

**FACTORS CONTRIBUTING TO A RELUCTANCE OF CLINICAL  
FACILITATORS AT A PRIVATE NURSING EDUCATION  
INSTITUTION IN GAUTENG TO FAIL STUDENT NURSES WHO  
ARE NOT COMPETENT**

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# **DISSERTATION STATEMENT**

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Nursing

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# DECLARATION

I, Sonia Willemse, declare that this research report

**“FACTORS CONTRIBUTING TO A RELUCTANCE OF CLINICAL  
FACILITATORS AT A PRIVATE NURSING EDUCATION INSTITUTION IN  
GAUTENG TO FAIL STUDENT NURSES WHO ARE NOT COMPETENT”**

is my own work. It is being submitted for the Degree of Master of Science of Nursing at the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

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Sonia Willemse 785216

\_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_ in \_\_\_\_\_

I dedicate this study to my husband,

*Hannes*

Who shared this journey with me, always believed in me and never gave up on  
me.

Thank you for your unconditional love, support and encouragement.

## **ABSTRACT**

The past decade has seen an abundance of research related to the assessment of nursing students in clinical practice. Assessment serves several purposes: to regulate entry into the profession, as a quality control mechanism for the profession, to motivate students and to support teaching and learning. Agreement in the literature exists that assessment of clinical competency is complex, although necessary to safeguard the public and uphold the professional image of the nursing profession. Clinical facilitators have a professional responsibility to act as the “*gatekeepers*” of the nursing profession preventing borderline and unsafe students from being entered onto the professional register. Evidence from the literature and anecdotal evidence confirmed that clinical facilitators are not effective “*gatekeepers*” to the profession. Anecdotal evidence suggested that students who are not competent during clinical assessments are frequently graded as competent.

The aim of this study was to establish whether clinical facilitators are reluctant to fail student nurses who are not competent and to identify and describe factors contributing to their reluctance to fail student nurses who are not competent.

### **Research methodology**

A qualitative, exploratory, descriptive and cross-sectional contextual research design was used. The population included the clinical facilitators employed at the clinical placement facilities where the students are placed for their clinical practicum or at the NEI itself. Focus group discussions and semi-structured interviews were used to collect data. The discussions and interviews were recorded and transcribed verbatim. The transcribed data was analysed and coded using “Tesch’s Eight Steps in the Coding Process”.

### **Main findings**

The study revealed that clinical facilitators were, in certain circumstances, reluctant to fail student nurses who are not competent. Four categories emerged from the data viz. student related factors, programme requirements, the assessment process and facilitator related factors.

## **Recommendations**

The Nursing Education Institution should review current assessment practices if assessments and should implement mentorship and training and development programmes to assist clinical facilitators to develop competency in their role as assessors. A review should be undertaken of the moderator's role in assessments, and policies regarding assessment and moderation policies to mitigate the risk of "*failure to fail*". There should be greater cooperation between the NEI and the clinical placement facility to optimize student learning and assessments. Further research should be directed at supporting teachers and learners regarding effective assessment.

## **Conclusion**

Assessing students in clinical practice is complex and identifying unsafe students in clinical practice is not as straight forward as it may seem. "*Failure to fail*" is a multifaceted problem that needs to be addressed across all faculties in health sciences to ensure that graduates from nursing programmes have met specific competence criteria and are "fit to practice" safely and competently.

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# **CHAPTER ONE**

## **OVERVIEW OF THE**

### **STUDY**

#### **1.0 Introduction**

Chapter 1 offers an overview of the study. The background to the study, problem statement, the rationale for the study, research aim, research objectives, research questions, and the significance of the study are outlined. The key concepts related to the study are defined.

#### **1.1 Background to the Study**

The nursing education system in South Africa is multifaceted and nursing education and training programmes are offered in three types of Nursing Education Institutions (NEI's) namely; universities, nursing colleges and nursing schools located in either the public or private sector (Vasuthevan, 2013: 109-111).

Nursing colleges historically were funded by the Provincial Departments of Health by means of unconditional grants provided by the National Department of Health. In the recent years, some of the private hospital groups commenced training their own nurses due to the critical shortage of nursing staff. Three of the private hospital groups have large nursing colleges with regional learning centres (Vasuthevan, 2013: 109-111).

In South Africa student nurses are required to undertake a pre-registration nursing programme that encompasses a pre-determined theoretical and clinical component (SANC, 1993a; 1993b; 1989a; 1989b; 1986; 1985). Currently, pre-registration nursing programmes include the Enrolled Nursing Auxiliary, a one-year certificate programme; Enrolled Nurse, a two-year certificate programme; Bridging Programme, which makes provision for Enrolled Nurses to complete a two-year diploma to qualify as a Registered Nurse; Professional Nurse, a four-year comprehensive diploma or a four-year comprehensive baccalaureate degree.

This research study's setting was a private NEI in Gauteng offering basic (pre-registration) and post-basic SANC accredited nursing programmes. The pre-registration and post-basic programmes offered at the NEI are in accordance with the South African Nursing Council's (SANC's) requirements for pre-registration and post-basic programmes.

Some of the students studying at the NEI are responsible for their own costs towards studying and are referred to as self-funded students. A percentage of the self-funded students receive a stipend contributing towards the cost of their studies. The rest of the students are employed at the clinical placement facilities that were selected to study to further their career. They were granted bursaries, should they however not complete the programme, they will be held responsible for the cost of the programme.

In accordance with the *Nursing Education and Training Standards* (SANC, 2013) the NEI requires the students to successfully complete a pre-determined amount of formative assessments to gain entry to the summative clinical assessment. The criteria for competency in the clinical assessments are set at institutional and program level consequently the requirements may differ from one clinical placement facility to another. In addition, different clinical facilitators often interpret what is required by each criterion in order to achieve a passing grade differently from one another.

Interim progression discussions held approximately every three months during the programme allow the student to progress to the next interval provided the student meets the stipulated criteria. Failure to meet the stipulated criteria, within the stipulated timeframes, may lead to an extension (an extended period of study) or discontinuation of the student's training. Self-funded students and employed students alike are responsible for the additional fee, related to the extended period of study. Clinical facilitators are fully aware of the consequences for students that fail to meet the stipulated criteria.

Clinical facilitators, in their role as assessors, are responsible for the quality of the assessments they conduct. According to Stuart (2013), clinical facilitators [assessors] need to be "gatekeepers" for the nursing and health professions in order to fulfil the quality control function of assessment. Evidence in the literature indicate that the "gatekeeping" role is inadequately performed as many researchers (Brown, et al., 2012; Deegan, Rebeiro and

Burton, 2012; Docherty and Dieckmann, 2015; Dolan, 2003; Dudek, Marks and Regehr, 2005) reported a “*failure to fail*” with grave consequences for the public served by health care professionals whose health and well-being are supposed to be protected by those entrants onto the professional register.

Schaub and Dalrymple (2013) referred to “*A decade of failing to fail*” as the last ten years seen the emergence of a growing body of literature on the phenomenon with Duffy’s (2003; 2004) foundational work on “*failure to fail*” in nursing. Findings from the study of Duffy (2003; 2004) revealed that students are passing clinical assessments even when there were doubts about their clinical performance.

Reasons emerging for the phenomenon of “*failure to fail*” included inadequate reporting of concerns resulting in moral dilemmas which lecturers and mentors struggle to deal with, underperforming students were often granted the “*benefit of the doubt*”, failing students were a difficult thing to do with personal, emotional and practical issues influencing the outcome of the assessment decision (Duffy 2003; 2004).

Competency assessment in the health care professions is worldwide a matter of concern to most practice-based disciplines (Hunt, et al. 2012). The phenomenon “*failure to fail*” was reported in nursing (Brown, et al., 2012; Docherty and Dieckmann, 2015; Jervis and Tilki, 2011; Larocque and Luhanga, 2013; Vinales, 2015), in medicine (Cleland, et al. 2008; Dudek, Marks and Regehr, 2005), in social work (Finch and Taylor, 2013; Schaub and Dalrymple, 2013) and education (Hawe, 2003).

In the study conducted by Docherty and Dieckmann (2015) faculty [educators] perceived a lack of support from course coordinators and senior administrators as a factor contributing to their reluctance to fail students, they raised concerns that administration will overturn fail decisions. Other pressures included meeting the grading norms of the team and failing students at later stages during their training.

The negative feelings associated with failing students included feelings of guilt, personal failure, anger, fear, anxiety and a lack of confidence amongst clinical facilitators. All of which may have contributed to a reluctance to fail students who are not competent (Black,

Curzio and Terry, 2014; Brown, et al., 2012; Hrobsky and Kersbergen, 2002; Luhanga, Yonge and Myrick, 2008a; Rutkowski, 2007).

Various other factors described by nurse mentors associated with “*failure to fail*” less satisfactory students included the complexity of assessing clinical performance, especially when student performance is borderline; failing students was emotionally demanding and stressful. Nurse mentors may lack confidence in their own clinical knowledge and experience to make a decisive decision to fail a student (Jervis and Tilki, 2011; Luhanga, Yonge and Myrick, 2008a).

Cleland et al. (2008) in a study conducted amongst medical educators in Scotland reported the time to complete assessment documents, to attend appeals and to provide remedial help played an important role in the decision to not to fail borderline students. Contributing factors included the educator’s professional self-image, feelings of personal failure, a lack of knowledge about available support systems and knowing the outcome of students who failed.

Hunt et al. (2012) reported in their study on comparing theoretical and clinical assessment results in England that a disparity exists between failure in the theoretical and clinical assessments in nursing courses in England. Referral and failure rates for theory outstripped practice by a ratio of 5:1. These results are in support of the findings reported by Duffy (2003; 2004) and Luhanga, Yonge and Myrick (2008a) that assessors avoid failing under-performing students in clinical assessments.

Irrespective of the profession or country, an agreement exists that those who assess [clinical] practice are the *gatekeepers* of their profession, having the responsibility to determine whether the students they assess are fit to be entered onto the professional register. Patient safety is the most important principle in the assessment of student nurses and other health care profession students. Neglecting this role would potentially threaten the safety of the client population served (International Council of Nurses, 2006 cited in Hunt et al. 2012; Oermann, et al., 2009b; Tanicala, Scheffer and Roberts, 2011).

## **1.2 Problem Statement**

Anecdotal evidence suggests that students who are not competent during formative and summative clinical assessments are frequently graded as competent. The impact of this practice on patient care can lead to incompetent nurses being registered and potentially leading to problems regarding patient safety and wellbeing. Apart from neglecting to protect the public from harm, the practice of “*failing to fail*” has a number of serious implications for the nursing profession as a whole. Professional self-regulation becomes doubtful affecting the public perception of and confidence in the nursing profession (Luhanga, Yonge and Myrick, 2008a; Scholes and Albarran, 2005). Pepper and Slabbert (2011) reported a sharp increase in medical malpractice litigation in South Africa with an increase in the number and size of claims in both public and private sectors.

Clinical facilitators have a professional responsibility to act as the gatekeepers of the profession preventing borderline and unsafe students from entering the professional register thereby protecting the public from unsafe, unscrupulous practice (Luhanga, Yonge and Myrick, 2008a).

It is not clearly understood why nurse educators engage in the practice of “*failure to fail*” as initially described by Duffy (2003; 2004) and further explored by other researchers. The phenomenon of “*failure to fail*” has been identified as a continuing problem internationally across all programmes but no studies have been undertaken in South Africa relating to this phenomenon to date.

There was a need to determine the clinical facilitators’ perceptions regarding this phenomenon and to identify the underlying reasons for “*failing to fail*” students, in order to understand and address the problems and ensure the competency and proficiency of future registered nurses.

## **1.3 Rationale for the Study**

The past decade has seen an abundance of research related to the assessment of students in clinical practice (Brown, et al., 2012; Docherty and Dieckmann, 2015; Deegan, Rebeiro and

Burton, 2012; Jervis and Tilki, 2011; Larocque and Luhanga, 2013; Luhanga, Yonge and Myrick, 2008a; Rutkowski, 2007; Vinales, 2015).

Assessment serves several purposes: to regulate entry into the profession, as a quality control mechanism for the profession, to motivate students and to support teaching and learning (Stuart, 2013: 14).

As a quality control mechanism for the health care profession, clinical facilitators are required to be able to identify the students who did not meet the educational standards and therefore make a 'fail' decision, preventing students that are not competent from being entered onto the professional register (Larocque and Luhanga, 2013; Stuart, 2013: 14).

Evidence suggested that clinical facilitators find it difficult to fail students who are not competent (Brown, et al. 2012; Deegan, Rebeiro and Burton, 2012; Docherty and Dieckman, 2015). Internationally various researchers described factors contributing to the phenomenon of "*failure to fail*" student nurses who are not competent (Jervis and Tilki, 2011; Larocque and Luhanga, 2013; Luhanga, Yonge and Myrick, 2008a).

A paucity exists in South African literature regarding "*failure to fail*" student nurses who are not competent.

Hunt et al (2012) found that a disparity exists between failure in theoretical and clinical assessments. Morolong and Chabeli (2005) found that newly qualified nurses were not competent in the implementation of nursing care. The focus of the study conducted was not related to the phenomenon of "*failure to fail*", but it does raise the possibility of "*failure to fail*".

In South Africa, quality of care is a national priority and a statutory demand. The health care system demands competent nursing practitioners and "*failing to fail*" places incompetent nursing practitioners in clinical practice, affecting the quality of health care.

## **1.4 Research Aim**

The aim of the study was to establish if clinical facilitators are reluctant to fail student nurses who are not competent and to describe the factors contributing to a reluctance of clinical facilitators to fail student nurses who are not competent.

The information obtained from this study will assist Nursing Education Institutions to understand the underlying issues experienced by clinical facilitators related to the assessment of students in clinical practice. The information will enable Nursing Education Institutions to assist and support clinical facilitators in future and to graduate competent, practice ready registered nurses on completion of their training.

## **1.5 Research Objectives**

The objectives of this study were to:

- Determine if clinical facilitators are reluctant to fail student nurses who are not competent during formative and summative assessments.
- Explore and describe factors contributing to a reluctance of clinical facilitators' at a private nursing education institution in Gauteng to fail student nurses who are not competent during formative and summative assessments.

## **1.6 Research Questions**

1. Are clinical facilitators reluctant to fail student nurses who are not competent?
2. What are the factors contributing to clinical facilitators' reluctance to fail student nurses who are not competent?

## **1.7 Significance of the Study**

The NEI's are accountable to the SANC and to the broader community to uphold the standards of nursing education and training. The SANC and the NEI's will be made aware the phenomenon and of the factors contributing to the phenomenon of "*failure to fail*" and will therefore be in a better position to address them. Strategies to support clinical facilitators

can be implemented, reputational damage limited and the image of the nursing profession protected.

## **1.8 Definition of Key Concepts**

### **1.8.1 Accreditation**

*“The approval and recognition of an organization, qualification or programme of study by an external professional body”* (Hughes and Quinn, 2013: 539). Accreditation, as applied to NEI’s in South Africa, refers to the legal status awarded to an NEI, in terms of section 42 of the Nursing Act, 33 of 2005. Accreditation entails that the NEI, together with its programmes and facilities comply with prescribed criteria (Subedar, 2013: 108, 114).

### **1.8.2 Assessment**

*“The process of collecting information about students’ learning and clinical performance over time”* (Oermann, et al., 2009a: 274).

In the context of this study, formative assessment refers to the assessment of students during their clinical placement at pre-determined intervals and provides feedback to the student regarding his or her progress towards the clinical objectives or learning outcomes of the educational programme.

The summative assessment refers to the student’s assessment at the end of an academic year and measures the student’s achievement towards the clinical objectives or learning outcomes of the educational programme, at the end of the academic year. If the student is competent in the summative assessment at the end of an academic year the student progresses to the next year of study. Competency in the final academic year of the educational programme may lead to certification and registration or enrolment with the SANC, provided both clinical and theoretical objectives are met.

### **1.8.3 Assessor**

According to Stuart (2013: 1) the term assessor encompasses all clinical practitioners who assess and support students during clinical practice, or lecturers from higher education institutions that assess academic work and / or clinical practice of students.

In the context of this study the clinical facilitators, as described later in this chapter, function as assessors of students during the students' clinical placement. Although a pre-requisite from the SANC is that all assessors should be trained as assessors (SANC, 2013: 40), this might not necessarily be the situation, especially newly appointed clinical facilitators involved in the assessment process of the students.

### **1.8.4 Clinical accompaniment**

Clinical accompaniment is a mindful and focussed process of guiding and supporting students in the clinical learning environment (Mochaki, 2007: 32). For the purpose of this study, clinical accompaniment refers to the time the clinical facilitator spends at the bedside with the nursing student to assist the student in developing her nursing skills. The time may not be utilized to do any form of assessment.

### **1.8.5 Clinical competence**

Hughes and Quinn (2013: 539) defined clinical competence as the ability of a person to practice safely and effectively. According to Oermann, et al. (2009b: 353) clinical competency is much more than just safe practice. Clinical competence is linked with theoretical knowledge, clinical skills, attitudes and values (Cassidy, 2009: 39; Oermann, et al., 2009b: 353). The competent nurse: *“must be able to analyse complex patient situations, solve problems, and communicate effectively with other health care disciplines and care recipients ...”* (Oermann, et al., 2009b: 353).

### **1.8.6 Clinical environment**

The term clinical environment simply refers to the environment where patient care and clinical activities take place (Stuart, 2013: 147).

The **clinical learning environment** is a formal educational setting where students learn about care and what clinical practice is about; students actively participate in the observation and treatment of patients (Deegan, Rebeiro and Burton, 2012: 43).

The term clinical learning environment, in this study, is contextual and refers to the clinical placement facilities or health care settings where students are placed for their clinical practicum.

### **1.8.7 Clinical facilitator**

Throughout the literature, various terms are used to describe the practitioner who supports, supervises and facilitates student learning during clinical practice including; mentor, assessor, preceptor, work-based supervisor, fieldwork teacher, practice learning facilitator, practice educator, clinical tutor or trainer (Stuart, 2013: xv). Stuart (2013: xv) uses the term ‘practice educator’ to describe the clinical practitioner who supports, guides, supervises and facilitates student learning during clinical practice. The practice educator also has the responsibility for conducting both the formative and summative assessment of competence.

The term used most frequently in the context of this study is clinical facilitator, thus the term clinical facilitator for purposes of this study shall mean the same as ‘practice educator’ as defined by Stuart (2013: xv). In the context of this study the clinical facilitator may or may not hold an additional qualification in Nursing Education.

### **1.8.8 Competency-based education**

Competency-based education refers to teaching, learning and assessment activities that are sufficient to enable students to acquire and demonstrate a pre-determined set of competencies as the outcome of learning (SANC, 2013: 3).

### **1.8.9 Educator**

Educator is an inclusive term referring to teachers, lecturers, facilitators, assessors, moderators, and others teaching and learning, educating, training, assessing, or enabling learning in learning contexts across the board (SAQA, 2015: 5).

### **1.8.10 Nurse Educator**

A **Nurse Educator** is a Professional Nurse with an additional qualification in Nursing Education and is registered as such with the SANC (SANC, 2014).

Nursing educators for the purpose of this study include, but are not limited to lecturers, clinical educators or facilitators and assessors (registered with the SANC and SAQA, as such) and are employed either by the NEI itself or in the health care setting where students are placed for their clinical practicum.

### **1.8.11 “Failure to fail”**

“*Failure to fail*” relates to the phenomenon of allowing students to pass clinical assessments without having demonstrated sufficient competence. Findings from Duffy (2003) revealed that students are passing clinical assessments even when there were doubts about their clinical performance.

### **1.8.12 Grade inflation**

Grade inflation refers to the assigning of higher grades to student achievement than the performance of the student warrants (Hodges, 2014; Scanlan and Care, 2004).

### **1.8.13 Nursing Education Institution (NEI)**

NEI refers to an institution conducting nursing education and training programmes and is accredited by the South African Nursing Council (SANC) under the Nursing Act, 2005 (Act No. 33 of 2005) as a nursing education institution (SANC, 2005).

### **1.8.14 Nursing students or learner nurses**

Nursing students refer to persons who are registered on a preregistration programme and are registered with SANC as learners under Section 32 of the Nursing Act, 2005 (Act No. 33 of 2005) (SANC, 2005).

In the context of this study, the term student or nursing student is used for any student who is registered on or enrolled in any of the basic programmes offered at the selected NEI.

