Reluctance to fail nursing students in practice-implications for nurse managers

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In many countries internationally nurses have an important role in the direct supervision, teaching and assessment of nursing students in clinical practice (Jokelainen et al., 2011; Tuomikoski et al., 2016). In countries such as the UK and Ireland, competency-based assessments of students are undertaken by nurses working in practice, with [varying levels of] support from third level institutions. Successful achievement of these practice based competency assessments is an integral component of contemporary nurse education programmes and a requirement of ultimate registration with relevant nursing boards. Nurses undergo basic preparation and training as assessors; and work closely with students in the role of mentor or preceptor. One ongoing concern for these nurses and their clinical managers is the issue of underperforming students. In addition to possible clinical safety issues, when a student is not achieving competence the mentor is then required to take the responsibility of failing the student. Many nurses place a high value on patient safety and see their role in these situations as gatekeeper to the profession insofar as they do not permit students to pass whom they believe do not have the core requirements of a nurse including competency (Vinales, 2015; Luhanga et al., 2008). However in some circumstances while it is obvious to the mentor (and perhaps others) that the student requires additional knowledge, skills and attitudes to achieve the required competencies, conferring a fail on the student can be difficult for a variety of reasons (Duffy, 2013). Consequently reluctance to fail nursing students is extensively written about in the literature as an on-going dilemma for mentors and preceptors over the past 25 years (Cassidy 2017). Yet at the same time this reluctance persists despite this awareness and the need to safeguard the public and ensure adequate standards of practice (Nugent et al., 2017; Cassidy, 2017). Gainsbury (2010) for example drew attention to a UK-based Nursing Times study of 1,945 nurses which highlighted that many nurses would permit nursing students to pass even if they were concerned about their competence. Citing Lawson's (2010) study they noted that up to 37% of mentors awarded students a pass on their assessments while at the same time holding reservations about the student's ability. The factors which influence this failure to fail include barriers to giving constructive feedback time constraints, lack of ample written evidence, poor staffing levels, lack of confidence, lack of support, and the burden of being responsible for possibly terminating a student's career (Wells and McLoughlin, 2013; Gainsbury, 2010; Vinales, 2015).

There appears to be an evolving history of failing to fail among the nursing profession despite awareness of the phenomenon and knowledge of the key barriers (Cassidy, 2017). Recently in the Republic of Ireland (ROI) we found that the main factors supporting preceptors failing students included the presence of written evidence, perception of dangerous practice, behaviour and attitude of student and support from other hospital staff and management (Nugent et al., 2017). Observations of student absenteeism, lack of skills/knowledge and competence and poor communication or obvious indifference to their nursing career also led preceptors to take strong action (Nugent et al., 2017). However at the same time subjective observations of the students' personalities (such as being hard-working, approachable or having a vulnerable mental state) sometimes encouraged staff to take a more lenient approach due to guilt and/or compassion or to offer a second chance (Nugent et al., 2017). Fear of legal repercussions or criticism from colleagues also supported lenience (Nugent et al., 2017). Our co-authors from Wales yielded similar findings (Cassidy et al., 2017). Interviews with students, mentors and practice facilitators revealed the assessment of practice competence to be a "conundrum" (Cassidy et al., 2017). Nurses with concerns about students performance looked more favourably upon weaker students who appeared to get involved, participating in and interested in the reality of practice; for example taking an active interest in dressing odorous wounds. Nurses also like to see that the students approached care actvities as more than simply tasks to be completed. As such *willingness* to participate in direct care equated with competence. Mentors also worked on intuition or subjective judgements, for example they might ask themselves whether they would want this person nursing them or their family. While they admitted basing their assessments on this subjective measures

(rather than relying on documentation for example) they did express concern about this (Cassidy et al., 2017). Consequently the mentors experienced difficulty aligning these subjective feelings about the student with the agreed assessment criteria (Cassidy et al., 2017). In general they struggled to find the appropriate language to use to describe and document their concerns (Cassidy et al., 2017). A further concern was the conflict between having both a pastoral and supervisory role with nursing students (Cassidy et al., 2017).

While there is a lot of discussion on this topic, and many small localised studies exist, a comprehensive evaluation and/or research of the area is lacking (Cassidy et al., 2017). In this context clearly more research is needed but more importantly support is required for the mentorship role. Advice around documenting concerns around failing students is needed, as well as the development of more objective assessments of student performance. Staff also need support, encouragement and feedback when failing students and greater feedback is required about the potential [or actual] repercussions from action or inaction in this regard (Cassidy, 2017; Duffy et al., 2013; Black et al., 2014). Nurses feel a particular burden when faced with the failing student (Cassidy et al., 2017; Duffy, 2013). They feel a legal, moral and ethical responsibility and take their role in safeguarding public safety seriously (Luhanga et al., 2008). At the same time they are torn with their supportive impetus and duties as mentors, and sometimes lack the specific language and/or support required to raise their concerns. A useful way to strengthen the learning in this field is through mentorship training that focuses on case study review (of failing students) and simulation of conflict situations (Cassidy et al., 2017). Our experience with including this type of case study approach within mentorship training locally is that the number of fails increased. Nurse managers have a pivotal role in supporting nursing staff with their endeavours, and anecdotally when mentors are supported by staff such as nurse managers they are more confident in assigning a failed grade, if warranted. In the clinical area staff could also begin to use learning from particular student assessment situations for reflective case reviews among the team, led by the nurse manager (Cassidy et al., 2017). This review ought to also encourage dialogue with the universities (third level institutions) to understand their perspective on the situation. Overall student assessment needs more systematic attention (among the team) rather than being a 'lone' affair that leaves the nurse feeling accountable and emotionally burdened (Cassidy et al., 2017). Mentors could for example aim to spend more time with students who need support, with nursing colleagues taking over some of their duties to lighten their burden (Cassidy et al., 2017; Hunt et al., 2016). When nursing student assessment becomes everybody's business an assessing community can develop and the 'gatekeeping' function of the profession is stronger (Cassidy, 2017).

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