: What is working well within the current processes related to student performance?

Participants identified that there are significant program successes that affect student success in clinical settings. First, participants identified that the current Faculty Navigator program are a successful supportive measure for faculty working with students at risk of clinical failure. Participants identified that the Faculty Navigator (FN) role provides both new and experienced clinical instructors in working with all students based upon sound, evidenced-informed pedagogical practices. Participants also identified that the FN role offers instructors a safe place to talk through student challenges, while providing resources and creative strategies to support student success. The FN program was also reported to validate instructors' concerns and give permission for faculty members to try new teaching approaches.

The environment and culture of the nursing program, too, was felt to be of benefit within the current process. Participants reported that there was increasing openness and willingness to discuss student underperformance and unsafe practice amongst faculty

members and administrators. Within the consultations, it was reported that the nursing programs are felt to be a learner-centered culture, with current processes that "meet the student where they are at", and focuses on evaluating learning. The current process used is felt to be successful by some participants in early detection of student clinical underperformance, though this was not a unanimous sentiment. Some participants articulated that the current process is clear and transparent, and readily available for both faculty members and students to reference. Learning contracts (LC) as a component of current process was reported by some participants to be an effective communication tool to articulate concerns regarding student performance. Finally, when a student is unsuccessful in the clinical setting, participants reported that the formal remediation course is beneficial in helping students identify areas of growth, providing that the student has had time to reflect upon their clinical performance.

Question: What are the challenges of the current process?

Participants identified clear student, faculty member, program, and institutional limitations that act as barriers when working with students who are unsafe or underperforming.

Student factors. Participants unanimously reported that students who were unsafe or underperforming lacked the insight and self-awareness necessary to receive and act on feedback given, and ultimately change their practice. Participants also reported that often students who are risk of being unsuccessful, or have been previously unsuccessful, will have worrisome patterns of behaviors that affect more than one domain of practice, including psychomotor, affective, and cognition. More than one participant identified that

many students will have repeated LC's during their program, due in part to a lack of insight. Participants identified that there are outside factors that affect student receptivity to feedback and coachability, including maturity, culture, and underlying physical and mental health concerns. The aforementioned student factors impede clinical instructors' use of current processes to facilitate student success.

Faculty factors. Participants also identified factors related to faculty members that affect the use and success of current performance protocols. In particular, the ability of a faculty member to offer clear, tangible, and actionable feedback to a student in language that the student can understand remains a limitation. Participants identified that not all instructors are comfortable having conversations with students that clearly identifies the areas of concern, and there is a persistent reluctance to use the word 'fail' in such conversations. One participant noted that articulating underperformance in ways that students could understand is challenging, and may not be intuitive. Further, faculty members are reported to have different abilities and comfort in analyzing performance concerns, and match to appropriate remedial and teaching strategies, which may lead to instructors placing a student on a learning contract without first engaging in teaching strategies to support success. Faculty members are not always confident in their own decision-making, and may doubt the seriousness of the concerns they see in student performance. Some participants spoke about the dichotomy in roles of nurse and educator, and that having an unsuccessful student does not align with the caring values inherent in nursing.

Program factors. Components of the program, namely the current process and the culture of the program were also reported by participants to be a barrier in supporting student success. Though some identified that the culture of the program was one that was open to discussing student concerns, other participants reported there remains a sense of secrecy and mistrust in the department. Participants identified significant limitations specific to the protocol currently in place, with a specific focus on LCs. Some participants felt that the current process was lacking in clarity and transparency, which fosters ambiguity in student's perceptions of underperformance and unsafe practice. When clinical students are placed on a LC, both faculty members and students are reported to see this measure as punitive. One participant noted that the language of a learning contract sounds "legalistic and threatening", and the perception is that the LC is not a tool for support, but a ceremonial component of assigning a failing grade. As many students who are at risk of clinical failure will have deficiencies in multiple aspects of their practice, the use of an LC is a challenge, as "Students will fix one issue, just for another to pop up". The uptake and use of LCs has been variable over recent years, with participants reporting that administrators and leaders in the program influences LC use, and the recent trend is to see more LC in place. The process of developing a LC for a student was reported to be a limitation, as the clinical instructor is required to collect data and proof of student concerns. More than one participant identified the LC process to be time-consuming, both in collecting data of student unsafe practice and underperformance, and then to have the FN review the contract prior to sharing with the student. Finally, the current process was reported by participants to not clearly define, nor give permission

for, direct clinical failure when practice warrants it. One participant stated "Sometimes the performance by the student is so bad, it warrants immediate fail, but the process doesn't always support this". Interview and focus group participants largely agreed on the limitations of the current process in place when a student is at risk of failure.

Institutional factors. Institutional factors, including policy, affect the perceived efficacy of the current process for student at risk of clinical failure. Participants readily discussed the larger institutional body as an impediment in the current process. The participants reported that there is reluctance for instructors to assign a failing grade to students due to the nature of resultant appeals processes. Currently, at RDC, if a student opts to appeal a grade assigned, there is an informal process involving the instructor, student, and Associate Dean, that escalates to an appeal board if the student remains unsatisfied. The appeal board consists of three staff members of the college-at-large and two students-at-large; no nurses or nursing instructors are a part of an appeal hearing for the nursing department. Participants reported that nursing instructors involved in a formal appeal with a student must teach the board about nursing as a profession, and the importance of the expectations of the program, as well as proving that the grade assigned was warranted. As one participant stated, "If I am trusted by the college to evaluate success, why am I not trusted enough to evaluate failure?" Many participants reported that the larger institutional processes, including appeals, are based on mistrust. Participants noted that faculty members avoid assigning a failing grade, even when well warranted, because the appeals process is long, time-consuming, and stressful, and is not guaranteed to even end with a decision from appeal. Two of the participants referenced

recent cases wherein students, unsatisfied with findings from the formal appeal board, subsequently filed harassment and discrimination complaints directed toward their nursing instructors. Participants reported that there were insufficient resources and supports for clinical instructors engaged in appeals or harassment processes. Due to confidentiality clauses, and a lack of faculty supports, instructors are left largely alone to navigate in such tumultuous times. There was overwhelming agreement in all participants about the impediment that the institutional body poses when working with unsafe or underperforming clinical students.

Question: What would the ideal process be in identifying and supporting students at risk of clinical failure?

Participants were asked to describe what an ideal student success protocol would include. When examined together, the responses to this question were clearly delineated into four themes: faculty development, human supports, transparency, and due process.

Faculty development. In all consultations, participants highlighted the necessity of faculty development in planning for a student success protocol. A dream protocol would provide faculty members with the tools to identify and act upon concerns with student practice. Participants identified that necessary faculty development would include how to identify struggling students sooner in clinical practice, for instance tools to assess student foundational knowledge and preparatory activities early in the term to establish an early benchmark of student performance. Participants recommended that an ideal process would include steps to take should a student demonstrate unsafe practice or underperformance in the clinical setting and should include a description of best practices

relating to giving effective feedback. Further, participants identified that instructors would benefit from having tools to support the appropriate analysis of the etiology of student underperformance, to be able to accurately identify which domain(s) are causing the student to struggle. In turn, if instructors can analyze the cause of a student's challenge, they will be better able to tailor teaching practices to the needs of the students. Participants identified that developing creative teaching strategies and learning activities can be time-consuming, and recommended faculty development activities include these. Multiple participants identified that an ideal process would include formal faculty mentorship opportunities, especially as a tool to change culture in the nursing department. In sum, there was overwhelming support for integrated faculty development within an ideal student success protocol.

Human supports. Participants identified that adequate human supports are needed in developing a successful protocol. Firstly, participants identified the FN role as one that requires continuation and refinement. Participants discussed the necessity of having FN more readily available, especially in the clinical setting, where issues tend to arise. Participants felt that more immediate assistance by the FN in the clinical setting would facilitate successful interactions with struggling students. Participants also recommended more consistent use of the FN role by all faculty members, and proposed greater transparency of the FN role as a proposed strategy to increase their consistent involvement.

Transparency. When considering a proposed student success protocol, all participants described the need for clear, transparent processes. Pursuant to this

recommendation, participants want a process that is easily understood for faculty and students that is found readily and discussed frequently in courses. Participants identified the necessity for a process to clearly articulate and describe unsafe practice, and underperformance across domains of practice: psychomotor, affective, and cognitive. The process needs to clearly outline the possible actions of a clinical instructor if or when unsafe practice or underperformance is noticed, as participants described that when students do not understand what clinical instructors do with students when concerns are observed, students may feel as though they are being targeted, picked on, or that the instructor does not like them. Individuals in the focus group and in the individual interviews recommended that a student success protocol detail the attributes that would warrant immediate failure and removal from the clinical course. The ideal process would clearly delineate student and instructor roles for student success and as one participant described, "Would act as the rules for engagement". The level of transparency desired was felt to support a trusting student-instructor relationship, while supporting student psychological safety.

Participants recommended that learning contracts have clear language, actionable outcomes, and be tied to the remedial activities that are most likely to support student success. When an instructor is initiating a LC, this needs to be done with student input, and faculty members identified the need for this process to occur outside of the clinical setting. Faculty participants cautioned against having the FN review all contracts, as this was reported to decrease trust and increase the length of time the process took. There were participants who recommended that LCs have a short time-frame for student

success, while others recommended that contracts remain in place for the duration of the term due to student's having practice concerns that persist across domains. The participants also recommended that there be separate processes for health and mental health concerns, as it was reported that learning contracts are largely inappropriate for students who have underlying health concerns. Overwhelmingly, participants described the need for a student success protocol that frames the use of a tool, such as a learning contract, as a non-punitive, support tool. The recommendations around transparency were reported as priority by most participants, in order to promote clear, consistent expectations and facilitate student success.

Due process. The last recommendation for an ideal student success protocol is that of fair institutional processes that support due process for students, without undue stress for faculty members. Overwhelmingly, participants identified that a desired student success protocol would include an internal appeal process, to reduce the number of student appeals that occur at the college level. Alternatively, working with the institution to ensure that there a nursing voice in the college level appeals process to facilitate dialogue was identified as a necessary change. Ultimately, there was a shared desire for greater institutional support for the decisions faculty make, without removing any of students' due process rights.