## **1.9 Conclusion**

Chapter 1 provided an overview of the study. The background to the study, problem statement, the rationale for the study, research aim, research objectives, research questions, and the significance of the study were outlined. The key concepts related to the study were clarified. The research design and method will be discussed in Chapter 3. In Chapter 2 an overview of the literature review discussing the phenomenon of “*failure to fail*” will be provided.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

Chapter two provides an overview of the literature review discussing the phenomenon of “*failure to fail*” student nurses who are not competent in clinical assessments in undergraduate nursing programmes. The progression of the chapter evolves from exploring the role of the South African Nursing Council in education and training in South Africa. The assessment context in South Africa is included. The chapter further reviews the significance of assessment in clinical practice, the complexities associated with clinical assessment and the challenge in defining clinical competence and describing unsafe practice. The role of the clinical facilitator, the dual responsibility of the clinical facilitator as assessor and mentor, and the role conflict experienced by the clinical facilitator is explained. The chapter concludes with the concept “failure to fail” and grade inflation.

#### **2.1 The role of the South African Nursing Council (SANC) in nursing education and training in South Africa**

The South African Nursing Council is involved in the monitoring of nursing standards through the registration of nurse practitioners, permitting them to practice as nurses; setting the minimum standards for education and training of nurses; accreditation of new nursing education institutions and nursing education programmes; and inspecting nursing education institutions and clinical placement facilities (SANC, 2015; Kotze, 2013: 77-78).

In order to register with the South African Nursing Council, a person has to complete an SANC-approved education and training programme at an accredited Nursing Education Institution (NEI) (Stellenberg, 2013: 168; Geyer, 2013a: 66).

Education and Training Quality Assurance bodies (ETQA’s), established in terms of the SAQA Act of 1995 (Act 101 Of 1995) are responsible for quality assurance of unit standards and qualifications and the promotion of education and training (Geyer and Vasuthevan, 2013:

82). The South African Nursing Council is accredited by South Africa Qualifications Authority (SAQA) as an ETQA with the primary function being the accreditation of training providers and training programmes in the field of nursing education and training. In terms of functioning as an ETQA, the SANC develop regulations, standards and criteria, which each education institution, including both the NEIs and the clinical placement facilities, must adhere to before accreditation, can be awarded.

## **2.2. Nursing Education and Training Standards**

The South African Nursing Council regulates nursing and nursing education and training in South Africa. In 2013, the SANC published the “*Nursing Education and Training Standards*” where issues affecting clinical placement areas are addressed to promote optimum training and education of nurses in South Africa (SANC, 2013). The standards and criteria address areas, which include, but are not limited to the retention of students, clinical support, monitoring of students’ progress and the assessment of students during clinical placement.

The various domains, subdomains, standards and criteria attempt to comprehensively regulate all the components of the nursing students’ theoretical and clinical education and training, ensuring that nurses and midwives who are entered onto the register on completion of their training programme are competent and fit to practice (SANC, 2013).

The South African Nursing Council’s “*Nursing Education and Training Standards*” (SANC, 2013: 41) makes provision for the assessment of students’ learning, knowledge and skills development, using reliable evaluation methodologies. The criteria make provision for the use of trained assessors, and different forms of assessment e.g. continuous, formative, and summative assessments, stating that assessments should be spaced realistically throughout the programme allowing adequate time for demonstrations, practice, and remediation.

Criteria to enable the achievement of the “*Nursing Education Training Standards*” includes the use of practice-based as well as simulated assessments for clinical evaluation, such as the Objective Structural Clinical Exam (OSCE) and the use of other of assessment activities, for example, patient presentations and case histories (SANC, 2013: 41-42).

The South African Nursing Council also states that NEIs must have a student retention system in place, to provide academic support for students that are slow to develop. The

retention programme includes extension programmes, remedial/intervention programmes and psychosocial support (SANC, 2013: 42)

Experienced academic staff, who is adequately prepared for their roles, should be involved in assessing and supporting students in order to produce graduates that are knowledgeable practitioners, and adhere to the code of ethics and standards of the profession (SANC, 2013: 14-15).

### **2.3 Clinical facilitators**

Clinical facilitators or lecturers comprise of nurses, midwives, and other health care professionals who are expected to remain clinically competent and possess educational expertise in their speciality area (SANC, 2013: 93-100). They have to provide evidence of preparation for their roles as clinical lecturers/preceptors and must have 3 years' experience in clinical teaching as a Nurse Educator.

Essential in the role of the clinical facilitator is the monitoring of practice and student achievement of learning outcomes. Furthermore, they have to participate in the formative and summative assessments of students, which in essence may create interpersonal conflict as clinical facilitators also need to inspire, support and role model professional and ethical behaviours for student nurses, requiring a close interaction with student groups allocated in a specific clinical facility to optimize clinical learning of students (SANC, 2013: 93-100).

In the context of this study, the clinical facilitators are responsible for assessing students, thus fulfilling the role of mentor and assessor. The term clinical facilitator is used throughout the study unless the context specifically refers to "assessor", "mentor" or "preceptor" such as a reference to other study contexts.

Clinical facilitators are faced with a dual loyalty. Geyer (2013b: 39) stipulates that dual loyalty occurs when there are conflicting roles and responsibilities (Geyer, 2013b: 39).

The clinical facilitator in clinical practice is assigned a dual role, namely that of facilitator, mentor, and supporter, as well as that of assessor (Hand, 2006: 49; Stuart 2013: 38). The dual role of assessor and mentor can create challenges for the facilitator-student relationship.

Failing a student may be seen as uncaring, whereas “*failure to fail*” poses a threat to the safety of the public and place the reputation of the nursing profession and the educational institution at risk (Stuart, 2013: 40).

Clinical facilitators are required to provide students with constructive feedback on their performance. Providing the feedback may require the facilitator to make a judgement regarding their performance. It is a challenge to maintain special relationships with students amidst the responsibilities of being a good assessor.

Clinical facilitators are accountable and responsible to the student, the professional body, the employer and the public. Accountability is based on the clinical facilitators’ ability and willingness to take responsibility for his or her actions. In this instance the clinical facilitator accepts responsibility for the quality of teaching, learning and assessment in clinical practice (Stuart, 2013: 40). They have to answer to and accept responsibility for their professional judgements about student’s performance.

Clinical facilitators are professionally, ethically, and legally accountable to the public to safeguard them from unsafe and incompetent practitioners, to the students for teaching and support supervision and to facilitate learning (Geyer, 2013c: 137-139; Stuart, 2013: 40).

## **2.4 Competencies of a Nurse Educator**

The SANC, as part of their role in education and training, described competencies for a Nurse Educator (SANC, 2014). The SANC defines a Nurse Educator as a Professional Nurse with an additional qualification in Nursing Education and is registered as a nurse educator with the SANC. Their roles include being lecturers, clinical educators, education managers, researchers, and specialists, both in NEIs and at clinical placement facilities.

Core competencies of the nurse educator are described in seven domains, including scholarship of teaching and learning; academic and student management; curriculum

development; management and leadership; personal development of the nurse educator; research and knowledge creation and professional, ethical and legal practice (SANC, 2014). Of particular interest in this study is the use of assessment and evaluation strategies by the nurse educator (SANC, 2014: 3) which are described in the core standards in the following manner:

- *“Use a variety of strategies to assess and evaluate learning in the cognitive, psychomotor, and affective domains*
- *Implements evidence-based assessment and evaluation strategies that are appropriate to the student and the learning goals*
- *Use assessment and evaluation data to enhance the teaching-learning process*
- *Provides timely, constructive, and thoughtful feedback to students*
- *Demonstrate skill in the design and use of assessment tools for assessing knowledge and clinical practice”*

## **2.5. Assessment**

Assessment is the cornerstone of a qualification; as assessment is integral to the curriculum, with both, assessment and curriculum being integral to the quality of qualifications and the extent to which qualifications articulate with each other (SAQA, 2015: 9).

Before any assessment can be undertaken, a decision needs to be made on how the assessment is going to be used in the process of learning, including the following decisions: what are the assessment criteria, the content of the assessment and the purpose of the assessment (SAQA, 2015).

## 2.5.1 The purpose of assessment in clinical practice

Stuart (2013) identifies four key purposes of assessment in nursing education. Figure 2.1 illustrates this framework.

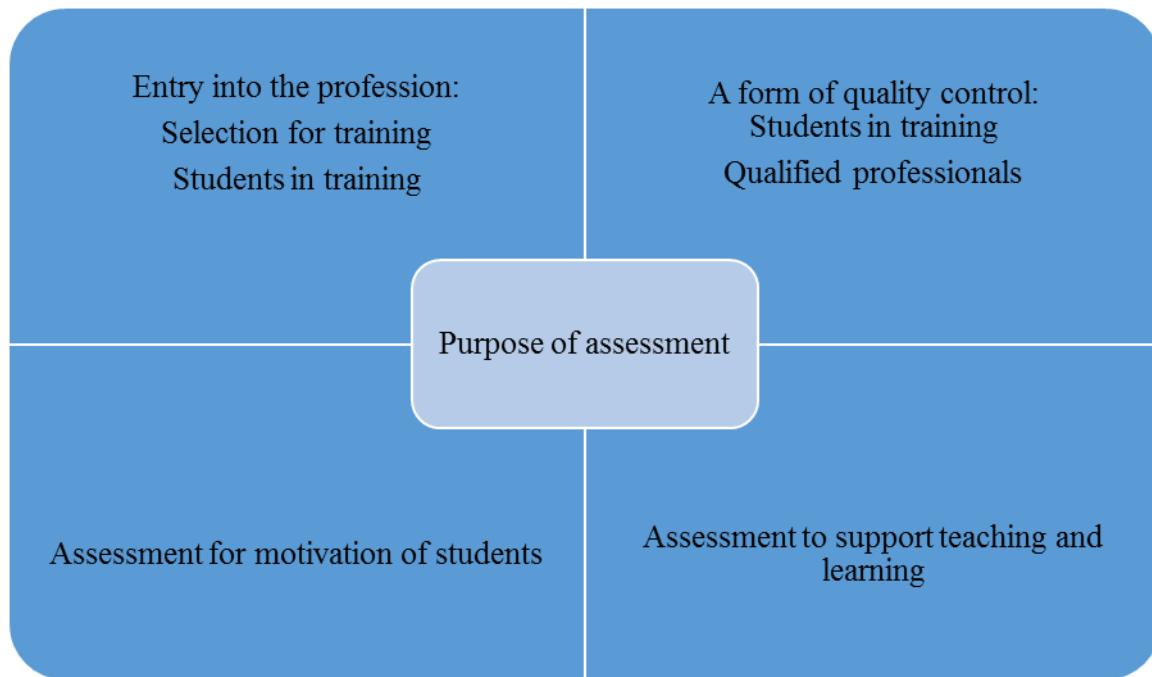


Figure 2-1 The purpose of assessment (Compiled from Stuart, 2013)

### 2.5.1.1 Entry into the profession

The educational outcome of pre-registration nursing programmes is a competent practitioner who demonstrates scientific knowledge and clinical competence, adhering to the professional values, norms and standards of the profession able to deliver safe, evidence-based quality nursing care to patients, families and diverse populations of individuals (Stuart, 2013; SANC, 2013).

The NEI is responsible for the facilitation of the learning and development of pre-registration nursing students and to ensure that only the students who achieved the required level of competence are entered into the professional register. It is incumbent on the NEI to provide evidence that the graduate is able to meet the required standards of competency leading to registration as a nurse. Evidence of competence should be generated through valid and reliable assessment methods and processes (Stuart, 2013; SANC, 2013).

### **2.5.1.2 Assessment as a form of quality control**

Fulfilling the purpose of assessment as a form of quality control for the nursing profession, assessors or clinical facilitators who act as assessors in the clinical area, are required to identify the students who did not achieve the required of competence. The students, who do not achieve the required minimum standard, then receive a “fail” result and are unable to progress, ensuring only those students who achieved the required level of competence are entered into the professional register.

Amongst other roles clinical facilitators or assessors are required to be the “*gatekeepers*” of their profession (Stuart, 2013: 6). The literature suggests that this “*gatekeeping*” role may not be adequately performed with possible instances where assessors “*failure to fail*” students, that may have grave consequences to the profession and the public (Docherty and Dieckmann, 2015; Larocque and Lahunga, 2013; Jervis and Tilki, 2011).

The grounded theory study of Duffy (2003; 2004) concerning the factors that influence decisions related to the assessment of students’ competence in clinical practice opened up more than a decades’ research on the complex phenomenon of “failure to fail” (Brown, et al., 2012; Jervis and Tilki, 2011; Larocque and Lahunga, 2013; Luhunga, Yonge and Myrick, 2008; Rutkowski, 2007; Scanlan and Care, 2004). The phenomenon of “failure to fail” is discussed later in this chapter.

### **2.5.1.3 Assessment for the motivation of students**

An important purpose of assessment is that assessments serve as powerful motivation for students (Crooks, 1988; Hughes and Quinn, 2013: 244; Stuart, 2013: 8). Assessment encourages the student to learn and without assessment many students would lack any real incentive to learn.

Crooks’ study (1988) highlighted the importance of assessment in defining the student’s attitude towards their work, their sense of ownership and control of their own learning, the strategies they employ in learning, their confidence, and self-esteem. These factors all impact on the quality of learning achieved. Conversely, Bowie (2010: 66) identified high levels of

stress and anxiety associated with the clinical learning environment as a barrier to effective learning during clinical practicum.

#### **2.5.1.4 Assessment to support teaching and learning**

Another key function of assessment, apart from obtaining evidence of competence, is that assessment is about supporting students in their learning, thus building the student rather than penalizing the student (Hernández, 2012: 490; Stuart 2013: 101-103). The student should be able to demonstrate what they learned, while they receive support and feedback. Formative and summative assessments alike can influence learning.

Assessments, both formative and summative, should be a cumulative process, i.e. monitoring students' progress as well as student achievements against set criteria or learning outcomes on a continual basis throughout the programme (Stuart, 2013: 117). Formative assessments take place throughout the student's placement or educational programme. Summative assessments take place at the end of the student's placement or educational programme. Formative assessments provide feedback to the student about the progress he or she is making, summative assessments determine if the student has achieved the learning outcomes of the educational programme (Hand, 2006: 50; Hughes and Quinn, 2013: 246; Stuart, 2013: 117).

The definitions of formative and summative assessments highlight two purposes of assessment, namely assessment "*for learning*" and assessment "*of learning*" (Hernandez, 2012: 489). Although Stiggins (2002) cautions that it is not simply a matter of equating formative assessments with assessment "*for learning*". Assessment "*for learning*" must involve the student in the process providing continuous information about student achievement. Hernández (2012: 490) contemplates that continuous assessment generally fulfils both purposes, i.e. formative "*for learning*" and summative "*of learning*".

Constructive feedback is an important element where assessments are used for learning and enhancing clinical performance (Crooks, 1988: 468; Duffy, 2013: 50-51; Hernández 2012: 491; Zsohar and Smith, 2009: 241). Feedback should focus the student's attention on task development and mastery, and takes place soon after task completion. Hernández (2012: 492)

emphasizes the importance of student engagement in feedback requiring the student to “*act upon it*” to improve learning.

In the opinion of Crooks (1988: 468) assessments should be used far more often in the support of teaching and learning, than in the grading of students. He suggests an approach to assessment where assessment is directed at providing the student with constructive feedback with less frequent use of assessments for summative purposes.

### **2.5.2 Principles of assessment**

Stuart (2013: 92) highlights that an assessor continually makes assessment decisions about the student’s performance, which must be fair and justifiable or ‘defensible’. Stuart’s analysis of fair and defensible assessments refers to assessments that are ‘according to rules’ and ‘justifiable with sound reasons’ (Stuart 2013: 92).

Stuart (2013: 98) and Hughes and Quinn (2013: 247-248) describe the cardinal attributes of fair and defensible assessments as; validity, reliability, feasibility [practicability] and discriminating power. In addition to the attributes described by Stuart (2013: 98) and Hughes and Quinn (2013: 247-248), the South African Qualifications Authority (2015: 11-12) refers to integrity, transparency, accountability, and absence of bias including sensitivity to language, as equally important in the assessment process.

Implementing a structured assessment process, as suggested by Price (2012) is time-consuming, however, necessary to refute challenges of unfair assessments and can successfully defend the quality of assessments in clinical practice. Addressing the complexity of clinical assessments necessitates a review of current assessment practices.

#### **2.5.2.1 Validity**

Validity refers to the extent to which the assessment measures what it is designed to measure (Hand, 2006: 51; Hughes and Quinn, 2013: 247; Stuart, 2013: 99). Assessment of student nurses in clinical practice should aim for a high validity factor.

A concern of validity in clinical practice is that validity is often inferred and the means of inferring validity is to collect evidence of the different types of validity (Stuart 2013: 92), i.e. content validity, construct validity and concurrent validity.

Content validity is the extent to which an assessment covers the appropriate and necessary content.

Construct validity is the extent to which the outcome of the assessment reflects the construct being assessed. Attitudes and values are difficult constructs to assess and the personal constructs of the assessors may influence the construct validity of the assessment (Stuart, 2013: 93).

Concurrent validity refers to the ability of an assessment to predict the outcome of an assessment in a related area of performance. In order to achieve concurrent validity the range of the assessment need to be specified (Stuart, 2013: 94).

### **2.5.2.2 Reliability**

Reliability is the overall consistency of a measure i.e. the same assessment-related judgment that will be achieved in similar contexts and under consistent conditions (Hughes and Quinn, 2013: 247; SAQA, 2015: 11; Stuart, 2013: 94). Reliability of the assessment is enhanced through an accurate record keeping of the assessment activities and assessment outcomes; and the context and conditions of the assessment (SAQA, 2015: 15).

Reliability is enhanced through a common understanding amongst assessors of the assessment criteria, knowledge of the application of the assessment criteria, learning outcomes, the purpose of the assessment and measures to ensure validity and integrity. Increasing reliability requires the use of the same assessment criteria amongst different assessors and consistent interpretation of the assessment criteria (Hand, 2006: 52, Stuart, 2013: 94-95).

Student related factors that may affect the reliability of assessment are those factors that influence the consistency of student performance (Stuart, 2013: 95). Numerous human factors influence student day-to-day performance. Physical and emotional factors affecting

performance include poor health, fatigue, lack of interest in the clinical placement, lack of motivation to learn, anxiety, lack of confidence in their own ability to provide patient care and personal problems affecting memory and concentration.

### **2.5.2.3 Feasibility**

Feasibility or “practicability” of assessments refers to time and resources available to do assessments as well to prepare students for assessments. (Stuart, 2013: 98; Hand, 2006: 52; Hughes and Quinn, 2013: 248). Assessments are seen as unfair if the students did not have sufficient time to practice and demonstrate competence (Stuart, 2013: 98). The limited amounts of time students spend in the clinical practice setting often contribute to the challenge of giving students sufficient time to practice skills and demonstrate competency.

### **2.5.2.4 Discriminating power**

Discriminating power refers to assessments that can reflect the different levels of competence required from different students at different times during their training (Hand, 2006: 52; Stuart, 2013: 98-99). During formative assessments, it is important to determine a student’s level of performance to identify areas in need of further development. In summative assessments, the discriminatory power of assessments is used to determine whether a student achieved the required level of performance appropriate for the stage of training or the awarding of a qualification.

### **2.5.2.5 Other principles of assessment**

The South African Qualifications Authority (2015: 11-12) refers to integrity, accountability, accountability, fairness and the absence of bias including sensitivity to language, as equally important in the assessment process.

- Integrity refers to honesty in the assessment process and transparency to the extent to which the students and educators have a clear understanding of the assessment process.

- Accountability – every person involved in the assessment process are accountable and responsible for his or her role in the assessment process.
- Fairness – where the assessment is used to enhance learning and students are assessed on what they know and have been taught.
- Absence of bias – the assessment does not hinder / benefit certain students or student groups, including sensitivity to language (language does not become a barrier in learning).

All of the above principles of assessment are effectively compromised should there be a failure to fail

### **2.5.3 Complexities associated with assessment in clinical practice**

Facilitation and assessment of learning in the clinical practice setting are a complex process and the clinical learning environment is described as a highly complex environment (Deegan, Rebeiro and Burton, 2012: 43; Oermann, et al., 2009b: 353; Stuart, 2013: xi). The clinical learning environment is unpredictable and clinical learning experiences of students are not subject to controls (Stuart, 2013: 12).

Teaching, learning and assessment in the clinical practice setting have to fit in with the flow of patient care, and at the same time the clinical facilitator must ensure the safety of the patient and mentor the student (Stuart, 2013: xi). A similar core problem was identified by preceptors in a study conducted by Luhanga (2006, cited in Killam, et al., 2010: 2) namely maintaining patient safety whilst supporting student learning.

Clinical assessments, once completed, cannot be reviewed and the outcome of the assessment rests solely with the clinical facilitator (Hand, 2006: 50), contrary to theoretical assessments, where a double-blind marking process may be followed contributing to the authenticity of assessments. Docherty and Dieckmann (2015: 230) also reported that assessing written work is less troublesome and more objective than assessing clinical work. Clinical assessments are mostly based on the human observation of clinical practice, lending it to bias and subjectivity.

Assessment of student competence in clinical practice is rife with challenges due to the dynamic nature of the clinical learning environment, unique client / patient needs, reduced number of available clinical placement facilities and limited support available to students during clinical placements.

## **2.6 Defining “Competence”**

Traditionally the concepts “competence” and “competency” sparked much debate and review amongst researchers over the past few years (Axley, 2008; Fahy, et al., 2011; McMullan, et al., 2003; Scott Tilley, 2008; Smith, 2012; Watson, et al., 2002). Yet a comprehensive definition for the terminology remains elusive. The confusion related to the definition of the mentioned concepts reflects the complexity of competence assessment in nursing and other practice-based disciplines (Smith, 2012: 172). One agreement though is the importance of competence, competency and competency-based education in practice-based health care education (Axley, 2008; Smith, 2012). Competency is a prerequisite in the successful preparation of nurses and health care professionals to provide safe patient care protect the public and safeguarding the reputation of the nursing profession (Axley, 2008: 221).

## **2.7 “Failure to Fail” and grade inflation**

The complex phenomenon of “*failure to fail*” is not new and it appears to be a continuing challenge for facilitators and assessors of students on pre-registration professional courses (Stuart, 2013: 6). Duffy’s (2003; 2004) leading research regarding “*failure to fail*” suggested that educators sometimes gave borderline students the benefit of the doubt. Deegan, Rebeiro and Burton (2012) attribute this inconclusiveness to two factors: The first being inadequate preparation of assessors for the multifaceted role they fulfill and the second being the complexity of the clinical learning environment.

Grade inflation refers to the awarding of a higher than expected grade for the level of student achievement (Hodges, 2014; Scanlan and Care, 2008). Concerns related to grade inflation are raised in internal medicine (Fazio, Papp, Torre, et al., 2013), social work (Sowbel, 2011), higher education (O’Halloran and Gordon, 2014) and nursing (Scanlan and Care, 2008).

The results of the study conducted by Docherty and Dieckmann (2015) indicate that “*failure to fail*” are not inherent only in theory or clinical practice, but may be evident simultaneously in both clinical and theoretical education. These findings contradicted an earlier study conducted by Calman, et al. (2002) who reported that students rarely failed their programme due to clinical grounds, students mostly left the programme due to academic failure or voluntarily and not due to clinical failure. Hunt, et al. (2012) reported similar findings to that of Calman et al. (2002).

A key consideration in the passing of students was the safety of the patient i.e. how “unsafe” the student was perceived to be (Docherty and Dieckmann, 2015:227). A student, therefore, would only be failed if it were clear from the student’s behaviour or actions that the patient’s safety was compromised.

It is not always clear what constitutes “unsafe” clinical practice (Luhanga, Yonge and Myrick, 2008b; Tanicala, Scheffer and Roberts, 2011). Luhanga, Yonge and Myrick (2008a: 1) use the term “unsafe student” to refer to students whose level of clinical performance is doubtful regarding safety, showing marked deficits in knowledge, psychomotor skills, motivation and interpersonal skills. However, identifying an unsafe student in clinical practice is not as straight forward as it may seem (Brown, et al., 2007).

## **2.9 Conclusion**

Chapter two provided a literature overview of the phenomenon of “*failure to fail*”. The context, significance, and complexities associated with assessment in clinical practice were reviewed and discussed. The factors contributing to “*failure to fail*” and grade inflation were highlighted and the role of the clinical facilitator was explained.

## CHAPTER 3

# RESEARCH DESIGN AND RESEARCH METHODS

### 3.0 Introduction

In this chapter, the research design, population, research setting, sampling and methods used for data collection and data analysis are discussed, as well as the measures to ensure ethical compliance and trustworthiness of the study.

### 3.1 Research design

A qualitative, exploratory, descriptive and cross-sectional contextual research design was used in this study to identify and describe factors contributing to clinical facilitators' reluctance to fail student nurses who are not competent.

Creswell (2014: 4) describes qualitative research as an approach that can be utilized to explore and understand the meaning individuals or groups ascribe to a social or human problem and how they attempt to understand the world in which they operate. The researcher used a qualitative research design to explore the clinical facilitators' reluctance to fail students within the context of their working environment. "*Failure to fail*" is a complex phenomenon and an exploratory design was used to uncover the meaning of this phenomenon amongst clinical facilitators.

Descriptive designs according to Brink, van der Walt and van Rensburg (2012: 112, 114) is used to collect more information in a specific field, creating a picture of the phenomenon in the natural setting of the phenomenon. The intention of descriptive designs is merely to describe the phenomenon. In the context of this study, a descriptive design was used to describe the phenomenon of "*failure to fail*" and not to establish any causal relationship.

A cross-sectional study is non-recurrent in nature, the information on a specific topic is collected at the same within a specific time frame, where after no identical study can be done

(Brink, van der Walt and van Rensburg, 2012: 101). A cross-sectional study design was used in the context of this study as “*failure to fail*” needed to be investigated at a fixed point in time to identify the existence of the problem and to describe factors contributing to the phenomenon in order to make recommendations to assist clinical facilitators and the NEI on how best to address the culture of “*failure to fail*”.

### **3.2 Population and sample**

Brink, van der Walt and van Rensburg (2012: 131) describes the population as the whole group of persons that is of interest to the researcher. The population (N = 34) in this study included all the clinical facilitators employed at the clinical placement facility where the students are placed for their clinical practicum or at the NEI itself, who were willing to participate, signed consent and were available for the focus group discussions or semi-structured interviews. A total sample was used for the study. Two facilitators were not included in the study, as they did not receive permission from their employer to participate. The final number of clinical facilitators included in the study was therefore 32 (n=32).

### **3.3 Site selection**

The study was conducted at a private nursing education institution (NEI) in Gauteng. The site for the study was purposively selected for convenience and accessibility. The researcher was employed at the selected NEI at the time of proposal development. During the period of data collection, the researcher transferred from the NEI to one of the clinical placement facilities ensuring that she did not have a supervisory relationship with any of the participants.

The NEI offers basic and post-basic SANC accredited nursing programmes. The basic programmes include the certificate programme leading to a qualification as an enrolled auxiliary nurse, the two-year certificate programme leading to a qualification as an enrolled nurse (first and second year students) and the two-year Diploma in General Nursing leading to Registration as a General Nurse (third and fourth year students).

The students registered at the NEI for basic nursing programmes are predominantly from Gauteng, Mpumalanga, and the North West Province. The theoretical component of the nursing programmes is offered at the NEI itself and the students are placed for their clinical

practicum at ten different hospitals in the Gauteng North East region. At the time of the study approximately, 600 students were enrolled in the basic programmes.

The clinical facilitators participating in the study were either employed at the clinical placement facilities where nursing students are placed for their clinical practicum or at the NEI itself. The smaller clinical placement facilities usually employ one clinical facilitator to assist with the facilitation of students, whereas the larger facilities employ between two and four facilitators. Most of the facilitators accompany students across the various programmes and various years.

### **3.4 Data collection**

Potential participants were sent an information letter (Refer Annexure A) explaining the study using the global email list of the NEI and requesting their voluntary participation in the study. The researcher contact details were included to ensure that potential participants could ask any questions regarding their participation. Those who responded positively were then contacted individually to organize a convenient time for the focus groups to take place. A suggestion was made to conduct the focus groups after a scheduled meeting when many of them would be available. A specified date and time at the selected NEI was communicated to the participants.

Six of the clinical facilitators who consented to participate were not available on the day of the focus group interviews. The intention was to create an additional focus group for them but, due to logistical reasons, this was not possible and they were included by means of semi-structured interviews instead. The same questions were posed to them as for the focus groups.

The participants that participated in the semi-structured interviews were contacted telephonically to request participation and a date and time were set up for the interview. After telephonic confirmation, the participant information letter and consent were e-mailed again to each participant individually, with time to review the information and to contact the researcher to ask questions or to clarify any uncertainties.

The researcher conducted two focus group discussions with the available participants. Brink, Van der Walt and Van Rensburg (2012: 158) describe focus group interviews as “... *interviews with groups of about five to 15 people whose opinions and experiences are requested simultaneously*”. Creswell (2014: 191) describes interviews, including focus groups, as a useful data collection method, as they can provide historical information and allow the researcher control over the questions.

The researcher’s prolonged engagement in the research field guided the researcher’s decision to divide the clinical facilitators into two categories – “novice” and “experienced”. The decision was further informed by Benner’s Stages of Clinical Competence (Benner, 1984). Benner’s Theory (1984) proposed that a nurse passes through five levels of proficiency in the acquisition and development of a new skill.

A number of recently qualified Registered Nurses had been appointed as clinical facilitators, some of whom had completed their training at the selected NEI. These clinical facilitators are at a “young professional age” to make a pass/fail decision, given that some of the students they are to assess were first, second or third-year students, while they were themselves, students. Clinical facilitators who are now their colleagues taught some of these newly appointed clinical facilitators. As this situation may have led to reluctance amongst the newly appointed clinical facilitators to voice their opinion in front of “their” former clinical facilitators a decision was made when planning data collection to divide the focus groups into two categories – “novice” and “experienced”, depending on their years of experience as clinical facilitators. Those categorised as “Novice” had less than 3 years’ experience as a clinical facilitator, and those categorised as “experienced” had three years or more experience as a clinical facilitator. Focus groups for the two categories were conducted separately, but consecutively on the same day and on the premises of the NEI.

The participants divided themselves into the different categories of novice and experienced according to their years of experience as a clinical facilitator.

Written consent for their participation and the digital recording of the focus groups and the semi-structured interviews were obtained from the participants prior to the onset of the focus group discussions and the semi-structured interviews. The researcher, with consent from the

participants, recorded the focus group and the semi-structured interviews (Refer Annexure C).

The researcher developed an interview guide for the questions and to record answers during the interview (refer Annexure B).

The participants were asked the following questions during the focus group interviews:

1. Are clinical facilitators reluctant to fail student nurses who are not competent?
2. What are the factors contributing to clinical facilitators' reluctance to fail student nurses who are not competent?

The interviews were conducted in the clinical facilitators' natural setting, their work environment. Permission was granted from the executive committee of the NEI to conduct the focus group discussions.

The discussions were mostly unstructured with a limited number of open-ended questions with the intent to elicit the views and opinions of the participants (Creswell, 2014: 190). The focus group discussions were useful as it allowed the participants to share their views with other participants (Brink, Van der Walt and Van Rensburg, 2012). The interaction between the participants and between the researcher and the participants stimulated further examination of the factors contributing to a "*failure to fail*". It afforded the participants the opportunity to justify their decisions.

The focus group discussions lasted approximately 60 minutes. The questions were posed to the participants where after the participants engaged in the discussion. The researcher did not intervene in the discussion. In instances where the participants drifted away from the topic a short focus sentence e.g. "*Remember we are looking at failure to fail*" was used to keep the discussion focused.

Participants were encouraged to elaborate on statements or asked questions to clarify vague or unclear statements. In instances where important comments were lost in the ensuing discussion, the researcher would recall the statement using the same words as the participant.

The interviews were transcribed verbatim. Creswell (2014: 194) recommended that the researcher takes notes during the interviews to supplement recordings. These are also useful should the recording equipment fail. The researcher's supervisor took notes during the focus group discussions. The notes were typed and compared with the transcribed data of the focus group discussions.

Semi-structured interviews were conducted with three participants in the "novice" category and three participants in the 'experienced' category. The semi-structured interviews facilitated further exploration of the factors identified by the participants in the focus group discussions.

The semi-structured interviews were also transcribed verbatim and compared with the field notes made by the researcher. In some instances participants' added information after the digital recorder was switched off which was captured as field notes. The participants agreed that this information could also be used. The information was written down and read back to the participant to confirm the accuracy of the notes.

The same interview guide was used for the semi-structured interviews. The focus group discussions were conducted in June 2015 and the semi-structured interviews in November 2015 after the initial focus group discussions were transcribed and analysed.

The semi-structured interviews lasted between 15 – 30 minutes. In the field notes, the researcher commented that a lot of valuable information was gained during the semi-structured interviews. The researcher experienced it more challenging to stimulate the discussion, whereas in the focus group the interaction between the participants stimulated the discussion. Probing questions were kept to a minimum. Interviewing techniques e.g. summarizing and paraphrasing was used to stimulate the discussion. Interviews were concluded when the participants indicated that they don't have any information more to add.

### **3.5 Data analysis**

The focus group and the semi-structured interviews were transcribed verbatim. As anticipated, some participants provided information that was not relevant to the study, and

this information was not included in the final results. This is a common phenomenon in qualitative research as supported by Creswell (2014: 195)

The first step in the data analysis consisted of organising and preparing the data for analysis, which involved the transcription of the data, typing up field notes and sorting and arranging the data related to the focus group interviews. Field notes were correlated with the transcribed data in order to clarify any uncertainties from the recordings. The data related to the focus groups and the semi-structured interviews were sorted according to the two categories, namely novice and experienced clinical facilitators.

During the second step, the data was read in order to gain a general sense of the information. Thoroughly reading through the data and repeatedly listening to the data assisted the researcher to construct meaning from the data and reflect on the data. General categories started to emerge.

The data was then coded using “Tesch’s Eight Steps in the Coding Process” (Creswell, 2014: 198). The coding procedure included asking oneself “What is this about?” writing emerging ideas in the margins of the transcribed text. Similar topics were then clustered together and formed into columns.

In the fourth step, the researcher returned to the data and wrote codes next to the appropriate phrases text. These codes consisted of words that described the category. The researcher then assembled the data belonging to each category in one place. Emerging categories were colour coded in the transcribed text.

In step five, the researcher described the themes and compared them with literature.

The six categories that emerged were tabulated. Subcategories were assigned to the categories and added to the table. Subcategories initially varied between four and ten subcategories.

After careful review, consideration and discussion of the data with her supervisors, the researcher merged some of the categories and subcategories into four categories with four sub-categories each. During January 2016 the categories and subcategories were presented to

the participants. Clarity was gained during the session with the participants, which led to a minor shifting of the subthemes.

### **3.6 Trustworthiness**

The researcher followed the framework of trustworthiness in qualitative research, as described by Lincoln and Guba (1985), to ensure the accuracy of data collection and analysis. The four criteria of trustworthiness described by Lincoln and Guba (1985) are; i.e. credibility, transferability, dependability, and confirmability.

#### **Credibility**

The researcher used trusted methods to collect and analyse the data. Data were collected through focus group and semi-structured interviews. The experienced participants in the study were able to provide historical information on the topic. Although the participants in the novice group did not have the wealth of experience the participants in the experienced category have, they shared more easily and could easily provide a student perspective as they were themselves recently students at the selected NEI.

The researcher stayed in the field until data saturation was reached and gained an in-depth understanding of the phenomenon of the study. This was assisted by her prolonged personal experience as a clinical facilitator and an understanding of the challenges facing facilitators faced with the problem.

Member checks were also carried out by taking the analysed data back to the participants and checking whether they were comfortable that the analysed data represented their input.

#### **Transferability**

*“Transferability essentially refers to the generalisability of the data”* (Klopper and Knobloch, 2010: 321). In qualitative research, transferability can be enhanced with techniques such as saturation of data, and in-depth description of the research context, design, methodology and supporting literature, and purposive sampling (Klopper and Knobloch, 2010: 321-322). This was, however, a relatively small study conducted at one site only. It remains uncertain whether the findings are transferable and further research would be required to ascertain whether this would hold true.

## **Dependability**

In ensuring dependability, which refers to evidence that if the study were to be repeated, findings would be similar, an effort was made to ensure that saturation of data was reached when no new information emerged and the themes elicited repeatedly occurred (Klopper and Knobloch, 2010: 321). Creswell (2014: 202) states that a rich, dense description of the research “... *may transport the readers to the setting and give the discussion an element of shared experiences.*”

The research report contains a detailed description of the research context, design, methodology and supporting literature. The themes elicited in the interviews are discussed and supported with direct quotations of the participants and reinforced with evidence from a detailed literature review. The researcher attempted to provide current literature with adequate, detailed information to evaluate contextual similarity and make the decision whether the findings are likely to apply in other organizations.

## **Confirmability**

An audit trail was maintained which included careful transcription of the raw data from the tape recordings, careful maintenance of the agreed upon research protocol with evidence of this provided in the research report, member checking, and careful storage of data.

Characteristics of qualitative research include the collection of data in the natural setting where the participants experience the identified problem, the researcher acts as a key instrument in the research and are actively involved in collecting the data and the meaning the participants, rather than that of the researcher, ascribes to the problem remains the central focus (Creswell, 2014: 185-186).

The data for the study was collected in a setting familiar to all the participants. Although the majority of the participants are not employed by the NEI itself, they are involved in a mutually beneficial relationship and interact on a regular basis.

The researcher is an experienced clinical facilitator who is actively involved with the assessment and facilitation of students in the basic programmes at the NEI and the clinical placement facility.

### 3.7 Ethical considerations

The following ethical requirements (Jooste, 2010: 277-289) were applied prior to and during the study:

- The rights of the participants, the community, and the research community were protected in a manner prescribed by the Ethics Committee.
- The right to privacy, confidentiality and anonymity were assured by ensuring that no identifying data appeared on the data collection sheets or in the research report. Confidentiality was maintained by using codes instead of names. Participants were requested not to share the data outside the focus group and were encouraged to keep the information to themselves. Data will be stored securely for at least two years after the results have been published, thereafter it will be destroyed.
- The right to freedom of choice and withdrawal: Informed consent was obtained from the participants prior to the commencement of the focus group interviews, no pressure was applied to obtain consent, and participants were assured that they could withdraw from the study at any time without any consequences. (Refer Annexure C)
- Access to information and communication: The researcher clarified all information with the participants. The specific descriptions or categories that emerged from the analysed data were taken back to the participants to determine the accuracy of the analysed data.
- The participants were given an opportunity to read through the findings from the focus group prior to the final research report being written and they were given the opportunity to request information to be omitted from the resultant report.
- The researcher was granted clearance to conduct the study by the Committee for Research on Human Subjects (Medical) of the University of Witwatersrand. (M141019) (Refer Annexure D)
- The researcher also applied for and was granted permission to conduct the study by the Ethics Committee, Hospital Management and Management of the NEI. (Refer Annexure E, F, G)
- The researcher does not have a supervisor /supervisee relationship with the participants and no coercion was applied or incentives offered.

### **3.8 Conclusion**

In this chapter, research design and methods were discussed. This will be followed in the next chapter by a description of the findings of the study.

## CHAPTER 4

### FINDINGS OF THE RESEARCH

#### 4.0 Introduction

In chapter 4 the key findings related to the research questions are presented. The results will be discussed in turn in chapter five according to each of the research questions.

The participants used abbreviations specific to the study setting during the discussions and the interviews. In order to assist the reader, a list of the abbreviations and their meaning in the context of the study is detailed below.

- BC 1 and BC 2 refer to bridging programme students in the first or second year of the programme respectively.
- PEN 1 and PEN 2 refer to the Pupil Enrolled Nursing students in the first or second year of the programme respectively.
- PSR (Performance Standard Review) refers to the interim review period assessing whether the student is meeting the progression rules of the programme.
- CPCA is the abbreviation used for a “Comprehensive Patient Care Assessment”. The assessment method used to assess a student’s total care of a patient; their theory-practice integration and their ability to function within the ethical-legal framework of the nursing profession displaying the values of the nursing profession. CPCA’s are used in the assessment of PEN 2, BC 1 and BC 2 students.
- IPCA or an “Integrated Patient Care Assessment” is the assessment method used to assess PEN 1 students. It is not as comprehensive as the CPCA.
- Facilitated Practical Activities (FPA) refers to clinical practicum that takes place mostly in a simulation laboratory at the NEI. Procedures are demonstrated and practiced in simulation. Structured clinical learning (SCL) and FPA are sometimes used interchangeably, although SCL is mainly used to refer to clinical practicum taking place at the clinical placement facility.

The participants in the study were divided into two categories, novice and experienced. The participants in the novice category are indicated with an “N” and in the experienced category with an “E” in the participants quotes. All quotes are verbatim.

#### **4.1 Reluctance to fail (“*Failure to fail*”)**

##### **Research question one: Are clinical facilitators reluctant to fail student nurses who are not competent?**

After some initial reluctance on the part of participants to admit that the phenomenon of “*failure to fail*” exists in nursing education, participants acknowledged that circumstances do exist where clinical facilitators are reluctant to fail student nurses who are not competent. This admission emerged once the clinical facilitators felt comfortable with the facilitated discussions.