Faculty Focus Group

The online faculty focus group were asked an additional two questions, to better capture the experiences and usual practices when an instructor is working with a student at risk of clinical failure. When asked about the experience working with struggling

clinical students, faculty members were unanimous that the experience is stressful. They identified that they all felt a sense of ownership over student success, and when students are unsuccessful they question what more they could have done, or what they may have done wrong. The first indicator that a student is unsafe or underperforming is often that of a "gut feeling", however participants identified they question often their initial judgements. Participants detailed that working with students who are underperforming or unsafe increases their workload, as reported by one participant, "the instructor is working harder than the student". The time required to be spent with struggling students takes away the instructor presence for the other students.

The current strategies used by faculty focus group participants when students are at risk of clinical failure varied. Participants reported that taking the time to review student clinical preparation a helpful activity to establish a benchmark of current practice. They further identified collecting feedback from a variety of sources, such as from nursing staff, patients, and peers, to be helpful in helping the student understand the impact of their practice. When concerns are identified, participants report reviewing clinical course outcomes and expectations with the student, accessing lab supports, and having students talk through skills as valuable activities to support student success. Finally, all participants identified that they continue to challenge the struggling student to see how they are able to manage with more complex or competing demands. It was important to hear from the faculty member participants specific to their experiences working with students at risk of clinical failure in order to ensure a designed student success protocol would be accountable to the local context. The findings from the faculty

focus groups support the findings reported in the extant literature, both in the experiences of working with unsafe or underperforming students, as well as in the usual approaches used in such circumstances.

Student Interview

Though only one student volunteered to participate in the consultation process, it is important to include the student voice in planning a new student success protocol. Open-ended questions were used to guide the interview with the student, found in Appendix A. Based on the discussion there were two key sentiments that warrant consideration in future student success protocols: student stressors and consistency/transparency.

The student participant detailed clearly the stressors that affect student learning while in the clinical setting. The student reported that nursing students feel internal and external pressure to do well. There is a perception reported that student performance in the clinical setting is seen as “do good or fail”. Internal pressures come from students having high expectations of their own performance, while external stressors may arise from the clinical setting and/or the clinical instructor. The student participant identified that not all clinical settings are welcoming of student nurses, and that hostile units or nurses may affect student confidence. Further, the student identified additional stress may be attributed to instructor inexperience with teaching or in a clinical setting. The student participant recommended that student performance might be improved when programs ensure all clinical instructors have faculty development opportunities and are familiar

with clinical teaching, and that units that are used for clinical learning be receptive to learners.

The student participant identified that a perceived lack of transparent and clear expectations negatively affects the student experience. They described how a lack of clear, tangible expectations at the start of the term increases student fear and uncertainty. The student recommended that students want to know both how they are in clinical at the start of the term, as well as how they should be performing at the end of the term, and that these benchmarks be transparent to students. The participant stressed repeatedly that there is a great deal of inconsistency and ambiguity in clinical teaching, which contributes to feelings of inequity and inequality in students, regardless of success or failure. Finally, the student participant recommended that early and frequent feedback would support student success, and that students need to know what the "non-negotiables" are in clinical practice, or those actions or behaviors that warrant immediate failure. The recommendation of clear and transparent processes aligns closely with the recommendations of the faculty and administrative consultations, which highlight the likely necessity of this consideration in planning future student success protocols.

Other Institutions

Of the 39 invitations sent to other institutions to complete surveys, two were completed by the return date. The two institutions consulted reported very similar definitions of underperformance and unsafe student practice as is used currently at RDC. Both described their current processes when a student is unsafe or underperforming to include feedback, both verbal and written, as well as identification of remedial activities.

The remedial activities identified by the other institutions align with current processes used at RDC, as well as those described in the extant literature. Finally, both institutions used learning contracts, co-created between instructor and student, to support success in the clinical setting. Of interest, both institutions had different resources available for faculty members when working with students at risk of clinical failure. One institution identified use of a progression committee to discuss student performance within, as well as having redacted learning contracts available for instructors to reference. Both institutions reported having dedicated clinical coordinators for faculty members to discuss for student performance concerns. Of interest, neither institution has a Faculty Navigator position. There were strong similarities in the reported actions and behaviors that would warrant immediate clinical failure between the consulted institutions and those identified in both the literature, such as significant threats to patient safety, and a lack of accountability. Both institutions consulted reported challenges with their respective processes, including identification of issues too late in the term, the process being perceived as punitive, and the demands of instructors' time and energy when working with underperforming students. These challenges were similarly reported by all faculty and administrative consultants at RDC, and while not surprising, it is clear that student success protocols account for these current limitations.

Conclusion

The consultation process was highly effective in validating the extant literature, as well as describing the current issues related to student success in the local context. The perspectives, concerns, and recommendations of faculty members and administrators

clearly identified a beginning direction for a student success protocol. The student voice strengthened the discussion initiated by the faculty members and stakeholders, and offered a glimpse into the perceptions of students. While one participant is not representative, there was agreement in the student perspective with existing literature. Finally, the limited consultation with other institutions confirmed the challenges reported by faculty members and administrators at RDC, while offering unique possible ideas to consider within a student success program. The consultations conducted will help ensure that the developed student success protocol will meet the needs of faculty and students alike, while being sensitive to the unique local context and setting.

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Appendix A

Consultation Questions

Population	Questions
Faculty Focus Group	1. Tell me about your experiences when working with students who you identified as being unsafe, or underperforming (at risk) 2. What is your usual practice when working with such students? 3. Tell me what is working well with current processes related to student performance? 4. Considering the current process used, what are the limitations? 5. What would a dream process look like to support students and faculty?
Student Interview	1. Tell me what you know about failing clinical courses? 2. What are the student perceptions about learning contracts and/or clinical failure? 3. What is it like when a peer is struggling in clinical? 4. When a student is unsafe in practice, what processes should be used?
Associate Dean	1. Tell me what is working well with current processes related to student performance? 2. What are the challenges that faculty and students experience when students are seen to be unsafe or underperforming? 3. What would the ideal process be in identifying and supporting students at risk of clinical failure?
Chairperson	1. Tell me what is working well with current processes related to student performance? 2. What are the challenges that faculty and students experience when students are seen to be unsafe or underperforming? 3. What would the ideal process be in identifying and supporting students at risk of clinical failure?

Faculty Navigators	1. Tell me what is working well with current processes related to student performance? 2. What are the challenges that faculty and students experience when students are seen to be unsafe or underperforming? 3. What would the ideal process be in identifying and supporting students at risk of clinical failure?
Lab Instructor	1. Tell me what is working well with current processes related to student performance? 2. What are the challenges that faculty and students experience when students are seen to be unsafe or underperforming? 3. What would the ideal process be in identifying and supporting students at risk of clinical failure?

Appendix B

Institution Response Form

Questionnaire to Other Institutions

Hello,

My name is Maggie Convey and I am a student in the Masters of Nursing program from Memorial University of Newfoundland. My final practicum project is focused on developing a student success protocol for undergraduate nursing students in clinical settings, moreover creating a process to support students and faculty when clinical nursing students are underperforming or unsafe. I am reaching out to Schools of Nursing across Western Canada to learn more about current processes in use, as well as to understand successes and challenges with processes in use.

Participation in this consultation is voluntary, and you are free to answer as many or as few questions as you would like. All of your answers will be downloaded and stored in a password-protected file within a locked office and destroyed after 5 years' time. The data that is collected will be considered in conjunction with literature to develop a protocol to assist faculty working with underperforming or unsafe students. The findings of these consultation activities will be summarized, generalized, and included in a practicum report. Once completed, the student success protocol, developed through consultation with students and faculty, environmental scans other nursing programs, and through a substantial literature review will be presented back to the Red Deer College nursing program for information and feedback. There is a chance that the finished developed protocol may be shared through publication in relevant nursing articles, or through presentation at nursing or educational conferences. Again, this would only include a generalized summary of all consultations, and no information that could be linked to you will be included. Every reasonable effort will be made to ensure your anonymity.

If you agree to participate, please provide your answers to the questions below, and reply to this email before July 25th, 2020.
If you have any other questions or concerns, I can be reached directly at 403-505-6159.

Sincerely,
Maggie Convey

Title: ***Development of a student success process for undergraduate nursing students***

Maggie L. Convey, MN student, Memorial University of Newfoundland
Maggie.convey@rdc.ab.ca

Supervisor: *Robert Meadus, Associate Professor, Faculty of Nursing, Memorial University of Newfoundland.*
meadusr@mun.ca

What does your institution identify as underperformance (unsuccessful) or unsafe clinical nursing student practice?
Click or tap here to enter text.
Do you make these descriptions publically available to students? ☐ yes ☐no

Please describe the current process your faculty use when a nursing student is underperforming or unsafe in clinical practice? (*Consider the use of feedback, verbal/written warnings, learning contracts/intervention plans, remedial activities*)
Click or tap here to enter text.
When a student is at risk of being unsuccessful in the clinical setting, what supports or resources do faculty have access to, both for supporting student success and for faculty development?
Click or tap here to enter text.
What behaviors or actions would constitute an immediate failure or removal from the clinical setting? Is there a limit to the number of clinical failures a student is permitted before removal from the program?
Click or tap here to enter text.
Many resources support the process of using learning contracts when a student is at risk of clinical failure. If you use learning contracts with nursing students, would you be willing to share a copy via email? ☐yes ☐no
What is working well in regards to your current processes when nursing students are unsafe or underperforming in the clinical setting?
Click or tap here to enter text.
What challenges do you see in regards to your current processes when nursing students are unsafe or underperforming in the clinical setting?
Click or tap here to enter text.

Appendix C

Research and Ethics Forms

Recruitment Email for Faculty Focus Groups

Dear BscN Faculty Members

My name is Maggie Convey, and I am completing my Masters of Nursing through Memorial University of Newfoundland. For my final practicum project, I am developing a student success protocol for undergraduate nursing students in clinical settings.
I am looking for individuals who have taught in the clinical setting, who have worked with students identified as being unsafe, unsuccessful or at risk of being unsuccessful, and who have taught for at least 2 years to take part in an online focus group. Participation in a focus group is completely voluntary, and the focus group will take no more than 60 minutes. All of the information obtained through this focus group will be kept anonymous and confidential.