Factors contributing to a “*failure to fail*” are multifaceted and assessment in the clinical environment is complex, contributing to the difficulty clinical facilitators experience making pass / fail decisions, particularly for **high-stakes** evaluations. The factors contributing to a “*failure to fail*” were discussed in response to the first question. Participants seemed to find the need to justify why they engage in the practice of “*failure to fail*” before admitting they do.

One of the participants’ responses illustrates the phenomenon of “*failure to fail*”:

*“... you know what, I just think, this is much more complex than just ... you know it depends on the circumstances, depends on the student, it depends on their support structure, depends on what is the situation, depends on the assessor, ... depends on how they handle stress, depends on emotional intelligence. It not a thing of just ...”* (Participant 11E)

Clinical facilitators in the novice category seemed to display less reluctance in admitting that they do sometimes fail to fail students. The majority of the participants in the novice category acknowledged that clinical facilitators are reluctant to fail student nurses who are not competent, with some stating this categorically while others felt the need to justify the fact, as illustrated in the quote below:

*“... let’s just pass the student, because we don’t wanna (sic) come back here ...”* (Participant 9N)

The complex interplay of factors’ contributing to a *“failure to fail”* became apparent in the responses of the participants in the novice category.

*“In some instances yes, I think it’s because of the remedial process, most of the time. Beside the remedial process, if I know it is my student I know the student is performing well in the hospital. Sometimes you think if you give the student the benefit of the doubt then I would say that it was just nerves that contributed to them failing that time, then you let them pass ...”* (Participant 1N)

The complexities of the factors contributing to the phenomenon of *“failure to fail”* were echoed by other authors Deegan, Rebeiro and Burton (2012) who described environmental factors, educational diversity, cultural and linguistic diversity and student expectations amongst other factors contributing to the phenomenon. Larocque and Luhanga (2013) reported that failing a student is a difficult process. They reported personal, professional and structural reasons exist for *“failing to fail”* a student.

Contrary to the novice group, the majority participants in the experienced category initially indicated that they are not reluctant to fail students. In the ensuing discussion, it became apparent that there are circumstances when the clinical facilitators are reluctant to fail students.

Comments from participant 10E and participant 11E below, reflect some of the circumstances when clinical facilitators are reluctant to fail students.

*“... there is only one area that I really start thinking: ‘Do I really need to fail you?’ ... when they’ve [the students] done – let’s say [the student have] failed one or two times already and those (sic) student are behind ...”* (Participant 10E)

*“... where people have failed, and you can see how it’s affecting them emotionally, and that you are actually breaking them down, then I am reluctant to fail.”* (Participant 11E)

In the responses of the clinical facilitators, it became clear that in some circumstances it is hard for clinical facilitators to fail students. Similarly, the majority of participants in the studies conducted by Luhanga, Yonge and Myrick (2008a) and Larocque and Luhanga (2013) acknowledge that failing a student was one of the most challenging experiences they encountered.

Participants indicated the type of assessment plays a role. Supplementary summative assessments have a final element to them. Clinical facilitators are aware of the consequences for a student should they fail a supplementary summative assessment. A student's programme may be discontinued or extended should he or she fail a supplementary assessment.

*"... Because, it's like you're cutting them off."* (Participant 12E)

Similar concerns related to the consequences of failing a student were expressed in other research studies. Failing a student may cause the student a loss of time, education, money, certification and a career (Larocque and Luhanga, 2013).

Participant 18E not only confirmed that clinical facilitators' are reluctant to fail incompetent student nurses; but indicated the phenomenon of "*failure to fail*" is increasing. Participant 17E commented similarly.

*"I can definitely say yes. They are reluctant, I've seen it over the time frame, and I think it's getting worse... (we are) more reluctant to fail the students."* (Participant 18E)

*"Overall I think most of the assessors now are very reluctant to fail the students, overall ... previously it was fail or pass. Now rather pass them [the students] it's easier."* (Participant 18E)

*"I mean if you look at the amount of supplementaries (sic) that we've done two years back in relation to the amount of supplementaries we are doing now ... I honestly believe we've been (making) passing easier ..."* (Participant 17E)

Jervis and Tilki (2011) explored mentor's reluctance to refer [fail] students who were not performing satisfactorily in the clinical learning environment. They noted in spite of mentors

dissatisfaction with the performance of students, in reality, no students failed in the two years preceding their study, this resonates with the experiences of the clinical facilitators in the current study.

Clinical facilitators in the novice and experienced categories indicated they are willing to negotiate around borderline students and give the students the benefit of the doubt.

*“... I think that one or two points we can still negotiate.”* (Participant 7N)

*“... and when it comes to a 48.9 where you feel, OK, should I go and look for a mark...”*  
(Participant 2E)

Deegan, Rebeiro and Burton (2012) partly ascribe the existence of this indecision to the complexity of the assessing clinical competence. The notion of “giving students the benefit of the doubt” is further discussed in the category “Assessment process / assessment decision and outcome” later on in this chapter.

Some of the clinical facilitators in the experienced category are appointed as moderators during clinical summative examinations. They confirmed *“failure to fail”* is a phenomenon they experience while acting as moderators.

*“We sometimes do see that as a moderator ....., they want to let a student pass ...”*  
(Participant 3E)

*“Most of the time ... I am a moderator and sometimes the assessors would end up with a 49. I am honest with you I then ask them: ‘Do you think she is a safe practitioner?’ ... If they say to me they think she is a safe practitioner I would say to them: ‘Would you like to re-assess your marks?’”* (Participant 8E)

In summarising the responses to the first question, it became clear that clinical facilitators in the novice and experienced categories are, in certain circumstances, reluctant to fail student nurses who are not competent, i.e. *“failure to fail”*.

## 4.2 Factors contributing to “failure to fail”

**Research question two: What are the factors contributing to clinical facilitators’ reluctance to fail student nurses who are not competent?**

Four categories emerged from the data viz. student related factors, programme requirements, assessment process and facilitator related factors. In each category three or four subcategories emerged as illustrated in table 4.1.

Student related factors	Programme requirements	Assessment Process	Facilitator related factors
<ul style="list-style-type: none"> <li>• Student reputation</li> <li>• Closeness to completion</li> <li>• Personal challenges</li> </ul>	<ul style="list-style-type: none"> <li>• Progression rules</li> <li>• Remedial process</li> <li>• Time / workload</li> <li>• Access to resources</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment principles</li> <li>• Purpose of the assessment</li> <li>• Assessment methods and instruments</li> <li>• Assessment decision and outcome</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitator experience and confidence</li> <li>• Interpersonal</li> <li>• Avoidance of failure to fail</li> <li>• Emotional involvement / attachment with the student</li> </ul>

Figure 0-1 Factors contributing to clinical facilitators' reluctance to fail student nurses who are not competent

## 4.3 Student related factors

It became clear during the discussions and the interviews that there are factors related to the student that influence clinical facilitators when making a pass / fail decision.

The sub-categories that emerged in the category “Student related factors” include the reputation of the student at the NEI, the clinical placement facility or amongst the clinical facilitators. Other factors include the personal challenges the students are facing and the progression of the students towards programme completion.

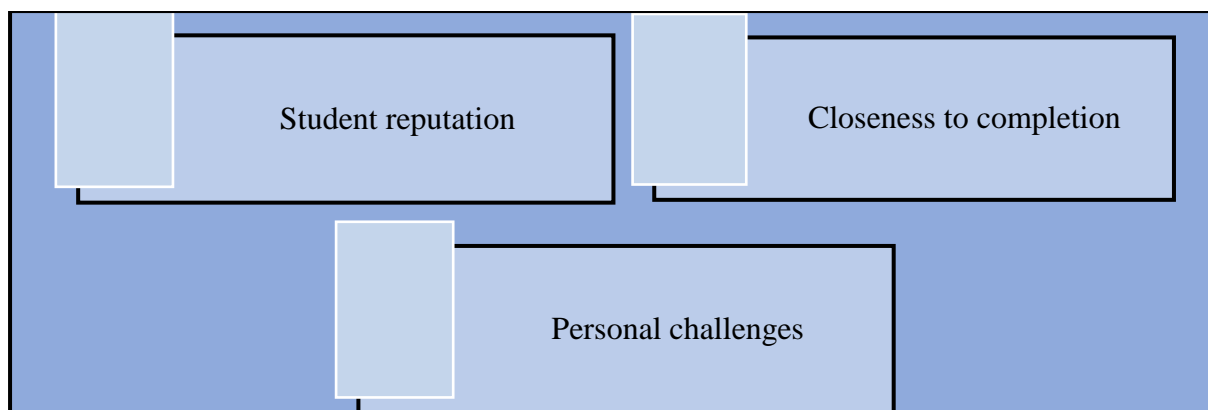


Figure 0-2 Student related factors

### 4.3.1 Student reputation

Both novice and experienced clinical facilitators acknowledged that the reputation of the student can influence their assessment decision. Reputation may be based on a previous good academic (theoretical and / or clinical) performance, a likeable personality and the pre-existing perception that the student is skilled and delivers good patient care. Clinical facilitators are more likely to pass students who have a good reputation amongst patients and nursing staff.

*“... some of the students may not fail, because of the good you hear ... so that attitude of the student can also make the student not to fail or we may be reluctant to fail that student, because of the positive attitude ...”* (Participant 14E)

Jervis and Tilki (2011), found in their study similar findings to the participants in the current study, reported that is difficult to fail likeable students. Docherty and Dieckman (2015) studied the phenomenon of “*failure to fail*” across clinical and theoretical environments in Nursing Schools in the United States. Interestingly, nearly 34% of the respondents acknowledged knowing the name of the student influenced their assessment decision.

Clinical facilitators acknowledged that knowledge is important in nursing, but considered knowledge less important than the attitudes and values inherent to nursing. Assessment decisions may favour students who have the reputation in the NEI of being clinically skilled, meaning that even if they do lack knowledge, they should pass.

*“... there are those nurses who have those sort of natural skills of nursing, you know they’ve got humanity ..., they don’t have that much good knowledge, somehow, but shall I say, they’ve got knowledge but they don’t have that power to be at 50% ...”* (Participant 2N)

*“... and some of the students in practice they are good, but theoretically they are not good”* (Participant 14E)

Knowledge of the student’s prior work or performance can influence the assessment decision, rendering clinical facilitators reluctant to fail students who had previously performed well. The student’s poor performance on the day may be attributed to personal factors influencing the student’s performance. Hence, it appears that it is not always what the student does on the day of the assessment, which determines the assessment pass/fail decision. The assessment decision may be based on the clinical facilitator’s previous experiences with the student.

*“She shouldn’t be a fail, she is a high performer [Group agreed]. She’s been high performing right through.”*(Participant 16E)

*“If it is students you know and they do something wrong then you like ... but I know they can actually do it like this and I think then we tend to pass a student because based on previous experiences.”*(Participant 11N)

*“Especially if you know the student from campus and then you think about how they performed here compared to how they performed in hospital ... that’s why we find it hard because we think they’ve [the students] done well all through the year and how come they do poorly in the exam (sic).”* (Participant 12N)

Respondents in the study conducted by Docherty and Dieckmann (2015) commented similarly. Pass / fail decisions were influenced by students’ previous excellent performance. Although referring to theoretical assessments it might well apply to assessments in clinical practice. As one of the findings of the Docherty and Dieckmann (2015) study indicated that the majority (72%) of respondents gave students the benefit of the doubt when determining clinical competency.

### 4.3.2 Closeness to completion

Closeness to completion relates to the progression of the student in the programme towards programme completion. Clinical facilitators are reluctant to fail a student if they have progressed to the final semester of their programme before certification. Participant 16E mentioned that students in their final year of the bridging programme can't fail.

*"... BC 2's. Because they can't come this far, BC 2's, and now fail."*

The notion that students can't be failed at the later stages of their studies were mentioned in other studies (Docherty and Dieckman, 2015; Jervis and Tilki, 2011; Luhanga, Yonge and Myrick, 2008a). Black, Curzio and Terry (2014) found failing students in their final placement contributed to and even exacerbated the feelings of guilt that mentors experienced when failing students.

The cost to the student in terms of finances and personal losses are considered in the assessment decision, especially when it becomes clear that the student's programme might be extended, or even discontinued close to completion when they have already spent a great deal of time and money on their education.

*"...it [failing them] is like you are handing them an extension."* (Participant 12E)

*"... and I always also bring in ... money issues, like they' paying a lot of money ..."*  
(Participant 12E)

Clinical facilitators felt genuine concern for the student, especially as they realize the impact the decision would have on the student's life and career.

*"... maybe the student she's doing ... she was extended and then maybe you also feel that maybe financially she was complaining about money, you feel pity for her ..."* (Participant 2N)

*“... because at the end of the day the poor student is paying a lot of money to be here and is actually paying our salaries to teach them. But then what do we do ... we fail them.”*

(Participant 1N)

### **4.3.3 Personal challenges**

Students face many challenges contributing either to academic success or academic failure. Challenges related to their health, personal circumstances and families can affect the academic success of the student. The student's previous experiences relating to assessment, their motivation and assessment anxiety may affect the student's performance.

The clinical facilitators expressed their awareness of the challenges students are faced with as the students sometimes share these challenges with them. Often the assessors' awareness of the challenges can flaw their judgement. Comments from Participant 3N and Participant 11N reflect the impact of this awareness on their clinical judgement:

*“... but they then turn to you for counselling and share with you certain challenges that they are going through and that flaws your judgement sometimes.”* (Participant 3N)

*“... let's say a person's Dad passed away and now you have to assess her. Especially if you know about the situation you tend to be less hard on them, you let them get off easy on certain points.”* (Participant 11N)

The challenges students face often relate to the fact that many of the students at the NEI are not school leavers. They have additional responsibilities of taking care of their families while earning money to support their families. Clinical facilitators can associate with the challenges students experience contributing to a reluctance to fail the students.

*“... for instance when they complain about leaving work late and arriving home at nine and they leave home very early and how much stress that they are under, so that sometimes played a role in the outcome of an assessment ...”* (Participant 3N)

*“... the thing is they are self-funders. And just as we all have home issues that we deal with, they also have homely (sic) situations they deal with.”* (Participant 17E)

Ramahlahfi (2015) explored factors contributing to academic success or academic failure amongst the second-year college based nursing students in Gauteng. The challenges that were noted include various social problems, including family responsibilities, traveling long distances and staying far away from their families. The students may be the breadwinners of their families and as a result may become financially indebted.

*“Mommy is not working, Daddy is not working, she’s [the student] having siblings that she is taking care of ... if you then fail the student, then you know that, OK, what is that whole household going to do, because she’s the only breadwinner ... so then it ... makes you reluctant to fail them.”* (Participant 17E)

#### 4.4 Programme requirements

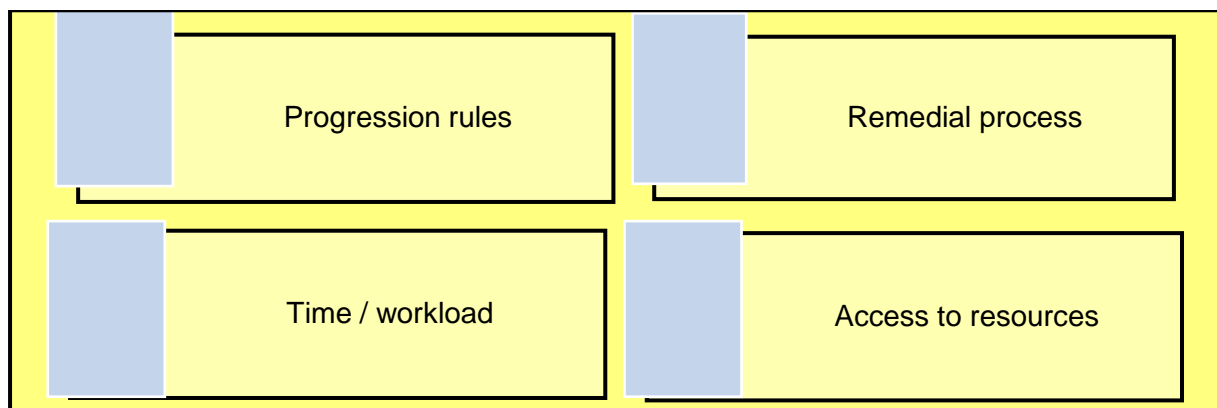


Figure 0-3 Programme requirements

A further category, programme requirements, incorporates the academic context and the clinical learning environment of the students. Aspects related the programme requirements include the progression rules, the remedial process, the workload of the clinical facilitators and the access to resources at the clinical placement facilities.

##### 4.4.1 Progression rules

The requirements of the programme include the progression of students at a specific pace in order for the students to continue with the programme, i.e. progression rules. Interim progress discussions are conducted every three months, numbered sequentially PSR 1, PSR 2 and PSR

3. Based on the review a student may continue with their programme, be extended or their programme may be discontinued.

In relation to the time spent in the clinical learning environment the timeframes to meet the stipulated outcomes are narrow. Clinical facilitators and students alike are under pressure to meet the required outcomes within the specified timeframes.

*“What I found, there are so many procedures to get through for PSR dates ... They just rush through to get through this procedure or formative assessment.”* (Participant 5N)

*“All we have to do is to meet the PSR deadline...”* (Participant 6N)

Clinical facilitators feel empathy for the students because of the narrow timeframes and the limited amount of time in the clinical learning environment contributing to a *“failure to fail”* as illustrated by Participant 12N:

*“... and sometimes we feel sorry for them because their dates are so close by and they have not had enough exposure, because they have been in campus for so long periods of time. We tend to be less ... or more lenient with them in the awarding of marks.”*

The pressure to meet the stipulated progression rules limited the opportunity for clinical facilitators to accommodate the individual student’s progression or challenges. Clinical facilitators may not feel comfortable failing a student if the student did not receive sufficient opportunities to develop competencies and skills.

*“I am sometimes really not feeling OK to fail a student, because on the bigger picture she maybe not yet competent because our deadlines are too strict. She is not ready; she is one of those students that’s taking a bit longer to reach their goals.”*(Participant 5E)

Participants in the studies conducted by Jervis and Tilki (2011) and Luhanga, Yonge and Myrick (2008a) expressed similar feelings. Failing a student too early in their programme limited the student’s ability to become competent. Nursing is a practice-based discipline. Nursing students need time to develop clinical competencies.

However, reluctance to fail a student too early in their programme may leave clinical facilitators with too little time for remedial action (Luhanga, Yonge and Myrick, 2008a; Scholes and Albarran, 2005).

#### **4.4.2 Remedial process**

The NEI has an academic support programme in place requiring that students receive remediation after they have been found not yet competent in assessments. Clinical facilitators are required to provide evidence of sufficient remediation before re-assessment of students, but remediation is time-consuming and clinical facilitators already experience a high demand for their time.

*“... then you have to go through the remediation process ...”* (Participant 5N)

*“... because there is not always time for remediation ... I can't always go on with remedial, remedial and remedial. There is no time.”* (Participant 9E)

*“Remediation plays a big role, because if a person fails an assessment, then you have to remediate, do another one and assess again ... altogether it's five.”* (Participant 18E)

The timeframe between the summative clinical assessment and the supplementary clinical assessments are limited. Clinical facilitators are left with a limited amount of time to remediate unsuccessful students before the supplementary clinical assessments.

*“And the other thing ... if you fail my student at the supplementary I need to remediate her ... you sit with one day (for it) ... how do you do remediation in one day?”* (Participant 10E)

Clinical facilitators are “considerate” towards their colleagues and would rather pass students. As stated by Participant 17E:

*“... then you know if you fail that student there is no time to re-do the exam. Then you already start thinking when are we gonna (sic) get time, when is the CF gonna do the remediation. Because you have to do remediation before you can do the exam. So now all of that plays around in your head, which make you then mark more leniently, just to see if you can't get her not to fail, but just at least ... just at least pass.”* (Participant 17E)

There was a general consensus amongst the clinical facilitators that failing a student places further strain on the already resource-clinical learning environment.

*“There is already such an enormous backload of work, failing a student will then create a bigger backflow, because of the remedial that you have to put in place, the short period of time as well before the next supplementary exams.”* (Participant 12N)

#### **4.4.3 Time / workload**

Clinical facilitators employed at the clinical placement facilities are responsible for the students’ clinical learning experience, including mentoring, learning and assessment. Various participants reflected on the factors impacting on the time clinical facilitators have available to mentor, teach and assess students.

*“... as a CF ... you don’t have the time ... to spend the time with each and every student, as you are requested to do. So I don’t think it is student-wise the procedure, that’s not the problem. I think the number of students is the problem.”* (Participant 17E)

Participant 6N expressed concern that clinical facilitators don’t have the time to mentor students. The lack of mentoring became apparent when students present with “*negative nervousness*” during assessments.

*“So I think the time that we have, as facilitators, to do the mentoring, cause that is the other thing we have to do – we don’t have that (time available)”*(Participant 6N)

*“So do we get that time in hospital to be able to build students? Cause really when you see negative nervousness, it is a sign, that this student from mock and from CPCA one, two and three we didn’t have that time ...”* (Participant 6N)

The amount of students in relation to the limited amount of clinical facilitators available at the clinical placement facility affects the workload of the clinical facilitators which renders it less likely for clinical facilitators to fail students.

*“I think due to the huge amount of students we have and the small amount of CF’s we have ...”* (Participant 10E)

*“... and again looking at the number, mentoring that big number it is not easy, cause now we have to show them how to do it. Support them, encourage them.”* (Participant 6N)

*“I purely think the amount of students that we have is the problem because we are having a lot of intakes ... two intakes per year per group ... but the amount of students per intake is quite a lot.”* (Participant 17E)

The clinical facilitator to student ratio is not adequate and some facilitators are faced with ratios exceeding 1:20. According to participant 18E, it is more realistic for a facilitator with fewer students for example twelve, to fail students and do remediation than it is for a clinical facilitator with 55 students. Participant 18E states that she would rather give the student a 50% than do remediation and re-evaluation.

*“I will oversee the factor that they’ve [the students] got 49 and rather give them a 50 than to do remediation and re-evaluate and all of that.”* (Participant 18E)

The amount of paperwork contributes to the workload of the clinical facilitators, which reduced the time the CF can be with the students in the clinical sites.

*“I think in some cases we would say it is the massive workload that the CF’s has, there is so much paperwork that needs to be done. I wish there is a magic spell we can put on the paperwork just to make it less – there is just too much and I think that is mostly the problem why CF’s don’t feel ... ag perhaps this nurse will ... ‘will come right’ (sic).”*

The problem is exacerbated with the amount of students allocated to a specific clinical facility, the various groups, and intakes of students per clinical facilitator. The larger the number of students, groups, and intakes per clinical facilitator the less likely the clinical facilitator will be to fail students. As Participant 9N expressed:

*“I think the numbers also. If, like you are a facilitator in hospital and you got Pen 1 when you are looking after all the groups. I think you will not have ... I think it will not be effective*

*for you to not to ... you will pass the students ... Will you really fail the students? I don't think so."* (Participant 9N)

The numbers of students necessitate clinical facilitators to assess at least four students per day to get through all the groups, without any breaks in between for themselves. This factor may also influence the outcome of the assessment.

*"The formatives I also only do four per day, but still and then it's an 8'00 clock, 10'00 clock, 12'00 clock and 14'00. Two hours per student – 1 hour to present, 1 hour feedback and if I stop you, it's teaching for the two hours ... you are necessitated to do it like that because otherwise, you don't get through your groups."* (Participant 2E)

Participant 11E indicated that this tight scheduling of assessments does affect the clinical facilitators' judgement as he or she becomes tired. From a moderators' perspective and in her experience Participant 8E confirmed that students assessed later in the day tend to get a bit better marks than the earlier ones.

#### **4.4.4 Access to resources**

The facilities and resources offered to the students at the various clinical placement facilities vary significantly. Participant 17E explained that the smaller hospitals have fewer resources available to students. The facilities and skills laboratories at the smaller hospitals do not always make provision for all the procedures the students require. The training opportunities are limited with fewer available disciplines and lower bed occupancies.

Clinical facilitators are reluctant to fail students where there is a lack of time, resources and opportunities for skills development. Participant 17E questions whether the students are getting value for their money.

*"That [reluctance to fail] would come in with facility as well, if you look at ... training departments, skills labs, because we all know that students pay quite a lot of money. So you feel that ... sometimes the feeling is there, personally now, that the students don't always get what they paid for. So is it fair towards them to fail them because you don't always have the*

*necessary procedures in your hospital or the necessary equipped skills lab ...” (Participant 17E)*

#### 4.5 Assessment process

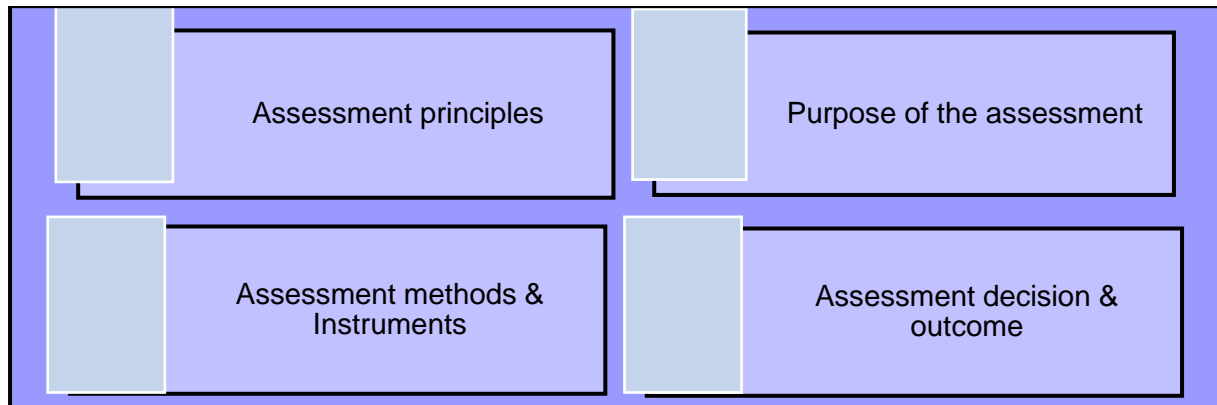


Figure 0-4 Assessment process

In the process of assessing students in the clinical learning environment, certain factors affect clinical facilitators when making a pass / fail decision.

The factors may affect the credibility of the assessment outcome e.g. assessment principles. The purpose of the assessment, whether the assessment is done to evaluate learning during the programme (formative) or at the end of the period (summative and supplementary summative) affect how stringently the clinical facilitators apply the assessment criteria.

Other factors in the assessment process include the assessment methods and instruments used during the assessment. When it comes to the assessment decision clinical facilitators may award borderline students a “pass” or giving them the benefit of the doubt. Safety or the absence of “dangerous nursing”, not necessarily the competency of the student appear to be determining factor in the assessment decision.

##### 4.5.1 Assessment principles

Assessment practices should be governed by principles of fairness, validity, reliability and practicability. Adhering to the principles of assessment contribute to the credibility of

assessment decisions. In the context of the study, the clinical facilitators identified several factors related to assessment principles that may influence their assessment decision. The factors related to the clinical environment, the assessor and the student.

Clinical facilitators identified instances of bias and subjectivity where the assessment benefits the student. The student may not be failed as a result of the clinical facilitators' bias or subjectivity.

Instances of bias are highlighted by Participant 18E:

*“... if you are biased, you can definitely ... if it is your favourite student and the person is not yet competent you will mark them competent ...”* (Participant 18E)

Participant 11N commented similarly stating clinical facilitators are more reluctant to fail students in their own clinical placement facility.

*“... if it's a different hospital, different students that you don't really know ... you tend to look at what's the expectations ... did not meet the expectations, OK, not yet competent. With your own students, you tend to be more reluctant to say they are not yet competent.”*

*“... and then it's unfair actually towards a student whom you didn't observe before.”*  
(Participant 11N)

Assessment of clinical competency is based on direct observation by a clinical facilitator or clinical facilitators. The nature of direct observation lends itself to subjectivity. The clinical facilitators find it is difficult to stay objective during assessments once they get to know a student. Participant 11E stated objectivity does not exist once you get to know someone.

*“... there is actually no such thing as staying objective if you get to know someone ... we are innate to ... to liking certain students and not liking, because of personality ...”* (Participant 11E)

Contrary to passing students because clinical facilitators favour their students. Students may pass when clinical facilitators find it difficult to work with them, as participant 11N noted:

*“Some students you just really, really want to get out of your hair. You just want to pass them and be like OK, just pass this ... because I really can’t work with you.”*

Knowing the student create the need within the clinical facilitator to understand what is happening to the student that is not performing well. If the clinical facilitator does not know the student, the students’ poor performance might be attributed to a lack of knowledge or preparation.

*“... if it is my student then I will understand what is going on. I might understand or try to understand what is going on with the student. But if it not my student then I am not going to understand probably because then I will just think no this student isn’t prepared. Or maybe she’s not knowledgeable ...”* (Participant 1N)

Participant 1N indicated that clinical facilitators might be reluctant to fail students if they understand what the students are experiencing and where they were part of the student’s preparation.

*“... but if it is my student, can you see then the factor comes where I know that ... maybe I know my student, she did prepare ... maybe I was part of that preparations”* (Participant 1N)

Participant 11N alluded to the fact that assessments in certain situations are not fair. Clinical facilitators expect more of the students than is required for the specific level of the student. It may be related to the fact that clinical facilitators become accustomed to the group of students they usually assess.

*“... let’s say you are a Pen 1 assessor or facilitator and you assess BC 2’s, you tend to be less hard on them. The expectations are less.”* (Participant 11N)

Participant 12N also commented that it is difficult to adapt from one assessment to another. The year programme is structured in a way that the some of the junior and senior groups of students’ summative clinical assessments have to be done consecutively.

A large number of students per group per intake not only affected the workload of the clinical facilitators at the clinical placement facility. It also affected the practicability of the summative clinical assessments.

The assessment schedule requires that up to four or five students are assessed per assessment cycle. The numbers of assessments done per day per clinical facilitator, the extended period over which the exams are scheduled and the traveling distances between the various clinical placement facilities are factors that contribute to the reluctance amongst clinical facilitators to fail students. Clinical facilitators get tired and award marks easier.

The responses from Participant 17E, in the experienced category and Participant 12N, in the novice category, clearly illustrate the situation.

*“... then the other factor there with exams is, the CF’s are tired, so you go into an exam, you know that if you fail a student you got to go back. There is no time already for all the students that we have on the exam list to ... to give them the fair time to do the exam. So we do four to five exams on one day, which is not fair to the CF as well. So she’s tired, so by the fifth one that you do per day, she’s tired, then you know if you fail that student there is no time to re-do the exam.”* (Participant 17E)

*“... because we have had so many exams running over so long of a period of time. People have had their exams in between student exams as well, so I think its fatigue ... you don’t listen attentively, you give the student the benefit of the doubt and they become competent.”* (Participant 12N)

#### **4.5.2 Assessment purpose**

Formative and summative assessments are conducted at the NEI to determine the students’ progression towards the achievement of the programme objectives. Formative assessments determine the students’ progress during the academic year.

Successful completion of the formative assessments gains students entry into the summative clinical examination. Successful completion of the summative clinical assessment, together

with the theoretical assessment, may lead to the awarding of a qualification or progression to the next year of study.

A supplementary clinical assessment is granted to students who are not competent in the summative assessment. The supplementary assessment awards the student an extra opportunity to complete their programme or their year of study.

Clinical facilitators' assessment decisions were influenced by the purpose of the assessment with Clinical facilitators more reluctant to fail students during summative assessments than formative assessments. Clinical facilitators contemplated that in formative assessment the opportunity for feedback and remediation existed. As illustrated in the responses of Participant 8E and Participant 16E.

*“In formatives, I still have the time to remedial her. I still have the time to build her, to correct her ...”* (Participant 8E)

*“Ja, the thing is realistically in a formative we have more interaction with the student, than with the summative ... But with a formative you can, there is like they say ... there is interaction ... you ask the student, you can give ... you must give feedback. Whereas with our summatives (sic) there is no feedback session to the student. So, unfortunately, there is a difference.”* (Participant 16E)

Clinical facilitators were more reluctant to fail a student during a summative assessment as the stress element associated with summative assessments was taken into consideration.

*“From my personal experience I am too strict during formatives, but with the summative because I know there is more stress related, I also tend to be less strict. Then I will also if it's a person that has 48, rather look for something that I can rather put it up to a 50. In my own experience, I'm doing that as well.”* (Participant 18E)

*“Thinking that exams is a stressful situation and that they can't ... that they under stress and therefore they forget or ... you know ... they tend to not remember the reasoning's why they are really doing something.”* (Participant 12N)

Clinical facilitators were more reluctant to fail students during supplementary exams. As highlighted earlier the supplementary exams do have a final element to them. Failing a supplementary assessment may lead to either discontinuation or extension of the student's programme.

*"Because it's like you're cutting them off, you are preventing them ... you are preventing them ... [from completion]"* (Participant 12E)

*"So I think supplementary-wise we tend to pass a student easier ..."* (Participant 11N)

The overall concern with the assessments is the absence of assessment for learning. Assessments are mostly, formative and summative assessments alike, used for grading purposes. Stiggins (2002) cautioned against the use of assessments purely as assessment "*of learning*". He questioned whether our assessment approaches are improving student learning?

Crooks (1988) in his influential study on the evaluation of classroom practices expressed a similar concern. He stated too much emphasis is placed on the grading function of evaluation. Subsequently the role of assessments to assist students to learn is neglected.

#### **4.5.3 Assessment methods and instruments**

The method of assessment of the students in clinical practice is mainly direct observation of the students' practice. The "Comprehensive Patient Care Assessment" is used to assess the student's competency in delivering total patient care. The assessment instrument, with a three-point rating scale, includes observation of practical skills, theory-practice integration and a section looking at the attitudes and values of the student. Testing theory-practical integration requires some questioning to take place.

Procedural knowledge is observed using a skills checklist with critical points. Should a student fail a critical point the student is deemed not yet competent in the procedure and the procedure need to be repeated after remediation were done. A procedural checklist is seen as an unreliable method to determine competency], as the emphasis is placed on whether the action is done or not, and it does not reflect the way the action was performed.

*“I think the other thing is the tool, the tool [checklist] is sometimes not conducive to failing a student, because it is ticking, so it is easy to pass a student, because ... yes ... yes did they do it yes, it is not really looking at the way they are doing it. It’s just “Did they do it?” “Yes”.*  
(Participant 11N)

During the discussions concerns were raised about the assessment instrument as the instrument might lend itself to different interpretations amongst the clinical facilitators. The factors contributing to the variances in clinical mark allocation can be related to the ambiguity when assessing students’ attitudes and values. Clinical facilitators are uncertain of the rating scale used in the assessment instrument.

*“... Still recently that has happened to me. Where the student will be seen as competent, but the 50 that is competent they are not actually competent to look after a patient. The fact that they got a 50, because the instrument passes them.”* (Participant 2E)

*“So most of the time what I experience is we don’t adhere strictly to the rating scale ...”*  
(Participant 19E)

*“... rather give them a ... mark up on the three of the values, because nobody can say with the values he’s actually a two. Something you cannot really prove, so then people mark them up on the values for instance or the philosophy or the patient’s rights or something ...”*  
(Participant 18E)

*“You can manipulate the outcome if it is a borderline person ...”* (Participant 18E)

*“I think the big factor there is that the clinical facilitators are not all on the same page with the marking tools ... we [are] two-two doing the exams, but none of us really know what to give a one for and what to give a two for and what to give a three for ... so everyone is marking on its own merit ...”* (Participant 17E)

*“IPCA and CPCA ... it is a difficult thing because it is person dependant. Everyone interprets the tool [evaluation instrument] differently; everyone interprets ... or has different expectations from different students. So I think there [IPCA and CPCA] its interpretation and then what do you as a person really expects of a student.”* (Participant 11N)

#### 4.5.4 Assessment decision and outcome

A pass or fail decision should be based on competency of the student. During the assessment process the student must deliver evidence of competence against set criteria. Should the student not achieve the desired level of performance a “fail” decision is required. Students whose performance is questionable may be given the benefit of the doubt, unless there was a concern about the safety of the patient.

*“The other thing that I could say is that I think that we tend to give them [the students] the benefit of the doubt a lot of times.”* (Participant 12N)

*“We try to, maybe read in between of what they are saying and come to conclusions that they [the students] are ... they could have meant this, you know, but not really taking it from what the student had done ... because they hadn't done it. They are not yet competent.”*

(Participant 12N)

Clinical facilitators in the novice and experienced categories were willing to negotiate around borderline percentages. It is a concern that clinical facilitators gave students the benefit of the doubt and likely passed students who should have failed.

Participant 4N indicated she was not reluctant to fail a student nurse that is not competent. Although admitting to giving a student “the benefit of the doubt” when faced with a borderline percentage.

*“... unless if she failed with like ... with a 0.5%, then you would say OK let us look for this mark somewhere so that she passes, ... or a 1, ...”* (Participant 4N)

Participant 7N acknowledged the role of the clinical facilitators as the gatekeepers of the profession. Suggesting clinical facilitators should not allow incompetent student nurses to enter the profession. Once again, Participant 7N, as Participant 4N, was willing to negotiate around borderline percentages.

*“... we are the gatekeepers and I am not opening the gate if I am feeling that you are not competent ...”* and later on *“... I think that one or two points we can still negotiate ...”*  
(Participant 7N)

In the responses of the clinical facilitators it was clear that they are aware of the consequences of allowing borderline students to pass. Notwithstanding the fact, clinical facilitators still considered passing borderline students.

*“I think I share Sr. ... [name omitted]’s opinion, if a student is not competent they should not be passed because patients suffer, but I must also be honest, there is times when I assessed students and when it comes to a 48.9 where you feel, OK, should I go and look for a mark?”*  
(Participant 2E)

Furthermore, there was no clear indication at what percentage the clinical facilitators were willing to give borderline students the benefit of the doubt. It is alarming even percentages as low as 44% - 45% were considered when failing or passing students. As illustrated by the comments of Participant 4N and Participant 2N.

*“... but if she has really failed, like by five marks, she has failed.”* (Participant 4N)

*“... if they got less than, let’s say 40%, ja there you will ... you might fail a student ... but somebody’s that got 40% plus, let’s say 45, 44 ...”* (Participant 2N)

Participants across the novice and the experienced group considered safety as a determining factor whether a student may pass or fail, irrespective of the percentage.

*“... and we see the student is unsafe, I don’t think one of us will say ‘Ag, just pass’ ...”*  
(Participant 7N)

*“... when you see this is dangerous nursing, there is no way that we will pass.”* (Participant 4N)

*“... sometimes we are reluctant, but at the end of the day there is only one parameter for myself ... safety ... Is it a safe practitioner?”* (Participant 8E)

It was not clear during the discussion if, in the view of the clinical facilitators, safety equates with competency. An unanswered question remains as to whether it is 'good enough' to be a safe practitioner. The concern surrounding safety vs competency was not explicitly discussed, although participant 11N stated that a student should be competent.

*“Some people are happy just to pass a student, because ... at least they will be OK. They will pass and they will learn a lot in the wards, but it's not sufficient. You do not want a 'sufficient' student to go out there. You want somebody who is really competent.”*

Participant 11N elaborated on her perception of competency; *“Competency for me is the interaction between the student and the patient. Can they actually work without being stressed, because somebody is watching them? Can they ... if there is a problem that arises, think on their feet, solve the problem and not constantly ask: 'What do you think? What should I do? How should we do it?' So, for me, it is more based on can you really have critical thinking ... think a solution for yourself.”* (Participant 11N)

Clinical facilitators are reluctant to fail students during formative assessments if the student can identify that they missed a critical point and motivate the importance of the critical point. The student's ability to correct herself is seen as a reflection of competence.

*“I look at the student in ... overall, and if she fails a critical point, ... I ask the student: “What could you have done better and why?” If that student can motivate that critical point and you know say that she know she's missed it out. That is reflection of competence, but then I am reluctant to fail her. So ... unfortunately with formative assessments that is one place where I do not fail. (Participant 16E)*

Critical points on the checklist may be overlooked by the clinical facilitator if the critical point is not deemed to have a long lasting effect on the patient.

*“So for me it depends on what is the critical point you missed and the lasting effect ... [on the patient] ... ”* (Participant 11N)

The perception of the clinical facilitators was that the moderation committee will overturn the fail decision, thus they will look for marks so that the student can pass.

*“... because we know the moderation committee will sit and then they are going to overturn that, so OK let her pass ...” (Participant 5N)*

A few participants raised the possibility that through-put rates and institutional finances may play a role. Interestingly, through-put rates and institutional finances as factors contributing to a “*failure to fail*” were mentioned in the semi-structured interviews. These topics were not raised in the focus groups.

*“We never ... we never spoke about it before this year and now it’s almost targets that you have to maintain to say that you have had so many percent (sic) pass ... and you have carried a student from the beginning right to the end of the training ...” (Participant 12N)*

Participant 11N similarly concluded that she experienced a lot of pressure from management to pass students in order to maintain the student numbers. Participant 18E commented in her experience over the past two years “... it’s really like you don’t get people deregistered or extended.”