If you are interested in participating, please contact me via email. Interested parties will be emailed a secure link to a virtual meeting.
Sincerely,
Maggie

Recruitment Email for Students

Dear Nursing Society President,

My name is Maggie Convey, and I am completing my Masters of Nursing through Memorial University of Newfoundland. For my final practicum project, I am developing a student success protocol for undergraduate nursing students in clinical settings.
I am looking for BScN students in years 2-4 to participate in a virtual focus group. I am interested in hearing the student perception of clinical practice, learning contracts, and how faculty can support students who are struggling in the clinical setting. Participation in a focus group is completely voluntary, and students are encouraged only to share as much or as little as they are comfortable. I anticipate the focus group taking 30-60 minutes.
Student participation will be confidential, and all data will be anonymous. If students are interested in participating, please email me at mconveyrn@gmail.com.
Sincerely,
Maggie Convey

Recruitment Email for Interviews

Dear (Associate Dean or Chairperson or Faculty Navigator or Lab Instructor),

My name is Maggie Convey, and I am completing my Masters of Nursing through Memorial University of Newfoundland. For my final practicum project, I am developing a student success protocol for undergraduate nursing students in clinical settings.
I am looking to interview you for approximately one hour about the BScN program's current approaches to supporting faculty and students when a student is at risk of clinical failure due to unsafe practice or underperformance. All information you share will be kept confidential, and

will not identify you personally. Of course, participation in this interview is completely voluntary. If you agree to participate, please email me so that we can make arrangements for a virtual one-to-one meeting

Sincerely,

Maggie Convey

Informed Consent Form: Faculty

Title: *Development of a student success process for undergraduate nursing students*

Researcher: *Maggie L. Convey, MN student, Memorial University of Newfoundland*
Maggie.convey@rdc.ab.ca

Supervisor: *Robert Meadus, Associate Professor, Faculty of Nursing, Memorial University of Newfoundland.*
meadusr@mun.ca

You are invited to take part in a project entitled "*Development of a student success process for undergraduate nursing students".*

This letter is part of the process of informed consent. It will give you the basic idea of the purpose, and what your participation will involve. It also identifies your right to withdraw. In order to decide whether you wish to participate, you need to understand the risks and benefits to make an informed choice; please take time to read this letter carefully. It is entirely up to you to take part in this consultation. If you chose not to take part, or if you decide to withdraw once the consultation has started, there will be no negative consequences for you, now or in the future.

Introduction and Purpose:
I am completing my Masters of Nursing at Memorial University of Newfoundland. For my final practicum project, I am developing a student success protocol for undergraduate nursing students in clinical. The purpose of these consultations is to understand your experiences working with students who have been unsafe or unsuccessful in clinical practice in order develop a robust process that is both student-friendly, as well as faculty-friendly.

Benefits and Risks
There is a theoretical benefit that your participation in this consultation will result in the development of a student-friendly, faculty-friendly process to support student success in the clinical setting. There is a theoretical benefit that future clinical instructors will be better equipped to work with students who are struggling to meet outcomes in the clinical setting. There are no real risks to participating in this consultation process.

Protection of Privacy

Please be advised that although I will take every precaution to protect your identify and the confidentiality of the data you provide, the nature of focus groups prevents a guarantee of full confidentiality. I would like to remind all participants that respecting the identity of your fellow participants and not repeat what is said or discussed is of significant importance.

The data that is collected will be considered in conjunction with literature and environmental scans to ultimately develop a protocol to assist faculty working with underperforming or unsafe students. The findings of these consultation activities will be summarized and generalized and included in a practicum report at the completion of my degree. Once completed, the student

success protocol, developed through consultation with students and faculty, environmental scans other nursing programs, and through a substantial literature review will be presented back to the Red Deer College nursing program for information and feedback. There is a chance that the finished developed protocol may be shared through publication in relevant nursing articles, or through presentation at nursing or educational conferences. Again, this would only include a generalized summary of all consultations, and no information that could be linked to you will be included. Every reasonable effort will be made to ensure your anonymity.

All handwritten notes made during this meeting will be transcribed to an electronic document. The handwritten notes are considered highly sensitive material and will be destroyed in accordance with the Red Deer College's *Information Access and Protection of Privacy Policy*. The transcribed notes will be stored in a password protected file on a secure computer, located in a locked office for 5 years, after which the file will be deleted. This consultation meeting is being conducted under the guidelines of the Freedom of Information and Protection of Privacy Act (FOIP) and has the approval of the Research Ethics Board. If you have any questions or concerns about this study, please contact Maggie Convey at 403-505-6159 or by e-mail at Maggie.convey@rdc.ab.ca . If you have concerns regarding the study itself that cannot be addressed by the researcher, please contact the Chair of the Research Ethics Board at (403) 314-2403; e-mail: Krista.Robson@rdc.ab.ca.

Webex® Platform
I will make every attempt to protect your participation during the virtual meeting. At the start of the meeting, the virtual room will be locked to outside participants, and only those persons with the meeting link will be permitted to participate. The meetings will not be recorded.

Data collected from you as part of your participation in this project will be hosted and/or stored electronically by Cisco Webex® and is subject to their privacy policy. Therefore, anonymity and confidentiality of data may not be guaranteed in the rare instance, for example, that government agencies obtain a court order compelling the provider to grant access to specific data stored on their servers. If you have questions or concerns about how your data will be collected or stored, please contact the researcher and/or visit the provider's website for more information before participating. The privacy and security policy of the third-party hosting data collection and/or storing data can be found at https://help.webex.com/en-us/nv2hm53/Cisco-Webex-Security-and-Privacy

Withdrawal from the Consultation
You may withdraw from the process at any time, without prejudice. To end your participation prior to the consultation, please email the researcher directly. To end your participation during the consultation meeting, please exit the virtual platform at any time. Any statements that were made and noted by you will not be included in the aggregate data, and thus will not be included in the final consultation report.

You are welcome to ask questions before, during, and after the consultation process. Please contact me at any time.
Thank you,
Maggie Convey
403-505-6159
Maggie.convey@rdc.ab.ca

Informed Consent Form: Students

Title: *Development of a student success process for undergraduate nursing students*

Researcher: *Maggie L. Convey, MN student, Memorial University of Newfoundland*
Maggie.convey@rdc.ab.ca

Supervisor: *Robert Meadus, Associate Professor, Faculty of Nursing, Memorial University of Newfoundland.*
meadusr@mun.ca

This letter is part of the process of informed consent. It will give you the basic idea of the purpose, and what your participation will involve. It also identifies your right to withdraw. In order to decide whether you wish to participate, you need to understand the risks and benefits to make an informed choice; please take time to read this letter carefully. It is entirely up to you to take part in this consultation. If you chose not to take part, or if you decide to withdraw once the consultation has started, there will be no negative consequences for you, now or in the future.

Introduction and Purpose:
I am completing my Masters of Nursing at Memorial University of Newfoundland. For my final practicum project, I am developing a student success protocol for undergraduate nursing students in clinical settings. The purpose of these consultations is to understand your experiences in clinical learning settings in order develop a robust process that is both student-friendly, and includes the student perspective.

Dual-Role
Though I am also a nursing instructor for Red Deer College, I wish to assure you that my role in facilitating this focus group is not that of an instructor, but that of a MN student. The discussion that will take place in the focus group is considered highly sensitive and confidential information, and so I can assure you that what you say will not be shared with the faculty in the nursing programs. I also want to reiterate that the decision to participate in this focus group will not impact studies or grades, in current or future academic experiences. I am very cognizant that my role here, in hearing your thoughts and perspectives as part of my own studies, is very different than my role as an instructor. I also want to make clear, that should I find myself in a role wherein I am your instructor in the future, that your participation will not affect your future academic performance.

Risks and Benefits
There are no substantial benefits to participating in this consultation. There is a theoretical benefit that the developed student success protocol will support future students in the clinical settings. There is a small, but real risk that discussing learning challenges in clinical settings may prove to be emotionally distressing. Though the questions I plan to ask are about general experiences, there is the chance that you may recall a negative experience. Should you find yourself distressed, please know that you are under no obligation to complete the focus group. Alternatively, please feel free to not participate in any discussions that you are not comfortable with by muting

incoming audio, muting your own microphone and video feed. Should the experience of participating in this focus group evoke strong negative feelings, the Red Deer College Counselling centre remains available for you as a free, confidential resource (https://rdc.ab.ca/current-students/facilities-services/counselling-career-centre/counselling-services)

Protection of Privacy

Please be advised that although I will take every precaution to protect your identify and the confidentiality of the data you provide, the nature of focus groups prevents a guarantee of full confidentiality. I would like to remind all participants that respecting the identity of your fellow participants and not repeat what is said or discussed is of significant importance.

The data that is collected will be considered in conjunction with literature and environmental scans to ultimately develop a protocol support nursing students in the clinical setting. The findings of these consultation activities will be summarized and generalized and included in a practicum report at the completion of my degree. Once completed, the student success protocol, developed through consultation with students and faculty, environmental scans other nursing programs, and through a substantial literature review will be presented back to the Red Deer College nursing program for information and feedback. There is a chance that the finished developed protocol may be shared through publication in relevant nursing articles, or through presentation at nursing or educational conferences. Again, this would only include a generalized summary of all consultations, and no information that could be linked to you will be included. Every reasonable effort will be made to ensure your anonymity

All handwritten notes made during this meeting will be transcribed to an electronic document. The handwritten notes are considered highly sensitive material and will be destroyed in accordance with the Red Deer College's *Information Access and Protection of Privacy Policy*. The transcribed notes will be stored in a password protected file on a secure computer, located in a locked office for 5 years, after which the file will be deleted. This consultation meeting is being conducted under the guidelines of the Freedom of Information and Protection of Privacy Act (FOIP) and has the approval of the Research Ethics Board. If you have any questions or concerns about this study, please contact Maggie Convey at 403-505-6159 or by e-mail at Maggie.convey@rdc.ab.ca . If you have concerns regarding the study itself that cannot be addressed by the researcher, please contact the Chair of the Research Ethics Board at (403) 314-2403; e-mail: Krista.Robson@rdc.ab.ca.