Participant 17E and Participant 18E commented on the finances:

*“... I believe we are a private business and to me the impression is sometimes that we need the funds.” (Participant 17E)*

*“... I think money plays a role. If you deregister a person too soon then there’s less money paid in.” Participant 18E*

## 4.6 Facilitator related factors

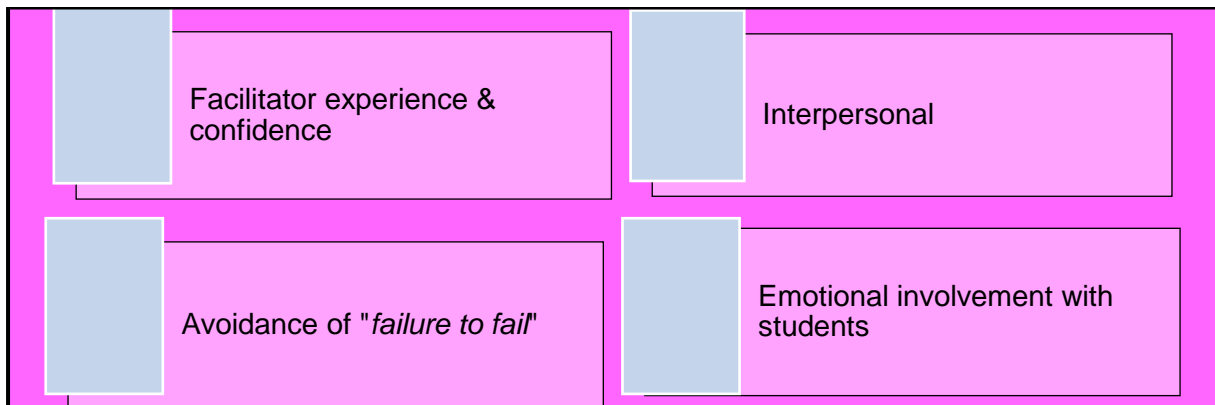


Figure 0-5 Facilitator related factors

Certain factors related to the clinical facilitators themselves contributed to the reluctance amongst clinical facilitators to fail student nurses who are not competent. The factors related to the experience and confidence of the clinical facilitators, interpersonal factors, avoidance of “failure to fail” and the clinical facilitators emotional involvement with students.

### 4.6.1 Experience and confidence as assessor

Clinical facilitators were divided in two categories – “novice” and “experienced”. The decision was made for the purpose of data collection. Clinical facilitators in the novice category (junior clinical facilitators) have less than three years’ experience at facilitating and assessing. Clinical facilitators in the experienced category (senior clinical facilitators) have three years or more experience in the field.

Junior clinical facilitators might have been reluctant to voice their opinion in front of their seniors. Participant 9N, for example, stated “... *you would have another facilitator, who is your senior would say let’s just pass the student because ...*”

All clinical facilitators, shortly after they were appointed as clinical facilitators, are required to do the assessors’ programme. Completion of the assessors’ programme did not guarantee knowledge of the assessment instrument amongst less experienced clinical facilitators.

The comment was made that the newer facilitators might not be as accustomed to the assessment instrument as they were supposed to be, which alluded to the fact that the newer facilitators might not have had sufficient mentoring in assessment. Even after completion of the assessors' programme, clinical facilitators in the novice category confirmed they experienced a lack of support and guidance in their assessments. As Participant 11N stated:

*“Yes we do this, yes it's moderators' [assessors'] course and all of that, but there is no real guidance for new assessors.”* (Participant 11N)

Junior facilitators have less exposure at assessing and dealing with failing students and they might not have the confidence yet to make a fail decision.

*“The senior facilitators are more experienced, juniors are less experienced, they are more reluctant to fail due to the less experience they have to assess. Also they are not sure how to handle their own and the student's emotions in a failure situation.”* (Participant 17E)

*“I think sometimes they also ... lack ... can't say lack knowledge ... but maybe they are not sure in their clinical practices as well .... That they are not too sure on if the answers are really correct or not. ....”* (Participant 12N)

Senior clinical facilitators acknowledged that they are able to influence junior facilitators to pass or fail students.

*“... the senior CF's we have at the moment are strong CF's, they are very opinionated and they won't be influenced by junior assessors ... we have a few very strong seniors, indicate that the student should get zero, the junior will not override that, or indicate that the student should get three, the junior won't have the emotional capability or the strong personality to override the senior.”* (Participant 17E)

The junior clinical facilitators were aware that the senior clinical facilitators influenced their assessment decisions.

*“... but I think maybe the younger facilitators, with less experience, maybe get swayed by the other assessor.”* (Participant 12N)

*“... let’s say new assessors say: ‘No, but I experience it like this’, then the older assessor will say: ‘No, this is how it is and this is the mark’”* (Participant 11N)

Clinical facilitators in the novice and experienced categories reported feelings of guilt when making fail decisions. Clinical facilitators reflected the students’ failure as a personal failure.

*“I take it very personal if I have to fail one of my students. It’s like ... a ... reflection on you. Sorry that is how I feel. I am there for the student. I am supposed to help them, to assess them, to facilitate them, if I fail then it comes back to me.”* (Participant 7E)

*“... when one of your students are failing, it bounces back to you. You are feeling, because you are human ... so you feel bad with the student.”* (Participant 9E)

The response of Participant 10N reiterated the intense self-reflection clinical facilitators experienced in lieu of the students’ success or failure.

*“... but I look at it as a reflection of how well did I facilitated that student, how well did I teach that student. ‘OOH’ now the student fails, ‘eeech’ ... I was a bad facilitator ... it’s not just a reflection of what the student did ... it feels to me it is also a reflection for me. I don’t know, I take it personally, feels to me it is also a reflection on me and what I have done.”* (Participant 10N)

*“So another factor could be you feel guilty because you didn’t get to spend with all the students like you would want to. So in a way you feel guilty of not providing the student with enough of your time and thus you give another chance and put through.”* (Participant 17E)

Some clinical facilitators took it as a personal reflection on themselves if they don’t have a 100% pass rate. The clinical facilitators perceived it as a compliment if they have a 100% pass rate. Throughout the formative assessments they allocated higher marks ensuring the students passed. Participant 12N noted similarly that there is a lot of competition. Not only between the different NEI’s, but also between the different hospitals in the current study.

*“... everybody wants a 100% pass rate, I suppose.”* (Participant 12N)

#### 4.6.2 Interpersonal factors

In the focus group discussions and the semi-structured interviews it became apparent that the clinical facilitators do not trust each other during assessments. Participant 19E explained her experience during the summative clinical assessment of the second year bridging programme students. The resident clinical facilitators were not allowed to select patients for their own students. The moderator had to select the patient for the students.

*“For example in the recent BC 2 exams where the resident CF is not allowed to select the patient for her own students. I received the list of the patients for the exams the following day and did not understand, the facilitator then informed me that, as the moderator, I must select the patients for the students.”* (Participant 19E)

It is not clear why the resident clinical facilitator was not allowed to select the patients for her students. The concern might have been that the clinical facilitator would unfairly advantage her student with the selected patient.

Participant 15E also noted that the trust relationship between the clinical facilitators affects the confidence of the facilitators and lead to self-doubt.

*“But it is also about us, the way we treat each other, the way we trust each other, ... Now I am going to assess with you for the first time and you think in your mind, I do not know anything or I am not at your standard, you pre-judge me, and you do not know what I know and you show it to me that you think I actually know nothing or I am not on your standard. Then I start doubting myself.”* (Participant 15E)

Clinical facilitators try to influence each other to be more reluctant to fail certain students. The resident clinical facilitator may point out the students' previous performance to the clinical facilitators, knowingly or even unknowingly, placing pressure on the clinical facilitators to pass the student. Failing that student create self-doubt within the clinical facilitator.

*“... even though we are one big team working together, you get some pressure sometimes from a fellow clinical facilitator, they come with little stories ... ‘Awh, but this one is the best, I never had a problem with this one’.”* (Participant 17E)

*“Because if it happens that you fail that student, then it is like ... but it can’t be ... this is my best student ... how did you fail my best student? So then you feel like ... oh, did I make a mistake, because the best student failed now and then you ... you ... you tend to doubt yourself.” (Participant 17E)*

#### **4.6.3 Avoidance of failure to fail**

Clinical facilitators mentioned they avoid failing students, especially their own students. Clinical facilitators would rather not assess a student than fail the student.

*“... and what one of my facilitators said she do not want to be part of the final exam and I also don’t want to be part of the final exam ... because I don’t want to be part of her failing ...” (Participant 7N)*

*“... and sometimes you realize the student is just not gonna make it. So you can’t make the decision that they can’t pass the year, so you actually want them to go into an exam where somebody else can find them not yet competent or where you can have a second opinion.” (Participant 11N)*

It is not unexpected that clinical facilitators in the novice category opted not to assess their students in a possible fail situation.

*“Ja, that’s why I actually don’t wanna (sic) assess my students, I’ll rather stand on the outside.” (Participant 10E)*

Participant 1N experienced it emotionally challenging to assess her own students and would prefer not to assess her students.

*“It is really emotionally wrecking. I’m thinking, sjoe, you know this one is able to pass. What if she fails and all of that? So maybe they should swop us around with exams because it is really not good for me to ...” (Participant 1N)*

The clinical facilitators did not seem to realize that prompting and guiding a student contributed to a “*failure to fail*”. Clinical facilitators admitted that they are prompting and guiding students because they don’t want them to “*miss out on important information*”.

“*I would actually prompt during the assessment: ‘Take a step back look, look at something, do you think there is something missing?’*” (Participant 12E)

“*... by the third time I really start thinking, OK, we can’t fail now. We sort of guide, we sort of ... prompt, plead, something so that we get there.*” (Participant 10E)

Clinical facilitators prompted and guided the students, rather than stopping the assessments.

“*... because I am reluctant to stop her, because the student knows what it means if I stop her ... and that ... that is an emotional experience for them. It is ... it’s a failure for them, it’s a personal failure ...*” (Participant 16E)

#### **4.6.4 Emotional involvement with students**

Various phrases throughout the discussions and interviews alluded to the fact that clinical facilitators became emotionally involved with the students. Clinical facilitators described this phenomenon in the following terms “*...we feel a lot of pity or empathy for them [the students] ...*” (Participant 12N), “*... you feel pity for her ...*” (Participant 2N) and “*... it’s heart breaking ...*” (Participant 5N).

It was clear from the participants that failing a student weighed heavily on their conscience and they have empathy with the students who fail.

“*I mean I failed a couple of students ... and you have to deal afterwards with that student’s emotions. Some of them start crying there - right there at the point when you giving feedback to them.*” (Participant 5N)

“*... we are still human, and it still hurts when they ... they fail ...*” (Participant 17E)

Clinical facilitators identify with the struggles of students similar to that of a “parent-child” relationship, and see it as their responsibility to put more effort in, in order for the student to succeed.

*“... I am never their friend but I am their support group and I will ... if I have a problem child I will work on that student a little harder and give more empathy ...”* (Participant7N)

*“... my heart says pass this child, because I know her so well ...”* (Participant 11E)

Clinical facilitators acknowledged that the students tried to manipulate the clinical facilitators to feel sorry for them and subsequently pass them.

*“I’ve experienced with one of the assessors when the student found out that she’s got 48, the assessor said ... because the student started crying ... and she said: ‘Don’t worry, don’t worry, I’ll fix it, I will mark you up, you’ve passed, are you satisfied now?’ And the student said: ‘Yes, now I’m satisfied’. Instead of a 48 she marked the things up, gave her a 50.”* (Participant 18E)

Clinical facilitators are faced with a dual loyalty. They are not only responsible for the mentoring, supporting, guiding and accompanying nursing students in clinical practice, but also that of assessor. As an assessor, the clinical facilitator has a “gatekeeping” role to fulfil i.e. ensuring that the public are protected against unsafe practice. Clinical facilitators may experience this as a conflict of interest.

*“... but we forget what we actually do and we forget that we are working with peoples’ lives. So, even though we are human, we are placing people in a profession that’s not capable of doing that, and that’s a danger for other people’s lives. So, it’s that catch 22.”* (Participant 17E)

#### **4.7 Actions to assist clinical facilitators and Nursing Education Institutions to respond factors related to the “*failure to fail*” phenomenon**

##### **What actions could be employed to assist clinical facilitators and Nursing Education Institutions to respond to the factors related to the “*failure-to-fail*” phenomenon?**

In the focus group discussions and the semi-structured interview it became apparent that clinical facilitators are aware of the current challenges related to the clinical assessment of the students at the NEI. The responses of the clinical facilitators were analysed to address the third research question.

The most pressing need amongst the clinical facilitators seemed to be factors related to the assessment process.

The clinical facilitators were aware that the current assessment environment is less than optimal. The environment was not always conducive to promote objective assessments. Participant 1N and participant 4N alluded to the fact that the clinical learning environment should support the students’ learning. It should be an environment where the students feel supported and not intimidated. The environment must be free from bias and subjectivity. Assessments should be done consistently amongst all assessors and across all clinical placement facilities.

*“... we need to create an environment where the student feels like, you know what when I am wrong the clinical facilitator is here to help me to get it right.”* (Participant 1N)

*“... I agree with Sr. [name omitted] saying the environment we create for our students have to be a student friendly environment. I don’t have to be their friend ... but I must be there that they must know I’m their support system. I am not there to intimidate them ...”* (Participant 4N)

*“... don’t we want to get to an environment where our student feels free with every clinical facilitator in this [name omitted] clinical facility. This is [organization name omitted] ... we are all [organization name omitted], we are supposed to be doing the same thing. Evaluating the student the same way. Everything being done the same way.”* (Participant 1N)

*“You see the thing is ... that worries me, yes, is that somewhere we have to be consistent in what we all doing. We all must do the same. If we agree that were circumstances that she shouldn't be assessed, then we all must act in the same way. There mustn't be leniency from a point. If we agreed that is what we are going to do ...”* (Participant 6E)

Participants suggested that the practicability of the assessments and number of students assessed per day should be reviewed. Clinical facilitators faced challenges regarding fairness and objectivity as a result of the amount of students assessed per day. The spacing of the summative exams should be reviewed. Spacing the exams out over a longer period of time would give the clinical facilitators more time to adapt between the various levels of students i.e. PEN 2, BC 1 and BC 2.

*“So one of the things would be, is to change how many assessments we do in a day. Maybe it would be then ... we'd get a fairer reflection of those students, and maybe also to ... to space exams out.”* (Participant 12N)

*“Sometimes we do at least four or five assessments per day ...by the fourth or fifth one ... you mustn't do more than three, because then you lose objectivity.”* (Participant 3E)

*“Because, but now our roster is of such a state, that there is just not enough hands ... and now you go into an assessment knowing that I am really ... ‘trek baie swaar vandag’[take a heavy load] (sic) ... are we doing ... who are we ... what are we doing then?”* (Participant 6E)

Participant 11E responded: *“Mens byt vas [sic] (You just carry on)”*

*“There is no time already for all the students on the list ... to give them fair time to do the exam. So we do four to five exams on one day, which is not fair to the CF as well ...”* (Participant 17E).

Clinical facilitators raised the concern that students experienced a great deal of pressure of starting with assessments immediately. Students just rushed through procedures not particularly developing the necessary skills and competencies. Participant 5N suggested the

practice of starting with assessments immediately when student nurses starts with their clinical practicum need to be changed.

*“Should we not change their training so that for the first six months, they are just getting that practical experience, where they don’t get formally assessed?”* (Participant 5N)

Participant 5N suggested that they still need to be informally assessed. Students still need to receive feedback. Constructive feedback is essential to assist students to identify future learning needs and actions (MMC, 2008 as cited in Duffy, 2013). She suggested more time should be spent with students in the form of clinical accompaniment.

*“No, you will still assess them. It won’t be a formal assessment, where we stand with our clipboards ...”* (Participant 5N)

*“... we will still keep on giving feedback. It will most possible something like longer accompaniment time with the students in the wards.”* (Participant 5N)

Participant 2N expressed concern about the number of formative assessments required from students in preparation for summative assessments. The amount of formative assessments should be reviewed to determine the amount of assessments that will be sufficient to prepare the students for summative assessments.

Participant 19E had a different opinion. She suggested, as participant 2N, that we look at how students are accompanied. Improved accompaniment practices will lead to better assessment outcomes.

The concern regarding the method of assessment were expressed a number of times.

Participants in the experienced group suggested the assessment method should be changed.

*“Maybe we should look at the methods of how we assess the students that maybe need to change.”* (Participant 12E)

*“... and what [name omitted] is saying ... is how we assess ... we really need to start actually working with students ...”* (Participant 10E)

The current assessment process of planned CPCA's, once-off or episodic assessment, lends itself to "staged" performance, giving an advantage to the student who "performs" well.

*"I still think the CPCA sometimes is performance ... staged performance ... you know how they work, you know the students, but then coming to the exam they do all the right things and they pass ..."* (Participant 3E)

*"... so I think the staged performance is also a problem, because some are very good with stage performance in doing exams ... I think there an unplanned option will be better. That ... or even continuous observation during the year, I don't really know what's the replacement of the CPCA's that we do currently."* (Participant 19E)

Hughes and Quinn (2013: 245) stated that episodic assessment does not reflect the student's typical performance over a longer period. The student can rehearse his or her performance to 'near perfect', not giving an accurate account of the student's everyday practice. A system of continuous assessment may overcome the weaknesses of episodic assessments as it attempts to sample the student's performance on a continual basis.

It became clear from the responses of the clinical facilitators that they realized that the assessment processes need to be addressed. Assessments need to be conducted more effectively to change the culture of "*failure to fail*".

Another suggestion that were voiced surrounded the support and development of clinical facilitators. Brown, et al. (2012), Sharples, Kelly and Elcock (2007) and Rutkowski, 2007 indicated a lack of support for mentors [assessors] in clinical practice contributed to a culture of "failure to fail".

A group of newly qualified Registered Nurses were appointed at the NEI. They participated in the discussions and interviews with the "novice" category of clinical facilitators. In the responses of the junior clinical facilitators or "novices" it became clear that they are still uncertain in their role as assessors and they feel unsupported in their role.

Responses from the senior clinical facilitators indicated that the junior assessors are not yet confident to make a pass / fail decision.

It is important to consider the amount of experience a registered nurse has, before appointing him / her as a clinical facilitator. The newly appointed, “younger” clinical facilitators also require support transitioning into their new role, especially when dealing with failing students.

*“If you look at our newer clinical facilitators, they still have that: ‘Ag shame feeling’. So they feel, is it sympathy, empathy towards the student and then they tend to put them through. I think with the older CF’s, meaning years-wise, not age-wise, more experienced CF’s, we tend to learn how to deal with that emotional side of feeling like the student is failing and you are stopping her from achieving a career or whatever.” (Participant 17E)*

*“I think the same thing goes for the reflection on yourself. I think there is a process that has to be done in your mind as well. You have to come past that point where you feel it is a personal reflection ... really you have to work on that. In the beginning it also upset me very much. But, with the years passing I had to go over that process. Not to feel personally incompetent if a student fails.” (Participant 6E)*

Newly appointed clinical facilitators had to complete the assessors’ programme. However, after completion they still felt ill prepared for their role as assessor. Participant 11N suggested that the more experienced clinical facilitators should actually engage in discussions regarding the assessment instruments, how it should be interpreted and what marks should be allocated and why.

*“Where I feel we should ... we should have an openness where we communicate and say: ‘How do you interpret it? What do you understand about this?’” (Participant 11N)*

Clinical facilitators are faced with many challenges in fulfilling their dual role as facilitator and assessor. The NEI should consider a system to support newer clinical facilitators in their role as assessors.

## **4.8 Conclusion**

The key findings related to the research questions were presented in chapter four. The findings related to the research questions were presented according to the categories identified, namely student related factors, programme requirements, assessment process and facilitator related factors. The discussion of the results will follow in chapter 5.

## CHAPTER 5

### DISCUSSION, CONCLUSIONS, RECOMMENDATIONS, AND LIMITATIONS OF THE STUDY

The researcher presented the findings of the study in chapter four. In chapter five the findings of the study will be discussed and conclusions drawn from the findings of the focus group discussions and semi-structured interviews. Chapter five concludes with recommendations for nursing education, nursing practice and nursing research and the limitations of the study.

#### 5.1 Discussion of the findings

The study revealed there are certain circumstances when clinical facilitators are reluctant to fail student nurses who are not yet competent. Four categories emerged from the data viz. student related factors, programme requirements, the assessment process and facilitator related factors. The study confirmed previous literature stating factors contributing to a culture of “*failure to fail*” are multifaceted and assessment in the clinical learning environment is complex (Black, Curzio and Terry, 2014; Docherty and Dieckman, 2015; Jervis and Tilki, 2011).

Clinical facilitators, in their role as assessors, are the *gatekeepers* to the nursing profession (Brown, et al. 2012). Evidence from the study confirmed clinical facilitators in the current study are not effectively fulfilling their role as *gatekeepers* to the profession. Clinical facilitators allowed nursing students whose performance was borderline or unsatisfactory to pass or gave them the benefit of the doubt. Similar findings were reported by Brown, et al. (2012); Deegan, Rebeiro and Burton (2012); Docherty and Dieckman (2015) and Luhanga, Yonge and Myrick (2008a).

Clinical facilitators are responsible and accountable to the nursing profession and the public to safeguard them from unsafe and incompetent practitioners (Geyer, 2013b). Clinical facilitators in the current study were aware of the potential negative consequences for the

public. Participants expressed their concern that they are placing people in a profession that is not capable of doing it. Placing incompetent or unsafe practitioners in the nursing profession threatens the safety of the public and damages the reputation of the nursing profession and the NEI.

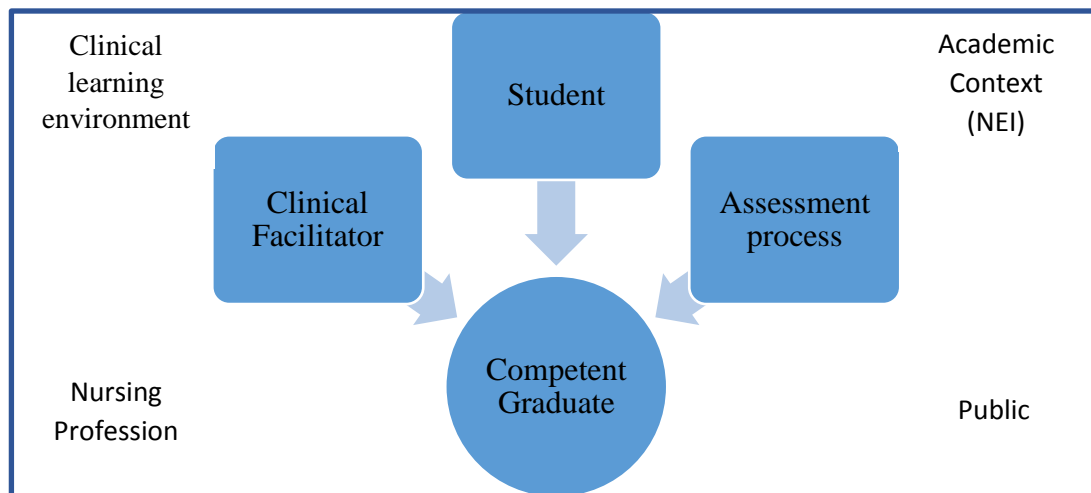


Figure 5-1 Factors contributing to a "failure to fail"

### Factors contributing to "failure to fail"

Figure 5.1 illustrates the dynamics of the factors contributing to a culture of “*failure to fail*”. Assessment of clinical competency is rarely straightforward. The clinical learning environment is complex and unpredictable. The programme requirements are set within the academic context (NEI). Various factors or challenges related to the clinical facilitator, the student and the assessment process impact on the development of competent graduates.

Within this framework clinical facilitators remain responsible and accountable to the nursing profession, the public and the NEI for the quality and the outcome of their assessments.

#### 5.1.1 Clinical Facilitator related factors

In the context of this study, clinical facilitators experienced certain challenges contributing to their reluctance to fail student nurses who are not competent.

The study revealed participants in the novice and experienced categories associated the years of experience as clinical facilitator with the confidence to pass or fail a student. The participants cited knowledge of the assessment instrument, dealing with a failing student and the ability to defend their decisions.

Brown, et al. (2012) explored factors influencing mentors to pass or fail students. They found no significant difference in the possibility of passing failing students between mentors with more than 10 years' experience and those with less than two years' experience. Brown and colleagues contended it to be an area for future exploration, as it could be argued mentors with more experience should be more likely to fail failing students. This finding contradicts the finding in the current study.

More experienced facilitators noted the newer facilitators might not be accustomed to the assessment instrument. The junior clinical facilitators expressed the need to talk about the interpretation of the instrument and the grading with the more experienced clinical facilitators. Instead their request were disregarded: "*No, this is how it is and this is the mark.*" The junior facilitators reported in spite of doing the assessors' programme they still felt ill prepared for their assessment role.

Calman, et al. (2002) reported clinical competence assessment instruments were difficult to understand. More alarmingly, they noted clinical staff did not have the knowledge to use or complete assessment instruments. Calman and colleagues (2002) suggested that preparation of assessors were not adequate in view of the complexity of assessment instruments.

In the study conducted by Fahy, et al. (2011) preceptors and students reported difficulties in understanding some of the language used in the assessment instrument. The perceived experience with and exposure to the assessment instrument alleviated the language difficulty. It can be argued that it was unfamiliarity with the instrument rather than language ambiguity.

Junior clinical facilitators found it difficult to defend their assessment decisions. Senior clinical facilitators were able to influence the assessment decisions of the junior clinical facilitators. It is not clear if this finding specifically related to the assessment context. The

junior-senior facilitator interplay would need to be explored in further studies across different contexts with larger population groups.

Reports found in the literature, evolved around pressure by the academic institution to pass students. Docherty and Dieckman (2014) reported educators experienced pressure from course coordinators or senior administrators not to fail students in the later stages of their programme. Jervis and Tilki (2011) reported participants passed unsatisfactory students related to previous experiences of pressure from the university to pass unsatisfactory students.

Other disciplines expressed similar concerns. Finch and Taylor (2013) examined practice educators' emotional experiences of assessing failing social work students. Practice educators mentioned feeling intimidated by the university to pass failing students. Feeling pressurized to pass failing students caused feelings of anger amongst practice educators.

The newer facilitators found it difficult to deal with the students' emotions when they informed the student of their fail decision. This finding was not limited to the clinical facilitators in the novice category. Clinical facilitators in the experienced category also expressed feelings of personal failure, self-doubt, self-blame and guilt.

Literature abundantly describes the feelings clinical facilitators experienced with failing students. Feelings reported include feelings of guilt (Black, Curzio and Terry, 2014; Finch and Taylor, 2013), personal failure, questioning their own competence and the quality of their mentorship (Black, Curzio and Terry, 2014; Hawe, 2003; Finch and Taylor, 2013; Jervis and Tilki 2011; Schaub and Dalrymple, 2013), lack of confidence, (Brown, et al., 2012; Mead, Hopkins and Wilson, 2011), fear and anxiety (Hrobsky and Kersbergen, 2002; Schaub and Dalrymple, 2013) and a fear of being labelled as a person who fails students (Black, Curzio and Terry, 2014; Brown, et al., 2012; Schaub and Dalrymple, 2013).

Negative feelings associated with failing students often contributed to a reluctance to fail a student in clinical practice (Duffy 2003, 2004; Black, Curzio and Terry, 2014; Brown, et al., 2012; Finch and Taylor, 2013; Rutkowski, 2007).

Clinical facilitators perceived a 100% pass rate as a compliment. At times clinical facilitators were willing to influence their colleagues to achieve a 100% pass rate. Experiencing a sense of success may negate the feelings of personal failure, guilt and self-doubt.

A finding, the lack of trust amongst clinical facilitators, needs further exploration. Clinical facilitators were afraid that their colleagues would unfairly advantage their own students to pass. It is not clear whether the clinical facilitators' fear of failure, their lack of confidence and self-doubt contributed to the distrust amongst clinical facilitators.

Avoidance of "*failure to fail*" was an expected finding amongst clinical facilitators in the novice category given their lack of experience as assessors. Clinical facilitators in the novice category needed to learn how to deal with the emotional aspect of failing a student.

Unexpected was the resonance of avoiding "*failure to fail*" amongst the clinical facilitators in the experienced category. Clinical facilitators in both categories avoided at times to assess their own students. They would rather leave the decision to someone else.

Some clinical facilitators would stop assessments if it became apparent that the student would fail. It was not clear whether the assessment was stopped for the safety of the patient or to prevent the student from failing. In certain circumstances, clinical facilitators would rather allow the student to continue and use prompts to prevent the student from failing. Clinical facilitators seemed unaware of the practice of guiding and prompting as preventing the student from failing.

Clinical facilitators are responsible for the mentoring, supporting, guiding and accompanying of nursing students in clinical practice as well as passing a judgment on the student's performance once assessed. Nursing is seen as a caring profession and failing students may be regarded as an uncaring practice (Black, Curzio and Terry, 2014; Luhanga, Yonge and Myrick, 2008a).

Participants in the study reported that they became emotionally involved with students to the point of "*identifying with their struggles*". The emotional involvement with the students influenced the clinical facilitators' judgement, making it difficult to fail the students. However, they were aware of their professional responsibility and accountability to protect the safety of the patient and to uphold the reputation of the profession.

In a literature review conducted by Finch and Taylor (2013), one of the themes that emerged was the role conflict or role strain experienced by assessors. The clinical facilitator is seen as “nurturer and enabler of learning” on the one side and “assessor and manager” on the other side. The role conflict experienced by clinical facilitators made it difficult to fail students.

Hand (2006) described the dual role of clinical facilitators as problematic, especially if there were an extended period of contact between the facilitator and the student. Gallant, MacDonald and Higuchi (2006) stated “*Clinical evaluation is one of the most complex aspects of nursing education because of the dual obligation of faculty [educators] to facilitate student learning in the clinical learning environment and to maintain standards of nursing practice*”.

Clinical facilitators should have support networks in place to assist them, especially in dealing with failing students (Rutkowski, 2007). Training should be available to new clinical facilitators to assist them in the development of their role as assessors. Workshops and continual professional development programmes should follow initial programmes (Larocque and Luhanga, 2013). According to Duffy (2013), it is necessary that clinical facilitators demonstrate how they maintained their competence as assessor. Currently clinical facilitators are required to register with the SANC as assessors; however, no system is in place to ensure assessors remain current.

The SANC (2013) mandated NEI’s to include selection criteria for clinical facilitators focusing on candidates who demonstrate clinical and educational expertise. The requirements could include that clinical facilitators provide evidence of their preparation for their role as facilitators.

Results from the current study indicated that junior clinical facilitators received inadequate preparation for their role as assessors. They need more guidance and support in understanding the assessment instruments. Junior and senior facilitators alike need emotional support in dealing with failing students. Participant 6E expressed: “*I think there is a process that has to be done in your mind as well. You have to come past that point where you feel it as a personal reflection ...*”

### 5.1.2 Student related factors

The students in the context of the current study come from diverse backgrounds. Physical, social and emotional factors may place students at a disadvantage. Clinical facilitators were willing to give students the benefit of the doubt and negotiate around the borderline percentage if they were aware of the difficulties students are facing.

Some of the students were breadwinners in their families and took care of their siblings. Failing a student in circumstances where it affects the student and their families at home contributed to facilitators' reluctance to fail the student.

The language of instruction is English and students may not be able to express themselves, as English is a second language to most of the students. The students are not proficient in skills such as academic writing, mathematical and computer literacy. Students are not prepared for the pressures of tertiary education. Clinical facilitators may opt to pass students because they might not be sure if the student had difficulty in expressing herself, or is it a question of a lack of knowledge.

The finding in this study correlate with the findings of Breier, Wildschut and Mgqolozana (2009) who reported that students in South Africa are exposed various to challenges including social and academic problems. Students are supporting family members at home, are inadequately prepared for tertiary study, and they struggle to speak, write and understand English.

Positive student characteristics rendered clinical facilitators in the novice and experienced categories unlikely to fail students. The “good” they hear about students, positive attitudes and being clinically skilful are some of the factors that made clinical facilitators “... *not to fail ...*” students. Contradicting the literature on clinical competency, clinical facilitators viewed knowledge as less important than skills and attitude.

In spite of the ambiguity surrounding the term competency in the literature, most authors agree competency include knowledge, skill and attitude (Cassidy, 2009; Fahy, et al. 2011; McMullen, et al. 2003; Rutkowski, 2007). Focussing on clinical skills, according to Cassidy (2009) would reduce nursing care to a “*procedure rather than an art*”.

Clinical facilitators considered students prior satisfactory work performance in their assessment decision. Consequently, students may pass clinical assessments based on previous experiences. One of the participants in the novice category raised a concern. She questioned whether this approach would not cause clinical facilitators to miss the student's poor performance. The student might become comfortable or the student might not understand

Clinical facilitators expressed their reluctance to fail a student in the final stages of their programme before certification. They considered the impact it would have on the student's life and career. In the study conducted by Luhanga, Yonge and Myrick (2008a) preceptors opted not to fail unsafe students. They did not want to jeopardize a student's future due to the significant personal cost to the student. Black, Curzio and Terry (2014) reported mentors felt failing students late in their studies were unfair.

Clinical facilitators were acutely aware of the potentially devastating consequences of failing on the students. Students invested a lot of money in their studies. They considered the emotional effects of failing on the student. The potential loss of a career and an income contributed to the reluctance amongst clinical facilitators to fail students. The theme resonated amongst novice and experienced facilitators. There is a paucity regarding this phenomenon in the literature from sub-Saharan Africa.

Students experienced high levels of stress and anxiety during assessments. The emotions students experienced during assessments rendered clinical facilitators reluctant to fail students. Clinical facilitators were willing to "*excuse certain things*" if they attributed the student's poor performance to anxiety. Conversely, Luhanga, Myrick and Yonge (2008b) attributed extreme nervousness as a warning sign of poor performance.

Crooks (1988) contemplated anxiety does not simply arise from a lack of knowledge or skills. He alluded to the fact that testing conditions that are particularly intrusive e.g. rigid time limits increased the debilitating effects of high levels of anxiety. The question arises whether the students' poor performance can be attributed to anxiety or whether anxiety is indicative of poor performance.

Repeated failures caused students to become demotivated. Clinical facilitators acknowledged that demotivated students are not learning. Bowie (2010: 66) identified high levels of stress and anxiety associated with the clinical learning environment as a barrier to effective learning during clinical practicum.

Clinical facilitators did not fail students to motivate them and create a sense that they can succeed. The emphasis placed on assessments to determine students' progress is concerning. All assessments are graded determining progression between progress review periods, academic years and programme completion.

Assessments mostly used for grading purposes, “*assessment of learning*”, results in a lack of “*assessment for learning*” (Crooks, 1988; Stiggins, 2002). If the purpose of assessment is to improve competency, greater emphasis should be placed on assessment for learning.

#### **5.1.4 Programme requirements**

Clinical facilitators felt overwhelmed with the increased amount of students allocated to the clinical placement facilities. The amount of students in relation to the amount of clinical facilitators available at the clinical placement facilities affected the workload of the clinical facilitators and the time they had available to facilitate and assess students. The participants in the study indicated that larger numbers of students rendered them less likely to fail students.

Similar findings were reported in the literature. Larocque and Luhanga (2013) found that faculty [educators] and mentors were “*failing to fail*” student nurses, because they were reluctant to take on the additional workload of mentoring a failing student due to a lack of time. Rutkowski (2007) concluded that staff shortages, the reduced amount of time available for mentors to assess students and too many students allocated to a clinical placement facility contributed to the reluctance of mentors to fail students.

The remediation process contributed to the reluctance amongst clinical facilitators to fail students. Clinical facilitators were required to remediate students prior to the next assessment attempt. Remediation was described as stressful and time consuming. There were no clear guidelines or structured process for remediation.

Gallant, MacDonald and Higuchi (2006) reported educators frequently implemented remediation processes haphazardly. Gallant and colleagues cautioned that such an approach might lack objectivity, openness and transparency. They suggested a student-centred process, based on mutual respect, a positive learning environment, clear learning objectives, multiple sources of evidence and timely feedback to the student.

Clinical facilitators commenced assessments shortly after the programme commencement. Assessing students early in the programme rendered clinical facilitators less likely to fail students. The programme requirements and progression rules necessitated facilitators to assess students before they were ready for assessments. Students did not have time to adjust to the clinical learning environment. They did not have sufficient time to practice competencies and display competence.

Participants in both the novice and experienced groups agreed on the importance of scheduling assessments not to disadvantage students.

The South African Nursing Council's "*Nursing Education and Training Standards*" (SANC, 2013: 41) make provision for the assessment of students' learning, knowledge and skills development throughout their programme specifically stating that assessments should be spaced realistically throughout the programme allowing adequate time for demonstrations, practice, and remediation.

Scholes and Albarran (2005) mentioned mentors are reluctant to fail students early in their programme. The mentors hoped their practice would improve with time. As one of the participants in the current study stated "... ag, perhaps this perhaps this nurse will ... 'come right ...' (sic).

Feasibility or "practicability" of assessments refers to time and resources available to do assessments as well time to prepare students for assessments (Stuart, 2013: 98; Hand, 2006: 52; Hughes and Quinn, 2013: 248). Assessments are unfair if the students did not have sufficient time to practice and demonstrate competence (Stuart, 2013: 98).

Clinical facilitators, lecturers and programme coordinators should all participate in the planning of the clinical outcomes and the progression rules of the programme allowing students more time to adjust to the clinical learning environment before assessments commence.

Students placed at smaller clinical placement settings had fewer resources available to them. The clinical placement facilities and the skills laboratories did not always make provision for all the procedures the students require. Facilitators mentioned smaller hospitals did not have all the disciplines and did not have enough facilitators. Conversely, in the bigger hospitals, the facilitator-student ratio was not optimal. According to the *Nursing Education and Training Standards* (SANC, 2013) the clinical facilitator to student ratio in the clinical setting must be sufficient to ensure optimum student learning and safe practice. Paucity in the document exists on what the ratio should be. The ratios were determined at institutional level.

A lack of time, resources and skills development opportunities rendered clinical facilitators less reluctant to fail students. Facilitators argued that students could not be failed if sufficient guidance, mentoring and access to resources were not available.

According to the participants, assessment of students should not commence early in their programme. Clinical facilitators needed more time to provide constructive feedback, remediation opportunities and clinical accompaniment.

According to Crooks (1988), fewer assessments with a greater focus on teaching and learning is more valuable. Such an approach will leave clinical facilitators with more time for clinical accompaniment.

Clinical accompaniment considers students' unique learning needs, create learning opportunities enabling students to grow and become critical thinkers (Mochaki, 2007). "*Nursing education and training cannot succeed without a properly planned accompaniment programme for students*" (Mochaki, 2007)

#### **5.1.4 Factors related to the assessment process**

Assessing nursing students' competency in clinical practice is a complex process widely researched and reported (Cassidy, 2009; Fahy, et al., 2011; Fordham, 2005; Hand, 2006). Agreement exists that clinical experience is a key component in all practice-base disciplines, including nursing. In the current study identified factors related to the assessment process contributing to a "failure to fail". Assessment principles, assessment purpose, assessment methods and instruments, and the outcome of the assessment contributed to a "*failure to fail*".

Assessment at the NEI served several purposes. Formative assessments determined progression between review periods. Summative assessments determined progression between academic years and towards programme completion. Students are granted a supplementary assessment if they were found not yet competent in the summative assessment.

Clinical facilitators in both the novice and experienced categories acknowledged they were more reluctant to fail students in summative assessments. Students experienced more stress during summative assessments than formative assessments. With formative assessments, the opportunity for remediation still exists. In supplementary assessments, clinical facilitators were even more reluctant to fail students. They felt they were "... *handing the student and extension ...*" and they "... *are stopping her from achieving a career ...*"

Clinical facilitators often gave students the benefit of the doubt if they perceived the student may have problems or experienced that high anxiety levels on the day of the assessment could have contributed to the student's poor performance on the day of the assessment.

Formative assessments even done at regular intervals may be perceived as a "*continuous assessment process*"; however, it rather reflects "*episodic assessment*". Hughes and Quinn (2013: 245) criticized episodic assessment. Episodic assessment rely on the student's once of performance on the day of the assessment. It does not reflect the student's general performance over a longer period. The continuous assessment process aim to sample the student's nursing practice on a continuous basis, informing a more accurate reflection of the student's achievement in the education programme (Hughes and Quinn, 2013: 245-246).

Prince (2012) alluded to the fact that the complexity and familiarity of the caregiving environment contributes to student performance. The caregiving environment will influence

student performance contributing to both good or bad performance and more or less skilful practice. It is necessary to consider the assessment context to make correct inferences regarding student performance. The facilitator should consider more than just the student's performance on the day.

Senior clinical facilitators raised the concern that the junior clinical facilitators are not accustomed to the expectations for student achievement as they are supposed to be. However, the junior facilitators reported that the senior clinical facilitators rarely take the time to explain the expected outcomes to them. Students should also be aware of what is required of them.