Webex® Platform

I will make every attempt to protect your participation during the virtual meeting. At the start of the meeting, the virtual room will be locked to outside participants, and only those persons with the meeting link will be permitted to participate. The meetings will not be recorded.

Data collected from you as part of your participation in this project will be hosted and/or stored electronically by Cisco Webex® and is subject to their privacy policy. Therefore, anonymity and confidentiality of data may not be guaranteed in the rare instance, for example, that government agencies obtain a court order compelling the provider to grant access to specific data stored on their servers. If you have questions or concerns about how your data will be collected or stored, please contact the researcher and/or visit the provider's website for more information before

participating. The privacy and security policy of the third-party hosting data collection and/or storing data can be found at https://help.webex.com/en-us/nv2hm53/Cisco-Webex-Security-and-Privacy

Withdrawal from the Consultation

You may withdraw from the process at any time, without prejudice. To end your participation prior to the consultation, please email the researcher directly. To end your participation during the consultation meeting, please exit the virtual platform at any time. Any statements that were made and noted by you will not be included in the aggregate data, and thus will not be included in the final consultation report.

You are welcome to ask questions before, during, and after the consultation process. Please contact me at any time.

Thank you,

Maggie Convey
403-505-6159
Maggie.convey@rdc.ab.ca

Consent Scripts (read at the beginning of the meeting)

Informed Consent Script for Faculty Focus Groups

My name is Maggie Convey and I am completing my Masters of Nursing at Memorial University of Newfoundland. For my final practicum project, I am developing a student success protocol for undergraduate nursing students in clinical. I am interested in hearing your experiences and thoughts about working with students who were unsafe or unsuccessful in the clinical setting. Though I have a few questions prepared, I hope that you will share additional insights and experiences working with unsafe or underperforming nursing students in the clinical setting. You will see me taking notes, however, all information, stories, and experiences shared will be kept confidential. All information you share is voluntary and I am ensuring all data is anonymous. The information obtained through discussion may be used in the development of the student success protocol. Data from my consultations will be included in a consultation report, shared with my advisor from Memorial University, and will be included in my practicum report once the development of the protocol is complete. All data will be generalized only in these reports, and nothing will identify you personally. It is likewise requested that all participants in this focus group respect the confidentiality of all participants.

There are no risks associated in participating. There is only theoretical benefit that your participation will help develop a process that will be faculty friendly and support future work with struggling clinical students. Again, your participation is voluntary and you are free to withdraw your consent to participate at any time without prejudice. All of this information can be found on the letter you received prior to this focus group.

At this time, I would like to verify that I have your consent to begin.

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____

Signature Date

Informed Consent Script for One to One Interviews

My name is Maggie Convey and I am completing my Masters of Nursing at Memorial University of Newfoundland. For my final practicum project, I am developing a student success protocol for undergraduate nursing students in clinical. I am interested in hearing your experiences and thoughts about working with students who were unsafe or unsuccessful in the clinical setting. Though I have a few questions prepared, I hope that you will share additional insights and experiences working with unsafe or underperforming nursing students in the clinical setting. You will see me taking notes, however, all information, stories, and experiences shared will be kept confidential. All information you share is voluntary and I am ensuring all data is anonymous. The information obtained through discussion may be used in the development of the student success protocol. Data from my consultations will be included in a consultation report, shared with my advisor from Memorial University, and will be included in my practicum report once the development of the protocol is complete. All data will be generalized only in these reports, and nothing will identify you personally.

There are no risks associated in participating. There is only theoretical benefit that your participation will help develop a process that will be faculty friendly and support future work with struggling clinical students. Again, your participation is voluntary and you are free to withdraw your consent to participate at any time without prejudice. All of the above information can be found in the letter you received prior to this interview.

At this time, I would like to verify that I have your consent to begin.

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____

Signature Date

Informed Consent Script for Students

My name is Maggie Convey and I am completing my Masters of Nursing at Memorial University of Newfoundland. For my final practicum project, I am developing a student success protocol for undergraduate nursing students in clinical. I am interested in hearing your experiences and thoughts about students in clinical practice, and the perceptions of learning contracts.

Though I have a few questions prepared, I hope that you will share additional insights and experiences with me. You are welcome to participate as much, or as little as you would like, and you are free to leave at any time.

You will see me taking notes, however, all information, stories, and experiences shared will be kept confidential. All information you share is voluntary and I am ensuring all data is anonymous. The information obtained through discussion may be used in the development of the student success protocol. Data from my consultations will be included in a consultation report, shared with my advisor from Memorial University, and will be included in my practicum report once the development of the protocol is complete. All data will be generalized only in these reports, and nothing will identify you personally. It is likewise requested that all participants in this focus group respect the confidentiality of all participants.

There are no risks associated in participating. There is only theoretical benefit that your participation will help develop a process that will be student-friendly and support future students in the clinical setting.

Again, your participation is voluntary and you are free to withdraw your consent to participate at any time without prejudice. All of this information can be found on the letter you received prior to this focus group.

At this time, I would like to verify that I have your consent to begin.

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____

Signature Date

RDC

CERTIFICATION OF ETHICAL ACCEPTABILITY FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

Project Title	**Development of a Student Success Process for Undergraduate Nursing Students: Consultations**
Principal Researcher	**Stephanie Powers**
Approval Date	**June 29, 2020**
Expiry Date	**August 31, 2020**
Application Number	**2020-21-1**

The Red Deer College Research Ethics Board, having examined the application for the project named below, consider the procedures, as outlined by the applicants, to be meet the requirements of RDC's *Research Involving Humans* policy, and full ethical approval has been granted.

The standard conditions of this approval are:

- Approval will be for a period of one year, with continued approval for up to a total of 3 years, conditional on submission of Annual Status Reports.
- Conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the Research Ethics Board.
- Advise immediately of any issues in relation to the project which may warrant review of the ethical protocols. The REB's role is to advise in such instances to ensure the safe and ethical continuation of research projects. Such matters include:
  - Serious or unexpected adverse effects on participants
  - Proposed changes to protocols
  - Any changes to the research team
  - Unforeseen events which might affect continued ethical applicability of the project

(continued)

RDC Research Ethics Board | www.rdc.ab.ca/ethics
Red Deer College | 100 College Boulevard | Box 5005 | Red Deer | AB | Canada | T4N 5H5 | ethics@rdc.ab.ca

Appendix D

Health Research Ethics Authority (HREA) Screening Tool

Student Name: Maggie Convey

Title of Practicum Project: Development of a Student Success Protocol for Undergraduate Nursing Program Students

Date Checklist Completed: July 6, 2020

This project is exempt from Health Research Ethics Board approval because it matches item number _____3_____ from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at

https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix C

Student Success Protocol

Student Success Protocol

Faculty Guidebook:

Student Success Protocol

Red Deer College Faculty of Nursing

2020

Student Success Protocol

Background

Student attrition, whether voluntarily or involuntary, is of particular concern to nursing programs due to loss in revenues and impact on program reputation. However, nursing programs need to ensure that students graduating have sufficient knowledge, skills, and abilities to be safe practitioners in increasingly complex practice settings. When students demonstrate behaviours or actions that do not align with their Code of Ethics, or expected behaviours congruent with their year and sequence of the program, they are at risk of clinical failure. Early identification of student underperformance or unsafe practice is necessary, in order to protect public safety whilst supporting overall student success.

Underperformance or Unsafe Practice

In general, safe, successful students come prepared to clinical, they communicate well, have positive attitudes, adapt to the clinical setting, are willing to receive and act on feedback, and are eager to learn while demonstrating progress in meeting course outcomes. In contrast, unsuccessful students may be unprepared or underprepared, have ineffective communication, and do not function well in new or unfamiliar settings (Craven, 2015; Lewallen & Debrew, 2012).

It is important to note that students will often have problems in many areas. The following table includes the more common attributes of underperformance or unsafe practice:

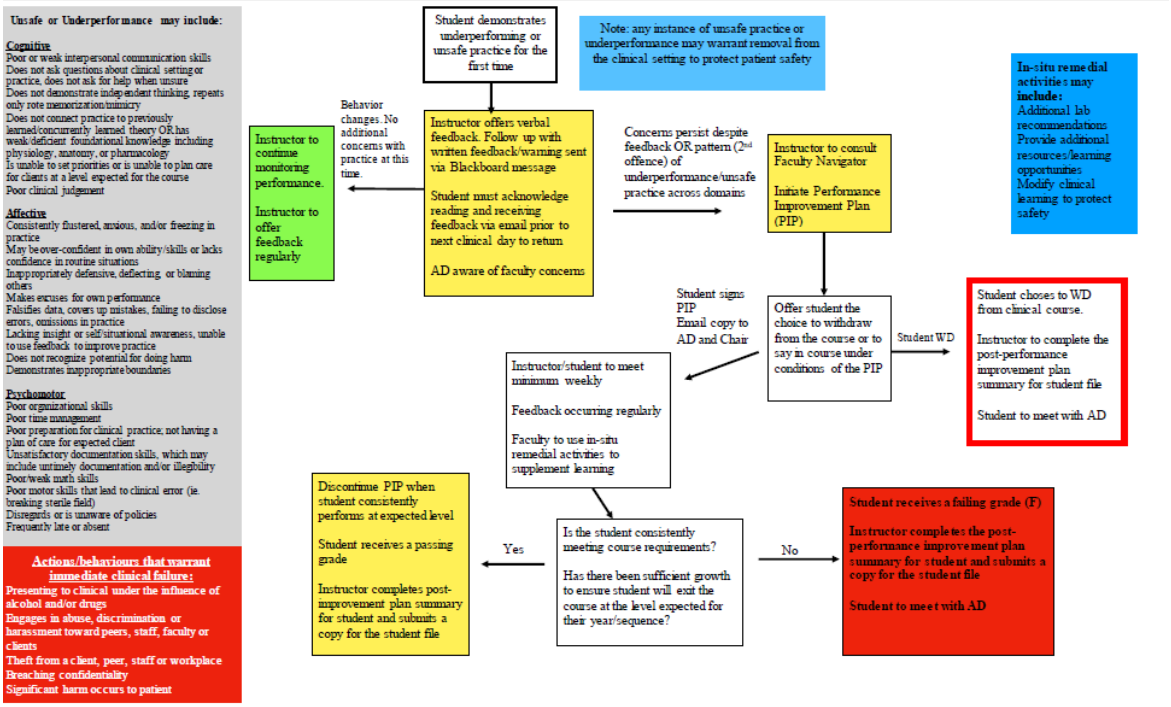
Cognitive	Affective	Psychomotor
Difficulty in communication (written or verbal) with others. May limit communication to superficial/casual conversation	May be flippant, cocky, arrogant, angry or defensive. Lacks insight into own performance; does not see potential for harm.	Unable to demonstrate appropriate organization, time management skills. May be disorganized in their approach to care
Difficulties in connecting previous knowledge (clinical, theoretical) to current practice or current client context	May freeze, be overwhelmingly anxious or fearful, and unable to function	Assessments, medications, and documentation may be late and/or poorly performed
Knowledge is superficial or consists of rote memorization. Does not demonstrate independent clinical judgement	Is not accountable to own practice, may blame others/the setting, or deflect practice concerns ("of course I wouldn't do that if I were on my own").	May not have a solid understanding of medication math principles, or has made/nearly made medication errors. Motor skills lead to clinical error
Sets inappropriate priorities or cannot demonstrate flexibility in priority-shifting when necessary. Poor clinical judgement.	Does not follow or take direction, leaves the unit without permission/reporting off. Avoidance or hiding from others	Unprepared or underprepared for practice; lacks appropriate plan of care. Unaware of or does not follow policy.

- <u>There are behaviours for which there is Zero Tolerance</u>: actions or behaviours that violate ethical standards. This includes presenting to clinical under the influence of drugs/alcohol; abusive, harassing, or discriminatory towards others; theft; and failing to comply with confidentiality. Certainly, care that results in significant actual OR potential harm to a client may warrant immediate clinical failure based upon the

context of the clinical environment and the student's expected performance for the year/term of the program.

Using the Performance Improvement Plan Algorithm

The evidence from clinically based learning is clear—instructors need to identify and act on underperformance or unsafe practice attributes early, ideally in the first three weeks of a clinical course. Often the first signs that a student is in jeopardy of clinical failure is a "gut feeling", that this student is performing differently than expected, or differently than other students in the clinical group. Often, students will have multiple concerning behaviours that occur in all domains. It is important to consider the etiology of clinical performance deficiencies, as these may include deficient fundamental knowledge base, not having had opportunity to develop independent thinking skills, immaturity, cultural differences, learning disabilities, and mental health concerns. Consultation with the Faculty Navigators (FN) and/or Associate Dean (AD) may help you accurately identify the cause of attributes of underperformance or unsafe practice. The Performance Improvement Plan (PIP) algorithm is meant to clearly define for students and faculty, what constitutes underperformance and unsafe practice, as well as both the student and instructor roles include when students are at risk of clinical failure.



Progression Through the Algorithm

1. You see any occurrence or attribute of underperformance of unsafe practice, which does not include actions/behaviours that warrant immediate clinical failure. Give clear, constructive feedback to the student about their performance in private. Consider using the WRAP feedback method detailed in Appendix A. If the student performance is such that you cannot trust the student to be in the setting without continuous observation OR the student's presence in the clinical setting will significantly negatively affect your ability to attend to the other students, give the student feedback and send the student home.

2. Follow up with the verbal feedback in writing, and deliver via Blackboard messages. This constitutes a warning within the student non-academic misconduct policy. Ensure that the feedback includes (a) recommendation for in-situ remedial work (b) consequences if the student does not address your concerns; and (c) what your expectations will be for the next clinical shift. An example is available in Appendix B. At this point, email the Associate Dean (AD) with a brief synopsis of your concerns and plan for the student.
3. The student is expected to respond, in writing, to your written feedback prior to their next clinical shift. If the student fails to do so, they are not eligible to return to the clinical setting. If the student is eligible for clinical return, continue to observe student performance, consider additional measures to ensure success and safety, and continue supporting the student with high-quality feedback. If there are no further issues, the concern has been successfully remediated.
4. If the student has a pattern of underperformance or unsafe practice, marked by a second offence, OR if the student cannot <u>consistently</u> practice at the level expected for their course year, sequence, and place in the term, a Performance Improvement Plan (PIP) is warranted prior to continuing in the clinical course. Instructors are encouraged to consult with the Faculty Navigators (FN) at this point. The student is informed of the need for PIP, and can (a) choose to stay in the clinical course under the parameters detailed by the PIP; or (b) voluntarily withdraw from the course. The PIP is to be developed with student input, as research suggests that self-determination is improved when students can contribute their thoughts about the etiology of their

challenges, as well as strategies that are more likely to work for them. A copy of the PIP document is included in Appendix D.

5. Once the instructor and student have signed the PIP, the instructor is to email a copy of the PIP to the chairperson and the AD. If the student opts to take a voluntary withdrawal, the instructor is to complete the Post-Performance Improvement Plan Summary (P-PIPS) (Appendix E).
6. Both instructor and student work to satisfy the terms of the contract. It is important that the instructor consider using team and FN resources to identify additional in-situ remedial activities to allow the student opportunities for growth while protecting safety. In-situ remediation are those additional teaching and learning opportunities that occur in addition to the curriculum to meet individual learners' needs, especially if success in the course is at risk. In-situ remedial activities are detailed in Appendix C. The student and instructor should meet no less than weekly, to review the progress toward the outcomes of the PIP. Note: if a student demonstrates any of the attributes identified as warranting immediate clinical failure, they should be removed from the clinical course and receive a failing grade, regardless if they have/have not been issued a PIP.

Ending the PIP

Pass.

7. PIP end dates are flexible, and can be discontinued when the instructor identifies the student is performing at the level expected, consistently, for the course. If the student consistently performs at the level of cognitive, affective, and/or psychomotor

expectations for the clinical course, they will receive a passing grade. The instructor will complete a P-PIPS for the student and the student's file, in addition to the clinical evaluation tool for the course.

Fail.

8. If, following feedback, in-situ remedial activities, and adequate time (> 3 clinical days) under the parameters of the PIP, the student fails to make progress at meeting course outcomes or the PIP terms, the student should be removed from the clinical course and a failing grade be given. The instructor will complete a P-PIPS for the student and the student's file. Students who are unsuccessful in a clinical course will be required to meet with the AD to review the issues with performance, as well as to identify the next steps in their trajectory.
9. The Post-Performance Improvement Plan Summary will be reviewed by that AD prior to placement on the student file. As indicated, and to foster success in future clinical courses, the AD may make the P-PIPS available to subsequent clinical instructors. For instance, to share activities that supported student learning, or for habitual and perpetual concerns.

Glossary of Terms

Clinical Failure: The inability of a clinical nursing student to meet the course outcomes at a level of independence sufficient enough to permit progression in the program (Craven, 2015; Gallant et al., 2006).

Remediation, Remedial activities: The provision of additional or supplemental teaching activities in order to facilitate improved performance in student deficit areas (Craven, 2015; Gallant et al., 2006)

Underperforming student: A nursing student who had significant deficits in knowledge, applying knowledge, psychomotor skills, interpersonal skills, or attitude that may jeopardize patient safety (Craven, 2015; Duffy, 2003; Luhanga et al., 2008; Scanlan & Chernomas, 2016).

Unsafe practice: Behaviours that place the client or staff in physical or emotional jeopardy, including the risk of physical harm, anxiety, or distress. Unsafe clinical practice is a singular occurrence or a pattern of behaviours involving unacceptable risk (Scanlan et al., 2001 as cited in Scanlan & Chernomas, 2016).

References

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Teeter, M. (2005). Formula for success: Addressing unsatisfactory clinical performance. *Nurse Educator, 30*(3), 91-92. https://doi.org/ 10.1097/00006223-200505000-00002

Zuzelo, P. (2000) Clinical probation: Supporting the at-risk student. *Nurse Educator,*

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In-Situ Remedial Activities

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Dreifuerst, K. (2015). Getting started with debriefing for meaningful learning. *Clinical Simulation in Nursing, 11*(5), 268-275. https://doi.org/10.1016/j.ecns.2015.01.005

Gallant, M., MacDonald, J., & Smith Higuci, K. (2006). A remediation process for nursing students at risk of failure. *Nurse Educator, 31*(5), 223-227. https://doi.org/10.1097/00006223-200609000-00010

Appendix A

WRAP Feedback

Wonder	"Tell me how you thought that went" The instructor asks the student for their own reflection, including areas of strength and areas for future improvement.
Reinforce	"I agree with you that …., and I also noticed…." The instructor reinforces and affirms what the student has had success with. Additionally, the instructor adds to what went well with their own feedback.
Adjust	"While *x* went well, I noticed that…" Here the instructor acknowledges the areas for future growth, including those not reflected on by the student, and identifies specifically what was not consistent with expectation.
Plan	"Let's talk about how to change this for next time" The instructor and student discuss a plan to have a different outcome for the next occurrence. The student should drive this conversation, and offer up ideas of strategies that may have worked previously.

Reference

Besse, C., & Vogelsang, L. (2018). The WRAP: An alternative to sandwich feedback in clinical nursing education. *Journal of Nursing Education, 57*(9), 570. https://doi.org/10.3928/01484834-20180815-12.

Appendix B

Feedback Email to Students

Hello [student],

On [date] during your clinical shift on [unit/placement] of [course name and number], your clinical practice was unsafe for the following reasons: *(detail attributes of unsafe practice)*

Prior to your next clinical shift, I recommend that you complete the following remedial activities: *(detail in-situ remediation needed)*. On your next clinical day, you can expect that you will be: *(detail expectations for clinical day)*. If you do not complete the remedial work as detailed above, you will be removed from the clinical course and assigned a grade of 'F' for continued unsafe practice.

Following your clinical shift, we will meet to discuss your continued performance. If you have any questions, or would like further information, please do not hesitate to reach out. It is my goal that students are successful and safe in clinical. In order to attend your next clinical day, please respond to this email acknowledging you have read and acknowledge this message.

Thank you,

[Instructor]

Appendix C

In-Situ Remedial Activities

Early identification of concerns is of paramount importance. Consider using the early interventions in the first days of the clinical course, and in instances of performance concerns.

Early	
Case studies	These activities can be used prior to the first clinical shift (ie. orientation) or in the first days of the clinical term. These activities help to identify student's competence in the clinical setting, while anchoring their previous knowledge, skills, and experience. As well, such activities help identify decision-making skills, critical thinking, clinical judgement, and professionalism.
Group Concept Mapping	
Group Discussion	
Once Performance Concerns are Identified	
Case studies	Case studies with meaningful debriefing help correct student thinking, planning, prioritizing and allows instructors to better identify where thinking may be askew.
Individual concept mapping	Concept mapping is an evidence-based activity to support students' clinical judgement skills, as well as helping students make connections in prior learning.
Taking extra time to review pre-clinical preparation, additional debriefing and connecting learning at the end of the day	Allows the instructor to offer feedback on preparatory activities and evaluate resources the student may be using to prepare. Supports self-awareness, especially for debriefing. Instructors may consider using the Debriefing for Meaningful Learning (DML) framework to identify assumptions, reasoning, and knowledge deficits (Dreifuerst, 2015).

Working alongside students, joining them for clinical care, increasing observation and meeting the student "where they are at"	Builds and fosters a positive, trusting relationship. Allows for role-modeling of desired behaviors. Students may hide their clinical struggles if they perceive the student/instructor relationship to be safe. Allows the instructor to know the student as a person, and identify/understand the etiology of clinical struggle.
Bringing in new people (faculty, peers)	Consult team members (without breaching student confidentiality) for other teaching tips. Consider liaising with the FN for suggestions, resources. Allow the student to work in peer dyads for role-modeling, self-awareness. Allows peer-peer feedback, which may elicit change.
Referral to counselling	For those students with anxiety, mental health concerns, counsellors are the preferred professionals to optimize student success.
Referral to nursing lab staff	Drop-in or remedial lab time can address students deficiencies in psychomotor skills, priority setting, and clinical judgement in a safe setting. This will require direction-setting from the clinical instructor, and may require that the instructor prepare activities that allow work on deficits.
Use of simulation	High-fidelity and low fidelity simulation provides safe experiences for student learning. Additionally, virtual simulation activities are available for supplemental learning, however the outcomes of these activities need to clearly link to student performance.
Socratic questioning	Asking students "why" improves critical thinking skills, moves students from rote mimicry to thinking through why they are doing what they are doing.
Provide multiple opportunities for mastery	For students who are struggling with a task (ie. medication administration), assigning them to perform only particular tasks/skills enhances their mastery and confidence in the clinical setting. Similarly, giving students a similar patient profile over the course of 2-3 clinical days will solidify their knowledge, facilitate confidence, and allow

	more accurate identification of etiology of concerns. Supports application over multiple days.

Appendix D

Performance Improvement Plan

Red Deer College Nursing Program
Performance Improvement Plan

Student Name	
Faculty Name	
PIP Initiated:	
PIP Ending:	
Description of student performance concerns	
Description of strategies used to address/remediate concerns	
Course Objectives Impacted by Student Performance	
1. 2. 3. 4.	

Red Deer College Nursing Program
Performance Improvement Plan

Nature of Clinical Concerns (refer to PIP Algorithm)		
Cognitive	Affective	Psychomotor

Remediation Plan

The instructor will…	The student will…
○ Review student preparation daily for accuracy and completeness ○ Meet with the student daily/weekly (circle one) to review progress to date ○ Provide additional learning activities to support student learning ○ Observe student assessments and care ○ Observe medication administration ○ Obtain additional student feedback from nurses, patients, and others ○[other] ○[other]	○ Reduce outside work hours ○ Practice in college lab tutor during remedial lab time ○ Attend additional drop-in lab time ○ Ensure they are present and on time for all clinical learning ○ Develop patient-centred plans of care prior to clinical ○ Not administer medications without instructor observation ○ [other] ○ [other] ○ [other]

If, despite remedial activities and additional feedback, you are unable to demonstrate consistent safe, competent, and/or ethical care at a minimal level expected for your year, you will receive a failing grade (F) in this clinical course:_____.

- *I have read and acknowledged that as a student I have responsibilities to ensuring my continued growth as a learner.*
- *I understand that my clinical instructor will be completing a Post-Performance Improvement Summary to be placed on my student file, in order to support my success in my next clinical course.*
- *I understand that I have the right to withdraw from the clinical course without academic penalty **except** in instances where my practice results in patient harm (actual or potential) OR if I demonstrate any of the actions/behaviors that warrant immediate clinical failure.*

Red Deer College Nursing Program
Performance Improvement Plan

Signature (Student)		Date
Signature (Instructor)		Date

Faculty Notes on Student Progress

Use this to detail student performance and responses to remedial learning activities, feedback etc.

Date	Note	Initials (student and faculty)

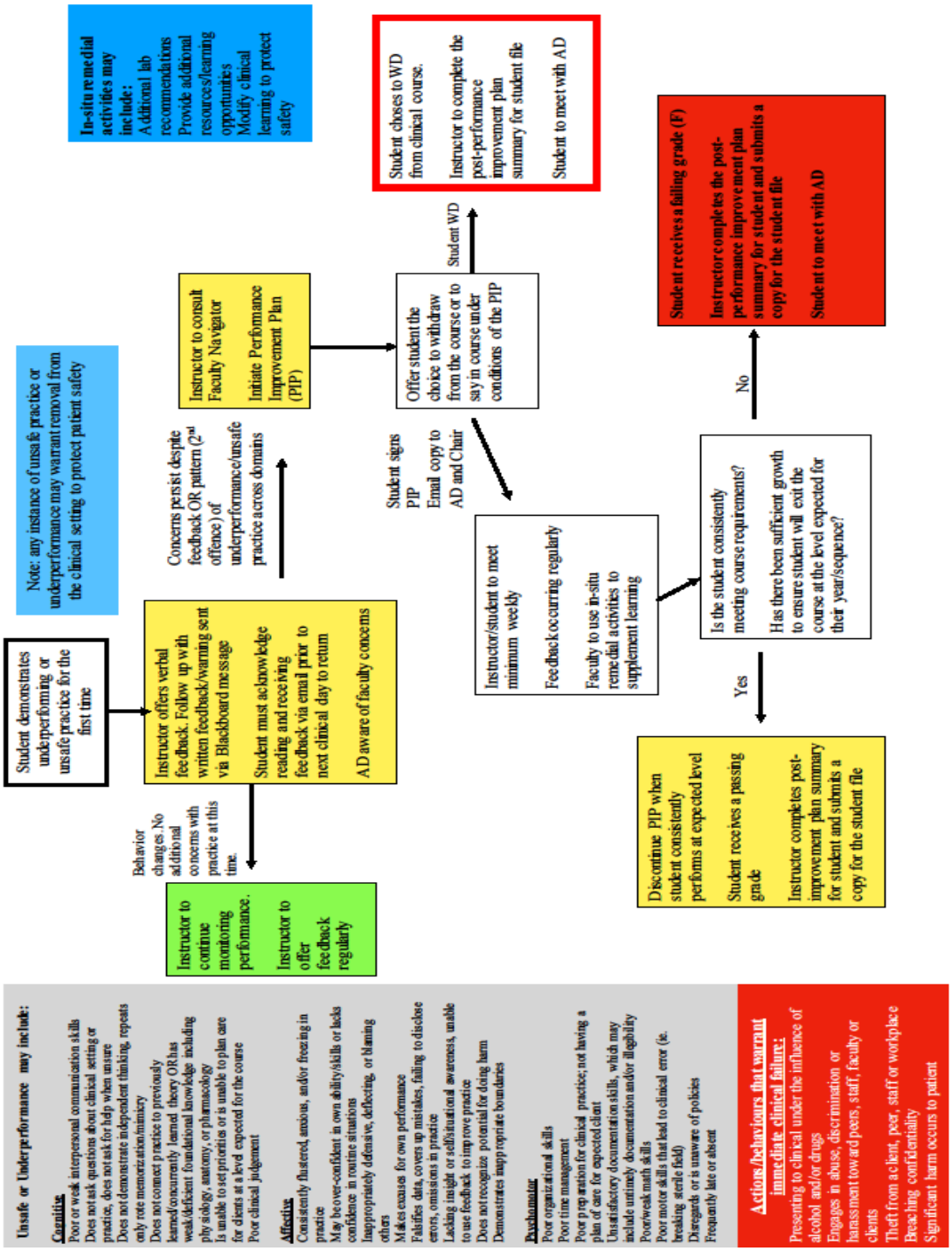
Appendix E

Post-performance Improvement Plan Summary

Red Deer College Nursing Department
Post-Performance Improvement Plan Summary

Student Name:		
Course Name:		
Date PIP initiated:		
Key actions/behaviours that constituted underperformance or unsafe practice:		
Cognitive:	Affective	Psychomotor
Remedial activities used in PIP and summary of effectiveness		
Student areas of strength:		
Student areas of growth:		
Suggestions for future clinical instructors to support student success:		
Signature		
Date		

Student Performance Algorithm



Student Performance Improvement Plan	
Student Name	
Faculty Name	
PIP Initiated:	
PIP Ending:	
Description of student performance concerns	
Description of strategies used to address/remediate concerns	
Course Objectives Impacted by Student Performance	

1.
2.
3.
4.

Nature of Clinical Concerns (refer to PIP Algorithm)		
Cognitive	Affective	Psychomotor
Remediation Plan		
The instructor will…	The student will…	
○ Review student preparation daily for accuracy and completeness ○ Meet with the student daily/weekly (circle one) to review progress to date ○ Provide additional learning activities to support student learning ○ Observe student assessments and care ○ Observe medication administration ○ Obtain additional student feedback from nurses, patients, and others ○ [other] ○ [other]	○ Reduce outside work hours ○ Practice in college lab tutor during remedial lab time ○ Attend additional drop-in lab time ○ Ensure they are present and on time for all clinical learning ○ Develop patient-centred plans of care prior to clinical ○ Not administer medications without instructor observation ○ [other] ○ [other] ○ [other]	

If, despite remedial activities and additional feedback, you are unable to demonstrate consistent safe, competent, and/or ethical care at a minimal level expected for your year, you will receive a failing grade (F) in this clinical course:_____.

- ☐ *I have read and acknowledged that as a student I have responsibilities to ensuring my continued growth as a learner.*
- ☐ *I understand that my clinical instructor will be completing a Post-Performance Improvement Summary to be placed on my student file, in order to support my success in my next clinical course.*
- ☐ *I understand that I have the right to withdraw from the clinical course without academic penalty **except** in instances where my practice results in patient harm (actual or potential) OR if I demonstrate any of the actions/behaviors that warrant immediate clinical failure.*

Signature (Student)		Date
Signature (Instructor)		Date
Faculty Notes on Student Progress *Use this to detail student performance and responses to remedial learning activities, feedback etc.*		
Date	Note	Initials (student and faculty)

Post-Performance Improvement Summary		
Student Name:		
Course Name:		
Date PIP initiated:		
Key actions/behaviours that constituted underperformance or unsafe practice:		
Cognitive:	Affective	Psychomotor
Remedial activities used in PIP and summary of effectiveness		
Student areas of strength:		
Student areas of growth:		
Suggestions for future clinical instructors to support student success:		
Signature		
Date		

Faculty Development Plan: Student Success Protocol

Maggie L. Convey

Faculty of Nursing

Faculty Development Plan: Student Success Protocol

Target Group

The target group consists of approximately 40 nursing instructors, teaching in full-time and part-time capacities at Red Deer College Bachelor of Science nursing program (BScN). This is a predominantly female group, with a wide variety of nursing and educator experience. The educational background of the target audience, too, is varied and includes bachelors, masters, and doctorate degree holders.

General Considerations

The ultimate goal of faculty development is to support instructors in their roles, while facilitating change in knowledge, attitudes, and skills in order to improve student outcomes (Thomas & Steinert, 2014). The newly developed *Student success protocol* requires that faculty development occur prior to use, in order to reduce confusion and reticence of use. As the instructors will be expected to use and integrate the *Student success protocol* into their practice, adequate introduction to the protocol needs to occur in a meaningful manner. However, simply taking part in faculty development rarely leads to knowledge transfer or change in practice, thus the proposed development session will include opportunities for individual and group work, self-reflection, and case studies. It is anticipated that the use of interactive and experiential activities will allow application to practice and ultimately improve implementation success (Spencer, 2014).

Learning outcomes

By the end of the one-hour faculty development session, participants will be able to:

1. Describe the behaviours and attributes of an unsafe or underperforming student

2. Identify appropriate remedial activities for student performance concerns
3. Practice using the performance improvement algorithm for clinical performance decision-making
4. Create a performance improvement plan (PIP) and post-performance improvement plan summary (P-PIPS) for a fictional case study.

The Workshop

Attendees

Based on the known time constraints that exist for nursing instructors, a one-hour workshop is a reasonable expectation to introduce the *Student success protocol*. In order to accommodate instructors' schedules, there will be two offerings of the workshop, one occurring on a Tuesday morning, and the other on a Thursday afternoon. In light of the current pandemic situation, both workshops will be held virtually via the Mircosoft Teams platform. One of the sessions would be recorded for those members who are unable to attend. Invitations to participate will be sent electronically via Red Deer College internal email. Given the small faculty size, there is no need to limit participation numbers per offering. Though student performance is not a new phenomenon for faculty, the language and expectations around student performance may not be congruent with current practices of instructors. As such, preparatory materials for participants will include a self-assessment and worksheet (Appendix A). The self-assessment would include assessing current practices and knowledge related to working with underperforming or unsafe students using Likert style questions. The remainder of the worksheet includes opportunities for participants to identify student behaviors or actions

that cued instructors be concerned about student performance. Lastly, there is opportunity for participants to establish and identify one to two relevant goals for their own learning in the faculty development session.

Activities

1. Clinical education case study

I would introduce the topic using an unfolding case study, which is considered common in nursing clinical education. This case study would be threaded through the workshop for experiential learning opportunities. A copy of the unfolding case study is found in Appendix B.

2. Discussion of student attributes

As the language of domains of learning is a particular change from previous practice, the use of group brainstorming and categorizing behaviors and attributes of underperforming or unsafe students into respective domains is planned. This will offer opportunity to clarify and discuss the specific behaviors, as well as finding new language to describe student concerns.

3. Presentation of supporting evidence

Based upon an extensive literature review, environmental scans, and individual consultations, a brief overview of the project will be presented using PowerPoint. The purpose of this presentation is to ensure that participants identify the evidence-based components within the *Student success protocol* as well as to share the findings obtained from the internal stakeholders and students consulted to increase the sense of ownership

of the protocol. Additionally, the evidence supporting the protocol derived from the comprehensive literature review will be summarized and presented.

4. Using the algorithm, PIP, and P-PIPS

Returning to the case study, participants will walk through using the *Student success protocol* components. Should future offerings of this workshop be possible in-person, this activity would include small group work. In the virtual setting, participants will have opportunity to work through the now-unfolding case study in smaller breakout groups, returning to the workshop group for debriefing after each element of the case study is presented. The unfolding case study will take participants from initially identifying student performance concerns, providing written feedback, and remedial activities through implementing a PIP, assigning a failing grade, and completing a P-PIPS.

5. Question and answer period

The last activity is to allot time dedicated for participant questions. As this is a new, but not unfamiliar, process I expect that there will be feedback and questions about the merits of the change. Having an open forum for such questions and concerns allows for transparency, as well as to clarify the process and to justify the components of the protocol.

Evaluation

Evaluative data from the workshop will not be collected, as the workshop is aimed at improving conceptual use of the *Student success protocol*. Conceptual use is merely the change in knowledge, without necessarily also changing practice (Graham et al., 2006; Thomas & Steinert, 2014). Also, the knowledge pertaining to the protocol is likely to be significantly varied amongst participants based on previous experiences and backgrounds. Data collected about the *Student success protocol* is likely more useful in a year after introduction to assess its efficacy. In addition to empirical data collected within the program, all full and part-time faculty members will be emailed a link to an anonymous online survey platform to assess the ease of use and satisfaction with the protocol.

References

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., et al. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in the Health Professions, 26*(1), 13–24. https://doi.org.10.1002/chp.47

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Appendix A

Participant Preparatory Worksheet

This worksheet will assist you in identifying your current level of experience and comfort with the topic, as well as identify your own particular learning needs.

I am confident in recognizing and responding to the behaviors and attributes of successful students

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

I am confident in recognizing and responding to the behaviors and attributes of unsafe students

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

I am confident in recognizing and responding to the behaviors and attributes of underperforming or marginally successful students

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

I am confident in giving high-quality, constructive feedback that clearly identifies all of my concerns to the student

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

I am confident in identifying, selecting, and implementing learning activities when students are struggling in the clinical setting

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
○	○	○	○	○

Describe the behaviors, actions, and attributes of unsuccessful students that you have previously taught.

Have you ever awarded a passing grade to a clinical student that you later felt should not have passed?

What were barriers to awarding a failing grade?

What were the facilitators in awarding a passing grade?

Appendix B

Unfolding vignette

Introduction

You are the clinical instructor assigned to a second-year clinical group in the winter term. You have a group of seven students, and are working on a surgical unit, where you have instructed previously. It is your fifth day on the unit, and students are working to plan, prioritize and evaluate care for a non-complex post-operative patient. Over the past three post-conferences, you have noticed that one student, Sam, has rarely participated. They have shared only superficial details about their day, and have not been actively listening to the discussion or debrief that has occurred. Yesterday, their documentation of a morning assessment was delayed, and Sam was asked twice to make corrections or additions by the primary nurse for details that were missed. You have a gut sense that something is amiss here, but you cannot quite put your finger on it.

Discussion of Attributes

It is now the sixth clinical day, and you have chosen to observe Sam's morning assessment. You know that Sam's patient today has had a cholecystectomy yesterday, with routine medications and follow up, and is planned for discharge tomorrow. Prior to observing Sam, you ask them for their priorities of care for this patient. Sam's chosen priorities are not the most appropriate – pain, monitoring for deep vein thrombosis, and discharge teaching—but their rationale and ability to recognize whether these priorities are actually occurring or potential is superficial and does not fit with the clinical picture for the client.

Questions to consider:

- To date, what attributes of unsafe practice or underperformance are evident?
- What should your next steps be?

Written Feedback

You verbalize your concerns to Sam in private after Sam has completed the necessary care for their client. You are sure to use the WRAP feedback method detailed in the *Student success protocol: Faculty guidebook*. Sam tells you during this encounter that they chose the priorities of care that they did because "the nurse told me that's what I need to focus on" and "I would not have actually worried about that stuff".

You follow up with written feedback at the end of the clinical day, and ask Sam to respond in writing that they understand the feedback they have received. *Participants to*

individually create a written feedback message to send to Sam, as well as a summary of concerns to send to the Associate Dean.

Escalation to Performance Improvement Plan

After your last clinical day with Sam, you decide that it would be helpful for Sam to be able to care for another client following a routine cholecystectomy. Sam's client today also has a history of atrial fibrillation and received digoxin daily. You know that students have extensive prior knowledge of this drug from both their pharmacology class, as well as their previous long-term care placements. When discussing the patient's clinical picture with Sam, Sam fails to identify the need to count the pulse prior to digoxin administration, and does not account for the patients diagnosis of atrial fibrillation in their plan of care and priorities for the day. Again, Sam's priorities of care do not reflect this patient's clinical picture. Additionally, Sam's documentation again needed remedying multiple times before considered complete.

Participants to work in small groups to use the PIP algorithm to (1) identify need for PIP (2) create a PIP for this student and (3) identify in-situ remedial activities that will support the student's success.

Ending the PIP

Sam has been working hard to improve their clinical performance over the past 10 clinical shifts. They have had success in connecting theory to practice using concept maps, and have solidified their priority setting using case studies provided to them. Further, they have been attending drop in lab on a regular basis to practice their clinical judgement and assessment skills.

Questions to consider:

- At what point would you consider discontinuing the PIP? Why?
- What would you expect to see if Sam is meeting the course outcomes at a level appropriate for their year?
- What would you expect to see if Sam is not meeting the course outcomes at a level appropriate for their year?

Completing the Post-Improvement Plan Summary

Sam was successful in the clinical course, after consistently demonstrating the knowledge, skills, and attitudes expected for a second year student. *Participants to work in small groups to complete the P-PIPS for Sam.*

Appendix D

Implementation and Evaluation Plan

Memorial University of Newfoundland
Faculty of Nursing
Master of Nursing Program

PRACTICUM: PLAN FOR IMPLEMENTATION AND EVALUATION

Student's Name: Maggie Convey **Student ID #: 201464179**

Supervisor: Robert Meadus **Date: July 21 2020**

Title: Development of a Student Success Protocol for Undergraduate Nursing Program Students

Brief Overview of the Project

The current process at Red Deer College (RDC) in place to identify and support undergraduate nursing students in clinical settings is failing to meet the needs of stakeholders. The development of a student success protocol will assist clinical instructors in being able to identify and address nursing students 'clinical deficiencies in a timely manner, whilst remaining learner centered, and faculty-friendly. When students with cognitive, affective, or psychomotor deficiencies in practice present to clinical learning settings, faculty members need to be able to accurately assess for and assist students in remediating such deficiencies without jeopardizing patient safety. Nursing programs must have clear and transparent processes that both define to students what underperformance and unsafe practice resemble, as well as provide clear identification of student and faculty roles and responsibilities when practice is unsatisfactory.

The development of a new student success protocol, which will detail the actions and behaviors that warrant clinical instructor intervention, as well as the steps to consider when a student is performing unsatisfactorily, will be developed following a thorough review of the extant literature, in nursing and within other human science educational programs. Consultations with key stakeholders, faculty members, and students will integrate the contextual perspectives and perceived needs of those who stand to be most affected by a process change. Finally, consultation with other programs of nursing may identify new and novel approaches not available in the literature.

The broad consultations and grounding in literature will determine the ultimate protocol developed in this project. It is anticipated that the developed protocol will be ready in September 2020.

Program Being Evaluated

The developed student success protocol will be ready for feedback from the nursing faculty at RDC in September 2020. There are approximately 60 full-time and part-time instructors in the Bachelor of Science in Nursing (BScN) program, which currently has approximately 360 students. Though the four-year program is offered in collaboration with the University of Alberta, the RDC program is responsible for defining and detailing their own processes for identifying and addressing unsafe and underperformance in the clinical setting by nursing students.

The developed student success protocol will be ready for introduction, initially to the Associate Dean and Chairperson for feedback. These two individuals have a broad knowledge of the college context, policies, and history to ensure that any deficits in the developed protocol will be sufficiently identified prior to presentation to the faculty-at-large. Questions for these individuals to consider will include: (a) does the protocol clearly identify faculty, student, and administrative roles and responsibilities when a student is at risk of clinical failure? (b) is the

protocol clear and easily understood? (c) will the protocol be understood to those outside of the program, should a student engage in a formal appeal process? Based on their feedback, any edits or amendments would be made prior to engaging in presentations to the faculty and subsequent faculty development.

As it is widely recognized that there are challenges in changing clinical and educational practices, the knowledge to action framework as detailed by Graham et al. (2006) is an appropriate tool to facilitate implementation of the developed student success protocol. The first phases of this framework have been addressed in the development of the protocol; the dissemination of the protocol will occur via faculty development activities (Graham et al., 2006). The goal of faculty development is to support faculty in their roles, while changing knowledge, skills, and attitudes for the goal of improving student outcomes (Thomas & Steinert, 2014). Effective faculty development is necessary for the successful implementation of the student success protocol, as otherwise, there may be confusion or reticence in using the protocol. Successful faculty development generally involves interactive and experiential techniques to apply new learning to practice, individual and group work to support peer relationships and informal mentorship, and a variety of instructional methods (Spencer, 2014). The faculty members at RDC are the knowledge users, responsible for integrating a new student success protocol into their current practices working with students. Barriers to the knowledge users' integrating a new protocol into their practice when working with students who are underperforming or unsafe may include a perceived lack of benefit for a new process, varying levels of experiences, and a lack of time to attend or participate in faculty development activities (Thomas & Steinert, 2014).

For this project, implementing the student success protocol will include interactive group workshops that will make use of individual and group work, case studies, and self-reflection.

Workshops will be facilitated by myself, and it is expected that over time the Faculty Navigator role will take over orientation to the protocol for new faculty members. Additionally, a written faculty guide to using the student success protocol will be developed and made available to all new and returning faculty. The guide will describe the use of the protocol, include case studies for reference, and provide literature support for the protocol.

Specific Objective(s) for the Evaluation

Evaluation of the implementation activities will support the conceptual use of the protocol (Graham et al., 2006; Thomas & Steinert, 2014). Conceptual use is described as a change in knowledge without change in practice (Graham et al., 2006; Thomas & Steinert, 2014). Case-study questions and self-reflective questionnaires developed for use in the faculty guide and within workshops will assess the conceptual use of the knowledge of the student success protocol.

Instrumental use of the student success protocol is the change in practice or behaviors that occur because of new knowledge (Graham et al., 2006). The instrumental use of the protocol would assess the efficacy of the new student success protocol. Evaluation of the student success protocol will be challenging, and would likely require a full year of use in the nursing program to ascertain the instrumental use. This is due in part to the low percentage of students who fall into the category of underperformance or unsafe clinical practice.

Following a year of use, evaluation of the student success protocol will consist of a retrospective review of frequencies of learning contracts initiated using the new process, and numbers of students who pass or fail when a contract is initiated. Comparisons about these frequencies with previous years would help identify the efficacy of the protocol, though there may be confounding factors that would limit the ability to draw conclusions. Additionally, faculty feedback about the ease of use of the protocol, and overall satisfaction with the protocol would be elicited through survey data after a year of use.

Participants

Evaluating conceptual use of the knowledge related to the student success protocol would not be collected, as it is anticipated that there would be significantly varied learning dependent on previous experiences. This data would be of limited value as well, as it is not generally tied to improving outcomes. As such, the instrumental use data collected a year after introduction would more accurately assess the efficacy of the new protocol. All full-time and part-time faculty who taught in the previous year in a clinical course would be invited via email to complete an anonymous, online survey using the Google Forms platform. It is anticipated that approximately 60 faculty members would be invited to offer feedback about the usability of the protocol.

Data Collection

Anonymous survey data will be compiled and collected using the Google Forms platform. A simple Likert scale will be used to elicit feedback about the ease of use and satisfaction with the protocol. Open-ended feedback questions would be used to elicit further depth and detail about the faculty experience, and would include: (a) what were your experiences using the student success protocol? (b) Overall, did the student success protocol support your work with underperforming or unsafe students in the clinical setting?

BScN student record data would assist in identifying if the protocol yielded different outcomes than that of the previous processes. The total number of learning contracts, withdrawals from clinical courses, and students who receive failing grades in clinical courses would be compared to the same numbers in the previous two years prior to the initiation of the new protocol. Additionally, the frequency of students who had received a learning contract but were ultimately successful in that clinical course would be compared to previous years.

Data Management and Analysis

Simple descriptive statistics, including the mean, will be collated from the online survey

tool. The responses from the open-ended questions will be analyzed for themes in order to assess strengths and deficiencies in the protocol.

The comparisons in student outcomes between previous processes and the newly developed protocol will employ inferential statistical measures, including t-test measures and analysis of variance (ANOVA). This will be completed using Excel spreadsheets, and SPSS.

Ethical Considerations

The faculty survey would include informed consent preamble to reiterate the anonymity of the data collected, the voluntary nature of participation, and the ability to withdraw consent. The anonymous survey data would be considered a quality assurance activity, and thus no research and ethical approval would be required. The results from the survey will be downloaded into a password protected computer file, and that computer stored in a locked office for security. Student success data, including frequency of learning contract initiation, outcomes of learning contracts, withdrawals from clinical courses, and clinical failures is tracked on a per annum basis by program assistants and the Associate Dean in the BScN program at RDC. As these frequency measures would not include student names or identification numbers, nor specific course numbers, this would constitute secondary use of anonymous data, and research and ethics board approval would not be required. The numerical data required to input in SPSS and Excel would be stored in a password protected folder in a protected computer, and located in a locked office.

Conclusion

The success and overall efficacy of the student success protocol is contingent on thoughtful implementation and faculty development. The evaluation of the student success protocol will measure both faculty satisfaction and perceived ease of use, but also measures of outcomes related to student success, such as attrition rates in clinical courses. The true efficacy of

the new student success protocol may not be evaluated until at least a year of consistent use, and even then, there may be confounding factors that limit the ability to draw final conclusions.

References

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in the Health Professions, 26*(1), 13–24. https://doi.org.10.1002/chp.47

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Appendix A: Consent Documents

Invitation to complete survey

Maggie Convey is seeking your voluntary feedback about the recently developed Student Support Protocol. Your feedback is valuable in ensuring that the protocol is easy to use and clear, and supports appropriate outcomes for students.

Your participation is voluntary, and you may choose to not participate without prejudice or penalty. You may withdraw your consent to participate at any time by closing out of the survey without clicking submit.

This online survey will take approximately 10 minutes to complete. Your responses will be confidential and no identifying information will be asked of you. All data compiled will be stored in a password-protected folder on a secure computer, within a locked office.

If you have any questions about this survey, you may contact Maggie Convey at maggie.convey@rdc.ab.ca**.** You will find the survey using the following link: Link to google form

Informed Consent in Survey

Maggie Convey is seeking your voluntary feedback about the recently developed Student Support Protocol. Your feedback is valuable in ensuring that the protocol is easy to use and clear, and supports appropriate outcomes for students.

Your participation is voluntary, and you may choose to not participate without prejudice or penalty. You may withdraw your consent to participate at any time by closing out of the survey without clicking submit.

This online survey will take approximately 10 minutes to complete. Your responses will be confidential and no identifying information will be asked of you. All data compiled will be stored in a password-protected folder on a secure computer, within a locked office.

If you have any questions about this survey, you may contact Maggie Convey at maggie.convey@rdc.ab.ca**.**

Clicking on the "agree" button below indicates that you have read the information above; you voluntarily agree to participate.

If you do not wish to participate, please decline participation by clicking on the "disagree" button or closing your browser window.

Appendix B: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Maggie Convey

Title of Practicum Project: Development of a Student Success Protocol for Undergraduate Nursing Program Students

Date Checklist Completed: July 10th, 2020

This project is exempt from Health Research Ethics Board approval because it matches item number _____3, 5_____ from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/