Sharples, et al. (2007) noted clinical facilitators with a poor understanding of student expected outcomes were not able to identify weak students in clinical practice. They were less likely to fail weak students.

Hodges (2014) identified this dilemma when she explored the issues of “*failure to fail*” and grade inflation. She identified that clinical facilitators or assessors often do not have clear expectations for student achievement themselves. In addition, they do not know how to communicate their expectations with their students. Hodges (2014) states: “*The statement, ‘I’ll know it when I see it,’ captures this dilemma. We each have a tacit idea of what excellent work looks like, and we assume our colleagues share the same standards.*”

Clinical facilitators reported inconsistencies amongst clinical facilitators regarding interpretation of expected outcomes. The rating scales leading to bias and the instruments are subject to manipulation allowing students either to pass or fail. Values are especially difficult to measure and may be used unfairly to benefit the student. Clinical facilitators described a second assessor present at the final assessments as a “... *safety net* ...” The presence of a second assessor reduced the possibility of bias. This should hold true were clinical facilitators were not influencing each other.

Fahy, et al. (2011: 44) and Calman, et al. (2002: 521) reported students and assessors experienced difficulty in understanding the assessment language, instruments were difficult to understand, open to interpretation and it appeared as if assessors did not know how to utilize the instruments.

A general feeling amongst the students was that even if the assessors attended a preparatory course prior to them assessing students there were still some assessors that did not understand the documentation (Calman, et al., 2002: 521). The students also complained of a lack of consistency amongst assessors.

The nature of assessment in clinical practice requires observation of performance of one individual by another, inherently creating the risk of observer bias or subjectivity (Calman, et al., 2002: 517; Dolan, 2003: 133; Stuart, 2013: 94). The risk of subjectivity increases where the competencies assessed are relatively vague such as attitudes and values (McMullan, et al., 2003: 287).

The assessment process was rife with factors challenging the credibility of the assessments. Factors related to the clinical facilitator, student, the programme required and the assessment process contributed to bias and subjectivity.

Clinical facilitators interpreted assessment criteria inconsistently challenging the reliability of the assessment. A variety of human factors influenced the students' day-to-day performance further challenging the reliability of the assessments.

A limited amount of time and resources available threatened the practicability of the assessments. Assessments lacked discriminatory power. Students were given the benefit of doubt and were passed if they were deemed safe practitioners, rather than competent practitioners, or if they had the potential to develop further.

Findings from the current study mandate Nursing Education Institution the clinical assessments process of the students nurses. Clinical facilitators need to fulfil their role as *gatekeepers* to the profession. In the interest of public safety, the reputation of the nursing profession and the NEI only those students who achieved the required level of competency should be allowed to qualify.

## **5.2 Recommendations**

The researcher analysed the factors contributing to a reluctance of clinical facilitators to fail student nurses who are not yet competent, i.e. a “*failure to fail*”. Data collected enabled the researcher to make recommendations for nursing education, nursing practice and nursing research to assist clinical facilitators, and the NEI to address the factors contributing to a culture of “*failure to fail*” in nursing education.

Included are recommendations for nursing education, nursing research and nursing practice to ensure that only practitioners who are competent are allowed to register with the South African Nursing Council.

### **5.2.1 Nursing Education:**

#### **5.2.1.1. Change assessment practices**

An important consideration for the Nursing Education Institutions is to change assessment practices, if assessments are to be used as a quality control mechanism for nursing practice, to motivate students and to support teaching and learning. The NEI should:

- Review the current assessment practices – assessment methods, assessment instruments and timing of assessments.
- Explore different assessment methods e.g. continuous assessments. Continuous assessment of student nurses practice would give a better reflection of the students’ competency and enable clinical facilitators to make an objective assessment decision.
- Distinguish between formative and summative assessments. It may be counterproductive to use formative assessments for grading purposes and progression in a programme.
- Strengthen the value of formative assessments. The focus of formative assessments should be to provide the student with constructive feedback, critical appraisal of their performance and to develop into competent nursing practitioners.
- Review the use of formative assessments. Re-evaluate the practice of using formative assessments to exclude students from continuing their programme midyear. Consider discontinuing a student’s programme only towards the end of the academic year.

- Reduce the amount of assessments. Allow more time for teaching, learning and clinical accompaniment of students in the clinical learning environment. Give students more time to adjust to the clinical learning environment prior to the onset of assessments.

#### **5.2.1.2. Implement a Mentorship Programme**

Clinical facilitators are responsible for teaching, learning and assessment of students in clinical practice. They are responsible and accountable to the NEI, the nursing practice and the public for the quality of their assessments. The NEI should:

- Implement a mentorship programme to assist clinical facilitators to develop competency in their role as assessors.
- Appoint experienced clinical facilitators assist novice clinical facilitators to develop their role as facilitators and assessors. The clinical facilitator can consult the mentor when faced with difficult and challenging assessment situations and decisions. The role of the mentor should include facilitating communication between the clinical facilitator and the nursing education institution.

#### **5.2.1.3. Clinical facilitation training and development programme**

It is important that the NEI take responsibility for the development and implementation of a clinical facilitators' training and development programme.

- The clinical facilitation and development programme need to address the challenges clinical facilitators face in the clinical learning environment.
- Update existing programmes.
- Topics development programme should include topics addressing all aspects of the assessment process:
  - Conduct valid and reliable assessments,
  - Assessment principles,
  - Providing constructive feedback,
  - Recognizing the unsafe student in clinical practice / early identification of weak students,
  - Managing the failing student in clinical practice
  - The implementation of effective remediation and student support practices.

- Dealing with the emotional responses of failing students
- Managing the dual role of the clinical facilitator

#### **5.2.1.4. Development of the moderator's role**

Developing the role of the moderator is a key recommendation to ensure that the assessment process is credible. The NEI should appoint a moderators committee consisting of appropriately qualified and experienced moderators. Responsibilities of the moderators committee to include:

- Provide feedback to clinical facilitators on their assessments
- Conduct pre-assessment meetings setting the scene for credible assessments
- Conduct post-assessment meetings reviewing the assessment process, discussing matters arising from the assessment, the assessment instruments and to clarify ambiguities
- Create debriefing opportunities for clinical facilitators after difficult assessment decisions and assist clinical facilitators with dealing with their emotions after failing a student.
- Create a platform for the development of evidence-based assessment practices.

#### **5.2.1.5. Policy development and change**

An important recommendation for NEI's is to review existing assessment and moderation policies to address the issues identified in the study. The NEI to implement the standards and criteria set for nursing education in the Nursing Education and Training Standards (SANC, 2013), including but not limited to:

- Set selection criteria for the appointment of clinical facilitators
- Use a variety of assessment methods in different contexts for the student to demonstrate competence
- Provide academic support for learners that are slow to develop, including remediation programmes
- Set clinical facilitator to student ration in the clinical learning environment to optimize student learning and safe client care

### **5.2.2 Nursing practice**

### **5.2.2.1. Clinical learning environment**

Hospital managers, nursing service managers and unit managers at clinical placement facilities should take co-responsibility for the development of competent nursing practitioners. The clinical learning environment is a complex environment where the student interacts with other health care workers, patients and their relatives. The students need role models in the clinical learning environment. Key role players at the clinical placement facility should:

- Identify and develop professional nurses with an interest in students. The main function of the specialist nurses would be to support students in the clinical learning environment, role model appropriate behaviour and assist student nurses to become competent practitioners.
- Actively involve unit managers in the teaching, learning and assessment of student nurses in clinical practice.
- The clinical placement facility and the NEI should adopt a participative process in the appointment of clinical facilitators at the clinical placement facility.
- Encourage registered and professional nurses to participate in CPD opportunities, relevant to their field of specialization. The participation in CPD activities should be compulsory and the employer should keep record of such activities.

### **5.2.2.2. The South African Nursing Council**

Section 39 of the Nursing Act, 2005 (No 33 of 2005) set the requirements for continuous professional development (CPD) of registered nurses. The SANC should:

- Prioritize the implementation of a CPD system for the nursing profession.

The SANC set the standards for the establishment of nursing education and training programmes (SANC, 2013). The SANC should:

- Sharpen the focus on the implementation of the *Nursing Education and Training Standards* (SANC, 2013).
- Hold the NEI's responsible and accountable for the quality of their assessments, and the quality of nursing educators appointed to fulfil the role of clinical facilitators and assessors.

### **5.2.3 Nursing research**

The researcher conducted the study at a private NEI in Gauteng. The study included a relatively small population. It is the recommendation of the researcher that the study should be replicated across different nursing education institutions, public as well as private and comparing the results.

A further recommendation would be to review current assessment practices. Evidence-based assessment practices can be developed based on the results of the research. Future research should aim to answer the following questions:

- How can assessments be used to support teaching and learning?
- How can assessments be used for the motivation for students?
- Do our current assessment practices place students at risk of failure?
- Does competency equate safety?

Topics worth exploring are the identification of unsafe clinical practice and unsafe students in clinical practice to assist clinical facilitators to identify unsafe students early in their programme. Early identification of student nurses who are not competent will prevent harm to patients and adverse incidents from occurring.

The validity and reliability of assessment instruments should be tested and time taken to develop assessment instruments that are valid and reliable.

### **5.3 Limitations of the study**

The study setting was a private nursing education institution in Gauteng. The site was purposively selected for convenience and accessibility and the views expressed by the clinical facilitators may not reflect the views of clinical facilitators in other geographical areas. Even though the researcher used a total population, it was still a relatively small sample making it difficult to generalize the findings.

Clinical facilitators were required during data collection to review and share their own practice. Exploring a relative sensitive topic requiring honest self-reflection would best be addressed in semi-structured interviews. The participants, just as seen with the assessments, were able influence each other and the facilitators might be reluctant to share more sensitive information in a group amongst their peers. The focus group discussions and the semi-structured interviews were conducted in English. English is a second language to most of the participants, making it difficult for the assessors to express themselves.

The researcher did not collect demographic data. The researcher relied on self-report of the participants as they divided themselves into novice and experienced categories. It would be valuable to know how many clinical facilitators were assessor and/or moderator trained. The education qualifications of clinical facilitators and attendance of previous clinical facilitator's development programmes could have given valuable insight into the responses of the clinical facilitators.

#### **5.4 Conclusion**

Assessing students in clinical practice is complex and identifying unsafe students in clinical practice is not as straight forward as it may seem. "*Failure to fail*" is a multifaceted problem that needs to be addressed to ensure that graduates from nursing programmes are "fit to practice" safely and competently.

This study has highlighted the many factors that contribute to the problem of failing to fail students many of which are systems issues and others could be corrected at an individual level. One of the remaining concerns is that until the psycho-social and economic position of the recruits into student nursing programme improves, clinical facilitators will always feel an obligation to assist them unduly. The Nursing Education Institutions need to carefully review the load on assessors and students and consider reducing the number and complexity of assessments to allow more time for teaching, learning and remediation.

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## **ANNEXURES**

- Annexure A - Participant information letter
- Annexure B - Interview guide
- Annexure C - Participant consent
- Annexure D - Human Research Ethics Committee Clearance Certificate
- Annexure E - Willemse S - UNIV-2015-0024 - Annon letter -doc13247420150603144831
- Annexure F - Organizational consent
- Annexure G - Clinical facility consent

## **ANNEXURE A**

### **FACTORS CONTRIBUTING TO A RELUCTANCE OF CLINICAL FACILITATORS AT A PRIVATE NURSING EDUCATION INSTITUTION IN GAUTENG TO FAIL STUDENT NURSES WHO ARE NOT COMPETENT**

#### **PARTICIPANT INFORMATION SHEET**

Dear Colleagues

My name is Sonia Willemse, currently registered as a student at the University of the Witwatersrand, Department of Nursing Education for the degree of Master of Science in Nursing. I would like to invite you to participate in my research project and kindly request your consent for inclusion in my sample of clinical facilitators at a private nursing education.

The aim of this study is to determine if there is a reluctance to fail nursing students and to explore and describe factors contributing to a reluctance of clinical facilitators' at a private nursing education institution in Gauteng to fail student nurses who are not competent.

Should you consent to participate you will be requested to participate in a focus group discussion exploring factors contributing to the reluctance of clinical facilitators to fail students who are not yet competent. The focus group discussion will take place at the \_\_\_\_\_ campus in the boardroom. The discussion should take approximately 60 – 90 minutes. Participants will be requested to keep all information discussed in the focus groups confidential amongst them.

If you consent, the focus group discussions will be recorded and transcribed. After transcription, you will have access to the transcribed data to clarify any information provided during the focus group discussions. I will obtain permission from your unit manager / nursing services manager to enable you to participate during your on duty time.

Participation is entirely voluntarily and you may choose not to participate in the study or withdraw from the study at any time, which will have no effect on you personally or professionally. Anonymity will be ensured by using code numbers instead of your real name and no personal information will be disclosed throughout the study. No participants will derive any benefit, nor harm from the intended research project.

The appropriate people and research committees from the University of Witwatersrand and \_\_\_\_\_ and \_\_\_\_\_ have approved the study and the procedures.

Thank you for taking the time to read this information letter. Please do not hesitate to contact me should you require any further information regarding your participation in the project. You can contact me on 083 276 0996.

Should you require any additional information kindly contact:

Prof P Cleaton Jones

HREC Chairperson

Tel: (011) 717 2301

E-mail: [peter.cleaton-jones@wits.ac.za](mailto:peter.cleaton-jones@wits.ac.za)

Ms Z Ndlovu

Administrative Officer

Tel: (011) 717 2301

E-mail: [zanele.ndlovu@wits.ac.za](mailto:zanele.ndlovu@wits.ac.za)

## ANNEXURE B

### FACTORS CONTRIBUTING TO A RELUCTANCE OF CLINICAL FACILITATORS AT A PRIVATE NURSING EDUCATION INSTITUTION IN GAUTENG TO FAIL STUDENT NURSES WHO ARE NOT COMPETENT

#### INTERVIEW GUIDE

##### Section 1: Demographic data

1. Focus group interview.

1		2		3		4		5	
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2. Number of participants: \_\_\_\_\_

3. Date: \_\_\_\_\_

4. Focus group category

Novice ( $< 3$ years' experience)		Experienced ( $\geq 3$ years' experience)	
--------------------------------------	--	--	--

5. Gender:

1	2	3	4	5	6	7	8		
Female	Female	Female	Female	Female	Female	Female	Female		
Male	Male	Male	Male	Male	Male	Male	Male		

##### Section 2: Interview questions:

1. Are clinical facilitators reluctant to fail student nurses who are not competent?
2. What factors do you think may lead to clinical facilitators finding it difficult to fail student nurses who are not competent?

## ANNEXURE C

### FACTORS CONTRIBUTING TO A RELUCTANCE OF CLINICAL FACILITATORS AT A PRIVATE NURSING EDUCATION INSTITUTION IN GAUTENG TO FAIL STUDENT NURSES WHO ARE NOT COMPETENT

#### CONSENT FORM

I, \_\_\_\_\_ (name)

Confirm that I read and understood the content of the information sheet and have been given the opportunity to ask any questions I might have regarding the study and my consent to being included.

I understand that my participation is voluntarily and that I can withdraw consent at any time. I consent that the focus group discussions will be recorded to ensure accurate capturing of data. I have the option to view the data transcribed from the audio recordings.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

ANNEXURE D



R1449 Mrs Sonia Willemse

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)**

**CLEARANCE CERTIFICATE NO. M141019**

**NAME:** Mrs Sonia Willemse  
**(Principal Investigator)**

**DEPARTMENT:** Nursing Education  
Netscare Education Gauteng, North East


**PROJECT TITLE:** Factors Contributing to Reluctance of Clinical  
Facilitators at a Private Nursing Education  
Institution in Gauteng to Fail Student Nurses Who  
are Not Competent

**DATE CONSIDERED:** 31/10/2014

**DECISION:** Approved unconditionally

**CONDITIONS:**

**SUPERVISOR:** Mrs H Thurling/ Dr S Armstrong

**APPROVED BY:**   
\_\_\_\_\_  
Professor P Cleaton-Jones, Chairperson, HREC (Medical)

**DATE OF APPROVAL:** 18/01/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

**DECLARATION OF INVESTIGATORS**

To be completed in duplicate and ONE COPY returned to the Secretary in Room 1004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. I agree to submit a yearly progress report.

\_\_\_\_\_  
Principal Investigator Signature

\_\_\_\_\_  
Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

## ANNEXURE E

### RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2015-0024

Ms S Willemse

E mail: sonja.willemse@netcare.co.za

Dear Ms Willemse

#### RE: FACTORS CONTRIBUTING TO RELUCTANCE OF CLINICAL FACILITATORS AT A PRIVATE NURSING EDUCATION INSTITUTION IN GAUTENG TO FAIL STUDENT NURSES WHO ARE NOT COMPETENT


The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospitals and Private Nursing Education Institution, has been approved, subject to the following:

- i) Research may now commence with this FINAL APPROVAL from the Committee.
- ii) All information regarding the Company will be treated as legally privileged and confidential.
- iii) The Company's name will not be mentioned without written consent from the Committee.
- iv) All legal requirements with regards to participants' rights and confidentiality will be complied with.
- v) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.
- vi) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date.
- vii) The Company has the right to implement any recommendations from the research.
- viii) The Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/ Company or should the researcher not comply with the conditions of approval.

- b) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE STUDY, WHICHEVER IS THE FIRST.

We wish you success in your research.

Yours faithfully

 30/4/2015

Prof David Preece

Full member: Research Operations Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Shannon Nell

  
Chairperson: Research Operations Committee

Date:

22/5/2015

This letter has been anonymised to ensure confidentiality in the research report. The original letter is available with author of research.

## ANNEXURE F

Sonia Willemse  
Department of Nursing Education,  
Faculty of health Sciences,  
University of the Witwatersrand,  
7 York Road  
Parktown  
2193

\_\_\_\_\_ Research Committee

\_\_\_\_\_  
\_\_\_\_\_

Dear \_\_\_\_\_

**RE: REQUEST TO CONDUCT RESEARCH AT \_\_\_\_\_.**

My name is Sonia Willemse, currently registered as a student at the University of the Witwatersrand, Department of Nursing Education for the degree of Master of Science in Nursing. I hereby request permission to undertake research titled “*Factors contributing to a reluctance of clinical facilitators at a private nursing education institution to fail student nurses who are not competent*” at \_\_\_\_\_ Campus.

The complex phenomenon of ‘failure to fail’ is well described in the literature over the past decade. Findings from studies revealed that nursing students are passing clinical assessments even when there are doubts about their clinical performance. The assessment of students’ competency is a worldwide concern to all practice-based disciplines including the fields of nursing, medicine, and social work.

The aim of this study is to determine if there is a reluctance to fail nursing students and to explore and describe factors contributing to a reluctance of clinical facilitators’ at a private nursing education institution in Gauteng to fail student nurses who are not competent.

I wish to assure you that the name of the institution and the clinical facilitators involved in the research will not be divulged in the research report. Written informed consent will be obtained from all the research participants. Should you require a copy of the research report would be made available to you.

Yours sincerely,

Sonia Willemse  
MSc (Nursing) student

Date:

## ANNEXURE G

Sonia Willemse  
Department of Nursing Education,  
Faculty of health Sciences,  
University of the Witwatersrand,  
7 York Road  
Parktown  
2193

\_\_\_\_\_ Hospital

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dear Ms. \_\_\_\_\_

**RE: REQUEST FOR THE CLINICAL FACILITATORS TO PARTICPATE IN FOCUS  
GROUP DISCUSSIONS AT \_\_\_\_\_**

My name is Sonia Willemse, currently registered as a student at the University of the Witwatersrand, Department of Nursing Education for the degree of Master of Science in Nursing. I hereby request permission for the clinical facilitators at \_\_\_\_\_ Hospital to participate in focus group discussions regarding the research titled “*Factors contributing to a reluctance of clinical facilitators at a private nursing education institution to fail student nurses who are not competent.*”

The complex phenomenon of ‘failure to fail’ is well described in the literature over the past decade. Findings from studies revealed that nursing students are passing clinical assessments even when there are doubts about their clinical performance. The assessment of students’ competency is a worldwide concern to all practice-based disciplines including the fields of nursing, medicine, and social work.

The aim of this study is to determine if there is a reluctance to fail nursing students and to explore and describe factors contributing to a reluctance of clinical facilitators’ at a private nursing education institution in Gauteng to fail student nurses who are not competent.

I wish to assure you that the name of the institution and the clinical facilitators involved in the research will not be divulged in the research report. Written informed consent will be obtained from

all the research participants. Should you require a copy of the research report would be made available to you.

Yours sincerely,

Sonia Willemse  
MSc (Nursing) student

Date: