Beyond a reasonable doubt:
An enquiry into the identification of marginal clinical practice performance and interventions that assure transition to registration nursing students' competence and confidence for professional practice.

by

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Thesis
Submitted to Flinders University
for the degree of

Doctor of Philosophy

College of Education, Psychology and Social Work
December 2020

ABSTRACT

The purpose of this study is to investigate a gap in what is known about how clinical educators form and act on judgements about transition to registration (TtR) students who do not meet the required standard of practice. Clinical placement for the practice discipline of nursing is a requirement that provides a context in which nursing students learn to apply their knowledge, develop competence and confidence in their psychomotor skills with real patients in real time, and become socialised into the future role of registered nurse. Successful transition to registration for professional practice requires assessment of students' readiness for professional clinical practice.

The study seeks to discover if a shared understanding exists among those responsible for assessing readiness for professional practice, and in what ways this shared understanding impacts on clinical education outcomes for TtR students. It seeks to determine what intervention measures and processes are used by clinical educators to contribute to successful mitigation of poor clinical performance in order to enable TtR students to demonstrate the required competence and confidence for professional practice. The research intends to advance a more detailed understanding of clinical educators' experiences that leads them to identify and distinguish safe, but marginal practice, from unsafe and dependent practice. It also seeks to uncover the strategies commonly used for managing and mitigating safe but marginal practice of these TtR students, who might otherwise fail so near to completion of their degree.

Gadamer's (1989) philosophical hermeneutics is the methodology chosen because it enabled the researcher to bring a pre-understanding to explore the perceptions of clinical educators in relation to the factors that contribute to TtR students being perceived as not meeting the required clinical practice standard. Two studies were undertaken. Study 1 involved a content analysis of historical clinical reports and academic documents for nine TtR students who had not met the required standard for registration. Analysis in Study 1 provides insight into what clinical educators assess, and subsequently manage, in regard to their perceptions of the clinical performance of TtR nursing students who were failing to meet the required standard of practice. It identified the common, causal factors the clinical educators align with practice performance when these TtR students did not provide safe, competent care that was consistent with mandated beginning level RN practice; established new and measurable criteria to be used by clinical educators to determine that some students' practice performance was unsafe and dependent; and exposed tensions between the practice environment and university arising from inconsistencies in relation to assessment and mitigation of TtR students' practice performance.

Study 2 was based on interviews with clinical educators involved in the assessment of TtR students' practice. This second study involved a thematic analysis of the clinical educators' responses to semi-structured interview questions and a standardised vignette. The design of the questions and the vignette was based on findings from Study 1. The findings in Study 2 are presented using thematic analysis of the transcripts in relation to three questions that were generated from undertaking Study 1. The analysis found that clinical educators' perceptions of TtR students' readiness for professional practice was informed by objective measures of what constitutes safe, quality, competent nursing practice. Clinical educators use practice hallmarks to distinguish 'safe, but marginal practice' from 'unsafe and dependent practice'. It was also identified that clinical educators possessed a tacit, but shared understanding, and common approaches to the management and mitigation process for marginal performance. Finally, it was found that there were context-based factors that impeded TtR students' progress and development.

The judgement of multiple factors that contribute to perceiving TtR nursing students' clinical performance as not meeting the required standard is complex and involves much more than merely judging whether a TtR student is ready or not ready for practice. Due to a tendency to give students the benefit of the doubt, it was found there were significant risks that clinical educators might 'fail to fail' TtR students in their final semester, when practice could be considered unsafe. Conversely, there was a risk of 'failing to pass' students whose practice was safe, but marginal, and who merely needed more time in the clinical environment to reach the expected standard of practice. This is a significant discovery, because clarifying the distinction between safe and unsafe practice is important to ensure that TtR students who are unsafe are not passed, and those who are safe, but marginal, are not failed unfairly. Implications of this study suggest that nursing education and assessment require curriculum design changes that are supported by a set of guidelines for clinical assessment presented in the final chapter.

TABLE OF CONTENTS

GLOSSARY: OPERATIONAL DEFINITION OF KEY TERMS

Academic Coordinator (AC)	University academic staff member who is responsible for coordinating the delivery of the topic/subject content and resulting students undertaking final semester nursing practice topics. May be referred to as topic coordinator in the examples/excerpts.
AHPRA	Australian Health Practitioners' Regulation Agency
ANMAC	Australian Nursing Midwifery Accreditation Council
ANMC	Australian Nursing Midwifery Council
ANSAT	Australian Nursing Standards Assessment Tool
Clinical Coach (CC)	The role of clinical coach was developed to facilitate the achievement by students of the NMBA nursing competencies and clinical placement objectives. The clinical coach provided one-to-one remedial practice sessions in the nursing clinical laboratories for students who were not progressing satisfactorily on 2nd and 3rd year practicum/clinical placement. The aim was to support these students to achieve mastery with a primary focus on skill development.
Clinical Educator (CE)	A specific role that may vary in its interpretation across various educational institutions but, for this study, refers to a designated role that provides a direct link between the academic and clinical learning sectors. A CE acts to facilitate student learning and is the principal assessor who assesses student linking of the theory that underpins actual nursing practice and, together with supervising RNs, determines a student's competence and confidence in readiness for professional practice so as to deem them fit and worthy to be RNs. It encompasses terms in examples/excerpts throughout this thesis including clinical facilitator.
Clinical Handover	The verbal transfer of a patient's relevant medical history, treatment and nursing care from one nurse to another. It occurs when patients move wards, or from the staff of one shift to staff on the next shift.
Clinical Supervisors	Collective term for preceptors, registered nurses (RNs) and other nursing staff who provide direct and indirect supervision for nursing students undertaking clinical placement.
Competence	The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a professional/occupational area and context of practice.

Direct Supervision	A Registered Nurse (RN) directly observes and instructs a student during implementation of nursing interventions and patient care that include medication administration, documentation, and new or unfamiliar procedures.
Indirect Supervision	An RN is not directly observing but continues to monitor and ensure a student's practice is safe and student learning is supported.
IV Injectables Book	The IV injectables book contains information regarding the reconstitution and administration of all intravenous (IV) medication, including other medications the drug cannot be administered with.
Medical Emergency Team (MET)	A MET call is part of the rapid response system that operates within hospitals to ensure changes in patients' health status are managed in line with the stipulated criteria.
NCAS	Nursing Competency Assessment Schedule
NMBA	Nursing and Midwifery Board of Australia
Preceptor (P)	A Registered Nurse (RN) who provides both direct and indirect supervision of nursing students' practice and acts as a liaison between ward/unit staff, the student and the university academic coordinator. A Preceptor may undertake some formal assessment work.
Registered Nurse (RN)	A nurse registered with the Nurses Board of Australia
Statement of Assessment Methods (SAM)	The topic SAM is a formalised assessment document detailing what students will be assessed on and how that assessment is to be conducted and marked. Students are afforded a grace period in which it is made public to them and they can seek changes. After that period, it is not open to change or other interpretation.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed: M. F. Kelton Date: 4th December 2020

ACKNOWLEDGEMENTS

Acknowledgement must go to the many students who inspired me over my professional career in nursing education whilst undertaking the various roles that contribute to creating new graduates. I would like to acknowledge and sincerely thank the sixteen individuals who consented to participate and gave willingly of their time, experiences, and expertise to be interviewed for this study, and whose discourses provide the insightful meaning of this study. I would like especially to thank my pilot interview participant whose input toward my thesis ensured that I could trust in its content. Thanks to the School of Nursing & Midwifery for permission to access the clinical educator participants and supporting my access to the relevant documentation examined.

My sincere thanks and gratitude to principal supervisor, Emeritus Professor Janice Orrell, and co-supervisor, Professor Lily Xiao, for their commitment, guidance, faith in my thesis and direction given willingly over what has taken much longer than planned. My thanks also to former colleagues and professional friends for their sage words and encouragement that instilled the belief that yes, I could do this.

I acknowledge that I am a recipient of RTP support through the 'Australian Government Research Training Program Scholarship.' I wish to acknowledge my gratitude for the writing stipend I was awarded to help me complete the final version of this thesis. I also wish to acknowledge Abby for her support with copy-editing.

This thesis is dedicated to my husband and our wonderful family. I could never have done this without you. My heartfelt thanks always for your love and support. To John, Shaun, Clare and James; thank you for the ongoing encouragement that kept me motivated especially when things got tough. Thanks to Von and Jackie for the walks and for listening. I also want to thank 'the village' that surrounds me and that first encouraged my lifelong love of learning.

CHAPTER 1 INTRODUCTION: TRANSITION TO REGISTRATION NURSING STUDENTS–PIECES OF THE PUZZLE!

1.1 Introduction

This thesis focuses on how, why, and in what ways clinical educators assess, manage, and mitigate the practice performance of transition to registration (TtR) nursing students that does not meet the required standard. It also examines factors that influence clinical educators' judgement of students' readiness for professional practice. The study takes place in an Australian university's School of Nursing and Midwifery (SoNM) and uses two investigative studies that focus on the context of assessment of nursing students during their final clinical transition placement. This chapter discusses the purpose of the study, the background and significance of the study, the research question and aims, together with a brief introduction to the methodology and an overview of the thesis chapters.

1.2 Purpose of the Study

The purpose of this study is to gain comprehensive understanding of the factors that lead to TtR nursing students being identified as not meeting the required standard when undertaking their final placement. At the heart of the study lies the broader notion that such practice performance may not always be unsafe and dependent. The study seeks to discover if a shared understanding exists among the assessors of the readiness for professional clinical practice of TtR students. It seeks to discover how, why, and in what ways the assessment of practice performance impacts on students' clinical education outcomes. This is important to ensure justice and fairness for the students, whilst upholding the professional requirements of safe clinical practice. Failing so near to completion of their degree does have significant repercussions for TtR students. The study seeks to identify what, if any, interventions and/or processes might contribute to successful mitigation to enable the students to demonstrate the competence and confidence required to be judged as ready for professional practice. In concert with this, the research seeks to advance an understanding of clinical educators' wisdom of experience regarding how they specifically identify the aspects of practice that are not meeting the required standard. This research will uncover a way forward so clinical educators can have confidence in their judgement about the practice performance of TtR students at this late stage in their course of study.

1.3 The Context of Assessment of Clinical Practice

Successful transition to professional practice for nursing students during their final clinical placement is multi-faceted and complex. The agenda for clinical placement throughout a Bachelor of Nursing degree in Australia is that, by completion of the degree, practice has developed to demonstrate the required knowledge, skills, and professional disposition behaviours, attitudes and values at the beginning-level RN standard (Henderson et al., 2010; Kelton, 2014; Levett-Jones & Lathlean, 2009a).

Practice performance of TtR students is rated and judged against the Nursing and Midwifery Board of Australia (NMBA) professional competency standards for the registered nurse (RN) (Australian Nursing & Midwifery Accreditation Council, 2012). Students must demonstrate these NMBA competency standards in their practice in order to qualify as meeting the mandated standard required of the beginning-level RN. The criteria-based competency standards were written in accordance with the applicable NMBA companion documents, including the codes of conduct and national frameworks. The Australian Nursing and Midwifery Accreditation Council (ANMAC) process mandates that in preparing nursing students for registration:

> The education provider is to ensure graduates have the required common and transferable skills, knowledge, behaviours and attitudes (articulated in the National Competency Standards for the Registered Nurse) upon which to build the competencies they need to practice. Accreditation evaluates whether the provider, on the basis of the evidence provided, is likely to meet this goal. (ANMAC, RN Accreditation Standards, 2012, p. 8).

Clinical placement also serves to ensure students' socialisation into their future roles as registered nurses (Chapman & Orb, 2001; Ha, 2015; MacIntyre et al., 2009; McNeish et al., 2011). Nursing students' practice is expected to increase in complexity with each progressive year of study, culminating in TtR students being assessed and judged, during final placement, as having attained the mandated standard required of the beginning, or novice-level registered nurse.

The assessment of TtR nursing students' practice performance occurs whilst undertaking mandated workplace experience that takes place in an actual clinical practice setting, as embodied within the national law that governs nursing (ANMAC, 2012). Assessment of TtR nursing students' competence should reflect the multi-faceted nature of what constitutes nursing practice that occurs across a broad range of settings amid the cultural differences that are part of the Australian health care system (Aranda & Yates, 2009). For this thesis, the term 'competence' is defined as:

> "Competence—the combination of skills, knowledge, attitudes, values and abilities underpinning effective and/or superior performance in a profession or occupational area (from the National Competency Standards for the Registered Nurse." (ANMAC–RN Accreditation Standards, 2012, p. 22).

1.3.1 History of changes

The ways in which RNs are educated and prepared in Australia for professional practice have undergone contemporary and historical changes in a relatively short space of time. As recently as 1991, the state in which this research study takes place, had its last group of hospital trained RNs commence the former apprenticeship style of training, the foundations of which dated back to 1868, replicating Florence Nightingale's model of general nurse training (Durdin, 1999). Tertiary nursing education first began in the state in which this study is situated in 1975 and operated alongside hospital-based training programs until 1993 (Durdin, 1999). The move to tertiary education being the only option in the early 1990s introduced a new model of clinical nursing education in Australia. It is important to acknowledge these historical occurrences because of their influence on shaping educational practices around assessment within the current clinical education context.

Assessment of practice performance was once the sole responsibility of the academic clinical educators who assessed all tertiary students' application of theory to practice, one-to-one in cluster models of placement, whilst also engaging in direct patient care as the supervising RN. From 2007, academic staff from the SoNM, where this study is situated, were no longer permitted to undertake the role of clinical educator. Assessment of TtR students' practice performance then became the responsibility of university-appointed clinical educators. More recently, another shift has seen increasing numbers of seconded hospital RNs appointed by their workplace to act as clinical educators. As non-university employees, however, the seconded RNs have no access to topic or course information, are not obligated to attend meetings on campus, or to undertake additional study.

Other factors that impacted TtR students' ability to successfully complete placement arose when nursing students' placements meant they could now be rostered for an 8-hour shift anywhere within the 24-hour period across seven days of the week, not just on weekdays, and almost every week of the year. The impact of this on the quality of the placement experience or the impact on TtR students' learning, or those who supported development of their practice could make a worthwhile study in itself. That change to rostering, also coincided with a decision by the SoNM, in which this study is situated, to abandon the well-researched, widely published, innovative Dedicated Education Unit (DEU) clinical placement model (Edgecombe, 2014). The collaborative style of teaching aligned with the DEU had proven so successful, it had been adopted nationally and worldwide (Edgecombe & Bowden, 2009; Moscato et al., 2013; Ranse & Grealish, 2007).

The DEU was both a model and a process for enhancing clinical teaching and learning using a strategic collaborative approach (Edgecombe et al., 1999; Edgecombe, 2014). Based on the findings

of the Commonwealth of Australia University Teaching (CAUT) report (Orrell et al., 1997), the DEU precepts sought to enhance the transfer of theory to practice; develop multi-disciplinary tutorials on the wards for supervising staff and students; and to incorporate peer teaching with all three year levels attending placement simultaneously (Edgecombe et al., 1999; Gonda et al., 1999). This model enabled clinical placement to be extended for TtR students who required more time to develop their practice in order to meet practice assessment requirements. Also unique to the DEU model was the role of the ward staff RN, who was appointed as the clinical liaison nurse, and who provided much needed support and monitoring of students' practice progress. All ward staff, including the clinical liaison nurse, who were responsible for the clinical supervision and assessment, could attend a three-day on-campus education program on teaching and learning and assessment. The axing of the DEU model meant that the clinical liaison nurse role also disappeared, as did the education program, prompting a shift away from collaboration that had during its time even increased postgraduate studies undertaken by ward staff.

The move to centralise the allocation of clinical placements and increasing numbers of nursing students across the state's universities led to a situation in which not all TtR students experience occurred in suitable, quality clinical venues. Added to this, increased expectations of academic staff, who were already undertaking what is viewed as "the domestic work of university teaching" (Cooper & Orrell, 1999, p.7), required them to be responsible for the coordination of large cohort numbers with no administrative support. A decision to stop objective-structured clinical examinations (OSCEs) had a further impact on the preparation for placement and left supervising RNs entirely responsible for the identification of practice performance deficits of TtR students. Changes in clinical facilitation models for clinical educators, coupled with a state health-care system in crisis, left supervising RNs facing ever increasing demands on their time. This situation was amplified with increasing numbers of international students, many of whom had undertaken only one previous placement and required close supervision. That provision of intensive supervision, that included ensuring patients' safety, was bound to be one task too many for supervising RNs who are not compensated for this responsibility. These conditions prompted requests from clinical venues for removal of TtR students whose practice performance is considered unsafe. The lack of a clear management process in these instances has meant that each student who did not meet the required standard was managed individually, and in a somewhat ad hoc manner, further compounding the pressures on all stakeholders.

1.3.2 Assessment of practice performance

Assessment of practice is undertaken by several informants including clinical educators and supervising RNs. The assessment of practice, was shown to be influenced by external factors (Henderson et al., 2010; Kelton, 2014), that included:

- the diversity, complexity and demands of the clinical environment sites across various healthcare sectors where placements take place;
- the assessment processes implemented in the clinical settings; and,
- the experience and expectations of clinical educators and supervising RNs who guide and assess student's competence of clinical practice.

Assessment of TtR nursing students' practice performance occurs through dual modalities of assessment that include the observation of their provision of nursing care and assessment of their application of theory to practice. Assessment of theory to practice occurs through both summative and formative assessments that, in the main, are conducted by the clinical educator. The observation and assessment of clinical nursing practice involves evaluation of TtR students' communication skills, psychomotor clinical and technical skills, and abiding of hospital policy and procedures. This delivery and provision of nursing care, in the main, is undertaken by the supervising clinical staff, that is the RNs.

This current model of assessment, utilised throughout most public and private metropolitan practice environments, meant clinical educators relied on supervising RNs to provide feedback and testimony about the TtR student's practice performance regarding their provision of patient care. An exception to this is the preceptor model, that is mostly implemented in rural and remote (R&R) placement settings. Preceptors are hospital-employed RNs who may undertake informal assessments and provide supervision whilst working alongside TtR nursing students. They may also conduct formal assessments.

The clinical practice environment also requires a level of student self-regulation of their learning to extend it beyond what a supervisor explicitly teaches (Dornan et al., 2009). The assessment of nursing students' clinical competence by supervising staff and students' self-assessment is mediated through their clinical reports and reflective learning practice (Henderson et al., 2010; McCarthy & Murphy, 2008). Nursing students are expected to identify their ongoing learning needs and develop strategies for meeting these in discussion with those who supervise and assess them (Henderson et al., 2010).

1.3.3 Assessment for judgement of readiness for professional practice

The assessment of TtR students' practice by clinical educators who are responsible for making this determination, in consultation with supervising RNs, is fundamental to this study. Responsibility for assessment of TtR students' readiness for professional practice that occurs through curriculum and assessment content, is designed to ensure these students achieve the required knowledge and skill level upon completion of their degree, and rests with the clinical educator. Clinical educators' understanding of assessment of competence in practice is informed by tacit knowledge (Henderson et al., 2010; Benner, 1984; Benner et al., 2009) and wisdom of experience to reason and make judgements and decisions that will determine what actions are to be taken (Shulman, 1987). Their understanding of performing the role of the registered nurse in practice, that includes clinical decision-making and clinical judgement, ultimately shapes their assessment of practice performance of TtR students. Clinical judgement of registered nurses has been defined as "the ways in which nurses come to understand problems, issues or concerns, attend to salient information and respond in concerned and involved ways" (Benner et al., 2009, p. 200).

Clinical educators assess TtR students' practice against the profession's standards for RN practice. Most TtR students will demonstrate what is required at the beginning RN level standard by completion of the final clinical placement, but some do not perform at this expected and required level. When this happens, supervising RNs will rightly question the students' practice capabilities and students may suddenly find themselves 'at risk of failing' clinical placement (Kelton, 2014). When achieving the required level of competence required for professional practice does not occur, the assessment of nursing students' practice performance is most often described as unsafe (Killam et al., 2011; Luhanga et al., 2008a; Luhanga et al., 2008b; Luhanga et al., 2014). The terms safe and unsafe, competent and incompetent, are accepted terms used within the profession, often indiscriminately, to describe practice that does not demonstrate the professional competency standards and codes of practice. Critical incidents that result in harm to a patient, staff member, or the public (Barksby et al., 2015) or even a near-miss event, in which potential harm is only averted due to intervention by the supervising RN's (Kelton, 2014), often prompts an investigation of student's practice performance irrespective of how many days of placement remain. Even during the last few days of placement, it is not unheard of for TtR students to be identified by clinical educators, as 'not being ready' which translates as not being expected to reach the required standard of RN practice and the academic assessment requirements by completion of the final placement.

1.3.4 Failure to fail

The issue of 'failure to fail' for marginal or borderline nursing students' practice (Chunta, 2016; Couper, 2018; DeBrew & Lewallen, 2014; Docherty, 2018; Duffy, 2003; Hughes et al., 2019a; Larocque & Luhanga, 2013; Lewallen & DeBrew, 2012) is well documented in clinical education literature. What is not as well understood, though, is the assessment of practice performance specifically in relation to those TtR students whose practice performance did not meet the standard required, and as such could not be assessed as safe and satisfactory, but neither could it be assessed as unsafe. These TtR students exhibiting less than satisfactory practice performance, and who are 'not quite ready' for professional practice, required a judgement to be made by the clinical educator to award them a pass or fail grade. With no capacity to undertake additional days, no remedial coach to refer these students to, more and more TtR students were awarded a borderline pass grade despite not being ready. Conversely, others found themselves informed on their last day that as they were not able to be assessed as at the beginning level RN standard, they would fail the TtR clinical placement.

1.3.5 Why do this research?

My commitment to the clinical education system for nursing students has been motivated by understandings gained from my lived experience of undertaking the role of clinical educator over several years and as a supervising RN on a busy medical ward and, later, being the clinical liaison in the foundational days of the DEU model described earlier. However, the role that deepened my understanding of clinical nursing education that became the catalyst for undertaking this study, and would influence my analysis of data, was my time as the inaugural Clinical Coach in the SoNM in which this study is situated. This unique role brought together my knowledge of clinical education with a sporting philosophy derived from coaching and enabled me to develop personalised modalities to improve unsatisfactory practice performance of second- and third-year nursing and midwifery students. In this role, I introduced a referral system for clinical educators that required details of issues and strategies that had been implemented to date in each case. Students were afforded remediation sessions that took place in a specially designed clinical laboratory, including my observation and assessment of their practice as part of a coaching process. Using scenario-based cases, individualised and targeted strategies were implemented during the remediation practice sessions that continued until students could demonstrate competent and confident nursing practice. The role taught me that clinical educators and supervising RNs often needed direction and support to guide their supervisory practices, and that the students should be returned to placement with a clinical learning contract which the referring clinical educator would help to implement. This model

of clinical coaching was extremely successful, with almost all students who attended clinical coaching going on to successfully pass their clinical placement (Kelton, 2014).

In addition, I had the opportunity to act in the seconded position as the university-wide Work-integrated Learning (WIL) Project Officer. This role fostered a different level of understanding of how other disciplines and professions successfully managed, assessed, and mitigated WIL placements when preparing students for future careers and professions. Finally, at the end of my role as the clinical coach, I became the academic coordinator responsible for the final nursing practice topic that included the transition to registration clinical placement. My time as academic coordinator exposed me to wider issues when TtR students did not always meet the required standard. This experience, in particular, has driven my desire to change the outcomes, not just for the students, but for all stakeholders.

Research was always going to be the answer to these challenging experiences so that I could build on what I had learnt along the way, to unpack factors that had contributed to the challenges, and to find out how difficult situations might be changed to ensure all TtR nursing students' future patients would be in safe, competent, confident hands. The research needed to seek to create a better understanding of the ways in which clinical educators identify, assess, manage, and mitigate practice performance of TtR students who do not meet the required beginning level RN standard. Having watched the devastation for TtR students, that included suicidal ideation, after having been informed they had failed clinical placement so close to completion of their degree, provided the motivation for this study to investigate and find a way to end this discontent that, as reflected in a quote from Florence Nightingale, could create a change for the better. "Were there none who were discontented with what they have, the world would never reach anything better." (Nightingale, 1860/1992, p. 29).

Assessment of clinical performance that does not meet the required standard raises a number of questions. Was the practice always unsafe if it was not safe and satisfactory? How was this determined? What measures were then implemented to mitigate and support the practice development of those TtR students when practice did not meet the required standard? These questions have become the core interest of this study. It is hoped that examination of how the assessment occurs, might generate greater understanding to support decision-making and future curriculum design. The end goal is to improve outcomes for students, their future patients, RNs who provide supervision, and the nursing education sector, as all are impacted by this phenomenon. I hope to do it justice.

1.4 Significance of the Study

Deliberate and meaningful assessment of practice performance of TtR nursing students is important. This is especially the case in relation to those TtR students whose practice is perceived as meeting the required standard during this final clinical placement and important for ensuring rigorous assessment occurs. Confidence in this assessment and demonstration of the required standard is important to ensure the safety of the students themselves, the staff they will work with, and the public for whom they will provide nursing care once they become registered to practice as a professional RN.

All students, many of whom are international students, have invested a great deal of time and effort in their degree by the stage within the education program this study was located in. Failing so close to completion is devastating on a personal level for the students, and difficult for all involved, especially the assessors, and a huge waste of resources. Failure to fail unsafe or unprofessional practice of TtR students, however, puts people in the health system at risk. Equally significant is the importance of ensuring a TtR student whose practice performance is not unsafe, nor unprofessional, does not fail unnecessarily so close to completion of their degree. The study, therefore, intends to gain an understanding of marginal practice performance and what can be done to mitigate it or to be very clear about the ways it needs to be assessed. These outcomes could help end the 'failure to fail' and 'failure to pass' culture that exists and thereby improve future clinical education outcomes for these students.

1.5 Research Question

This study seeks to answer the following research question: How do clinical educators assess, manage, and mitigate Transition to Registration (TtR) students when clinical practice does not meet the required standard and development expected in readiness for professional practice?

1.6 Research Aims

The research aims of this study are as follows:

1. To critically examine and identify the perceptions and meanings held by clinical educators that is evidenced in the assessment history of selected TtR nursing students whose practice performance is judged as not meeting the required standard.

2. To identify and analyse the mitigating approaches and interventions commonly used by clinical educators to assess and support TtR students when their practice performance does

not meet required standard to enable students to gain the clinical competence and confidence required for beginning-level RN practice.

3. To identify the changes needed to nursing education curriculum and professional learning for clinical educators to improve and enhance their management and assessment of practice performance of TtR students who do not meet the required standard.

1.7 Methodology

Gadamer's philosophical hermeneutics (Davey, 2006; Gadamer, 1989) has been chosen as the appropriate methodology because it lends itself to establishing an in-depth understanding of the multiple factors that contribute to TtR nursing students' practice performance being identified as not meeting the required standard during their final clinical placement. In the case of this research, a methodology that permits the extensive experience of the researcher to be included needed to be applied. Gadamer (1989) advocates that the researcher themself enriches the process and outcomes when they bring their knowledge that is formed from their personal experience. In relation to this research study, having experienced each of the roles under investigation, a methodology that promotes a philosophy of experience, such as Gadamer's philosophical hermeneutics, was the most suitable methodology, as this experience could not simply be bracketed (Davey, 2006).

This research is conducted as two studies. Study 1 involves content analysis of transcripts, including auditable email trails and relevant documents, including curriculum documents, assessment records, assessment results, and other documents associated with the judgement of students' competence during final placement. A research approach that enables richly detailed and historical investigation of the situation in question to occur across what are identified as nine cases was employed. The analysis of the documents using content analysis seeks to establish mitigating interventions that might provide optimal support for the development of practice performance of these TtR students, and ensure they reach the required beginning RN level of competence. Study 2 seeks to elicit and explore conceptions and meaning that clinical educators hold in relation to TtR nursing students being identified as safe but marginal, or as unsafe and dependent. The findings around assessment and management of the practice performance of TtR students who are not meeting the required standard, including mitigating interventions, and how and why this is significant for these students so close to the completion to their degree, are presented.

1.8 Overview of the Thesis

Following this introduction chapter, Chapter Two will examine national and international literature to establish what is already known and identify a gap in relation to the question and aims of this study. Chapter Three will establish and discuss the methodology, the overall design of this thesis, and the specific research approach and design for Study 1. Chapter Four will present the significant findings for Study 1. Chapter Five will present the research approach, design, and significant findings for Study 2. Chapter Six will present the integrated key findings from Study 1 and Study 2, and discuss the implications for nursing education, including future curriculum design and practices. Chapter Seven will draw conclusions and implications moving forward to ensure readiness for professional practice of all TtR students and propose recommendations for future research directions that could emanate from this study.

1.9 Conclusion

The next chapter will present literature that broadly considers notions of clinical education for nursing students, firstly to establish that the research question and aims of this study have not already been undertaken. It seeks to synthesise the current research relating to how assessment serves to establish that assessment requirements are being met and inform the judgement that TtR nursing students demonstrate the competence and confidence required of beginning-level RN practice. The research literature considered will examine the historical development of assessment of competence, including the use of criteria and rating scale tools. It will also examine research and theoretical literature that contributes to the body of knowledge about clinical nursing education, including situational factors that influence clinical learning outcomes when TtR students' practice does not meet the required standard.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

The purpose of the literature review chapter is to critically examine and present the national and international literature regarding clinical education and practice performance of transition to registration (TtR) nursing students, and factors impacting the assessment and judgement of students not demonstrating the competence and confidence of beginning-level RN practice. The nursing education literature has a substantive history of assessment of nursing students' practice performance within the context of the clinical placement. There is extensive literature around broader notions of clinical nursing education and assessment of practice. This review will present historical literature that remains relevant to this study, and contemporary literature from both the national and international perspective. The review is purposefully selective of what is a wide array of clinical education studies.

As the governing body of nursing in Australia, the Nursing and Midwifery Board of Australia (NMBA) remains steadfast that preparation of nursing students must occur in the practice environment. As such, studies that specifically evaluate the use of simulation for practice development, or simulation and clinical practice as dual strategies, are not included in this review. Studies exploring assessment of practice through the application of eLearning tools for practice development are also not included. Models of clinical placement that review preceptorship or mentoring are not included unless they specifically addressed assessment of practice of final placement nursing students.

The review includes literature around various perspectives and risk factors, including the hallmarks of unsafe practice and how such factors informed understanding of assessing the practice performance of TtR students who were not meeting the required standard. When undertaking clinical placement, nursing students gain exposure and immersion that should enable them to link contextual-based knowledge to clinical practice, develop professional communication skills, and gain understanding of the values and attitudes of the RN role. Studies relevant to this context, and those exploring factors that impact assessment outcomes of clinical placement, including the notion of failure to fail, were included. Where collaboration and communication between the university and hospital sectors, referred to throughout this study as the practice environment, have led to improving student outcomes, relevant studies were explored. The review makes overt the existing gap within current studies that this study seeks to close.

2.2 Assessment of the Development of Competence

Competence is a contested term in higher education (Barnett, 1994). Cassidy (2009) explored interpretation of competence and suggested that assessment of nursing students' competence needs to be given greater credibility when it is assessed within the practice environment context. Competence development of TtR students' readiness for professional practice remains strongly influenced by such studies, some of which were undertaken as long as three decades ago. Historical works by Bondy (1983) and Benner (1984), in particular, were instrumental in providing a framework and benchmark for judging nursing students' practice performance as meeting the required level of a beginning- or novice-level RN when assessed against the NMBA national standards for practice (Calman et al., 2002; Watson et al., 2002). Bondy's (1983) rating scale provided detailed criteria and meanings that could measure development of practice that enabled students to be assessed as passed or failed. For a long time, Bondy's (1983) study on criterion rating underpinned the assessment of practice development and achievement of mandated requirements for nursing students across Australia and adapted for use in practice' assessment documentation.

Benner's (1984) five stages framework of competence for nursing practice remains widely cited in studies examining just how nurses and nursing students learn and develop in the clinical setting and how they acquire knowledge and skills through interactions with patients and others (McNiesh, 2011; Milton-Wildey et al., 2014). Benner's (1984) landmark study sought to demonstrate how actual experience of nursing and development of capability in practice could be recorded, interpreted and, in turn, applied to improve clinical nursing education outcomes (Benner, 1984). From these early research studies undertaken by Bondy (1983) and Benner (1984), models of competence development emerged that, to this day, underpin assessment measures of nursing students' practice in some Australian universities.

Education approaches used in the exploration of models of competence and preparation for professional practice were influential in shaping clinical nursing education. Benner (1984) used the Dreyfus skills acquisition model (Dreyfus & Dreyfus, 1982) for her landmark descriptive phenomenology study which facilitated understanding around previously poorly understood nursing concepts of practice, including tacit knowledge. This study, that critically examined the impact of ways in which experience shapes clinical practice, still underpins the definition by which understanding of the novice- or beginning-level RN standard, as applied by the NMBA, is assessed to this day. Benner's (1984) five levels of competence distinguished criteria of expert nursing practice from the proficient, the competent, the advanced beginner and the novice levels.

Benner's (1984) study acknowledged that the more expert RN would reflect tacitly, and students observing the experts' practice may not be aware such reflection is taking place. Henderson et al. (2010) explored the notion of novice-expert in relation to how expert guidance can be best provided in clinical settings so as to enhance the outcomes for students undertaking WIL. According to Henderson et al. (2010), learning that uses a collaborative problem-solving approach between the novice and expert makes learner engagement more purposeful. Educating clinicians to consider themselves as partners in nursing students' education was found to result in clinicians being more likely to share tacit knowledge with students (Eraut, 1994; Henderson et al., 2010) and to explicitly display good role modelling even if not directly supervising (Benner et al., 2009; Henderson et al., 2010; Smedley & Penney, 2009).

Studies exploring the development of competence in readiness for professional practice using the application of educational frameworks viewed reflection as essential for final placement students. The substantive and historical research study, undertaken in the UK by Hallett (1997), critiqued Schön's (1987) reflective practice theory. Hallett (1997) showed reflection-in-action was pivotal for development of competence, especially as students neared professional practice. Hallett (1997) established that more reflection-in-action would occur as the students' knowledge developed, and this impacted their willingness to participate in clinical practice. A study conducted by Cooper et al. (2005) took 'thinking in action' further to explore cognitive and emotional experiences that precede transition for nursing students in their last semester. Cooper (2005) concluded that as nursing students became aware of the responsibilities of becoming RNs in their final placement, they moved to using a more reflective approach to practice. Edwards (2017) concluded the focus needed to take reflection beyond that of 'in-action' and 'on-action' to include reflection-before-action, as this helped the novice professional to think about possible situations before engaging in practice. Comer (2016), however, challenged the notion of reflection-in-action for those students whose practice performance was not at the skilful level, identifying that reflection would not necessarily occur at this level of performance.

Assessing TtR students' competence and readiness for professional practice requires students to move from a developing or functional level to a proficient skill level as a minimum (Helminen et al., 2014; Kelton, 2014; Levett-Jones et al., 2011). According to Helminen et al. (2014), the assessment of students' competence is made more difficult because competence depends on area of expertise and personal character traits. In exploring the assessment of practice, the study concluded that students focus their learning on issues being assessed (Helminen et al., 2014). Knowledge needs to be at the conditional level where the student shows how that knowledge applies to practice

(Stuart, 2007). According to the comparative framework identified by Bordage (1999), final placement students should demonstrate application of deductive thinking and elaboration, if not recognition of the compiled level of thinking (Bordage, 1999).

According to Yanhua & Watson (2011), competence assessment for nursing students needs to be systematic and occur through curriculum-driven assessment as well as the development of practice. Research regarding the assessment of competence of nursing students has established that a rigorous evaluation of students' practice performance when assessing competence is essential (Cant et al., 2013). Assessments against the professional standards do not consider students' status and, as such, obstruct a fair and equitable process for assessment of nursing students' competence development (Almalkawi et al., 2018; Helminen et al., 2017). Numminen et al. (2014) sought to identify what standards were regarded as important for competent practice and concluded there were different points of reference between the sectors that created a need to adapt curriculum to meet professional competency standards.

The assessment of competence in nursing practice is complex given the multiple and varied tasks that occur within diverse practice environments (Almalkawi et al., 2018; Helminen et al., 2014; Helminen et al., 2017; Immonen et al., 2019; Wu et al., 2015;). An audit of Bachelor of Nursing programs across Australian universities by Brown et al. (2015) identified nursing practice incorporated 272 clinical/technical skills. Curriculum design approaches including professional portfolios (Jones, 2013) and objective-structured clinical exams (OSCEs), when based on sound pedagogical foundations (Mitchell et al., 2015; Nulty et al., 2011), act to ensure that assessment modalities capture the diversity of practice to adequately prepare nursing students for assessment of competence during clinical placements (Yanhua & Watson, 2011).

2.2.1 Quality of the assessor

The move by universities to stop academic staff from acting as clinical educators left the lion's share of the supervision of nursing students with the supervising RNs who now have this pivotal role in placement structure of contemporary clinical placement (Henderson et al, 2012a). The supervising RN role can support or impede student learning (Pront et al., 2013). Supervising nursing students was shown to impact RNs' workload (Henderson et al., 2012b) especially when it included the imposition of what some RNs saw as 'being lumbered' (Brammer, 2006, p. 970) with problematic nursing students (Brammer, 2006; Henderson et al., 2012b). Luhanga et al. (2008a) warned that lack of preparation of RNs can impact their perception of what is unsafe or problematic practice of nursing students. Hutchison & Cochrane (2014) highlighted that the supervision of final placement students is so important, RNs require specific training and should only be responsible for

one student each semester. Several studies have shown there is often little or no preparation for RNs on how to undertake the role (Henderson et al., 2009; Henderson et al., 2012a; Mackay, 2014), but an expectation they will provide quality support (Mackay et al, 2014).

Several studies have explored the quality of the assessor as impacting on students' practice outcomes, mostly from the student perspective. In their phenomenological study, Günay & Kılınç (2018) identified that when students struggled to put theory into practice, this, in part, was due to assessment in practice varying from one clinical assessor to another. This was found to demotivate students' desire to learn in the clinical setting (Günay & Kılınç, 2018). A grounded theory study by Cassidy et al. (2017) that explored borderline pass grades from the assessor's perspective, rather than the students, concluded that mentors were not intentionally failing students but, rather, struggling to interpret practice learning outcomes around measures of competence. According to Cassidy et al. (2017), there is confusion with the assessment of competence that relates to difficulty with the diverse meanings held by assessors of what competence is and how it is exhibited when assessing students. This grounded theory study explored assessment of final-year students established that the assessors were willing to be supportive and nurturing without compromising their own accountability. Furthermore, even if they considered the situation to be hopeless, in the role of mentor, the assessors would still identify ways to be restorative (Cassidy et al., 2017).

2.2.2 Limitations in assessment of competence

According to Suikkala et al. (2018) and Helminen et al. (2014), assessment has been found to be inconsistent, especially when evaluating the competence of students who fail clinical practice. According to Brown & Crookes (2016), there is little literature around perceptions of nursing students' readiness for professional practice that requires them to meet mandated standards by demonstrating competent practice. Providing feedback is a fundamental role of the assessor when seeking to develop and improve students' learning outcomes (Biggs, 1999; Clynes & Raftery, 2008; Orrell, 2006; Rowntree, 1987). The attitudes, behaviours, and practices of the supervising clinical staff was shown to influence their ability to give feedback and to seek assistance, especially when dealing with marginal performing students for, without it, mistakes go uncorrected (Ende, 1983; Kelton, 2014). Providing feedback for these students is influenced by a reluctance on the part of the supervisor to provide feedback about difficult or confronting situations, and when the assessor is seeking to make themselves look like an effective supervisor (Hoffman et al., 2005). Feedback to students should be constructive, honest, and timely (Kelton, 2014; Koharchik et al., 2015), as this is essential for ensuring the development of their competence and practice performance (Immonen et al., 2019; Almalkawi et al., 2018).

It is important to ensure students understand that the purpose of assessment is to facilitate their learning (Immonen et al., 2019; Almalkawi et al., 2018), and that their assessment occurs against the profession's codes and standards (Wu et al., 2015). Standardisation of competence assessment has been proven difficult because it always involves some degree of judgement (Bradshaw & Merriman, 2008; Windsor et al., 2011) that is further complicated by the subjectivity within the assessment tools (Cassidy et al., 2017; Helminen et al., 2014; Price, 2012). According to Wu et al. (2015), the majority of the assessment tools used to assess students' competence, incorporate competency standards that have been prepared by national boards of nursing for professional RNs. Issues, however, have arisen from this, including the language used by governing bodies to describe competencies (Almalkawi et al., 2018; Helminen et al., 2017).

The validity and reliability of assessment tool design is another limitation that has long been challenged, with questions raised about whether these tools ensure the assessment of competence itself is both valid and reliable (Butler et al., 2011; Yanhua & Watson, 2011). Benner (1984) advocated that competency assessment tools were limited because they did not consider attributes between the stages of novice to expert. The assessment of competence in nursing, as with other health professions, is aimed at ensuring that students are competent and, therefore, safe to practice (Fahy et al., 2011; McCoy et al., 2013). The lack of validity and reliability within assessment tools that measure competence were shown to contribute to the assessor's confusion (Cassidy et al., 2017). Franklin & Melville (2015) concluded that the design of the tool was not the issue, but the limitations with these tools were pedagogical problems, because assessment of competence was being taken as a snapshot in time, rather than judged as a continuum.

Recent research to ensure that assessment tools for clinical placement experience evaluate students' knowledge, skills, behaviours, and competence (ANMAC, 2012, p. 15) resulted in the introduction of the Australian Nursing Standards Assessment Tool (ANSAT) (Ossenberg et al., 2016) and the Nursing Competency Assessment Schedule (NCAS) tool (Brown & Crookes, 2016). The introduction of new assessment tools that place strong emphasis on self-concept of the students (Ossenberg et al., 2016) explored the impact that self-appraisals can have in influencing assessment reporting by clinical educators who are not skilled assessors (Burke et al., 2016; Levett-Jones et al., 2011). Difficulties with managing unsatisfactory practice sheds doubt on the veracity of the usefulness of self-appraisals when overconfidence results in students acting outside their scope of practice (Levett-Jones & Lathlean, 2009a).

2.2.3 Situational aspects of assessment

Situational aspects have been shown to impact variability of nursing students' performance when assessment of practice is being conducted. Aspects affecting assessment of competence around nursing students' practice performance, including venues such as highly specialised wards, impact assessment outcomes for students (Coyne & Needham, 2012). Research studies exploring assessment of competence for nursing students stress the importance of creating a supportive learning culture (Henderson et al., 2010; Levett-Jones et al., 2009; Nash et al., 2009), as the assessment process itself may be stressful (Levett-Jones et al., 2011; Wu et al., 2015).

Organisational factors around placement (Brackenreg, 2004; Hughes et al., 2019a), including students' previous placements (Henderson et al., 2006) and the environment itself, can impact outcomes or prove stressful for students (Henderson et al., 2010; Cooper et al., 2005). A case study by Pront et al. (2013) established that relationships impact the achievement of learning outcomes for students when undertaking placements within the Australian rural environment. Situational factors such as the bullying culture of some practice settings (Anderson & Morgan, 2017; Blackstock et al., 2014; Sauer, 2012) and a lack of empowerment (Bradbury-Jones et al., 2011) impact outcomes of placements for students, especially those lacking confidence (Babenko-Mould et al., 2012). Students are reluctant to speak up, especially to those who are assessing their clinical practice (Bradbury-Jones et al., 2010) or report these issues to academic staff as they "don't want to rock the boat" (Levett-Jones & Lathlean, 2009b, p346).

2.2.4 Relationships between students and assessors

Students need to negotiate multiple relationships during clinical placement that are "highly complex and power-laden" (Trede & Smith, 2012, p. 616) and impact assessment of practice performance (Ha, 2015; Pront et al., 2013). Students' relationships with clinical staff were valued highly when students rated practice placements (Lamont et al., 2015; Pront et al., 2013). The clinicians that students interact with during their placements were identified as having the most significance on development of their professional values (Lyneham & Levett-Jones, 2016; Trede, 2012). Mohamed et al. (2014) established relatedness through meaningful interpersonal relationships helped reduce anxiety in the practice setting. Studies have shown students experience anxiety in the clinical setting that impacts their performance (Melincavage, 2011; Pai, 2016) and that even students' personality has been shown to influence the assessment process (Helminen et al., 2017).

A study by Levett-Jones and Lathlean (2008), that evaluated the student voice about what helped most to develop their clinical practice, first identified the notion of 'belongingness' and how

important this was to the students. Clinical placement experiences influenced students sense of belonging that, in turn, was shown to influence their workplace satisfaction (Borrott et al., 2016). Belongingness was dependent on the interpersonal relationships with staff (Levett-Jones et al., 2007; Levett-Jones & Lathlean, 2008; Levett-Jones & Lathlean, 2009a; Mohamed et al., 2014) that were pivotal to students' willingness to engage in practice (McNeish, 2011; Thrysoe et al., 2010) and their overall desire to strive to achieve excellence in clinical practice (Perry, 2009).

Conversely, studies showed that nursing students comply and conform at the expense of their learning (Levett-Jones & Lathlean, 2008), and that they take steps to invest time and energy in managing relationships with staff (Pront et al., 2013). Students actively seek to avoid conflict situations, such as being singled out or ignored by supervising staff (Curtis et al., 2007) and can endure patronising staff attitudes and not always feel supported in their learning (Ha, 2015; Pront et al., 2013). A longitudinal study by Newton et al. (2009) highlighted barriers to knowledge translation in the clinical environment that occurred with lack of engagement by the supervisor and/or academic staff. Clinical staff taking over the nursing interventions was shown to result in students feeling they were being left with the mundane tasks and not given opportunity to learn (Newton et al., 2009). As students neared completion of their degree, many felt they were taken advantage of and given responsibilities beyond their experience, especially during periods of under-staffing (Ha, 2015; Hoel et al., 2007).

2.2.5 Student engagement and identity

Nursing students need to engage in clinical placement to achieve outcomes connected to learning, in and through the workplace experience (ANMAC, 2012). Clinical placement gives students the opportunity to engage in an authentic learning space with maximum exposure (Stuart, 2007). Prior experiential learning and required theoretical knowledge influence outcomes of practice placement learning (Helminen et al., 2014; Nash et al., 2009). A hermeneutic study by Thrysoe et al. (2010), examining factors that contribute to engagement for learning by final semester students, identified the need to feel included as staff members was pivotal. McNeish et al. (2011) provided further perspective on how students develop concepts of themselves as nurses. Practical reasoning was illustrated as central to how the students formed their identity, character, and agency as nurses, with the students themselves wanting to be able to provide what they termed 'good care' to patients (McNeish et al., 2011).

2.2.6 Becoming professional

The experience of clinical placement provides students with the opportunity to engage in authentic, situated learning (Cope et al., 2000), but the experience itself is not enough (Cooper et al., 2003;

Cooper et al., 2010). Clinical placement experience, therefore, is about more than just learning about nursing work. As they move towards professionalisation, nursing students are expected to have the skills for providing safe and effective nursing care (Helminen et al., 2014; Fater, 2013; Tanner, 2007). This professionalisation requires students to engage in critical reflection and focus on their learning, enabling them to apply a clinical reasoning approach (Brookfield, 2008; Hunter & Arthur, 2016; Levett-Jones et al., 2011). Students' socialisation to nursing is influenced by staff who act as role models (Fitzpatrick et al., 1997). Development of professionalism is informed by professional identity (Trede, 2012) and, in turn, professionalism informs students' decision-making (Trede, 2012).

The socio-political culture also impacts development of students' professional concept (Lyneham & Levett-Jones, 2016). Inclusion by staff and self-concept appraisal (Levett-Jones & Lathlean, 2008; Malouf & West, 2011; Malouf & West, 2015) helps motivate students to engage and learn (Kaihlanen et al., 2013; Thrysoe et al., 2010). The benefits of self-concept and inclusion, however, need to be assuaged and issued with some degree of caution in considering challenges that specifically confront students whose practice is less than satisfactory (Helminen et al., 2017). A landmark study undertaken by social workers, Bogo and Vayda (1999), showed inclusion by staff may be misinterpreted, especially by students' whose practice performance is marginal who may see this acceptance as an indication that they are achieving at the required level. Conversely, the unsatisfactory practice performer may interpret staff 'not liking them' as the reason they are being 'criticised' when practice deficits are identified (Bogo & Vayda,1999; Cooper et al., 2003).

Emotional intelligence, resilience, and effective communication for patient-centred care round out the qualities recognised in literature as necessary for nursing students approaching professional practice. Emotional intelligence is described as the ability to control one's personal emotions while undertaking the caring role (Foster et al., 2017; Zhu et al., 2015). It develops from experience that teaches the ability to act empathetically, whilst building self-confidence that enables nurses to care for their patients and themselves in stressful situations (Nightingale et al., 2018). Resilience that develops from emotional intelligence (Thomas & Revell, 2016) enables nursing students to adapt to new environments and meet the taxing emotional demands of caring for patients (Delgado et al., 2017; Hart et al., 2014; Thomas & Revell, 2016). Effective communication for person-centred care (Kitson et al., 2012; Ross et al., 2014), is viewed as critical for nursing students as they demonstrate meeting the required standard in preparation for professional practice (Bramhall, 2014; Manninen et al., 2013; Phillips et al., 2014).

2.2.7 Assessment of unsafe practice

A significant body of research around assessment of unsafe practice performance exists. The inability to communicate, and inadequate preparation and functioning, were identified as key risk factors when comparing unsuccessful and successful practice in clinical placement (Lewallen & DeBrew, 2012). Failing to achieve competence, according to the literature, however, rarely occurs (Duffy, 2003; Killam et al., 2011).

Students who do not meet the expectations of professional practice at the required standard may find themselves being labelled as unsafe (Kelton, 2014). Internationally, much of the literature around unsafe practice has focussed on the clinical educators' perspective, which has included supervising clinicians and preceptors, of what constitutes unsafe practice (Killam et al., 2011; Killam et al., 2012; Luhanga et al., 2014), or examined it from the student's perspective (Killam et al., 2012; Mossey et al., 2012). For students, the social, economic, and personal consequences of their practice being deemed unsatisfactory, and subsequently failing so close to completion, cannot be overstated (Lewallen & DeBrew, 2012; Luhanga et al., 2014). Risk factors for compromising patient safety were more likely to occur when students felt overwhelmed by program expectations and lacked trust in the clinical educator's competency and/or ability to facilitate their learning (Killam et al., 2011; Killam et al., 2012; Mossey et al., 2012). Lack of student preparation for placement, misdirected practices of staff and students when providing clinical care, and not acknowledging professional boundaries were all found to pose a risk to patient safety (Montgomery et al., 2014) and to see students' practice labelled unsafe. Unsafe students who pose a threat to public safety and/or threaten the nursing profession's professional standards (Killam et al., 2012) should be failed if remediation is unsuccessful (Chunta, 2016).

Failing to achieve competence, according to the literature, rarely occurs (Calman et al., 2002; Duffy, 2003; Killam et al., 2011). Whilst the impact of failing students can be problematic for all involved, such difficulties must not outweigh the need to fail students who do not meet competency requirements (Duffy, 2003). The consequences of allowing unsafe students to pass cannot be overstated (Duffy, 2003; Killam et al., 2012). Hallmarks for unsafe practice that included poor standards of nursing practice that increased patient safety risk (Killam et al., 2011; Killam et al., 2012; Luhanga et al., 2008b; Luhanga et al., 2014; Mossey et al., 2012;) and a lack of knowledge, skills or clinical judgement (Luhanga et al., 2008b; Luhanga et al., 2014) could lead to a perceived lack of trust by the public of the nursing profession (Killam et al., 2011). These hallmarks were all considered significant enough consequences to ensure that appropriate steps were taken to prevent this from happening (Killam et al., 2011).

2.2.8 Failure to fail

Failure to fail remains a significant issue, long debated in nursing literature, and is used to describe allocation of a pass grade to students when their practice has not always been satisfactory (Hughes et al., 2016). In looking at the broader issue of failure to fail, it is important to recognise that the issue is not an inability to recognise students' practice performance as unsatisfactory; the problem arises from factors that influence assessors' willingness to assign a fail grade (Chunta, 2016; Couper, 2018; DeBrew & Lewallen, 2014; Docherty, 2018; Duffy, 2003; Hughes et al., 2018; Larocque & Luhanga, 2013; Lewallen & DeBrew, 2012; Tanicala et al., 2011). Human influences (Hughes et al., 2018, 2019a), and the subjective nature of assessment itself, were shown to impact assessment of practice of borderline students (Elliott, 2016; Yepes-Rios, 2016). Emotional consequences for the student and the assessors also contributed to the reluctance to fail students (Couper, 2018; DeBrew & Lewallen, 2014; Lewallen & DeBrew, 2012; Yepes-Rios et al., 2016).

Lack of support from the university faculty is attributed to intensifying emotional consequences for clinical educators when students are not meeting assessment requirements (Couper, 2018; Docherty, 2018). The lack of willingness, however, to fail students, especially towards the end of their degree, raises the question of whether students always deserve to pass, or are being passed because no one wants to fail them (Killam & Heerschap, 2013; Luhanga et al., 2008a, 2008b). According to Docherty (2018), not wanting to fail students early in their program becomes problematic because it sets up student expectations that their poor performance meets required standards. A qualitative study undertaken by Hughes et al. (2018) explored assessment of clinical practice in placement and other assessments within the clinical course that included laboratory practice sessions across all year levels. The assessment of marginal students' practice was compromised by organisational failure to prepare the assessors and other impacting issues, such as time and workload pressures, that were found to cause assessors to pass these students (Hughes et al., 2019a). A descriptive study by Hughes et al., (2019b) later identified that assessors were satisfied with time allowed for their role, except when students' practice performance was marginal. According to Hughes at al., 2019a, assessors also acknowledged the reluctance to fail too many students was embedded in their fear that this may affect their future job prospects.

2.2.9 Mitigation of practice performance that is not meeting the standard

Literature has paid scant attention to mitigation for final-semester nursing students except studies that evaluate this issue in relation to adequate preparation for entry exams, such as the National Council Licensure Examination for Registered Nurses (NCLEX-RNs) in the United States (Custer, 2016; Elder et al., 2015; Pennington & Spurlock, 2010). Australia does not conduct a national exam

to assess attainment of the standard prior to registration except the national assessment of English language proficiency. Lynn and Twigg (2011) concluded that, whilst remediation was necessary for health science students to ensure public safety, it was less likely to be implemented if students posed a threat to patient safety. Remediation should be meaningful, as this encourages students to participate in the process (Maize et al., 2010). Cultural and linguistic diversity (CALD) issues require support to ensure successful outcomes of clinical placements (Harvey et al., 2013), and accounted for the majority of international students undertaking third year who were referred for remedial clinical coaching (Kelton, 2014). According to Custer (2016), literature lacks empirical data around mitigation and remediation to substantiate its effectiveness in nursing education. Wider WIL studies have established the importance of higher education support through mitigation for the marginal 'at risk of failing' student when so close to completion of their degree, is considered a way of "turning failure into a learning opportunity" (Ajjawi et al., 2020, p. 196). Furthermore, helping students to recover from failure "seems a fundamental responsibility of the higher education institutions" (Ajjawi et al., 2020, p. 196).

2.2.10 Mitigation strategies

Literature that discusses mitigation strategies, that include clinical learning contracts, and afford opportunity to develop and improve students' practice performance (Chunta, 2016; Kelton, 2014; Ness et al., 2010), does not focus specifically on TtR students whose practice does not meet the required standard. Gregory et al., (2009) recorded unsafe patient events in clinical learning contracts and the standard mitigation strategy implemented across all year levels for nursing students if their practice was deemed unsafe. This quantitative study explored unsafe practice events, coding the events as "error", "near-miss", "potential adverse event", or "adverse event" (Gregory et al., 2009, p. 22). This study, that had unpacked the use of mitigation and explored what could be learnt from mitigation strategies, showed why mitigation was not something to be hidden or ignored. Gregory et al., (2009) concluded that international students and male students were overrepresented and, that because students' contracts were filed away, curriculum design review did not benefit through intentional design to overcome common contributing factors (Gregory et al., 2009).

2.2.11 Identifying the gap

No studies were found that explored how clinical educators assess and subsequently judge the practice performance of TtR students that was not competent as being anything other than unsafe. Research that evaluates risk factors that might impede development of practice performance for TtR students whose practice is safe, but marginal, and management processes for wise practice to mitigate this practice, have not been uncovered. These gaps in the available literature pave the way

for this study that seeks to examine TtR final placement nursing students whose practice performance is assessed and judged as not meeting the required standard because they lack the requisite competence and confidence required for beginning-level registered nurse practice.

2.3 Conclusion

This literature review presented issues surrounding the assessment of practice through critical examination of international and national literature. Competence assessment from an historical and contemporary standpoint, and the importance of education strategies for assessing competence, including the hallmarks of unsafe practice performance and achieving best practice learning outcomes and professionalisation in readiness for professional practice, were explored. These factors have been shown to shape competence as nursing students move towards readiness for registration. International and national literature explores and identifies specific skills graduates will need, and what unsafe practice looks like, but has shown that gaps exist. Practice needs to be critiqued to avoid it becoming ritualised, ineffectual, task oriented, and, as such, a habit and not a learning experience that initiates change through understanding. This review has established that a gap exists within the literature regarding practice performance of TtR students that is not meeting the required standard and, in the management, and mitigation of these students' practice development that this study seeks to close.

The next chapter presents the methodology and justification for the chosen methodology that has been determined as the most suitable way to answer this research question and close the gap this review has shown exists. An overview of the research method that applied to both studies including rigour and ethics is provided, followed by the specific research approach used to generate data for Study 1.

CHAPTER 3 METHODOLOGY SELECTION AND JUSTIFICATION

3.1 Introduction

The previous chapter presented the literature review and identified a gap in the literature on clinical assessment in relation to students who failed to demonstrate the required and expected practice standard. This chapter presents the selected methodology and provides explanations of, and justification for, the selection of Gadamer's philosophical hermeneutics (Davey, 2006; Gadamer, 1989), for answering the research question and meeting the study's aims. In addition, the chapter addresses attention to rigour as well as the ethical considerations and limitations inherent in the scope of the research study. An overview of the research method of the two studies is provided. The specific research approach that was used to generate data for the first of these studies is presented.

3.2 Research Paradigm

Research is undertaken either to discover new knowledge or expand current knowledge and understanding (Schneider et al., 2016). The term 'research paradigm' is used to describe research models or research traditions which are shaped by their ontological and epistemological dimensions (Guba & Lincoln, 1994). The ontology of a research project explains the understandings of the nature of existence that underlie the conceptual scheme, theory, or system of ideas for the study (Crotty, 2003; Flew, 1979). The epistemology explains the way the knowledge is known that will guide the interpretation of the data and findings of the studies (Bailey, 1997; Polit & Beck, 2012).

There are three main research paradigms: positivism paradigm, constructivism paradigm, and critical theory (Guba & Lincoln, 1994). The decision regarding which research paradigm is most appropriate is determined by the research question and the aims of the study (Guba & Lincoln, 1994). Positivism, that is entrenched in a realist ontology and aligns with objectivist epistemology (Bailey, 1997; Guba, 1990), suits research trying to predict cause and effect relationships through observation and measurement (Mackenzie & Knipe, 2006; Polit & Beck, 2012). The aim of this type of study is to test hypotheses (Polit & Beck, 2012). This paradigm was not appropriate for the aims of this present study which sought to examine the meanings and perceptions of those involved in making the judgement about TtR students' readiness for professional practice.

The constructivism paradigm seeks to emphasise greater understanding of human experience as it is lived (Mackenzie & Knipe, 2006; Polit & Beck, 2012). It assumes a subjective reality that seeks meaning through descriptions or discourse (Bailey, 1997) in order to better understand an aspect of

a phenomenon about which little is known, and in which no reality is privileged over another (Polit & Beck, 2012). The constructivism paradigm enables research approaches to be used in the quest for comprehensiveness and cohesiveness, including discovery through examination of the voices and interpretations of those who are play a critical role in the phenomenon being investigated (Polit & Beck, 2012). This alignment with the aims of this research study meant the constructivism paradigm was deemed as the most suitable.

Critical theory, developed by the Frankfurt School of philosophers including Horkeimer, Adorno, and Marcuse (Taylor et al., 2006), drew inspiration from the works of Marx, Kant, Hegel, and Weber (Denzin & Lincoln, 2011). Its ontological roots are in assumptions about power relations (Taylor et al., 2006). Unlike positivism and post-positivism that drives quantitative research in which the world is perceived to be natural or real, critical theorists adopt an historical perspective to emancipate the oppressed (Taylor et al., 2006). Whilst it could be argued clinical education, especially in relation to the governance and control issues, does influence outcomes for TtR final placement nursing students, the need to conduct this study is about more than power and politics. Socio-political and cultural influences do exist within nursing and have some relevance; however, altruism and empowerment (Polit & Beck, 2012) are not the primary focus of this research. Rather, it seeks to gain a wider perspective of what influences the clinical educators' judgement regarding TtR students' readiness for professional practice within the profession itself. Thus, critical theory was discounted for this study.

The choice of a research paradigm indicates the intent, motivation, and expectations for the research (Mackenzie & Knipe, 2006), and reflects the researcher's worldview (Caldwell et al., 2011; Polit & Beck, 2012). As a nurse educator immersed in clinical education over many years, my worldview of what constitutes reality, that is, my ontology, is a recognition that the supervision of nursing students in clinical placements over time has led to the development of a rich and unique body of knowledge relating to clinical education in nursing that is often tacit and taken for granted. What constitutes valid knowledge and how it can be obtained, that is, my epistemology, is this existing body of knowledge has shaped and paved the way for nurse educators to apply long held beliefs and assumptions about how the clinical practice capabilities of nursing students develop during their final clinical placement and are assessed. Despite this, little is known about assessing the practice performance of TtR nursing students who are not meeting the required standard and how this act of assessment has been experienced by the clinical educators who must make the judgement about students' readiness for professional practice. In light of these ontological and epistemological positions, a research methodology has been selected that will assist in the exposure of the meanings

held about how TtR students' practice performance that does not meet the required standard is assessed, interpreted, and experienced by the clinical educators.

3.3 Research Methodology

The research methodology is the framework developed to obtain, organise, and analyse data to find out how the research is to be conducted (Polit & Beck, 2012). Methodology is shaped by the research paradigm (Polit & Beck, 2012; Schneider et al., 2016). As this study seeks to gain understanding of clinical educators' experiences in assessing, managing, and mitigating practice performance of TtR students who are perceived to not meet the required standard, constructivism was chosen as an appropriate paradigm, and Gadamer's (1989) philosophical hermeneutics is the chosen methodology. There are a number of methodologies within the constructivism paradigm, including ethnography, Gadamer's (1989) philosophical hermeneutics, and grounded theory. Each requires different methods to collect and interpret data (Bailey, 1997). Some methodologies within the constructivism paradigm, are discussed in the following sections to provide further justification of why Gadamer's (1989) philosophical hermeneutics was eventually chosen as the methodology for this PhD study.

Ethnography, with its foundation in anthropology, generates understanding through deep immersion in the activities, meanings, and beliefs of an identified cultural group as its primary focus (Higgs et al., 2009; Polit & Beck, 2012). Nursing groups perceive the world in a unique way; thus, this methodology was given some consideration. As a methodology for this research, however, it was discounted because the question being researched is not focusing on the culture of nursing per se, but rather on identifying the perceptions and experiences of the participants while acting within the nursing profession. As there is an essence to be understood about assessment of practice performance of TtR nursing students who are not meeting the required standard, the focus of this research is less about the culture and more about the role and experience of those who conduct it. Hence, ethnography was discounted.

Grounded theory, originally developed by Glaser & Strauss in the 1960s (Polit & Beck, 2012; Taylor et al., 2006), was also considered because it has the capacity to facilitate an investigation of the ways in which participants define their reality and how this reality then relates to their actions. This method is most often used to develop understanding of social experience and it aims to develop a theory grounded in the observations made by the researcher that could be applied to others within a field of little-known research ignoring, particularly in the first instance, existing theories on the subject (Polit & Beck, 2012; Thorne, 2008).The research focus within this

methodology develops through the progressive analysis of the data collected (Munhall, 2007). Grounded theory does not begin its investigation based on formulated questions but rather initiates the study with a statement of purpose (Polit & Beck, 2012; Thorne, 2008). Thus, grounded theory, has been discounted because the research is not seeking to generate a theory from observation but, rather, to facilitate understanding and interpret meaning from the perceptions of those who conduct assessment, and the management and mitigation of practice performance of TtR nursing students that does not meeting the required standard.

Phenomenology, with its foundations in philosophical traditions, is interested in capturing multiple interpretations of reality and a depth of detail that is used to analyse the experience (Schneider et al., 2016). Phenomenology is further distinguished as being either descriptive or interpretive (Polit & Beck, 2012; Bailey, 1997). Descriptive phenomenology is most suited to research that seeks to understand the participants' conscious awareness of the phenomenon (Schneider et al., 2016). It always requires 'bracketing' of prior knowledge by researchers (Polit & Beck, 2012). Interpretive phenomenology facilitates interpretation of a complex relationship in a unique environment and results in generating understanding of the phenomenon within that environment (Polit & Beck 2012; Taylor et al., 2006). Unlike descriptive phenomenology, interpretive phenomenology does not necessarily involve bracketing of researchers' knowledge and prior experiences (Polit & Beck, 2012). The focus is on the subjective experience to enable interpretation (Polit & Beck 2012; Thorne, 2008). This approach would facilitate discovering how clinical educators identify TtR students as not meeting the required standard. Unlike descriptive phenomenology, interpretive phenomenology would not require me, as the researcher, to bracket my years of experience assessing practice performance of TtR students but, rather, permit me to bring that 'knowing' and pre-understanding into the design of the study, the development of semi-structured interview questions, and into the interpretation of the data.

Husserlian transcendental phenomenology (Koch, 1995) is an example of descriptive phenomenology, while Gadamer's (1989) philosophical hermeneutics is an example of interpretive phenomenology (Polit & Beck, 2012). Husserl's phenomenology represents a cartesian duality, with an emphasis on describing (Koch, 1995). This methodology requires intentionality, essences, and phenomenological reduction that occurs through bracketing to defend trustworthiness of the study (Polit & Beck, 2012; Koch, 1995). In contrast, Gadamer's philosophical hermeneutics allows the researcher to bring pre-understanding into the study in order to gain new understanding of the phenomenon of interest (Polit & Beck, 2012).

Gadamer's (1989) philosophical hermeneutics (Davey, 2006; Gadamer 1989) is an appropriate consideration for research that is concerned with interpretation of text for the purpose of generating understanding (Bazeley, 2013; McManus Holroyd, 2007). Hermeneutic studies do not look to develop a procedure of understanding but, rather, to give meaning and to clarify the conditions in which that understanding takes place (Koch, 1995). Gadamer's important contribution was that attention to detail in the research process requires judgement emanating from the pre-understanding that originates in the history of the researcher (Koch, 1995). Gadamer believed people are embedded in the history and culture that shapes them, creating understanding when what is studied articulates and resonates with the interpreter's own history and background (Crotty, 1998; Davey, 2006; Gadamer, 1989; Regan, 2012). This stance is especially pertinent to this study. Gadamer's philosophical hermeneutics facilitates the fusion of past and present horizons (Schneider et al., 2016) and the broadening of horizons to view something differently to how it has been understood before (Kakkori, 2009). Based on these considerations, Gadamer's (1989) philosophical hermeneutics was considered the most appropriate methodology for this research.

Adopting Gadamer's philosophical hermeneutics enabled the practice performance of TtR students who fail to meet the required standard, as well as the clinical educators process in forming judgements about the practice performance of TtR students that fail to meet the required standard, to be explored as a relational phenomenon (Schneider et al., 2016). Teaching, learning and assessment in clinical contexts are grounded in complex relations that require a research approach that allows participant experiences to be explicated and examined to elicit the conceptions and meanings clinical educators hold. This study also seeks to explore management approaches, and mitigation interventions considered effective and employed to ensure TtR students will develop the required competence and confidence for professional practice. It aims to generate understanding about how the judgement and the assessment of practice performance that fails to meet the required standard is made by clinical educators. It seeks to discern the distinguishing features when there is a determination that TtR students' practice performances are 'safe, but marginal practice' in contrast to a determination that the performance is 'unsafe and dependent practice'. This research will draw heavily from a detailed analysis of university assessment and curriculum documents as well as the experience, perceptions, and interpretations of clinical educators who, as principal assessors, will make that judgement of TtR students' readiness for professional practice.

Gadamer's philosophical hermeneutics was criticised for a lack of methods in a research scheme (Cuff, 2019). In responding to the criticism, Cuff (2019) noted that Gadamer believed approaches that enable the interpreters to achieve their understandings of a phenomenon of interest is warranted

(Cuff, 2019). Therefore, commonly used data collection methods, such as in-depth interviews using semi-structured questions, analysing documents, and reflections were applied to this PhD study. In addition, thematic analysis and content analysis, when appropriate, were also applied to data analysis in this study.

Gadamer's philosophical hermeneutics would enable tradition to shape historical pre-understanding that influences ways of knowing and acting, and functions as pre-agreements, or what Gadamer referred to as 'prejudices' (Warnke, 2012). There is an attention to detail required in the research process (Koch, 1995) that facilitates continual movement between the parts and the whole of the text being analysed (Polit & Beck, 2012). Gadamer argued understanding from interpretation always involved a fusion of horizons, and that the researcher is part of the fusion (Regan, 2012). An interpretive study based on Gadamerian hermeneutics requires the inclusion of numerous examples that have guided the analysis from which interpretations have been drawn (McManus Holroyd, 2007). The ability to include multiple examples of parts of the transcript texts for Study 1 and Study 2, to illustrate interpretation of the whole text, was important for generating understanding of the phenomenon. This methodology also permits prior knowledge to fortify the analysis (Vessey, 2009) and, thereby, discover new knowledge about the assessment of practice performance of TtR students when it was not meeting the required standard. In keeping with Gadamer's philosophical hermeneutics, the significant findings emanating from this study culminate in what is a fusion of horizons (Schneider et al., 2016; Regan, 2012). Broadened through the investigator's own horizon (McManus Holroyd, 2007), they will come to represent something different to how it was previously understood (Kakkori, 2009). Gadamer's philosophical hermeneutics, therefore, has been deemed a suitable methodology for this research study.

3.4 Research Method

The research method for this investigative study was conducted as two studies. Each study had its own research approach and analysis process. Study 1 involved the analysis of university assessment and curriculum documentation that pertained to selected TtR students from a single cohort whose practice performance had been judged as failing to meet the required standard. The analysis was undertaken using content analysis. Findings from the first study informed the design of Study 2 that involved interviews with clinical educators from multiple clinical venues, and analysis was undertaken using thematic analysis. The figure below diagrammatically represents the research method for the undertaking of these two studies.

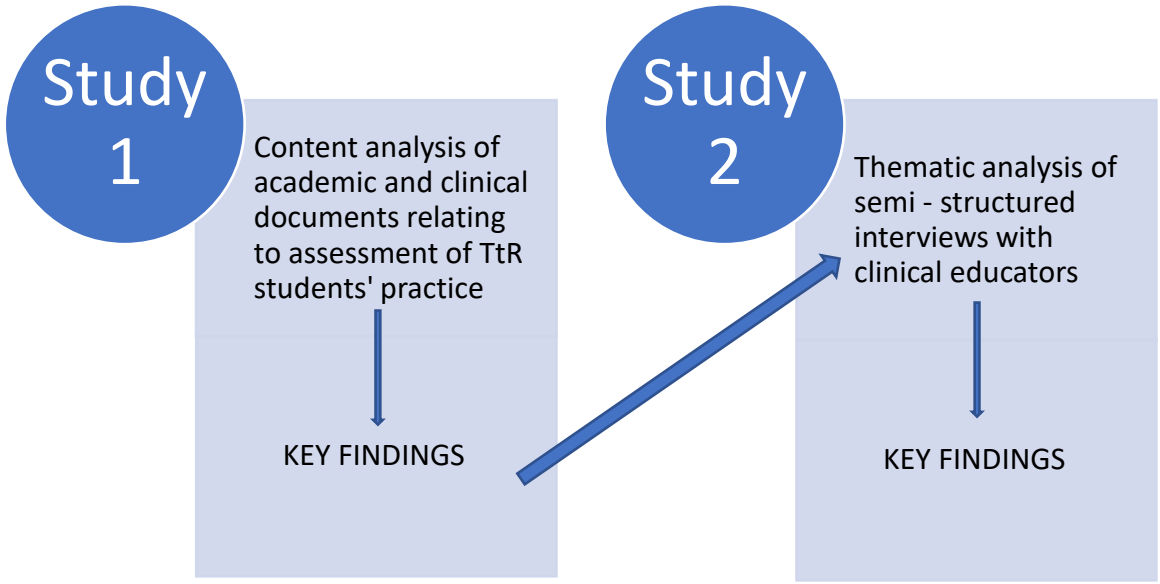

Figure 3.1: Diagrammatic representation of the research method for the two studies

The research approach for the first study is presented later in this chapter. The approach for Study 2, however, will be presented in Chapter Five, following the presentation of findings from Study 1.

3.5 Rigour

The issue of rigour, that is the quality of being thorough, and of trustworthiness, that is research deserving of trust, in qualitative studies have been long debated. Rigour is achieved when the researcher aspires to strive for excellence (Burns & Grove, 2001) through detailed adherence to the parameters of the chosen process which allows replication and scrutiny by others (Polit & Beck, 2012; Taylor et al., 2006). Common criteria, as first identified by Lincoln and Guba (1985), provide a framework for establishing this quality and trustworthiness of qualitative research through credibility, dependability, confirmability, and transferability. Credibility refers to confidence in the truth of the data and is analogous to internal validity of a quantitative study (Polit & Beck, 2012). Dependability refers to stability of the data over time that is analogous with reliability in quantitative research (Polit & Beck). Confirmability ensures objectivity or neutrality of the data (Cope, 2014; Polit & Beck, 2012). Transferability is the capacity for findings to be applied to similar contexts or settings (Houghton et al., 2013). Authenticity (Polit & Beck, 2012), an additional key factor, refers to the emotions or feelings of participants being presented in a faithful manner (Cope, 2014).

Achieving rigour in a qualitative study requires thoroughness when collecting the data and careful systematic consideration of all data, prompting both deconstruction and reconstruction processes

(Polit & Beck, 2012). A methodological log and reflexive journals are accepted methods for maintaining rigour in qualitative research (Polit & Beck, 2012; Taylor et al., 2006). Both were used for this study. The methodological log consisted of electronic diarised entries that were maintained for the two studies. A reflexive journal that recorded emerging understanding throughout the data generation process was maintained during Study 2. Notations that were made during the interviews facilitated a cross-checking mechanism for comparison to the final transcript during the thematic analysis process. Further measures to address issues of rigour included providing opportunities for member checking by inviting each interviewed participant to review their transcript for trustworthiness (Morse, 2015).

Comprehensive logs kept during the research enable processes to be scrutinised or duplicated by other researchers that ensures outcomes could be transferable to other contexts (Cope, 2014). To ensure conformability (Cope, 2014), only verbatim examples and excerpts were included within the findings. Examples from Study 1, and excerpts from Study 2, that are included, serve to illustrate interpretation of the findings to ensure issues of authenticity were addressed (Cope, 2014).

3.6 Ethical Considerations

The *National Statement on Ethical Conduct in Human Research* identified a framework by which researchers should conduct their study to minimise the risk of harm to participants and maximise ethical responsibility (National Health and Medical Research Council, 2007). Ethics approval for this study was sought and granted by the participating university's Social and Behavioural Research Ethics Committee (SBREC). The first submission sought and obtained approval for undertaking this research project and approval to access historical clinical and academic documents for former students. Subsequent modifications for this project were submitted to SBREC in relation to Study 2.

3.7 Study 1

Approval to access historical clinical and academic documents was granted in accordance with the process within the SoNM at that time. In line with the ethical considerations applied in granting approval of this study, the nine cases used in Study 1 were each allocated a case number and a pseudonym. Every effort was taken to protect the privacy of these nine students, the venues, and the clinical educators. This required removal and replacement of students' names, clinical venues, and any other details that may have identified the student, the venue, and, by association, the clinical educator. Explanation of the substitutions used when presenting examples from the transcript of the nine cases are provided in the findings chapter.

3.8 Study 2

Ethics for Study 2 was granted by the University's Social and Behavioural Research Ethics Committee (SBREC). Application for permission to recruit participants for interview, who were under the jurisdiction of the SoNM in which the study is situated, was submitted to the Executive Dean, and conditional approval was given with some exclusions. Permission to approach the university employed clinical educators (facilitators) was granted, but access to recruit seconded clinical hospital staff, who undertake this role and remain employed by the hospitals and/or venues, was denied. No substantive reason was provided for the decision, but the researcher abided this condition.

Permission from participants was sought in accordance with ethics approval. An email invitation, sent out by a third party to ensure participants were not contacted directly by the researcher and reduce any risk of coercion, was accompanied by a letter of introduction (Appendix 1) and the information sheet (Appendix 2). A consent form (Appendix 3) to participate in a recorded interview was provided following participant's indication of their willingness to be interviewed. These were all signed prior to the interview commencing.

As protection of participants is considered paramount (Thorne, 2008), concerted effort was taken to ensure protection of the participants through allocation of a pseudonym which they chose. Participation was voluntary and could be terminated at any point. Protection of participants' anonymity was strictly adhered to throughout the interview, with room bookings made under the researcher's name. In the use of all illustrative excerpts for Study 2, all identifying details were replaced using the same substitutions as for Study 1.

As discussions of instances of unsafe practice by students or personal experiences with failing a TtR student so close to completion of their degree could prove upsetting, steps were taken to provide all participants with information on how to access support if required. Participants were afforded the opportunity to retract any shared experience from the transcript and to check their transcript accurately reflected their comments if they wished to do so.

Ethics approval for this study was granted on the proviso that students, venues, and their staff and clinical educators would not be identifiable through recounting of the shared experiences. For this reason, that also applied to the documents used in Study 1, the transcripts are not provided as an appendix. Clinical educators' reports were so detailed and, when interviewed, they spoke from the heart and willingly shared their experiences with TtR students. Redacting the many inferences,

including the use of names and uniquely identifiable situations, would have made inclusion of the transcripts meaningless.

3.9 Limitations

Although qualitative studies yield rich information to achieve an in-depth understanding of phenomena studied, limitations with this type of research are well documented (Polit & Beck, 2012). A limitation of this study is that it was conducted in a single SoNM. Therefore, there is a lack of data triangulation to gain multiple perspectives. Another limitation, in keeping with ethical considerations, was that only clinical educators employed by the SoNM, and not seconded hospital employees, could be approached to participate in this study. As research bias during analysis may be unconscious, using processes such as having the findings from the first study inform the design of the second study, as occurred, according to Morse (2015), helps to reduce such risk.

3.10 Research Approach: Study 1

The research process for Study 1 was conducted over ten months. The research approach for this study, that was informed by Gadamer's philosophical hermeneutics, is presented in accordance with the sequence of steps that were undertaken for the process. Description of this research approach includes: an explanation of the research setting; criteria relating to selection of the nine cases; and a description of specific clinical and academic performance documents pertaining to the nine cases and additional curriculum and assessment documents.

Data were analyzed so the findings were underpinned by the researcher's reflection on issues arising within, and across, the nine cases. In summary, analysis comprised content analysis that resulted in the identification of codes in each case that were then grouped across the cases. Following this process, the grouped codes were sorted into sub-categories that were then aligned with broader categories; a process that facilitated identification of how the TtR students' practice was previously assessed as not meeting the required standard.

3.10.1 Study setting

Study 1 is situated in an Australian university's SoNM, encompassing two campuses: one metropolitan and one rural. Data were generated from the documentary evidence detailing practice performance of nine third year TtR nursing students, undertaking their final clinical placement in the Bachelor of Nursing degree, whose clinical practice performance had been judged as not meeting the required standard.

3.10.2 Selection criteria for cases

Nine cases were drawn from a single cohort of 482 full- and part-time Bachelor of Nursing students enrolled in the final nursing practice topic that required attending 35 shifts of clinical placement. Limiting selection of students to a single cohort was purposeful. This enabled the range of variables arising from curriculum and assessment changes that could confound specificity of the expected learning outcomes to be reduced. The timing of this data generation was also deliberate to be one in which I, as the researcher, was not the academic coordinator for this cohort.

The essential criterion for selection of each TtR student included in this study was that they had been judged and assessed by clinical educators as not meeting the required standard of practice. Of the cohort who commenced final placement, a total of sixteen TtR students did not successfully complete. Of these, six students were not eligible to be included because they had not completed placement due to other considerations, such as illness or personal circumstances. One student whose practice had been assessed as not meeting the required standard was not included because the actual details contained in the report were so unique, it presented an ethical risk of identifying them, the venue, the clinical educator, or staff. In all, nine TtR nursing students who commenced their first TtR placement together and did not successfully meet the assessment requirements remained. These nine cases are the sample cases presented in the Study 1 analysis.

3.10.3 Data Collection

Data for Study 1 involved the creation of an individual case dossier of historical clinical and academic documents for each of these nine students. Curriculum and other documents that relate to delivery of the topic content and assessment requirements are also included. Following ethics approval from the University's Social and Behavioural Research Ethics Committee (SBREC), approval was sought and granted from the SoNM to access and analyse students' reports and associated documents that included the following clinical and academic documents.

Clinical documents:

- all relevant email correspondence from clinical educators and supervising RNs;
- clinical based assessment results and mark sheets for their TtR placement;
- written feedback sheets completed by supervising RNs if made available;
- formal warnings (FWs) and/or clinical learning contracts (CLCs); and,
- all clinical placement professional experience placement records (PEPRs).

Academic documents:

- results for all clinical-based and academic assessments in this topic;

- academic transcripts; and,
- curriculum details including assessment details and required topic outcomes.

3.10.4 Data Analysis: Study 1

Study 1 data analysis was undertaken based on interpretive phenomenology, informed by Gadamer's philosophical hermeneutics (Polit & Beck, 2012) that used the accepted structured process of content analysis. This enables data to be organised and integrated to facilitate identification of key concepts or patterns and trends within the data (Polit & Beck, 2012; Saldaña, 2013; Yin, 2014). An inductive approach (Burnard et al., 2008), suits analysis of data when there is little or fragmented knowledge of the phenomena under investigation (Elo & Kyngãs, 2008). Content analysis is appropriate where exploration of large amounts of textual information across multi-faceted sources reporting common issues is required (Vaismoradi et al., 2013). Content analysis, therefore, was deemed a suitable method for conducting this deep level of analysis (Bengtsson, 2016) of the multiple, relevant clinical and academic documents for nine cases. A structured process for this analysis employed the distinct stages of decontextualization, recontextualization, categorisation, and compilation (Bengtsson, 2016). Explanation of the content analysis process that resulted in the categorising of the Study 1 data is now described in detail.

Content analysis of documents that pertained to the nine examined cases involved constant comparison, contrasting (Yin, 2014), and reflection on the researcher's experience in coaching students in similar situations. My roles as the clinical coach, clinical educator and topic coordinator for final semester nursing students' practice topic over many years, shaped my assumptions and understanding regarding assessment of TtR students' practice performance. Rather than bracket these, as befits the selected methodology of Gadamer's philosophical hermeneutics (Gadamer, 1989), I applied this understanding to extract the common words and phrases (Saldaña, 2013) during the decontextualization phase (Bengtsson, 2016). This approach enabled identification of factors contained within the detailed clinical and academic performance documents for these nine cases during what should have been TtR students' final clinical placement. Content analysis of the documents was undertaken using separate coding and categorising processes (Polit & Beck, 2012; Saldaña, 2013; Yin, 2014) within, and across, the nine cases. This led to identification of descriptors that clinical educators employed when assessing the practice performance of TtR students. Furthermore, factors that informed and influenced clinical educators' judgement about TtR students' readiness for professional practice were revealed.

Analysis involved initial coding and grouping of these codes, and synthesising of the grouped codes into sub-categories that were then arranged under broader categories. These categories, namely,

knowledge deficits, skills deficits, and unprofessional practice issues, were explored in relation to emerging content that is presented using three cycles of the hermeneutic circle (Denzin & Lincoln, 2011). Hermeneutic circles used for presentation of Study 1 findings meant decisions about codes were made within the context of knowledge gained from the previous cycle that ensures reliability (Morse, 2015).

3.10.4.1 Content Analysis: Coding

The analytical strategy used to generate the codes began with linking the information around the identification, management, and mitigation of the students that captured the essence of the data in an endeavour to explore its meaning (Saldaña, 2013; Yin, 2014). This form of coding is applicable to multiple types of data and, as such, was suitable for comparison and analysis within and across nine cases involving multiple documents, that were either case specific, or related to the delivery of the course content. Each case, allocated a number from 1 to 9, was examined to identify common words and phrases amongst the reported events. These initial codes were further refined to enable patterns to emerge of similarity, difference, frequency, sequence, correspondence to other events and/or causation (Saldaña, 2013). Following grouping of the codes, descriptors and indicators of what became sub-categories emerged. This led to the further categorisation under broader categories that were then regrouped under a specific practice deficit framework reflecting the type of deficit. Table 3.1 provides an illustrated example of how reported events were coded and grouped to enable patterns and trends from the content analysis to emerge.

The example demonstrates the coding process from three recorded events for Case 1 in which the clinical educator reported the student had: (1) taken an hour to draw up medications; (2) taken more than 20 minutes to organise an oral medication; and, (3) omitted an ordered medication and required prompting to recognise this. These events were categorised under codes, grouped into relevant sub-categories and further categorised as a skills deficit in relation to medication administration as seen in Table 3.1 below.

Table 3.1 Example of data coding

Event (E)	Codes (Co)	Grouped codes (GCo)	Sub-categories (SC	Category
E1: Took an hour to draw up (prepare) 4 medications in Week 4!!	Co1: Very Slow Co2: Unorganised Co3: Uncoordinated Co4: Lacking confidence	GCo1: Slow, unorganised, uncoordinated. GCo2: Lacks confidence with skills.	SC1: Uncoordinated, slow and lacks confidence with skills (Medication administration)	**Skills deficit (Medication administration)**
	Co5: Inefficient Co6: Poor time management	GCo3: Poor time management skills	SC2: Inability to plan and implement medication administration in a timely manner	

	Co7: Lacks proficiency with medication skills	GCo4: Not working at expected third-year level	SC3: Less than satisfactory medication administration skills SC4: Not meeting required standard (NMBA, 2010) Units 1, 2 & 7 = Bondy score 4	
E2: Took more than 20 minutes to organise an oral medication	Co1: Very Slow Co2: Unorganised Co3: Uncoordinated Co4: Lacking confidence	GCo1: Slow, unorganised, uncoordinated. GCo2: Lacks confidence with skills.	SC1: Uncoordinated, slow and lacks confidence with skills (Medication administration)	**Skills deficit (Medication administration)**
	Co5: Inefficient Co6: Poor time management Co7: Lacks proficiency with medication skills	GCo3: Poor time management skills GCo4: Not working at expected third year level	SC2: Inability to plan and implement medication administration in a timely manner SC3: Less than satisfactory medication administration skills SC4: Not meeting required standard (NMBA, 2010) Units 1, 2 & 7 = Bondy score 4	
E3: Omitted an ordered medication and required prompting to recognise this	Co4: Lacking confidence	GCo2: Lacks confidence with skills.	SC1: Uncoordinated, slow and lacks confidence with skills (Medication administration)	**Skills deficit (Medication administration)**
	Co6: Lacks proficiency with medication skills	GCo4: Not working at expected third-year level	SC3: Less than satisfactory medication administration skills SC4: Not meeting required standard – NMBA (2010) Units 1, 2 & 7 = Bondy score 4	
	Co8: Required prompting to check order Co9: Unfamiliar with safe, medication administration process	GCo5: Requires prompts to perform tasks GCo6: Does not follow medication administration process safely GCo7: Unable to effectively manage care for patients	SC5: Does not follow skill process safely SC6: Unable to manage patient care in a safe, coordinated manner.	

As seen in Table 3.1, sub-categories relating to TtR students not demonstrating medication administration processes at the required standard included clinical educators' descriptors such as 'uncoordinated', 'slow', 'lacks confidence', 'inability to plan and implement medication administration in a timely manner', 'unable to manage patient care in a safe, coordinated manner', 'less than satisfactory medication administration skills', and 'not meeting required standards'. These sub-categories were refined further under three broad categories, namely, knowledge deficits,

skills deficits, and unprofessional practice issues.

The broader categories, for the context of this thesis, emerge from the coding and content analysis, and are defined in relation to clinical educators' descriptors of practice performance of these TtR students they assessed as not meeting the required standard. The three broad categories and their meaning for the purpose of this thesis include:

- knowledge deficits that were indicated when the TtR student did not demonstrate appropriate application in practice and the ability to articulate a satisfactory explanatory knowledge base;
- skills deficits when the TtR student did not demonstrate a proficient level with clinical skills including psychomotor and technical skills, communication, interpersonal and documentation skills; and,
- unprofessional practice issues when the TtR student did not demonstrate behaviours and attitudes commensurate with beginning RN level professional practice.

3.11 **Conclusion**

This chapter has presented the selected methodology and provided explanation of, and justification for, the selected methodology, Gadamer's (1989) philosophical hermeneutics. Issues relating to rigour, ethical considerations, and identification of the limitations inherent within the research have each been addressed. An overview of the research methods for both studies, that included representation as a model, were presented. Details of the research approach specific to the first study, including how events were coded and categorised, were presented. The broad categories, namely, knowledge deficits, skills deficits, and unprofessional practice issues, that emanated from the coding process through content analysis, have been presented and defined. The findings relating to this in relation to the principal question and aims of this study are presented in the following chapter, using three cycles of the hermeneutic circle. The research methods used for Study 2 will be presented at the beginning of Chapter 5, followed by the findings emanating from the identified themes and associated sub-themes.

CHAPTER 4 FINDINGS: STUDY 1

4.1 Introduction

The focus of this chapter is the analysis of documentation of clinical educators' assessment of the practice performance of nine transition to registration (TtR) final-semester nursing students who were identified as not meeting the required performance standard in their clinical placement. The findings emanating from content analysis of the historical clinical and academic documents for these nine cases are presented. Elaboration of the key findings are presented using three cycles of the hermeneutic circle (Denzin & Lincoln, 2011). Examples from the reports of the nine cases are included to support the findings.

Throughout the clinical documents and reports, terms and phrases used by clinical educators when describing the practice performance of TtR students they assessed as not meeting the required standards included 'unsuccessful', 'unsatisfactory', 'borderline', 'at risk', 'marginal', and 'not yet ready'. These terms will appear in their verbatim examples. Ethical considerations for presentation of data require the de-identification of the student, clinical educator, and venue. While the quotes were important for the thesis examiners to be able to read, many details have been redacted for the published version of the thesis to protect the students identity and confidentiality of their records. Replacements were used to ensure ethical considerations including bracketed text for omission or substitution of criteria that may identify a student; 'XXX' replaces text to avoid identification of a patient, staff member or the venue; ellipses are used to omit text deemed not relevant. Presentation of the findings commence with the first cycle of the hermeneutic circle.

4.2 Purpose of Study 1

The purpose of Study 1 is to conduct a hermeneutic study to examine the documentary evidence of clinical educators' assessment of the clinical practice of TtR students whose performance does not meet the required standard. It seeks to ascertain features of students' practice performances that give rise to clinical educators forming judgements about their readiness for practice, or to determine if their performance is unsafe. Clinical educators' assessment of TtR student clinical performance and their readiness to practice is a largely unexplored phenomenon, particularly in relation to those students whose performance is judged to be less than satisfactory. It is important to gain a more detailed understanding of how clinical educators form judgements about TtR students' clinical practice performance and, in particular, what provokes them to assess the TtR students to be safe or unsafe, competent, or not competent and not meeting the required standard. Gaining a better

understanding of this phenomenon will help close current gaps in nursing education scholarship, particularly about the ways TtR students' readiness for professional practice is measured and assessed. This detailed understanding is necessary to drive changes to curriculum design, including implementation of purposeful mitigation, that ensure TtR students can complete their degree successfully and meet the profession's expectations of beginning-level RN practice.

4.2.1 Introduction to Study 1 findings

Identifying factors that contributed to assessment of these nine TtR students as not meeting the required standard, and its impact on their subsequent judgement about whether the TtR met the assessment requirements, were embedded in reports from clinical educators to the university. They contained descriptions of practice performance they considered did not demonstrate safe, competent nursing practice. These findings are presented using three cycles of the hermeneutic circle. The first cycle identified the common, causal factors that were found to influence clinical educators' assessing TtR students' practice performance as not meeting the required standard. The second cycle identified the criteria that informed clinical educators' judgement of TtR students' practice performance as unsafe and dependent, and established findings in relation to how clinical educators responded when TtR students were not meeting the required standard. The third and final cycle of the hermeneutic circle exposed a tension between the practice environment and university regarding assessment of TtR students' practice performance, professional judgements, and impact on final outcomes.

For the purpose of presenting the findings, each student, as presented in Table 4.1, was allocated a case number and pseudonym to ensure anonymity for ethical considerations. Table 4.1, for each of the nine selected cases, also includes the details of the specific core degree program the student was enrolled in, whether they were enrolled full-time or part-time, the number of years to date they had completed in this degree, and whether any credit for previously undertaken programs of study had been granted. These factors have relevance to this study, as part-time students can have had up to 18 months since their last placement, the particular degree impacts the total number of prior clinical placements TtR students would have undertaken within the program to date, and the curriculum also differs between the various entry pathways.

Table 4.1 Cases 1-9: Student details

Case	Pseudonym	Degree	Years completed to date	Credit for previous study	No. of prior clinical placements
1	Tracey	BNsg, Part-time	[redacted]	No	5
2	Maria	BNsg, Full-time	[redacted]	Yes, Diploma EN (Overseas qualification)	3
3	Jo	BNsg, Part-time	[redacted]	Yes, Diploma EN (TAFE qualification)	3
4	Stella	BNsg, Full-time	[redacted]	No	5
5	Sally	BNsg, Part-time	[redacted]	Yes, Registered Midwife	2
6	Janet	BNsg, Full-time	[redacted]	No	5
7	Kim	BNsg, Full-time	[redacted]	Yes, Graduate entry - Overseas degree	3
8	Moni	BNsg, Full-time	[redacted]	Yes, Diploma EN (TAFE qualification)	3
9	Pete	BNsg, Full-time	[redacted]	No	5

4.3 First cycle of the Hermeneutic Circle

This first cycle of the hermeneutic circle identifies the common, causal factors that were found to influence clinical educators' assessing TtR students' practice performance as not meeting the required standard. The purpose of assessment of practice performance for TtR students was to establish they were demonstrating the standard associated with the provision of safe, competent nursing practice, commensurate with beginning-level RN practice. Critical examination of documents revealed assessment of TtR students' practice performance was conducted through formal and informal assessments. Formal, summative assessments include a clinical case conference presentation (CCCP) (Appendix 4) and professional experience placement record (PEPR) (Appendix 5). Informal assessment processes include weekly clinical handover that involves questioning and discussion about their allocated patients.

When TtR students did not meet clinical educators' expectations of benchmark standards of safe, competent nursing practice, the practice performance was judged as not meeting the required standard. Patterns and trends from which the common, causal factors emerged indicated how clinical educators assessed these TtR students' practice performances as not meeting the required standard. These were aligned with the broad categories identified during the coding process,

namely, knowledge deficits, skills deficits, and unprofessional practice issues. Following identification of each factor, mapping of the reporting of these across the cases was undertaken. This mapping is represented diagrammatically in Table 4.2.

Table 4.2 Mapping of common, causal factors: Cases 1-9

Categories	***Knowledge Deficit***	***Skills Deficit***	***Unprofessional Practice Issues***
Common, Causal Factor	Unable to always demonstrate integration of knowledge to ensure patient safety	Requires prompts and direction from RNs when providing routine patient care	Does not always recognise professional boundaries towards staff / others
No of Cases	(9/9)	(9/9)	(7/9)
Common, Causal Factor	Not assessing the clinical needs of patients and planning care in response to that assessment	Does not always perform nursing procedures safely and confidently	Does not use reflective practice to identify own professional development needs
No of Cases	(9/9)	(9/9)	(6/9)
Common, Causal Factor	Does not always demonstrate integration of hospital policies and procedures	Does not always communicate effectively to facilitate provision of care	Does not always seek clarification from supervising RNs if unsure
No of Cases	(9/9)	(9/9)	(6/9)
Common, Causal Factor	Does not recognise the deteriorating status of patients	Unable to meet the workload requirements due to ineffective time-management skills	Does not consider health and wellbeing in relation to being fit for practice
No of Cases	(7/9)	(5/9)	(4/9)

Exploration of these common, casual factors, and the frequency with which each occurred across the cases, provided confirmation that clinical educators identified these when reporting TtR students' practice performance that was not meeting the required standard. Attaining the standard was necessary for passing curriculum-based assessment requirements (Appendix 6) and it is mandated for TtR students to demonstrate meeting the required standard of a beginning-level RN by completion of their degree. In the case of these nine students, this meant meeting the required beginning-level RN standard, in line with the NMBA competency standards for the registered nurse, 2010 version (Appendix 7).

Analysis of the case reports, as presented in Table 4.2, showed clinical educators formed their professional judgement that practice performance of these TtR students was not meeting the required standard because students demonstrated these common, causal factors that do not align with descriptors of safe, competent nursing care. Supporting extracted statements from the case reports, referred to as examples, are provided to illustrate the analysis that resulted in identification of these factors. It commences with indicators aligned with knowledge deficits.

4.3.1 Knowledge deficits

Exploration and analysis show common, causal factors acted as indicators to clinical educators that TtR students' level of knowledge was less than satisfactory and, as such, they were not demonstrating readiness for professional practice. The common, casual factors identified with knowledge deficits include:

- unable to always demonstrate integration of knowledge to ensure patient safety;
- not assessing patient's clinical needs and planning care in response to that assessment;
- not always demonstrating integration of hospital policies and procedures; and
- does not recognise the deteriorating status of patients.

These common, causal factors, that emerged following analysis of the clinical educators' descriptors of TtR students' knowledge deficits, are now presented with illustrative examples. Integration of knowledge with their practice is required for the provision of safe, clinical nursing practice. These students' inability to demonstrate that they could think critically, and articulate accurate clinical rationales, occurred across all cases. Based on this, the clinical educators judged that these students could not apply relevant theory to the clinical nursing interventions and actions they were implementing. The following examples illustrate how the clinical educators judged TtR students' inability to articulate rationales as an indication the TtR students' practice performance was not at the required level. The relevant student's assigned pseudonym precedes each quote from the clinical educators.

> **Janet:** Inability to articulate sufficient rationale for actions, lack of knowledge.

> **Moni:** Feedback [redacted] was that even after thorough explanation the student was still unable to explain why she was performing tasks. Cannot provide clinical rationales for her nursing care. Not at 3rd year level.

> **Stella:** [Stella] does not yet recognise the priorities of care with an obvious deficit in knowledge. She is unable to demonstrate the expected level of practice required of a student on their final clinical placement.

From the reports, a pattern emerged of the clinical educators expecting these TtR students to apply explicit aspects of knowledge, particularly patho-physiology and pharmacology. Their failure to do this prompted some clinical educators to contact academic staff and raise concerns that these students' lack of knowledge was an indication that their practice performance was not meeting the required standard.

In their accounts, it was evident that nursing students were expected to understand and apply knowledge about how the body works (normal anatomy and physiology); how illness and medical conditions impact normal bodily function (patho-physiology and microbiology); and how medications and pharmacology knowledge underpin specific nursing care required for their patients, as illustrated in these examples.

> **Maria:** [redacted] The RN determined that the student demonstrated "No insight" into the need to manage [redacted] and had no knowledge about how to do this showing a lack of knowledge.
>
> **Sally:** [redacted] thought that sepsis was [redacted]. She does not understand the information [redacted]
>
> **Pete:** Concerns about his knowledge base as he is unable to answer any questions on patho and meds. [redacted]
>
> **Tracey:** When pressed to give me a handover of her patients, she was very unsure and when asked basic questions was quite unsure. She did not know what sepsis was.
>
> **Tracey:** Poor knowledge base as evidenced by lack of knowledge around medications that had she not been directly supervised could have resulted in potential for harm to the patients as her pharmacology/pathophysiology knowledge is so poor.

Examination of curriculum documentation showed these students had studied sepsis in at least three previous topics, including patho-physiology and nursing practice topics, and, thus, could be reasonably expected to be able to apply this knowledge to their practice. It also showed that the clinical educators' expectations and assessment of Sally and Tracey was reasonable and required.

Students' failure to assess the clinical needs of patients, and to plan their care in response to the nursing assessment process, was an indicator for clinical educators that TtR students were not demonstrating application of contextual learning. Nursing assessment is integral to planning relevant nursing care at the required standard of beginning-level RN practice. Nursing assessment is

also a constant process, and often means aspects of care need to be reprioritized in response to changes in a patient's condition. For these TtR students on the verge of transitioning to autonomous professional practice, the following examples illustrate that they failed to assess patients, interpret the findings, and use the information to plan nursing care which resulted in their practice performance being reported as not meeting the required standard.

> **Kim:** She is appearing to still have problems with the practical skills and the interpretation and reasoning behind these skills…
>
> **Stella:** [Stella] has poor assessment skills. She does not complete nursing assessments and that can be seen to be unsafe when giving results to staff who are trying to diagnose and treat a patient based on their signs and symptoms.
>
> **Sally:** [Sally] has had two placements in XXX and still can't articulate simple nursing assessment findings and support a patient's trends and actual/potential problems with rationale.
>
> **Tracey:** Not assessing patients care needs and does not understand why changes are made or what to do when changes occur, cannot plan/prioritise care. Lacks ability to link knowledge to practice.
>
> **Tracey:** Requires significant direction in analysing and interpreting assessment data to generate appropriate goals of care for her patients.

Closer analysis of these examples revealed that clinical educators were, in fact, seeking a clinical reasoning approach from these TtR students, as is required by this stage of the degree. Students demonstrate clinical reasoning when they can effectively interact with a patient, collect cues through assessment and questioning, process information, and then plan relevant interventions. This expectation extends to evaluating the care they have provided, reflecting on it and learning from this process. These students' failure to apply this clinical reasoning approach to patient care indicated to the clinical educators that their practice performance was not meeting the required standard.

The application of professional legal responsibilities is required in order to demonstrate safe, competent nursing practice and is at the required standard for beginning-level RN practice. This includes the need for TtR students to integrate organisational policies and procedures when undertaking provision of care. Not following hospital policies and procedures, as seen in these examples, resulted in the TtR students' practice performance being reported as not safe.

> **Janet:** Proceeded without discussion with an RN to [redacted]. Did not follow the hospital policy.
>
> **Maria:** Any vital sign in the purple zone is a MER requiring a MET call. She did not alert staff; did not report high BP to nursing or medical staff; did not call a MET call. Did not follow hospital protocol. She is not safe.

Moni: Even though she was told that hospital policy requires [redacted] must be done with RN present the student went and performed [redacted] unassisted and unsupervised.

Tracey: Not following hospital drug administration guidelines – is not meeting competencies.

Not ensuring hospital policies and procedures are always adhered to when providing patient care was an indication these TtR students were not demonstrating the legal parameters of professional practice. Exploration of curriculum documents showed the students had studied applied law for nursing practice in the nursing practice topics where it was incorporated into clinical scenarios and discussed in class. Academic transcripts revealed eight of these nine TtR students had undertaken and successfully completed the law and ethics topic.

Failing to recognise the deteriorating status of their patients, or not responding appropriately when a patient's health deteriorated, places the patient in harm's way. As illustrated by these examples, failing to recognise and report the deteriorating status of their patients was so important at this stage of the degree that, for the clinical educators, it provided justification that these TtR students' practice performance was not meeting the required standard.

Maria: Student took patient's BP during routine observations at [redacted]. Patient had [redacted] on RDR …did not alert staff; did not report high BP to nursing or medical staff; did not call a MET call.

Tracey [redacted] She was not assessing patients' care needs and does not understand why changes are made or what to do when changes occur

Stella: Unable to demonstrate the expected level of practice required of a student on their final clinical placement. Unable to establish and maintain effective and collaborative working relationships - [redacted]

Not recognising the deteriorating status of their patients meant that these students had become involved in 'near-miss' events and was regarded as an indication these students were not safe. When harm to patients was only averted due to intervention from the RNs, staff regarded the student's practice as unsafe. In these cases, the clinical educator's response was often to request the student's immediate removal from the venue.

4.3.2 Skills deficits

Clinical nursing practice requires the implementation of a range of skills that are required in the provision of care. Throughout this thesis, the term 'skill' is used to describe interventions and actions required in the provision of nursing care that includes clinical and technical psychomotor

skills and professional communication skills, including documentation, clinical handover, and interpersonal skills. Common, causal factors associated with skills deficits that resulted in these TtR students being assessed as not meeting the required standard included:

- requires prompts and direction from staff when providing routine care;
- not always performing nursing procedures safely and confidently;
- not always communicating effectively to facilitate provision of care; and,
- unable to meet the workload requirements due to ineffective time-management skills.

By this stage of the degree, TtR students should require little prompting or direction from supervising RNs when providing routine patient care. As the following examples illustrate, TtR students were expected to demonstrate the ability to provide nursing care by planning, prioritising, and coordinating nursing care. When they could not provide nursing care without prompting and direction from the staff to plan, prioritise, and coordinate care, their practice was reported by clinical educators as not meeting the required standard.

> **Jo:** Despite only having the one patient to complete observations for, [redacted], these were still incomplete [redacted] RN had to prompt her to complete this [by end of third year level [redacted] of placement, this should be routine practice]. [redacted] She did not go to AM Tea until 1130 am, it indicates her inability to plan.

> **Jo:** [Jo] has struggled again today, poor infection control practices. She was allocated 3 patients [redacted] but she still required direction in providing their care and her ability to initiate care was of a minimal level. By this stage though she should be needing very little direction from staff. She appeared flustered at times. She is not coping at level expected of a third year. RN needed to get in and complete part of the workload.

> **Moni:** Needs prompting with all tasks. Unable to plan shift for [redacted]. Not meeting 3rd year expectations.

> **Stella:** Unable to adequately prioritise the care of her patients as demonstrated when she has not understood the importance of pain management and was undertaking patient observations instead.

> **Tracey:** Not assessing patients care needs and does not understand why changes are made or what to do when changes occur. She cannot plan/prioritise care. Does not comply with the competencies.

> **Tracey:** Unable to plan care for allocated patients. Requires constant direction and supervision – at level of a first or second year at best.

The requirement for staff input with management of routine nursing care, that occurred across cases, was found to be a critical factor that influenced clinical educators' professional judgement that these TtR students were 'not ready' for professional practice as autonomous RNs. By the TtR placement, clinical educators expected students to perform nursing procedures safely and confidently. The high stakes associated with medication administration meant these clinical educators, who are RNs themselves, showed no tolerance for error. The following examples illustrate that clinical educators were seeking a level of competence and confidence from these TtR students with this skill, so that patients were not exposed to any risk of harm. When that did not eventuate, clinical educators reported TtR practice performance was not meeting the required standard.

> **Jo:** She had taken [redacted] – is slow and uncoordinated. When administering [redacted] bent the cannula upwards causing leakage of the solution, pain for the patient... She is "Not safe".
>
> **Jo:** Does not administer medications on time; reluctant to answer staff about meds when questioned. Not performing at required standard.
>
> **Kim:** Poor level of medication knowledge and medication administration process.
>
> **Maria:** Patient was ordered antihypertensive medication. Failed to recognise the need to administer these as a priority given the pt's elevated SBP. Not ready.
>
> **Sally:** [Sally] could not tell me where a [redacted] injection goes, [redacted], it was beyond her, she is not ready to be an RN.
>
> **Tracey:** [redacted]
>
> **Tracey:** Medication administration, very slow and uncoordinated resulting in medications not being administered in the correct time period. Is not competent in medication management. Has not been able to reach expectations of a 3rd year nursing student final placement.

Students' inability to accurately perform drug calculations, a critical part of medication administration, was an indication these students' practice performance was not meeting the required standard. The following examples were the catalyst for clinical educators contacting the academic coordinator to flag concerns that these TtR students were not meeting the required standard.

> **Kim:** Had difficulty working out what to set the mls/hr rate at for the pump to deliver [redacted]. [Kim] needed extensive prompting with this and then eventually had to be told that it would be [redacted] Again, this is not safe.
>
> **Moni:** [Moni] could not work out how to prepare [redacted] from [redacted] tablets, this is unacceptable at this level.
>
> **Sally:** Could not calculate a [redacted] of IV A/B, suggesting 30 mls

The inability of TtR students to undertake administration of medications proficiently, safely, and confidently, including accurate drug calculations, was instrumental in clinical educators reporting their practice performance as not meeting the required standard. When TtR students' skills were culpable, and had placed patients at risk of harm, clinical educators were more inclined to request these students be removed from the venue.

Communication skills also impact the provision of safe, competent care, so the inability to communicate effectively caused clinical educators to report these TtR students were not meeting the required standard. Communication skills that did put the provision of safe, competent care at risk were attributed by clinical assessors to cultural and language diversity (CALD) issues and ineffective interpersonal skills. Across the cases, there was evidence that ineffective communication skill deficits arising from CALD backgrounds had influenced the clinical educators' assessment of TtR students' practice performance. Stella's clinical educator, for example, expressed concern her English Second Language (ESL) background contributed to her failing to pass on treatment orders.

> **Stella:** English as second language impacted her ability to communicate at a level required for final placement [redacted] to supervising RNs; Difficulty with educating patients about their care.

Students CALD background was also identified by supervising RNs as impacting their provision of safe, competent nursing care, as illustrated in these examples for Kim and Moni.

> **Kim:** [Kim] had difficulty interpreting the [redacted] This is not safe. RN querying if there might be a language problem?

> **Moni:** [Moni] did not understand the importance of a [redacted] when explanations were given. Supervising RN felt this was due to a language/communication barrier. RN stated that the student is not safe because she could not follow simple instructions. Not at 3rd year level.

Effective interpersonal skills are aspects of collaborative and therapeutic practice, require emotional intelligence that can foster the relationships necessary for teamwork, and, as such, are an important skill set for TtR students. The following examples of ineffective interpersonal skills exemplified how TtR students' inability to communicate appropriately and professionally resulted in staff questioning their ability to perform the role of RN safely.

> **Janet:** Does not always communicate in a professional and effective manner. This affects her providing comprehensive, safe [redacted] as when she proceeded without discussion with an RN [redacted].

> **Tracey:** Poor interpersonal skills. [redacted] asked inappropriate questions. Communication is not at third year level.

The inability of TtR students to complete documentation accurately and within a timely manner was another communication issue reported by clinical educators as an indication that TtR students' skill performance was not meeting the required standard. As seen in the following examples, the inability to write accurate, succinct notes that reflect an understanding of patients' conditions and needs was unacceptable and prompted clinical educators to question TtR students' readiness for professional practice.

> **Jo:** Documentation is simplistic and incomplete. [redacted] She will not safely/competently meet professional learning objectives or competencies for a beginning RN…

> **Moni:** Documentation is not meeting 3rd year expectations. [redacted] and does not document until later.

> **Tracey:** Poor documentation skills - does not write succinct, comprehensive notes that address legal parameters. Critical thinking and documentation is lacking [redacted].

Efficiency and time-management are essential skills for managing patient care. Not meeting the required RN workload due to unsatisfactory time-management skills caused clinical educators to report practice performance as not meeting the required standard.

> **Jo:** Poor time management skills – had difficulty in providing safe, holistic care to one allocated patient [expected allocation 4 patients] independently. She is clearly not able to adopt the required RN load She will not safely / competently meet professional learning objectives for [redacted] and Competencies for a beginning RN, i.e. provision of comprehensive holistic care for a full patient load.

> **Jo:** Issues have been raised about student's ability to time manage. She is struggling to take the full workload and despite every effort is still unable to provide coordinated, consistent care for 3 patients.

> **Pete:** Unable to look after the required number of patients [redacted]

> **Stella:** She has continued to struggle with the management of half the required patient load, needing RNs to provide regular prompts for thinking when adjustments are required.

> **Tracey:** Still unable to manage the care of two allocated patients in a holistic, safe manner [redacted].

At this stage of their degree, TtR students needed to demonstrate they could effectively manage patient care. Statements within the case reports showed clinical educators expected TtR students to

meet the full RN workload for the venue in which their placement occurred. This was in accordance with the clinical placement objectives for this nursing topic (Appendix 8).

4.3.3 Unprofessional practice issues

Across all nine cases, descriptors of TtR students' practice performance held within the clinical educators' accounts identified various unprofessional practice issues as the basis of them being assessed as not meeting the required standard. Common, causal factors included:

- does not always recognise professional boundaries towards staff/others;
- does not use reflective practice to identify own professional development needs;
- does not seek clarification from supervising RNs if unsure; and,
- does not consider health and wellbeing in relation to being fit for practice.

Analysis across the cases showed that clinical educators' expectations for this final clinical placement was more than just demonstrating a satisfactory level of knowledge and proficiency of skills. Students were expected to demonstrate that they were capable of exercising professional boundaries towards staff/others to indicate they were ready to enter the profession. Failure to do this, as illustrated in these examples, through behaviours such as eye rolling when given adverse feedback, sighing, or criticising others, indicated to clinical educators that these TtR students did not demonstrate professional practice behaviours.

> **Janet:** Feedback over past few days from [redacted] RNs was that the [redacted] not actively participating in seeking knowledge or experience, [redacted] when asked to attend to a job.

> **Sally:** Last week [redacted] when staff [redacted] questioned her about her patients. She got upset [redacted] when questioned by [redacted] about what she should do for a patient with [redacted]. She could not answer this and as you know, it led to [redacted]. [redacted] She is unprofessional and needs to accept that all of us who have raised concerns about her practice are not wrong.

It is not uncommon for some nursing students to have difficulties establishing relationships to foster their learning with some RNs who supervise them, and it is important that nursing students do not display behaviours and attitudes towards staff that are disrespectful or childish. Clinical coaching often involved the need to educate TtR students that RNs should be shown respect, and that this was different from having to like them as people. It required that TtR students understand the socio-

political culture of the workplace and was an important part of practice during clinical placement because staff were assessing them as future colleagues.

Professional nursing practice requires the ability to continuously self-reflect and identify learning opportunities that develop nursing practice. As the following examples illustrate, clinical educators were expecting TtR students to actively seek feedback and use this to improve their practice and identify learning opportunities and set learning objectives as part of their professional development. Failure to do this caused clinical educators to report this was an indication TtR students' practice performance did not meet the required standard.

> **Janet:** Not utilizing available resources. Poor reflection on ongoing experiences and current level of practice performance. Refused to give her written feedback sheet to me [the facilitator].
>
> **Jo:** Asked student for her learning objectives, but she has said she did not have any formal objectives/goals for placement. She just wants to be finished.
>
> **Tracey:** No feedback sheets obtained - she did not seek any written feedback. Does not act on verbal feedback [acknowledges feedback but does not change practice].
>
> **Tracey:** Did not seek feedback from staff – no feedback sheets completed by staff and did not respond to requests from me [the facilitator] to reflect on and develop her practice.

For clinical educators, the professional responsibility to actively endeavour to develop practice was measured through TtR students' engagement in their own learning. This analysis established that engagement was less likely to occur with TtR students whose practice performance was not meeting the required standard. Having failed clinical placement, one student produced several feedback forms (Appendix 9) to support an appeal on the grounds that none of the written feedback, as assessed by the supervising RNs, had rated her practice performance as unsatisfactory. The appeal was upheld. Further correspondence, however, revealed that this student had not submitted all feedback sheets. Her practice performance had been assessed by several supervising RNs as not demonstrating the competency standards on more than one occasion.

Seeking clarification, guidance and support from supervising RNs when/if unsure is another important requirement for safe, competent professional nursing practice. For these TtR students, who were being assessed against these competency standards, not seeking clarification, as the following examples show, was reported by the clinical educators in relation to the harm or the potential for harm that had resulted for their patients.

> **Jo:** [redacted] There was no checking [redacted] prior to administering this medication and she required prompting to do so. Does not ask questions or seek any help or clarification from staff if/when unsure.

Kim: When asked if she had reported this [redacted] to her RN, she stated that she had not. In fact, she had instead gone onto to do [redacted]. All of this occurred without consultation with supervising RN. She does not seek help or clarification if she is unsure.

Maria: [Maria] did not alert staff; did not report high BP to nursing or medical staff; did not call a MET call, did not seek clarification.

Stella: When communicating with the supervising RN, she needs to ensure she asks when unsure and seeks further clarification for understanding of what is being asked.

The national competency standards (NMBA, 2010), against which these TtR students were being assessed, requires a safe, competent RN to seek clarification when questions, directions, and/or decisions are unclear or not understood. For some of the clinical educators, not seeking clarification when unsure meant these TtR students were acting outside the student scope of practice that caused them to report students' practice performance as unsafe.

The professional standards for nursing practice require RNs to consider their health and wellbeing to ensure they were fit for practice. The SoNM in which this study was situated had a strict 'fitness for practice' policy that stated students were responsible to ensure that they not attend shifts if unwell or not fit to practice. Failure to meet these requirements was found to be met with a degree of empathy and compassion for these students' wellbeing. As seen in these examples, however, this pastoral care was tempered with clinical educators' expectations that, by this placement, TtR students needed to ensure they could focus on their responsibilities and therefore, deliver safe, competent care to their patients.

Jo: [redacted] Currently her practice is sitting at a second-year level at best, so she is definitely not ready to be an RN.

Pete: Feedback from [redacted] RN is that [redacted] but patient safety must come first.

Tracey: [Tracey] was asked if [redacted] She is not safe. Have told her today she needs to withdraw from this placement.

By final clinical placement, it was expected students understood the need to undertake self-assessment to ensure they would meet the expectations relating to being fit for practice. Several students appealed their failure of their TtR placement due to personal circumstances and, consequently, their appeals were upheld on compassionate grounds. Analysis of the academic transcript shows this TtR placement did not display the incomplete grade they were awarded and

was converted when they successfully passed a subsequent TtR placement. The exceptions were Tracey and Jo, who both failed their subsequent TtR placements. Neither student appealed, as the academic coordinator for this second TtR placement incorporated fitness for practice into the requirements in the statement of assessment methods (SAMs).

4.3.4 Summary: First cycle of the Hermeneutic circle

Critical examination of descriptors throughout the case reports and additional documents established all nine TtR students demonstrated practice deficits and behaviours that resulted in their practice performance being assessed as not meeting the required standard. The purpose of assessing the practice performance of TtR students was to ensure they met the mandated beginning-level RN standard. Clinical educators, as the principal assessors, had to make a professional judgement that TtR students had achieved the required standard, because, unlike with previous clinical placements, there is no further opportunity within the degree for students to develop their nursing practice after the TtR placement.

Assessment of TtR students' practice performance was conducted through informal strategies and formal, summative assessment processes that informed clinical educators' judgement of these TtR students' readiness for professional practice. Analysis of clinical educators' reports described TtR students' practice performance that was not meeting the required standard and related to their knowledge deficits, skills deficits, and unprofessional issues and behaviours.

4.4 Second cycle of the Hermeneutic Circle:

The second cycle identifies the criteria that inform clinical educators' judgement of TtR students' practice performance as unsafe and dependent. Having identified how clinical educators assessed TtR students' practice performance as not meeting the required standard because they do not provide safe, competent nursing care at the required professional standard, the implications of that assessment are now presented as the foci of the second cycle of the hermeneutic circle. Assessment of TtR students' practice performance, at the time data was collected, occurred against the 2010 version of the national competency standards for the registered nurse (NMBA, 2010). Assessment of competence at the beginning RN level standard was made more difficult because TtR students could not demonstrate independent, autonomous nursing practice because they must still be directly supervised by the accountable RN.

To gain understanding of the implications for TtR students when clinical educators assessed their practice performance as not meeting the required standard, exploration of additional documents, including professional experience placement records (PEPRs), clinical learning contracts (CLCs),

and formal warnings (FWs), was undertaken. The PEPR report is completed by the clinical educator in consultation with the supervising RNs whose observation of TtR students' practice performance occurs in real time, with real patients within the context of the clinical environment. Exploration of these documents exposed a shift in the ways clinical educators assessed students' practice who were not meeting the required standard. The shift was seen to occur when the identified practice deficits and behaviours of these TtR students could no longer be viewed by the clinical educators as isolated, unrelated issues.

To exemplify how this risk to patient safety contributed to clinical educators' assessing TtR students' practice performance as unsafe and dependent, interpretation of documentation for 'Tracey', who undertook consecutive TtR placements, is presented as an example. Tracey's practice performance, assessed by two clinical educators in different venues, was rated as unsafe and dependent for almost all units when measured against the competency standards (NMBA, 2010) using the Bondy (1983) Scale Rating (BSR). Reports of ongoing practice deficits and behaviours not only indicated the practice performance was unsafe and dependent when rated using measurable criteria, but that in both placements the two clinical educators were identifying and reporting the same practice deficits and behaviours. Table 4.3 below provides exemplars of practice deficits and behaviours as reported by the clinical educators. Reports for the first placement were all received after Tracey was informed by the clinical educator (a seconded staff member) that she should not return to the placement. Reports for the second placement comprised weekly email updates from the university-appointed clinical educator to the academic coordinator. The academic coordinators for each of these two placements removed Tracey for unsafe and dependent practice. Her academic transcript records this fail grade for the second placement.

Table 4.3 Identified practice deficits and behaviours of Tracey's practice

Placement [redacted]	**Placement** [redacted]
Still requiring constant intensive supervision in all aspects of practice. Does not comply with the RN competency standards. Unsafe. Slow, uncoordinated, inefficient, dependent, requiring constant direction and supervision at all times. Is unable to care for patients in a holistic, safe manner. Still not managing to provide comprehensive nursing care for even two patients. Showed no initiative when planning care; did not attempt to problem solve. Task oriented. Involved in several near misses that could have had serious outcomes for vulnerable patients had RNs not intervened. Not following hospital policy when administering medications. Lacks ability to link knowledge to provide safe level of practice. [redacted] No feedback sheets obtained. Does not act on verbal feedback (acknowledges feedback but does not change practice)	Requires constant direction and supervision – at level of a first or second year at best. Unsafe. Practice is very slow and uncoordinated resulting in medications not being administered in the correct time period; poor handover skills; poor documentation skills. Unable to plan care for her allocated patients without input from staff; Task oriented. Involved in several near- miss events - Failed to report a significant change in a patient's health status with consequences resulting for the patient Has a lack of knowledge around medications that had she not been directly supervised could have resulted in potential for harm to her patients due to her pharmacology / pathophysiology knowledge being so poor. Poor [redacted] practices - lacks knowledge about this Did not seek feedback from staff – no feedback sheets completed - and has not responded to verbal requests from me (facilitator) to reflect on and discuss how she can develop her practice.

These identified practice deficits and behaviours, as reported in Table 4.3, provide evidence Tracey's practice performance presented a serious risk of harm to patients. Tracey's professional experience placement record (PEPR) summaries (Appendix 10) confirm this. Further analysis of the BSR for each competency unit, together with the assessor's comments provide evidence that Tracey's practice performance was unsafe and dependent. That judgement was interpreted through valid and reliable assessment strategies using the curriculum-based measurable criteria that supported the professional judgement of these clinical educators who rated her practice performance as unsafe and dependent. Being assessed in any one unit as a BSR 4 meant TtR students did not meet the assessment requirements. In accordance with the topic SAM, they would fail the placement and the topic (Appendix 6).

In an endeavour to establish whether the practice deficits that had been identified in both her TtR placements and reflected in the PEPR summaries were accurate, a further investigation of all Tracey's placement reports was undertaken. The previous third-year semester PEPR showed she had met assessment criteria but had undertaken additional activities to improve her medication

knowledge and was providing patient care ‘under the guidance of the registered nurse.’ These issues, that continued into and throughout her TtR placements, provided insight that has significance to this study, namely, that the assessment of practice performance of TtR students differs from all other placements. Clinical educators in the TtR placement must decide to pass or not pass a student. There is no further opportunity to develop practice, as seen across Tracey’s previous clinical reports that had indicated her practice would improve.

Close analysis of all nine students’ PEPRs revealed the TtR students who were assessed as unsafe and dependent, that is a BSR 4, did not meet the required standard in at least five of the ten competency units. Assessor’s comments on these PEPRs identify the practice deficits and behaviours that match the allocated scores in units for which they had been rated as a BSR 4. In stark contrast, the TtR students who were not reported as unsafe and dependent, were rated as a BSR 4 in only one or two units of the competency standards (NMBA, 2010).

Investigation of the pivotal reason why TtR students were reported as unsafe and dependent was found to be directly related to their involvement in a critical incident or another near-miss event. This finding is significant to the aims of this study. The reports also established that when the clinical educators assessed these TtR students’ practice performances as unsafe and dependent, a judgement of their involvement in critical incidents and its consequences for their patients was reported. Added to this was the students’ involvement in another near-miss event was also included and found to be influential in relation the assessment of the risk of harm. The higher the degree of risk of harm, the more likely a request was made for the students’ immediate removal from the venue, irrespective of how many shifts the student had attended.

Further examination of the ways that unsafe and dependent practice (BSR 4) was measured showed this occurred in accordance with the rating criteria, as was stipulated on the PEPR form (Appendix 5), that clinical educators needed to complete and assess students’ practice against, that included:

- Deficit in knowledge underpinning practice.
- Requires frequent prompting to elicit knowledge.
- Uncoordinated, unconfident and lacks proficiency with skills.
- Professional conduct and caring not consistently demonstrated.
- Frequently demonstrates ineffective interpersonal communication skills.
- Inability to synthesise theory with practice even with frequent prompting and support.

All nine students were assessed as not meeting the required standard for beginning-level RN practice, but not all nine were assessed as unsafe and dependent, in accordance with the above adapted Bondy (1983) criteria. In analysing the clinical documents more deeply, it became evident that students whose practice performance was rated as unsafe and dependent were being described using language that did not always align with the descriptions used as measurable criteria within the PEPR (Appendix 5). What also became evident was that there was application, across the case reports, of an additional sub-set of criteria. Clinical educators, when describing unsafe, dependent practice of these TtR students, reported it in terms of the following additional criteria:

- "Acted outside the student scope of practice and as a result placed patients' safety at risk."
- "Unable to safely meet required workload without close supervision and input by RNs."
- "Not taking responsibility for identified practice deficits and behaviours."

Clinical educators had judged TtR students' practice performance as unsafe and dependent when the practice deficits and behaviours contributed to their involvement in ongoing events that resulted from having acted outside the student scope of practice. Scope of practice in relation to TtR nursing students requires that they abide by professional boundaries that are put in place to keep both them and the patients safe. TtR students must be directly supervised by the RNs when administering any medication, or when undertaking unfamiliar procedures, and all their documentation must be checked and countersigned. As these examples illustrate, clinical educators expected TtR students to seek support from supervising RNs to ensure adequate supervision and patient safety.

> **Janet:** [Janet] gave a [redacted] to patient without consultation or supervision from the RN. Again, practicing outside her scope of practice.
>
> **Moni:** [redacted] Acts outside her scope of practice, she is unsafe.
>
> **Sally:** [Sally] did not check with staff when unfamiliar with a procedure, just did it! [redacted] and she acts outside the students scope of practice.
>
> **Tracey:** [redacted] Acted outside student scope of practice. She is unsafe.

When TtR students exercise clinical skills independently for which direct supervision by RNs is required, clinical educators assessed their practice performance as acting outside the student scope of practice. When this placed their patient's safety at risk, it was reported as unsafe, dependent

practice. All four students' practice performance was rated as BSR–4 for multiple units; most commonly those units aligned with the domain of professional practice.

Another additional criterion of unsafe, dependent practice of TtR students related to the amount of close supervision they required. The continued need for close supervision and input from RNs to ensure patient safety, as illustrated in the following examples, provided a measurable indication of unsafe and dependent practice at this end stage of the degree.

> **Jo [redacted]):** There is no possible way that she could have adopted [redacted] patients on this shift as she requires ongoing close supervision and assistance, at all times. Unsafe and cannot be left unsupervised.
>
> **Kim:** [Kim] did not appear to understand the importance of this and still seemed keen to perform this task, requiring supervising RN again to reiterate that this was not appropriate. The RN feels this student still needed close supervision as she did not understand safe practice measures.
>
> **Moni:** Cannot be left unsupervised [redacted] she is not safe.
>
> **Tracey:** [Tracey] does NOT comply with the competencies and requires constant intensive supervision still in all aspects of her practice and she [redacted]
>
> **Tracey:** Failed to report a significant change in a patient's health status placing the patient at risk. Could not independently comply with the NMBA competencies as she requires constant intensive supervision still in all aspects of her practice. She is at the level of a first or second year at best.

As TtR students approach completion of their final placement, supervising RNs evaluate how much supervision and input is still required as a determinant of readiness for independent, autonomous practice. It is assessed against the competency standards under the domain of provision and coordination of care. When RNs needed to supervise TtR students providing routine nursing care, as seen with several of these students, supervising RNs reported this to clinical educators as the inability of these TtR students to keep the patients safe. As the RNs remain accountable by law for nursing care that students provide to their allocated patients, directly supervising TtR students to ensure patients' safety served as a measurable indication of TtR students' practice performance.

Close scrutiny of these TtR students' PEPRs when their practice was rated as a BSR-4, that is, unsafe and dependent, also showed evidence of descriptors of what were unprofessional behaviours. This was evident when reports of practice performance deficits indicated they did not meet expected elements and cues as described within the units and domains of the national competency standards for RNs (NMBA, 2010). As the following examples illustrate, clinical educators described behaviours, including not taking responsibility for practice deficits, blaming others, and lacking insight into the need to improve their practice as the descriptors of this unprofessional practice.

> **Janet:** Lack of insight into her scope of practice as evident in her inability to articulate sufficient rationale for her actions, her lack of knowledge and the potential danger that her behaviour may cause to the patient. Lacks insights into her own learning needs. Poor reflection on ongoing experiences and current level of practice/performance.
>
> **Jo:** She lacks insight and does not take responsibility. When discussed with her, she said it was because [redacted] By this stage, however, she should not need any direction from the staff, as by now, she should only require clarification.

Students who were not meeting the required standard did not recognise the need to improve their knowledge and the understanding of why it was important to access resources so they could provide safe care.

> **Janet:** Student avoids situations and lacks initiative, missing valuable learning opportunities. She lacks insights into her own learning needs. Poor reflection on ongoing experiences and current level of practice/performance. Not utilizing available resources to the best of her ability. Unsafe. There is a lack of knowledge about the potential danger her behaviour may cause to the patient.
>
> **Jo:** Although she agrees that she is struggling in most areas, she does not appear to acknowledge that this should affect [redacted]. Despite provision of assistance in enhancing her knowledge she appeared continually challenged and overwhelmed. Her practice is not meeting the national competency standards.
>
> **Tracey:** She has not undertaken additional suggested activities to improve her knowledge base and in fact does not recognise that she has a knowledge deficit!

Not taking responsibility for practice deficits by blaming others, or lacking insight into the need to improve their practice performance, was sometimes described as unprofessional behaviour of the "unconsciously incompetent" (Lake & Hamdorf, 2004, p. 327; Peyton, 1998, p. 16) student. Such behaviour places patients' safety at risk and, therefore, does not meet the required standard of safe, competent, quality nursing practice of a beginning-level RN. In assessing this practice performance, a decision must be made about the degree of risk of harm. When this risk was high, clinical educators would request the student be removed from the venue. A lesser risk resulted in clinical educators being more inclined to afford the student mitigation. This key finding goes someway to explaining inconsistencies noted across the cases relating to the use of mitigation strategies to support these TtR students to develop their practice.

4.4.1 Summary: Second cycle of the Hermeneutic Circle

Analysis of case reports and additional documents established clinical educators responded to practice performance of these TtR students not meeting the required beginning-level RN standard in response to students' involvement in events that placed patients at risk of harm. Not providing safe, competent care that had consequences for patients, or even carried a high degree of risk of harm, was instrumental in creating a shift, and clinical educators were seen to then report the practice

performance as unsafe and dependent. Analysis of additional documents established criteria, other than those included on the assessment form, were applied by clinical educators when assessing these TtR students' practice as unsafe and dependent.

All nine TtR students were identified as not being ready for beginning-level RN practice, but not all were identified as unsafe and dependent. Determining that a TtR student was unsafe and dependent often prompted a request for their immediate removal. Contentious issues surrounding assessment of practice performance of TtR students not meeting the required standard contributed to the overturning of the clinical educators' assessment result. This was seen to create a tension between the practice environment and university milieu. The investigation of this tension and findings are presented as the third cycle of the hermeneutic circle.

4.5 Third Cycle of the Hermeneutic Circle

The third and final cycle of the hermeneutic circle exposed a tension between the practice environment and university regarding assessment of TtR students' practice performance, professional judgements, and impact on final outcomes. Additional analysis of documents, including curriculum and clinical documents, was undertaken to identify how and why this tension around assessment outcomes of TtR students' practice performance that did not meet the required standard occurred. Curriculum issues, borderline passes, and differences in the mitigation of these TtR students between key stakeholders, namely, clinical staff, clinical educators, and academic staff, are explored in relation to the tension. Investigation of these issues and the findings are presented.

Clinical educators were found to seek demonstration of a satisfactory knowledge base that incorporated successful integration of learned theory to provide safe, competent nursing care. In exploring the tension surrounding assessment of practice performance, it became evident the clinical educators expected TtR students to begin to make meaning of the practice environment itself as they provide care for multiple patients with the same condition. As seen in these examples, the clinical educators expected TtR students to apply and articulate relevant science-based theory commensurate with readiness for professional practice.

> **Jo:** Very poor knowledge of basic medications. [redacted] and could not explain why the patient may be taking this medication by looking at her PMH [redacted] totally incorrect, all guesswork. [redacted] After [redacted] weeks, there has been no improvement.

Pete: Missed [redacted] not making links I do not feel he is ready to become an RN yet.

Tracey: Poor knowledge base as evidenced by lack of knowledge around medications that had she not been directly supervised could have resulted in potential for harm to her patients.

Exploration of curriculum content showed the students had learnt the content that the clinical educators were seeking. In an endeavour to establish reasons they may not have been applying this learned theory, investigation of the students' academic transcripts was undertaken. Science-based topics (subjects) were degree-specific, and students had undertaken different pathways within the Bachelor of Nursing program, as previously presented in Table 4.1. Recognition of prior learning (RPL) for studies undertaken elsewhere meant several of these students had been granted RPL for anatomy and physiology topics. Grades for students' science-based topics were analyzed for patterns and trends, and the results are presented below in Table 4.4. The table includes each student's overall Grade Point Average (GPA), and their grades for each of the science-based topics they had completed to date.

Table 4.4 GPA and academic results for science-based topics: Cases 1-9

Case	Pseudonym	Overall GPA	Anatomy & Physiology 1	Anatomy & Physiology 2	Foundations of Nursing Knowledge	Microbiology Patho-physiology & Pharmacology	Patho-physiology & Pharmacology 1	Patho-physiology & Pharmacology 2
1	Tracey	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2	Maria	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
3	Jo	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
4	Stella	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
5	Sally	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
6	Janet	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
7	Kim	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
8	Moni	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
9	Pete	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

RPL: Recognition of Prior Learning NPD: Not Part of Degree * Original score & repeated score

Table 4.4 shows that five of nine of these students had not undertaken any Anatomy & Physiology (A&P) topics. Anatomy & Physiology provides fundamental building blocks, upon which the other

science-based learning for pathophysiology, pharmacology, and microbiology are scaffolded. Curriculum programs, approved by the governing body, meant some students received credit for prior learning for A&P 1 and 2, and for Microbiology. The Foundations of Nursing Knowledge topic, that was part of the graduate-entry degree (a two-year rather than three-year degree), is open to students, including overseas students, who have completed a previous university degree in any discipline.

Analysis of the results supports the clinical educators' reported concerns that some students were not demonstrating knowledge of theory essential for providing safe, competent nursing care. Tracey, for example, received low grades for all science-based topics. Numerous examples throughout her reports showed Tracey was not synthesising knowledge with clinical practice. Synthesis is demonstrated when TtR students can critique nursing care using a clinical reasoning approach (Higgs, 2008) that is underpinned by accurate, relevant theory. Several students, including Tracey, were not synthesising theory with practice that was found to be most evident when TtR students provided accurate clinical rationales. Analysis of results in Table 4.4 indicated that TtR students' assessed as not meeting the required standard had not undertaken fundamental science-based topics due to curriculum design, and/or achieved low-grade passes, and this impacted their demonstrating satisfactory knowledge that ensured patients' safety.

Borderline pass grades also contribute to the tension surrounding assessment of the TtR students' practice performance as not meeting the required standard. Table 4.4 shows several of the students received a score of precisely 50% that would indicate they had failed an initial exam and later passed a supplementary assessment. In investigating this further, a connection was found to exist between multiple low scores and the TtR students who were reported as not having demonstrated the ability to synthesise theory with nursing practice, as is required of the beginning-level RN. This brings to the fore the importance of safeguarding curriculum design in nursing education that would ensure that, by their final clinical placement, TtR students have acquired more than just half of what is essential learned theory that underpins the provision of safe, competent nursing care.

Borderline pass grades did not only occur with academic marking. Results for the nine students' formally assessed clinical case conference presentation (CCCP) assessment, as marked by their clinical educator, show [redacted] scored 50% and [redacted], scored 51%. Assessors' comments, as per these examples taken from the marksheet, indicated that neither student was demonstrating the depth of knowledge the clinical educators were seeking.

> [redacted] Poor knowledge base as evidenced by below par CCCP presentation. [redacted] knowledge is not much more than early 2nd year standard at best. [redacted]

[redacted]

[redacted] CCCP presentation quite poor - underperformed. Failed to demonstrate an adequate knowledge base of patient despite prompts. [redacted] not up to standard.

Investigation of the students' CCCP results provided evidence of a wider issue within clinical nursing education around assessment of practice performance of TtR students. The issue of failure to fail has serious implications that seem more alarming when this results in TtR students being awarded a borderline pass. To provide a comparison, review of these students' results for the formally assessed written component of this case study marked by their class tutors, was undertaken. Although [redacted] did not score well in the patho-physiology and pharmacology section, [redacted] did do well in other sections and received an overall score of [redacted]. [redacted] received [redacted] and comments reflect those made by the clinical educator, providing more evidence the CCCP should not have passed. These results illustrate inconsistency and poor application of the marking criteria by some clinical educators. They also indicate a lack of moderation by the university sector in checking clinical educators' assessment was made against the rubric.

Exploration of descriptors of practice performance for some of these TtR students, who were not meeting the required standard, established their practice performance was not that of safe, competent clinical care. As presented in the second cycle, measurable criteria were used to rate TtR students' practice performance as unsafe and dependent. This judgement coincided with determining the degree of risk of harm that led to many of these students being removed. What was also evident was that the greater the risk of harm from unsafe, dependent practice of TtR students, the less likely mitigation approaches and strategies had been implemented. The common response to practice performance of TtR students that did not meet the required standard was to implement mitigating strategies to help them to develop the competence and confidence required for beginning-level RN practice. Table 4.5 presents details of mitigation, including clinical learning contracts (CLCs) and formal warnings (FWs), the outcome of the placement, judgement of the clinical educators, and final academic outcome for each student.

Table 4.5 Mitigation and outcomes: Cases 1-9

Case	Pseudonym	Shifts /35	FW	CLC	Placement Outcome	Clinical Educators' Assessment Result	Academic Outcome
1	Tracey (1)	[redacted]	No	No	Removed	Fail	Not resulted
	Tracey (2)	[redacted]	No	No	Removed	Fail	Fail
2	Maria	[redacted]	Yes	Yes	Failed CLC	Fail	Not resulted
3	Jo (1)	[redacted]	Yes	No	Removed	Fail	WNF
	Jo (2)	[redacted]	Yes	Yes	Failed CLC	Fail	Fail
4	Stella	[redacted]	No	Yes	Failed CLC	Fail	Not resulted
5	Sally	[redacted]	No	No	Removed	Fail	Not resulted
6	Janet	[redacted]	No	Yes	Failed CLC	Fail	Not resulted
7	Kim	[redacted]	Yes	-	WN*	Fail	WNF
8	Moni	[redacted]	No	No	WN*	Fail	WNF
9	Pete	[redacted]	No	No	Removed	Fail	Not resulted

WN*: Student withdrew from placement and the final nursing practice topic prior to census date.
WNF: Withdraw not fail.

As clinical coaching was no longer an option within this SoNM, despite its excellent, proven outcomes, mitigation that consisted of clinical learning contracts (CLCs) was implemented for some students following their involvement in a near-miss event. As reflected in Table 4.5, not one student issued with a CLC successfully redeemed it. This is most unusual. Further analysis shows some CLCs were not redeemed following the students involvement in another near-miss event that prompted the supervising RNs to request their removal, or when they did not meet the specific criteria against which they were evaluated. Failing a CLC, as stated in the Statement of Assessment Methods (SAM) assessment requirements, automatically translated to failing the topic outright.

As Table 4.5 shows, Tracey was not afforded any mitigation strategies for either of her TtR placements. This was because her practice performance was rated as unsafe and dependent following her involvement in a series of near-miss events, and the risk to patient safety was considered too high. For clinical educators to allow unsafe and dependent TtR students to remain on placement could place their own competence as RNs in jeopardy. This need for clinical educators to act as both regulator for the profession, and educators for the university, highlights the complexities

of the role in relation to conducting assessment of practice performance, especially when TtR students' practice does not meet the required standard.

Other results presented in Table 4.5 reveal Moni withdrew herself from the topic, as her removal from the clinical placement occurred prior to the university census date. Kim also withdrew prior to this census date when informed she would be issued with a clinical learning contract (CLC). Whilst this might be a good outcome for a student, it warrants some caution for an accountable profession. Kim's practice deficits, that had placed patient's safety at risk, had resulted in the clinical educator, in consultation with supervising RNs, determining the need to issue a CLC. Clinical learning contracts were recorded on students' records but did not appear on their academic transcript. Auditing of student records provides information that can influence school policy and drive curriculum changes around clinical education. During the coaching period, such information would result in workshops being conducted on site for the RNs to provide them with strategies for supporting and supervising students on CLCs.

Clinical educators only make a judgement that nursing students are demonstrating the required standard of beginning-level RN practice, as is mandated by the profession, in this final clinical placement. A disparity between the practice environment and university milieu surrounding assessment of practice performance was evident when these clinical educators' professional judgements, for the most part, were overturned, as seen in Table 4.5. Analysis of reasons why the clinical educators' assessment results were being overturned found that these were embedded in the socio-political culture of the practice environment. Claims of bullying or racism, cited as grounds for appeals, resulted in placement outcomes for some students, including Jo for her first TtR placement, being changed, as academic staff responded in accordance with equity and natural justice processes.

Overturning of clinical educators' professional judgements is an issue that contributes to the tension between the practice environment and university milieu surrounding assessment of practice performance of these TtR students. Despite evidence from her first TtR placement that her practice performance was unsafe and dependent, as reflected in her PEPR summary (Appendix 10), Tracey's placement outcome was overturned following her appeal because she was not given any feedback from the clinical educator prior to being informed she should not return to the venue, and nor had she been afforded mitigation in line with School policy. The lack of a commonly understood and shared understanding around mitigation amongst clinical educators should have provoked much earlier intervention for this student and others. It became a contentious issue that had an impact on

final outcomes, and, in doing so, contributed to the tension surrounding the clinical educators' assessment of TtR students who were not meeting the required standard.

In stark contrast to the overturned grades resulting from appeals, as seen in Table 4.5, Tracey and Jo had a fail grade recorded on their academic transcript for their second TtR placement. For Jo, as seen in this testimony from a senior RN, not meeting the expected RN workload, a stated objective on her clinical learning contract, was the main reason she did not redeem the contract and, as a direct result, she failed placement.

> **Jo:** [Jo] is struggling taking a full workload of [redacted] patients. She's aware that her time management and prioritising need to improve in order for her to be clinically competent. She is definitely not ready to be an RN.

Tracey did not pass the CCCP assessment. The clinical educator assessed her presentation, according to the marksheet, as meeting the criteria for a fail grade. Tracey was removed for unsafe practice in accordance with the university's work-integrated learning (WIL) policy that was incorporated into the topic assessment requirements. This permitted any student who demonstrated unlawful, unethical, unprofessional or unsafe practice to be removed without warning.

> **Tracey:** Verbal response indicates the patients' safety is at risk. Despite numerous prompts and cues, the student is unable to state [redacted]. She is unsafe.

Pete's report provides insight into the dilemma clinical educators face when deciding to fail a TtR student who is not meeting the required standard, but they do not meet the criteria for either unsafe and dependent, nor safe and satisfactory practice performance. In this example, there was a sense of urgency about him not being ready for professional practice as the end of placement approached.

> **Pete:** He needs to do more placement as [redacted] he "does not feel prepared for registration." He is unable to look after the required number of patients [redacted] and will not be able to achieve this in his remaining [redacted] shifts…

Reports of concerns on day [redacted], regarding Pete's less than satisfactory knowledge base and of him not meeting the RN workload, as seen in this example, show the clinical educator was reluctant to fail this student.

> **Pete:** [redacted], but he is not ready – he is not unsafe though either.

Pete's case shows some TtR students are 'not ready,' but that this is not the same as being unsafe and dependent or unprofessional. The clinical educator did not complete a PEPR because that

required Pete to either be rated as a BSR 3 (safe and satisfactory) or BSR 4 (unsafe and dependent) and the clinical educator believed Pete's practice performance could not be rated accurately using those criteria. In accordance with assessment requirements, the placement outcome was recorded as a fail because he had not successfully completed it. As identification of his practice deficits came too late to afford him any mitigation, this TtR placement outcome was overturned.

Tracey and Pete's cases provide good examples of the tension between the clinical practice environment and the university in relation to assessment of the practice performance of TtR students who were not meeting the required standard. Tracey was unsafe and dependent and, as such, should have failed outright, despite the lack of mitigation, because she was placing patients in harm's way. Pete needed to be provided with mitigation earlier in the placement. The concerns from his clinical educator that his practice performance could not be rated as either safe and satisfactory or unsafe and dependent using the assessment tool, contributed to the tension and, as such, was a critical finding from this third cycle of the hermeneutic circle.

4.5.1 Summary: Third cycle of the Hermeneutic Circle

Critical examination has established students undertaking TtR placements were required to demonstrate a sound knowledge base, effective communication skills, act professionally, and execute clinical and technical skills ensuring the safety of all patients allocated to their care. Curriculum issues, including program content and borderline passes, overturned placement outcomes, and mitigation, were explored and analysed in relation to both the impact on final outcomes for these students and the resultant tension surrounding assessment of practice performance of TtR students not meeting the required standard. Of critical significance was the finding that the assessment tool criteria did not enable accurate assessment of all TtR students' practice performance who were rated as not meeting the required standard.

Analysis of academic transcripts upheld clinical educators' judgement that some students lacked ability to synthesise learned theory of science-based topics and this impacted their ability to articulate accurate rationales for providing safe, competent nursing care. Other curriculum-based issues, including borderline passes that contribute to failure to fail, are equally concerning. Overturned grades, in some cases due to the socio-political culture of the practice environment, left academic staff with little choice but to follow equity and natural justice processes. The lack of a commonly understood and shared understanding amongst clinical educators around mitigation also impacted assessment outcomes. This widened the tension between the practice environment and university milieu as students who were unsafe and dependent as established using the assessment

criteria and, therefore, should have been failed, also had their placement outcomes and results overturned.

4.5.2 Key findings from Study 1

The findings in Study 1 have been presented using three cycles of the hermeneutic circle and provide some insight into how and what clinical educators assess, and subsequently manage, in regard to the practice performance of TtR final placement nursing students. Critical examination of key documentation pertaining to academic and clinical performance history of nine students, identified as not meeting the required standard in this TtR placement, has provided clarification around the phenomenon being investigated.

The first cycle identified the common, causal factors the clinical educators align with practice performance when these TtR students did not provide safe, competent care that demonstrated the requirements of beginning-level RN practice. The second cycle established that there were measurable criteria that were applied by clinical educators in their deliberations that some students' practice performance was unsafe and dependent. The third cycle exposed tensions between the practice environment and university arising from an inconsistency in relation to assessment, management, and mitigation of the TtR students' practice performance.

The key findings established following the analysis and interpretation of documents include:

- Clinical educators based their professional judgement that practice performance of TtR students was not meeting the required standard when students demonstrated the common, causal factors that did not align with descriptors of safe, competent nursing care.
- Clinical educators seek demonstration of a satisfactory knowledge base that incorporates successful integration and synthesis of specific aspects of learned theory to ensure safe, competent nursing care is being provided.
- Assessment of practice performance of TtR students differs from all other placements, as clinical educators must judge that the professional standards have been met and make decisions either to pass or not pass TtR students, knowing there is no further opportunity within the degree programs for practice development.
- TtR students' practice can be distinguished as unsafe practice or as unprofessional practice.
- The most common reason TtR students were reported as unsafe and dependent was found to be directly related to their involvement in a critical incident or another near-miss event.
- Inconsistencies around the implementation of mitigation for TtR students correlated with the degree of risk of harm to patients. If the risk was high, clinical educators requested the student be removed from the venue to ensure patient safety. Lower risk resulted in clinical educators being more inclined to afford the student mitigation.

- The assessment tool for rating TtR students' practice performance does not provide criteria for students who are not ready for professional practice but are not unsafe and dependent.
- Borderline passes were awarded by some clinical educators when marking clinical-based curriculum designed assessments.
- A tension exists between the practice environment and university milieu that impacts final outcomes and sees clinical educators' professional judgements overturned.

4.6 Conclusion

The identified findings from Study 1 have been presented in relation to the purpose of this study and implications for clinical nursing education. The findings go some way towards answering how assessment of practice performance of TtR students informs substantiation of clinical educators' judgement of readiness for professional practice. These findings established the common, causal factors clinical educators identify as an indication of the required standard through provision of proficient and coordinated nursing care that must be underpinned by a satisfactory knowledge base to ensure patients' safety is not being placed at risk by these TtR students who are not meeting the required standard.

Despite exhaustive analysis of the documents that has generated some understanding regarding the phenomenon of clinical assessment of TtR students readiness and competence for practice, the research question has only partially been answered and further investigation is required to meet the aims of this study. Further insight is required from the very people, that is the clinical educators, who make this professional judgment about practice performance of TtR students who are not meeting the required standard. The purpose of Study 2 is to build on the key findings from Study 1, and to gain answers to the following questions, specifically from the clinical educator's perspective:

- How does clinical educators' assessment of TtR students' readiness for professional practice inform identification and distinguishing of the hallmarks of safe, but marginal practice from unsafe and dependent practice when TtR students do not meet the required standard?
- What practice-situated factors impact clinical educators' ability to ensure TtR students have the competence and confidence required in readiness for professional practice?
- What education interventions are needed to ensure clinical educators' judgement of TtR students' practice performance reflects professional and academic assessment expectations and requirements to prevent the awarding of borderline passes?

The next chapter presents the research approach and findings of the ways clinical educators assess, identify, and subsequently judge practice performance of TtR students who are not meeting the required standard. In addition, it will address the principal question of this study, namely, how do clinical educators assess, manage, and mitigate TtR students when clinical practice does not meet

the required standard and development expected in readiness for professional practice, together with meeting the aims of the study that seek to ensure TtR students gain the competence and confidence required for professional practice.

CHAPTER 5 STUDY 2: RESEARCH METHOD AND FINDINGS

5.1 Part A: Introduction to Study 2

This chapter describes the research methods and processes for Study 2. Its goal is to present the findings of an analysis of clinical educators' perceptions and experience of assessment and mitigation processes in relation to three questions emanating from Study 1. To accomplish this, the chapter is divided into two sections. Part A describes, in detail, the research methods used for this second study, including the purpose, the research setting, participant selection criteria, recruitment, and the data generation and analysis processes. The second section, Part B, outlines the research findings based on the semi-structured interviews with 16 experienced clinical educators and their interpretations of a standardised clinical performance assessment case vignette, based on a compilation of elements from the nine cases analysed in Study 1, as reported in the previous chapter.

5.1.1 Purpose of Study 2

The overall purpose of Study 2 was to utilise and build upon the findings from Study 1, with a view to gaining a grounded understanding from those directly involved in conducting the assessment of TtR students' readiness for professional practice, namely, the clinical educators. Study 2 examined experiences and perceptions held by clinical educators of assessment of practice when TtR students' clinical performance did not meet the required standard. It also examined how clinical educators managed and mitigated the limitations of students when practice performance did not meet the required standard. The goal of Study 2 was to gain greater understanding of how clinical educators' judgements of performances of TtR students who failed to meet the required practice standards was shaped by their past experience and their perceptions of how readiness for professional practice is demonstrated. It also aimed to identify the contextual factors that influenced their judgements.

5.1.2 Setting

Study 2 was situated in an Australian university's SoNM program, involving clinical educators of third-year Bachelor of nursing students from both the metropolitan and rural campus. Data was generated from the responses to semi-structured interviews of sixteen participants employed by the SoNM in the role of clinical educator (facilitator).

5.1.3 Recruitment Process

An email invitation to participate, together with the letter of introduction (Appendix 1) and the information sheet (Appendix 2) providing details for Study 2, was emailed out by a third party to

the SoNM's bank of 156 clinical educators (facilitators). Participants were provided with details about how they should contact the researcher if they were willing to be interviewed. Details were provided regarding the expected amount of time required to attend a single semi-structured interview. Participants were required to sign a written consent form (Appendix 3) prior to their interview commencing and were aware they could withdraw their participation at any time without providing a justification of their decision. Confirmation of an agreed time and place was emailed. Most interviews, including those with R&R participants, were conducted on campus in a pre-booked meeting room. Alternative arrangements were made to better suit some participants. Measures were taken to minimise interruptions of the interviews, including signs on doors with mobile phones turned off or silenced.

5.1.4 Participant Criteria

In order to ensure their input would be relevant to the contemporary conditions and not merely speculative comment, criteria were established for participants for Study 2. Participants must have been appointed to the role of clinical educator within the previous three years and were experienced in assessing third-year nursing students' practice performance.

These participation criteria were checked with potential participants following their initial contact. The number of participants was not predetermined but, in order to provide rich data to enable thorough investigation of the issue, the aim was to recruit 10-15 participants (Polit & Beck, 2012) or to stop when saturation is reached, that is, no new information was forthcoming (Fusch & Ness, 2015; Guest et al., 2006). Seventeen participants contacted the researcher agreeing to be interviewed, however, one had to withdraw due to personal circumstances prior to the scheduled interview. A total of sixteen voluntary participants were interviewed.

5.1.5 Data Generation Techniques

Data was collected from semi-structured interviews including the discussion of a case vignette that simulated factors of a TtR student's assessment whose practice might be considered marginal. These two methods were used to facilitate dialogues with participants to elicit their perceptions of assessment issues. The semi-structured questions and the design of the case vignette were derived from the nine cases from Study 1. The dialogue between myself, as the researcher, and the clinical educators helped me to gain rich data pertaining to their perceptions and interpretations of the assessment activities and processes for clinical education for TtR nursing students and meet the aims of this investigation.

5.1.5.1 Semi-structured interview question design

The semi-structured interview questions (Appendix 11) were designed to elicit the clinical educators' perceptions of assessment of practice performance, and of their lived experiences with TtR students whose practice performance they had assessed as not meeting the required standard. Underpinned by research literature regarding clinical education for nursing students, and guided by the professional parameters that govern safe, competent nursing practice, and the findings that emerged in Study 1, questions were grouped by focus. The foci included: background, competence assessment, knowledge assessment, approaches to practice development, scope of practice, and case vignette assessment.

5.1.5.2 Standardised case vignette design

Design of the case vignette incorporated the practice deficits observed and recorded in documentation relating to the TtR students in Study 1 and aligned with contemporary policy and procedure to ensure it was clinically relevant. The case vignette process (Appendix 12) occurred prior to commencement of the interview. It included fifteen minutes for reading the vignette, making notes if they wished to, and seeking further clarification. Details for the practice deficits that were included in the case vignette were purposeful and intentional. They aligned with the criteria that could enable the details to be distinguished as safe, but marginal practice or unsafe, dependent practice performance of TtR students. All participants received this same information. The details included in the case vignette were as follows:

> Mary Cheng is a final semester nursing student. She has commenced the fifth week of her eight-week block placement on a busy surgical ward at a large metropolitan public hospital where you are the clinical (PEP) facilitator/educator.
>
> The CSC who has been on leave for the past two weeks updated you today about your students' progress when you arrived at the venue and tells you that a couple of staff have expressed some concerns to him about Mary. Mary received a credit (72%) for her Clinical Case Conference presentation to you last week and you have been happy with her progress.
>
> Mary is coping with 75% of the RN patient load (she needs to be doing 100% by the completion of this placement). She can be a bit slow at times when she is administering medications and documenting patient care. Last week she had a patient with a low BP (101/48) that she had recorded in the chart, but she failed to report it to the supervising RN. She followed up by taking a repeat BP that was within normal limits. Last evening, she took the right medications but wrong nursing chart to the bedside but on checking the patient's name band realized her error and corrected it. Whilst no adverse outcome resulted from these situations staff have expressed to the CSC today that they do not believe Mary is safe. It seems she is sometimes reluctant to answer some staff's questions about new patients' medical conditions and/or medications. The CSC tells you that given this he cannot see Mary being ready by the end of the final placement, so he thinks it would be best if she was removed now.

After finishing reading the case vignette, the recorded interview was commenced.

5.1.5.3 Design of the assessment rating tool

The case vignette assessment rating tool combined an adapted Bondy (1983) rating scale together with the clinical coaching assessment tool designed and used by the researcher. The assessment rating tool (Appendix 13) was given to the participants toward the end of their interview. They were asked to reread the vignette and to then rate, quantify, and justify their assessment of Mary's practice performance using the assessment tool. As illustrated in Table 5.1 below, each level included a number, rating, and the meaning and descriptors relevant to the level of practice performance for a TtR student.

Table 5.1 Extract: Assessment tool criteria for rating of case vignette

Level	Rating	Specific Criterion Hallmarks (Meaning and Descriptors)
4	**Safe, but Marginal Practice Performance**	**Shows evidence core competence will be developed by completion of placement:** • **Details removed due to copyright restrictions**
5	**Unsafe Practice Performance**	**Dependent & Requires constant verbal and physical prompts and direction:** • **Details removed due to copyright restrictions**

5.1.5.4 Validation of the questions and tools

Two former academic colleagues with expertise in clinical nursing education were asked to review the interview questions, vignette, and assessment rating tool as an initial check and validation process. Their feedback supported the following aims of this aspect of the data generation process and tools, namely:

- the questions should elicit participants' perceptions of facilitating practice performance of TtR students.
- the vignette contained sufficient information for participants to be able to make a judgement.
- when the vignette and assessment tool were compared, there was sufficient information for participants to make it possible to rate Mary's practice performance as a level 4 that is, safe, but marginal.

5.1.6 Pilot study

Following the final ethics approval, a pilot study was conducted. The pilot study participant was a senior RN and clinical educator with over ten years' experience with third year students. She had also been a casual classroom tutor for the third-year nursing practice topic during her time as a clinical educator. The pilot study sought to check clarity of the interview questions, feasibility of the vignette, and the utility of the assessment rating tool. Based on the feedback, some minor adjustments were needed for the vignette. These did not alter the content but ensured it did not contain distractors such as not meeting contemporary documentation requirements and hospital policy and procedures regarding current hospital rapid detection and response (RDR) protocol.

Using the assessment rating tool, the pilot participant worked through the vignette details, rating them against the stipulated, measurable criteria. She concluded that Mary's practice performance was not meeting the required standard, but she was not unsafe and dependent, and met the criteria of safe, but marginal practice. The pilot participant reviewed Study 2 findings to ensure her understanding and meaning had been accurately reflected as intended. Member checking is appropriate for ensuring credibility of a study's findings (Cope, 2014).

5.1.7 Conducting and transcribing interviews

The sixteen interviews were conducted over a ten-week period. The researcher took notes throughout the interview using a digital logbook. This ensured dependability, or reliability, as it is sometimes referred to (Morse, 2015). Participants were free to answer any way they wished, resulting in the generation of thick, rich data (Morse, 2015). All interviews were audio-recorded with timing varying from one hour to one and a half hours. Semi-structured interview questions were asked in the same order, enabling the responses to be systematically coded and numbered (Morse, 2015). As this study sought to elicit the perceptions and interpretations of these clinical educators, interviews took on a conversational style in which participants were encouraged to answer freely and take as much time responding as they wished. Participants were given the option to review the interview transcript, though only one participant requested to do this, and no changes were required.

Participants were provided the opportunity, toward the end of their interview, to add any further comments and to retract any statements about the experiences they had shared. Several made additional comments about their perception of the role and its responsibilities within clinical education of nursing students. One participant asked that a particular experience shared during the interview not be included in the final transcript. The nature of the situation discussed in this

instance was so unique that the clinical educator was concerned the student and clinical venue and, by association, herself may be identifiable. The recounting of this experience, therefore, does not appear in the transcript document. Following completion of all interviews, the verbatim typed transcript was completed and collated. The number of participants was not predetermined, and saturation of data was reached (Fusch & Ness, 2015; Guest et al., 2006), adding further to the reliability of this study (Morse, 2015).

5.1.8 Demographics

Demographic information for each participant was collected prior to the interview using the demographic form (Appendix 14). Interviewees were asked to provide details of their experience undertaking the role of clinical educator (facilitator) that included the number of years of experience, the types of clinical placement venues where they had undertaken the role, casual classroom tutoring experience, and their qualifications. Their experience in teaching in nursing education programs as casual classroom tutors is presented and further categorised to indicate postgraduate and/or undergraduate teaching. The participants' qualifications in higher degrees are presented under one collective heading incorporating PhD, Master of Nursing, or a master's degree in a related field to reduce any risk of them being identified by these higher degree qualifications. The demographic details for each participant are presented below in Table 5.2.

Table 5.2 Demographic information

Table 5.2: Demographic Information																		
Pseudonym	**Facilitation Experience**					**Casual Tertiary Tutor Experience U - Under graduate; P - Post graduate; O - Other**					**Qualifications**							
	Years	Acute Care - Public	Acute Care - Private	Rural and / or Remote	Aged Care and or Community	Level	1 - 3 years	4 - 6 years	7 - 10 years	11- 15 years	RN	PhD; Master of Nursing or related field	Bachelor of Nursing / Health Science	Bachelor of Education Other	Diploma of Applied Science	Graduate Diploma - Nursing	Graduate Certificate - Nursing	Cert IV
Ann	10	X	X			P	X				X	X						
Betty	3	X				U	X				X		X					X
Chris	10	X				U; P			X		X	X	X			X		
Deb	9		X			U				X	X	X	X		X		X	
Eric	1	X			X	O		X			X		X	X		X		
Grace	16	X	X			U			X		X	X	X				X	
Heidi	10	X	X	X		U		X			X		X				X	
Jayne	6	X	X		X	U		X			X		X					
Kitty	5	X	X			U		X			X	X	X				X	
Lucille	2	X				U	X				X		X				X	
Marilyn	10.5	X			X	U	X				X	X			X			
Pauline	12	X				U				X	X	X	X				X	
Robbie	5	X		X		U; P	X				X		X	X				
Terri	1			X							X		X					
Viola	12	X				U; P			X		X	X	X				X	X
Wilma	3	X				P	X				X		X				X	

The number of years undertaking the clinical educator role ranged from one to sixteen with a mean of seven years. Terri and Eric had not undertaken any additional tutoring, but Eric had a background in education having been a teacher for many years overseas.

5.1.9 Data Analysis

To gain deeper understanding by exploring the nature of human understanding through the history and culture and the perceptions that shape those involved (Crotty, 2003; Gadamer, 1989; Polit & Beck, 2012), interviews of the sixteen clinical educators were undertaken and transcribed verbatim. Analysis commenced with collating of the sixteen clinical educators' responses to each of the interview questions. Analysis of the transcript sought to capture common meaning (Ho et al., 2017; Van Manen, 1997) of the clinical educators' experiences, perceptions and insightful responses to the interview questions, and their interpretation and appraisal of the standardised case vignette. Thematic analysis, from which the structure and explanation of the whole data set was derived (Braun & Clarke, 2006), suits interpretive phenomenology (Van Manen, 2014). This process was undertaken manually and checked against the notations made in the reflexive journal during the interview process.

Reflexivity throughout the process of analysis was informed by my own experience and understanding of the assessment of clinical practice performance of TtR students gained through the various roles I had held as Clinical Coach, clinical educator and topic coordinator of the final nursing practice topic. In keeping with Gadamer's philosophical hermeneutics in which the parts can only be understood in relation to the whole (Liu & Sui, 2014), an analysis of the full and entire verbatim transcript was undertaken. Using an inductive approach (Burnard et al., 2008; Braun & Clarke, 2006) required every interview question to be analysed in relation to the whole transcript in order to capture the common themes (Braun & Clarke, 2006; Vaismoradi et al., 2013). In seeking to answer how clinical educators assess, manage, and mitigate (TtR) students not meeting the required standard and the expected development of their practice as indicative of readiness for professional practice, thematic analysis provided a flexible approach to facilitate extrication of this from within the data (Braun & Clarke).

Themes and sub-themes arising from focussed thematic analysis (Braun & Clarke, 2006) of clinical educators' experiences, perceptions, and interpretations, were used to generate insight into how clinical educators assess, manage, and mitigate TtR students' practice performance. Informed by their past experiences as assessors of TtR students, and their interpretations of the case vignette, thematic analysis was guided by the three unanswered questions emanating from Study 1:

- How does clinical educators' assessment of TtR students' readiness for professional practice inform identification and distinguishing of the hallmarks of safe, but marginal practice from unsafe and dependent practice when TtR students do not meet the required standard?
- What practice-situated factors impact clinical educators' ability to ensure TtR students have the competence and confidence required in readiness for professional practice?
- What education interventions are needed to ensure clinical educators' judgement of TtR students' practice performance reflects professional and academic assessment expectations and requirements to prevent the awarding of borderline passes?

From this focussed analysis, the themes and associated sub-themes that represent a patterned response or meaning (Braun & Clarke, 2006; Vaismoradi et al., 2013), relevant to the research question and study aims, emerged. Each theme has two associated sub-themes, as presented below in Table 5.3. The phrases or terms used by clinical educators in their responses that captured the essence of the theme and associated sub-themes became the single quoted heading included in Table 5.3. The table also provides a brief synopsis of what each theme or sub-theme represents of the analysed data.

Table 5.3 Guiding question; Theme and sub-themes

Question	Theme	Sub-themes
How does clinical educators' assessment of TtR students' readiness for professional practice inform identification and distinguishing of the hallmarks of safe, but marginal practice from unsafe and dependent practice when TtR students do not meet the required standard?	**'What do we mean by ready'** This theme explains how clinical educators identify and distinguish TtR students' practice performance that is not meeting the required standard.	**'Are you a safe practitioner?'** This sub-theme explains how readiness for professional practice is informed and judged by clinical educators' comparison against benchmark measures of safe, quality, competent nursing practice **'Not ready, not unsafe either'** This sub-theme explains the hallmarks of practice the clinical educators identify that distinguish safe, but marginal practice of TtR students from unsafe and dependent practice.
What practice-situated factors impact clinical educators' ability to ensure TtR students will have the competence and confidence required in readiness for professional practice?	**'Just because we can do it with our eyes closed, the students still need to gain their confidence'** This theme explains strategies and approaches clinical educators implement to ensure TtR students will have the confidence and competence for professional practice.	**'Last placement, last safety net'** This sub-theme explains the shared understanding and common approach to strategies for the management and mitigation of TtR students to ensure practice development to the required standard. **'Where is the RN in all of this?'** This sub-theme explains practice-situated factors impeding clinical educators' management and mitigation of TtR students' progress toward the required standard.
What education interventions are needed to ensure clinical educators' judgement of TtR students' practice performance reflects professional and academic assessment expectations and requirements to prevent the awarding of borderline passes?	**'When they start to become independent and show they're comfortable in the role of the RN, I'm happy they are competent and ready to work alongside me.'** This theme explains broader education issues relating to clinical educators' assessment of TtR students' practice that is not meeting the required standard and how this informs their judgement of readiness for professional practice.	**'Simply being a registered nurse does not make you a facilitator, simply being a registered nurse does not make you an educator'** This sub-theme explains the necessary skills of their multi-faceted role enabling clinical educators to assess, manage and mitigate TtR students' practice that was not meeting the required standard. **'Facilitation is so variable and it's so subjective and some facilitators are just not invested in the whole process.'** This sub-theme explains assessment tools and curriculum issues that shape assessment of TtR students' readiness for professional practice in an accountable profession.

Exploration of the themes and sub-themes, together with substantiating evidence of numerous examples from the verbatim response, hereafter referred to as excerpts, provide illustration of how the clinical educators assessed, managed, and mitigated the practice performance of TtR students that was not meeting the required standard. In keeping with Gadamer's (1989) philosophical hermeneutics, the fusion of horizons that points toward something more (Vessey, 2009) informed analysis of the transcript and focussed understanding of the phenomenon as an event, and not just as an objective interpretation (Cuff, 2019). This analysis revealed several key findings in relation to the principal question and aims that are now presented in Part B.

5.2 Part B: Introduction to Study 2 findings

This section presents findings of this hermeneutic study investigating the perceptions and meaning that clinical educators hold regarding assessment of practice performance of TtR nursing students to make judgement that their practice meets or does not meet the required standard of beginning-level RN practice. Study 1 findings established that clinical educators recognise TtR students as not meeting the required standard when they demonstrate common, casual factors that are not commensurate with safe, proficient, and coordinated nursing care, and do not apply a satisfactory knowledge base that aligns with patient safety. As principal assessor, and as RNs themselves, clinical educators must make a judgement that TtR students are meeting the mandated requirements indicating readiness for professional practice. To gain understanding of clinical educators' assessment practices and management and mitigation of TtR students' practice not meeting the required standard, an analysis was conducted of the collected date that included: details of their own experiences as assessors with former TtR students who were not meeting the required standard; their responses to the interview questions; and, their interpretation, assessment, and rating of the case vignette.

As a result of this investigation, emerging themes and sub-themes, as detailed above, are now presented together with numerous excerpts from the data. This provides evidence of how the thematic analysis and resultant findings relate to the principal questions and aims of this study.

5.2.1 "What do we mean by ready?"

This theme explains how clinical educators identify and distinguish TtR students' practice performance that is not meeting the required standard. Clinical educators' judgement of readiness for professional practice, was found to be informed and influenced by TtR students' ability to apply contextual-based learning to their clinical practice, against benchmark measures. Not all TtR students whose practice does not meet the required standard, meet the criteria of unsafe and dependent practice. This theme explores specific hallmarks of safe, but marginal practice of TtR students, together with key findings of how these might be distinguished from unsafe and dependent practice.

5.2.1.1 "Are you a safe practitioner?"

This sub-theme explains how readiness for professional practice is informed and judged by clinical educators' comparisons against benchmark measures of what constitutes safe, quality, competent nursing practice. Recent changes in language describing nursing practice as used in the professional standards (Appendix 7) resulted in the introduction of the word 'quality', alongside the more

familiar terms of ‘safe’ and ‘competent’. Clinical educators’ understanding, that informs their judgement of TtR students’ readiness for professional practice was found to be embedded in a wisdom of practice (Shulman, 1987) and tacit knowledge (Benner, 1984) derived from their experience that includes knowledge of performing the role of registered nurse. Clinical educators’ assessment of TtR students’ practice as meeting, or not meeting, the required standard, occurred through comparison against expected benchmark measures of the ways safe, quality, competent nursing practice is exhibited as illustrated in these excerpts.

> **Ann:** Final semester students need to be safe, to be competent. Competence is safe patient care. They must focus on the delivery of high-quality patient care.

> **Heidi:** So, it comes down to are you a safe practitioner, are you a safe professional nurse. It’s about working within your scope of practice, being able to work at the level of a third-year novice RN when nearly a graduate.

Their judgements of the provision of safe, quality, competent nursing care also required application of a satisfactory knowledge base that was inherent in TtR students’ ability to perform the role, explain rationales that align theory with practice, and reflect and critique their practice to identify any gaps in their knowledge or practice.

> **Betty:** I weigh up their ability to perform whatever task or particular skill that I’m looking at, their ability to explain the rationales behind those actions and also to be able to align the theory with the practice, and reflect and critique their own performance and identify gaps in their own knowledge and practice.

> **Deb:** That they are safe, that they have the appropriate and relevant knowledge, they're able to link their knowledge with their skill and they're able to prioritise patient's needs. As a final placement student, they need to be at the point where they are ready to become a competent graduate nurse by providing quality care.

> **Eric:** If they’re able to establish the links–all this knowledge is very important to me. We discuss all these issues about this patient, and they present how they’re going to look after this case, this patient, considering all these conditions, everything, then you know it’s a good knowledge base.

Assessment of knowledge was found to occur through TtR students’ application, and articulation, of contextual-based theory to practice. Clinical educators employed informal assessment measures that included regular questioning with the purpose of assessing knowledge.

> **Deb:** I would be questioning to assess their knowledge, looking at how they're linking concepts together and how they're prioritising things.

> **Eric:** I start from the basic, discuss common chronic conditions, type 2 diabetes, heart failure and everything and then I throw in the questions, from simple to complex ideas.

> **Pauline:** I ask open questions and just probe a little bit more. After a while you just seem to know whether they know what they're talking about. The more information they tell me and how well

> they can make the connections, it's like reading an assignment that with experience you think, yep, this paper is a pass.

Another purposeful and informal assessment strategy, employed by the clinical educators to assess TtR students' level of knowledge, included their application of a clinical reasoning approach during clinical handover.

> **Grace:** I want the rationale. You need to tell me why. Know you're doing something not because someone said go do this, but because you think about why you're doing it. You're understanding what needs to be done and doing the whole clinical reasoning process. Knowing that and being able to articulate it, well, then you are ready.

> **Kitty:** Can they clinically reason, provide a rationale for what they are doing. It's what I look most at for final semester students who are soon going to be registered nurses.

> **Wilma:** They begin to apply clinical reasoning and justify why they are doing the nursing actions that they're doing during their handovers.

Clinical educators reported that their assessment of knowledge required TtR students' application of a depth of understanding that is evident in their contextual-based learning being integrated with patient care. This evidence, they argued, translates to the provision of safe, quality, competent nursing care. In keeping with the Study 1 findings, clinical educators observed TtR students applying and articulating specific aspects of contextual-based learning, including anatomy and physiology, patho-physiology, and pharmacology when discussing their patients.

> **Eric:** When they are able to establish the links, between pathophysiology and, lung failure, heart failure. Their ability to analyse, synthesis and put it all together…

> **Heidi:** Being able to integrate and meaningful way the science of the body so telling me what a SaO2 [saturation] of 88% means and then being able to apply it. It is the pathophysiology and pharmacology and the body systems….

> **Jayne:** The most important things at this stage are pathophysiology and medications because you can't assess patients without these, as these are the cornerstones of being an RN. You must know how the body works and you can't problem solve if you haven't got that knowledge.

> **Kitty:** What I look most at for final semester students who are soon going to be registered nurses is if they have got good anatomy and physiology, pathophysiology, pharmacology knowledge and they can voice that to me.

Clinical educators reported seeking other additional aspects of contextual-based learning, namely, law and ethics, as indicators that safe, quality, competent nursing practice, in line with the benchmark measures of the required standard, were being exhibited.

> **Betty:** The legal and ethical aspects are also very important because I have quite a concern if people don't have a good understanding of ethical practice.

Deb: You need the legal understanding as patients are our legal responsibility…

Jayne: I am really into the legal side of things, so the law (of nursing), they must know this and know how it applies in practice.

Clinical educators reported another indication of readiness for professional practice was having more than a basic level of knowledge, because safe, quality, competent practice also requires critical thinking. This was indicated when TtR students demonstrated understanding of not just what they were doing, but, more importantly, could justify why it was required.

Robbie: Being ready is that critical thinking, so not just doing something because you are told to. Its analysis of what could go wrong; what are the nursing implications; what are the potential complications? That is safe practice.

Terri: Focus on critical thinking. We want them to be knowledgeable and approach all of the tasks with a critical thinking approach. What else could I be doing, people who are doing those things are definitely ready and likely to be excellent nurses.

Clinical educators felt assured that TtR students were ready for beginning-level RN practice when they demonstrated the ability to seek out relevant information for their patient care. This demonstrated a required capacity of the profession's benchmark measure of applying an evidence-based framework to clinical practice.

Eric: That spirit of enquiry, I encourage their sourcing out the literature and self–learning and when they apply evidence–based practice it stands out. Their ability to analyse, synthesis and put it all together and discuss all the issues about this patient. It's not separated conditions. And tailoring good nursing practice and the nursing plan. If they do this, this is evidence-based practice, they're good, they are ready.

Clinical educators' assessment of TtR students' readiness for professional practice sought evidence that students could synthesise knowledge to integrate it with practice, that is, apply theory-in-action. As illustrated in the following excerpts, when TtR students responded appropriately to a deteriorating patient, worked within their scope of practice, and reflected on and critiqued their clinical nursing practice through critical reflection, clinical educators could judge their knowledge was at the level required for beginning-level RN practice.

Chris: I want them to be able to recognise a deteriorating patient and know what to do about that. I need them to be able to reflect upon their practice, what they did very well and what they could improve upon. I need them to know what their scope of practice is and when they step out of that, and what are the ramifications for that. I want them to remember to treat their patients as human beings. Then they are ready.

Jayne: I've had several students identify where practice could be improved and in one case, a student changed a policy/procedure. The students who can synthesise, who are enthusiastic, who engage with their patients, who are always looking for more goals to reach, looking to learn something new, always researching. They are the students that you want to work with, you just think I would love to work beside you. On all levels you are what we want in an RN.

> **Wilma:** They are able to assess and determine a deteriorating patient and feedback to the appropriate people what's happening. They are able to show clinical reasoning and justify why they are doing the nursing actions that they're doing.

Review

The key finding to emerge from this sub-theme established that clinical educators' interpretation of TtR students' readiness for professional practice was embedded in, and guided by, their professional understanding, as experienced RNs, of the ways that safe, quality, competent nursing care is exhibited. Their judgement of readiness for professional practice was assessed through application and articulation of explicit areas of contextual-based learning, namely, anatomy and physiology, patho-physiology, pharmacology, and law and ethics, that underpin the provision of safe, quality, competent nursing care. Clinical educators employed informal assessment strategies that included questioning with purpose and clinical handover to appraise TtR students' knowledge about their patients. The ability to synthesise and analyse assured clinical educators that TtR students would respond appropriately to a deteriorating patient, work within their scope of practice, and reflect and critique their nursing practice. These indicators informed clinical educators' judgement that TtR students meet the profession's benchmark measures at the required beginning-level RN standard and students are, therefore, ready for professional practice.

Of greater significance to this study, however, is the analysis of how the clinical educators identified some TtR students' practice was not meeting the required standard of practice. This is now presented as the next sub-theme.

5.2.1.2 "Not ready, not unsafe either"

This sub-theme explains the hallmarks of how practiced clinical educators distinguish safe, but marginal practice from unsafe and dependent practice. Clinical educators seek application and articulation of conceptual-based learning that underpins provision of care, demonstration of proficiency with clinical and technical skills, and appropriate professional behaviours and attitudes. For some TtR students, one or all of these requirements will not be demonstrated. Clinical educators must then make a professional judgement if the TtR student will be able to meet the required standard by completion of their degree. How they assessed when the standard was not being met was influenced, as illustrated below, by factors that included poor time management, ineffective communication skills, not making connections, or lacking ability to justify and provide sound clinical rationales. These factors indicated to clinical educators that TtR students' practice was not meeting the required standard.

> **Deb:** He just rang alarm bells from the beginning basically. His time management was poor. If they can't manage their time looking after four or five patients, they're not going to be able to function as a graduate.
>
> **Eric:** I had a student who didn't know what electrolytes are. A third-year student. I was like, are you serious? It was a very good indicator of a knowledge problem.
>
> **Grace:** When your gut tells you that they're not safe because you've seen where they miss those cues and they actually make no connection whatsoever, even with prompts.
>
> **Lucille:** If they can't justify and provide clinical rationales for what they're doing and explain and provide evidence on what their interventions are, then that is a problem.

Deeper exploration of the clinical educators' interpretations of the case vignette, as befits Gadamer's (1989) philosophical hermeneutics, uncovered that, in their sharing of past experiences with TtR students whose practice did not meet the required standard, a common understanding existed amongst clinical educators regarding what constitutes unsafe, dependent practice of TtR students. Clinical educators were unified in their individual deliberations, that at this late stage of the degree, TtR students whose practice meets the criteria of unsafe and dependent practice should be removed from placement to reduce the potential risk of harm to patient safety.

> **Chris:** … the male student needed to be removed from placement because he was a risk to patients. He was just unsafe and dangerous...
>
> **Grace:** I've had [TtR] students removed from the ward for being unsafe. They were not able to explain or understand what they had done was dangerous, a risk to themselves and the patient... They didn't understand the concepts of legality, scope of practice, ethics, the broader supposedly non-clinical skills which we know are part and parcel of everyday work, but they couldn't see it. They could not understand that what they had done was wrong.

Clinical educators weighed up if TtR students had insight into the risk of harm their unsafe practice presents to patient safety when making their decision about whether TtR students' practice was unsafe and dependent.

> **Betty:** I have found with students whose performance is unsafe that they have a lack of ability to identify gaps in their knowledge and insight into their practice and it wouldn't matter how many weeks you gave them, that's still there.
>
> **Grace:** It's when alarm bells start ringing - when they cannot articulate even some of the most basic stuff. And even the reflections are not insightful. They're the ones who will do danger to themselves, to their patient.
>
> **Marilyn:** Some have done well in their theory at the uni but in that hot learning environment, lots of communication, lots of staff in different situations, they miss vital cues and that becomes potentially dangerous especially for the patient.

Clinical educators recognised that TtR students' practice that was not meeting the required standard did not always pose this risk of harm. They acknowledged that less than satisfactory practice arising from unprofessional behaviours and attitudes was difficult to fail.

> **Robbie:** Often it's the professional behaviour ones that are harder to fail because they have the knowledge and will have passed all their theoretical topics, so it's an arrogance or something else but they are the ones I am more scared about being nurses because they will be the ones that will be unethical or do something dodgy.

> **Grace:** He knew exactly what answers to give, but it was those non-verbal things, the eye rolling. All of his professional demeanour, all of that kind of behaviour he was not competent in. He ended up being put on a contract and for that period of that contract he did what he needed to do to pass. It kind of weighed down on me.

Other indications of unprofessional behaviours and attitudes were evident in TtR students' practice when they failed to take responsibility for their practice deficits and resorted to swearing or begging clinical educators when informed of staff concerns. One clinical educator was accused of bullying for asking too many questions.

> **Betty**: When some staff came and spoke to me and said about the way that she spoke to not only patients and families but medical staff, and I spoke to her, she actually swore at me. I really didn't know how to manage that because in a million years I would never think of swearing at somebody that was assessing me.

> **Deb:** I had one student saying that I was bullying her because I was asking her too many questions. Australian student, not school leaver, not mature age and very, very difficult to deal with actually. I would be asking her questions about her patient, and she would start singing "under pressure" and just walk away and roll her eyes. She was a very, very difficult student to deal with.

> **Kitty:** The end result was he actually got quite angry with me and said I'm paying you, and you have to pass me, and so it wasn't a very nice situation at all.

> **Pauline:** They're not saying they disagree with the fact that they're not competent, what they're saying is because I'm failing them their family will do this or they will have to pay another $16,000. I remember one student that was begging on the floor.

At the same time, clinical educators recognised that TtR students' practice performance could sometimes be unfairly labelled as unsafe, as this can result in the student being removed.

> **Chris:** It seems a bit lop-sided with the CSC just wanting her to be removed straight away from placement…

> **Robbie:** I find it really upsetting when staff says that a student is not safe. I don't think they realise how big a word that is when we are talking about students because it's just such an issue with students getting taken immediately out of placement when they are unsafe. They [staff] need to be really careful about that because you wouldn't say it about a fellow nurse without having a very good reason.

> **Viola:** A few staff have expressed concern, but I have not been informed of that. I think it is unfair for the student for them to come and say we are failing her. The CSC has been on leave and so no-one else has taken it up until now.

Clinical educators recognised that sometimes TtR students' practice was 'not ready, but not unsafe either.' This contrasting description of being 'not ready', as opposed to being 'unsafe', is most significant to the context of this study.

> **Kitty:** You expect them to meet the competencies within the timeframe so if they weren't meeting it then, were they ready or did they need more time or another placement? With things like they are now though, we find it so hard to leave them on placements or get placements.
>
> **Terri:** I mean students are not always ready by the end of their final placement, but it doesn't mean that they don't get there because what do they mean by ready, as fast as a practising Registered Nurse, but they are not like that so it bears a bit of discussion.
>
> **Viola:** They are not ready, not safe either.

The dilemma for clinical educators was when TtR students' practice could not be assessed as not meeting the safe and satisfactory standard, but it was not unsafe or unprofessional either. In their deliberations about the case vignette, several clinical educators identified the aspects of Mary's practice performance that showed that it was not meeting unsafe and dependent practice criteria.

> **Betty:** The staff are saying that they don't feel that she's safe, but I can't see anything here that is really jumping out at me as being unsafe. She's got the ability to align what she's seeing in the clinical setting with theory, so there's nothing alarming.
>
> **Eric:** She's speaking up on her findings and stuff like that, so she is not unsafe. It's easy to label them I think there's a bit of a mismatch in the lexicon to be honest. What do we mean by unsafe? You know it's like if they draw up medication and go and give it without any supervision, then that's unsafe. Absolutely unsafe. But, you know, in this case she's not a candidate to be pulled out from placement. It would be unfair.
>
> **Grace:** Whilst the CSC believes she's not safe I actually disagree. I think that she's safe but she's actually not necessarily up to standard either. If they're the only examples that he (the CSC) can give then I can come back and actually go, well, no, these are examples that she's actually got the linkage because for her to be unsafe in those two examples would be she didn't do a patient check and didn't pick it up and gave the medication and that she just wrote down and documented the blood pressure and did nothing about it.
>
> **Pauline:** She's not unsafe but she's definitely not there either.

Analysis of clinical educators' initial assessment, undertaken early in the interview process, showed a lack of uniformity and an indecisiveness across their decision-making. Currently, safe, but marginal practice of TtR students sits outside the processes of assessment. The assessment tool (Appendix 13), used for rating Mary's practice performance in the case vignette, enabled the clinical educators to consider these specific criteria that, in turn, enabled them to assess and rate her

practice as safe, but marginal. The change in clinical educators' assessment of Mary's practice demonstrated conclusively that when provided with the additional set of criteria describing safe, but marginal practice of TtR students, clinical educators would rate practice in these terms. The tool enabled a decisiveness within their judgement that was previously not evident, and all clinical educators were now in agreement.

Table 5.4 below provides each clinical educators' initial assessment to question 4 (Appendix 11) that is presented as a phrase, together with their reviewed rating when using the assessment tool (Appendix 13) for question 28. Several clinical educators, as evidenced below, changed their initial judgement and a consensus was reached using the assessment tool that Mary's practice performance was safe, but marginal.

Table 5.4 Clinical educators' assessment of Mary's practice performance

Clinical Educator	Initial assessment (Question 4)	Final judgement (Question 28)
Ann	Not unsafe, needs mitigation	Safe, but marginal
Betty	Not unsafe, needs mitigation	Safe, but marginal
Chris	Marginal and needs strategies	Safe, but marginal
Deb	Needs to be assessed - ? unsafe	Safe, but marginal
Eric	Needs to improve to pass	Safe, but marginal
Grace	Safe, but not up to standard	Safe, but marginal
Heidi	Needs to be assessed	Safe, but marginal
Jayne	Borderline – needs assessment	Safe, but marginal
Kitty	Needs to be assessed - ? unsafe	Safe, but marginal
Lucille	Needs mitigation	Safe, but marginal
Marilyn	Staff say unsafe, so will need to be removed?	Safe, but marginal
Pauline	Not unsafe, but definitely not there either	Safe, but marginal
Robbie	No major issues, needs mitigation	Safe, but marginal
Terri	Needs mitigation	Safe, but marginal
Viola	? Unsafe – as is not ready	Safe, but marginal
Wilma	Needs mitigation	Safe, but marginal

In addition to the criteria in the assessment tool, clinical educators identified other hallmarks of how safe, but marginal practice of TtR students is exhibited that differentiate it from unsafe, dependent practice. These additional hallmarks include that TtR students:

- do not act outside the student scope of practice;
- self-correct without intervention or prompts from staff;
- may be slow where caution is required with some clinical skills;
- keep the patient safe even when unsure about what to do next;
- demonstrate insight into their practice deficits; and
- want to improve and are willing to develop and improve practice deficits.

Illustrations of these additional hallmarks, as identified by the clinical educators, are now provided. Safe, but marginal practice of TtR students could be distinguished from unsafe and dependent practice, because these students do not act outside the student scope of practice.

> **Betty:** I wouldn't say that anything that she has done here is a critical incident. She has not acted outside her scope of practice. Actually, scope of practice to me is a big red light…

> **Chris:** She's safe, knowledgeable, working within the scope of practice. At no time has she stepped out of that. She self-corrected. She's marginal and needs strategies.

Clinical educators acknowledged Mary made errors, but she self-corrected. Self-correction meant staff intervention or prompts were not required to avoid the risk of harm to patients.

> **Betty:** She took the right medications but the wrong nursing chart to the bedside. Okay, that's a concern but she went through the process and she realised that she'd made an error and she corrected it and surely, we should be acknowledging that as adhering to quality nursing practice.

> **Jayne:** She followed up the BP, she could have reported it, but she did do what an RN should do and that is part of the RDR chart policy criteria. So, you are meant to go back 30 mins later and recheck it and if there is still a problem you might want to do something about it.

Safe, but marginal practice of TtR students could be further distinguished from unsafe and dependent practice, because these students keep their patients safe even when they are unsure about what to do next. Being able to distinguish hallmarks between safe, but marginal practice and unsafe and dependent practice was important to these clinical educators.

> **Kitty:** Ultimately, Mary is showing that she is keeping the patients safe. She followed up the low BP in accordance with protocol. An unsafe student is going to take those observations and not let anyone know the patient is unconscious in bed. A marginal student at the start of the shift doesn't know what the conditions are, what the medications are, but throughout the shift is safe and looks up what they don't know.

> **Viola:** If their marginal they know what to do which makes them safe. Mary followed the chart and repeated the BP. If they are not going to go and get someone, or don't know when to do that, then that makes them unsafe.

> **Wilma:** She did the blood pressure; it was low but then she went back and checked it again and then it was back to normal limits. So, she had a rationale behind that one. I determine they're safe if they've got clinical reasoning skills, they're able to think about the patient and think about

> whether they're deteriorating or not deteriorating. If they are unable to do that that's when they're unsafe.

Clinical educators also reported that safe, but marginal practice could be distinguished from unsafe and dependent practice when the slowness with particular clinical or technical skills, including administration of medications and documentation, was due to exercising a degree of caution in order to ensure the patient's safety.

> **Betty:** She's slow when administering medications and documenting her patient care, but is her documentation poor? Is it slow and poor or slow, quality documentation? Is that slow as judged by a 30-year experienced RN, or is it slow for a third year?
>
> **Eric:** She can be slow at times. So, administering medication and documentation. I'm always thorough too, you need to make sure because we're giving substances and it can be fatal error, so her being slow with these, no, that's not an issue for me at all.
>
> **Lucille:** They've said she's slow at administering medications and documenting her care, but they are not saying she's doing it inaccurately. Obviously in this case she double checked the patient's details, and she was following her rights of medication administration which is how she determined that she had the wrong chart.

Safe, but marginal practice of TtR students could be distinguished from unsafe, dependent practice because these students demonstrated insight and self-awareness of practice deficits. This distinction meant TtR students were consciously aware of their practice limitations and, as seen in these excerpts, ensured the clinical educators that they would keep patients safe.

> **Betty:** Safe but marginal to me would be that they knew what they didn't know, so that maybe they weren't 100% confident why a certain medication needed to be given or they maybe didn't fully understand why in certain medical conditions the vital signs might be such, but they did understand what they needed to do in that situation and they could keep the patient safe.
>
> **Grace:** The fact is to be safe you have to have insight into your own scope of practice and your own limitations. If you don't that's when you can go over your boundaries and you become unsafe.
>
> **Robbie:** To me it is all about their insight. If they recognise, they have a knowledge deficit and are struggling then I would say they are safe but marginal. It's the ones that think they know everything and keep going despite their lack of knowledge I worry about because they are unsafe.

Safe, but marginal practice performance of TtR students was further differentiated from unsafe, dependent practice when TtR students wanted to improve and were willing to work hard to overcome their practice deficits.

> **Ann:** If they're prepared to work to overcome it, they're marginal. You give them the strategies and you talk with them about what they need to improve, and they get there.
>
> **Chris:** If they are marginal, they can explain to me all of what's going on with their patient and then say "These are the issues that I found with the patient. This is what I've done. I did this today,

but I could improve upon this", so then actually being able to reflect on their own practice and their own knowledge, and also to understand that they have a knowledge gap as well.

Kitty: The big thing for me is when they identify what they need to work on, do they do anything about it and make sure they work on improving.

Pauline: Knowing their own ability and reflecting on it and being able to reflect on the fact that they are competent at doing something. It's knowing where they need to improve and of finding out how to do that. That's the difference.

Review

Not all TtR students whose practice does not meet the required standard should be judged as unsafe and dependent. Safe, but marginal practice, as this thesis names this phenomenon, depicts the practice of TtR nursing students who, in this very final clinical placement, meet a unique set of criteria that this sub-theme has identified are the hallmarks of safe, but marginal practice of TtR students. Equally important was that this sub-theme has identified that clinical educators' assessment of practice performance of TtR students not meeting the required standard could be differentiated to distinguish their practice as safe, but marginal practice from unsafe, dependent practice, or unprofessional practice. When provided with the assessment tool that included criteria describing safe, but marginal practice, a consensus was reached that was not previously evident in the clinical educators' earlier appraisal of the same case vignette. Clinical educators recognised safe, but marginal practice of TtR students does not present a risk to patient safety, but the student is not ready for professional practice.

When TtR students could be assessed as demonstrating safe, but marginal practice, clinical educators identified that it provided opportunity for them to engage in mitigation in an endeavour to foster development towards readiness for professional practice. The ways in which clinical educators approached this management and mitigation, together with practice-situated factors that impeded developing TtR students' practice to the required standard, will now be presented as the next theme.

5.2.2 "Just because we can do it with our eyes closed, the students still need to gain their confidence"

This theme explains the strategies and approaches clinical educators implement to develop TtR students' competence and confidence for professional practice. Practice-situated factors are shown to impact on the success of clinical educators' approaches to managing and mitigating these TtR student's practice deficits. Clinical educators identified several common strategies they employed to ensure these students could reach the required beginning-level RN standard. The key findings for

management and mitigation of TtR students' practice towards readiness for professional practice are presented in this next sub-theme.

5.2.2.1 "Last placement, last safety net"

Analysis of clinical educators' approaches to managing and mitigating these TtR students' practice performances revealed their decision-making was informed by their past experiences with mitigation such students. These prior encounters shaped their future approaches to clinical education when reporting strategies, they would use to manage and mitigate Mary's practice within the case vignette.

Meeting with the key informants, namely, the RNs, the CSC, and the student, was the first strategy most clinical educators identified in their approach to managing the staff's reported concerns about Mary's practice.

> **Betty:** I'd want to talk with her, and after I'd spoken to the clinical staff or maybe beforehand even, I'd want to speak to the CSC, so that once we've had a meeting we can have a plan of how we're going to move forward.
>
> **Chris**: First off, I want to have a conversation with Mary to get her side of things and also speak with the nurses directly involved with the two incidents.
>
> **Kitty:** I would talk to the student first and get her side, the CSC said there are concerns so I'd need to sit down with her and talk about what's going on and then it would depend on that.

Assessing Mary's practice from multiple points of view, especially from the student's, was the next strategy several clinical educators identified. As these excerpts illustrate, the direct observation of Mary's practice enabled some clinical educators to conduct an assessment for the purpose of appraising whether her practice deficits presented a risk of harm to patients.

> **Deb:** I would want to watch the student administer medications or doing tasks, so assessing the knowledge and skills that way. I'd assess her and if I felt she was unsafe then she would have to be removed.
>
> **Heidi:** I'd be doing the drug round with her. Is she safe? I need to assess to see what's happening and decide whether this is a communication or a knowledge base issue. You have to assess and breakdown what the problems are.
>
> **Kitty:** I would not want to remove her because ultimately, she is showing that she is keeping the patients safe. I do need to assess whether or not she is safe to continue, otherwise let her stay on as long as there are no major concerns about patient safety.

Developing a plan of action to mitigate Mary's practice performance deficits came next. The predominant mitigation strategy clinical educators identified was the implementation of a professional learning plan (PLP). In the context of this research, it is important to note the PLP had

recently replaced the long-used clinical learning contract within this SoNM. The PLP needed to provide details and a specified timeframe for improving practice.

> **Ann:** I'd use a contract, a professional learning plan, better for her to have that structure.
>
> **Chris:** My suggestions would be for the CSC that Mary needs a plan; a contract with a set plan of the things that she needs to do. I believe she's marginal and needs strategies. Last placement, last safety net.
>
> **Deb:** I would put her on a learning plan and be continually meeting with that student to make sure they're meeting the criteria and what we're expecting.
>
> **Marilyn:** She'll definitely go on a, professional learning plan (PLP). This is where they are at, this is where they need to be at, and this is the timeframe they need to be there. You know, so here's some steps to get there basically.
>
> **Terri:** A learning plan is what's required, and it's required for her to improve their practice quickly, but it's also saying you are not there yet, let's get on to this.

Gathering evidence to evaluate her progress was necessary in their overall management and mitigation of Mary's practice performance deficits. Several clinical educators reported that they would implement a purposeful strategy of daily written feedback from the supervising RNs.

> **Deb:** Getting continual feedback from the staff, who are working with the student normally and watching what she's doing and talking to the student about her patients.
>
> **Kitty:** I would want her to get written feedback every single shift from the staff and there would be no discussion about not doing that and I would want to go through that feedback. They (the TtR student) need to be doing everything for the patient and they need to show the staff and daily feedback shows me they are doing this.
>
> **Marilyn:** I would get written feedback from staff every day. That's the top priority. If there's no improvement, then, yes, she'd probably have to be taken off the placement.

For several clinical educators, this reliance on supervising staff to provide feedback was even more critical when they did not have opportunity to directly observe TtR students' provision of nursing care. Testimony of supervising RNs, in this instance, was the only evidence available to some clinical educators to determine progress towards the required standard was being made.

> **Robbie:** Very little practical assessment and then the rest comes from the feedback from the preceptors and staff they have worked with. Facilitation models these days do not allow us to really spend much time clinically with the students. I can't wash a patient with them like I used to and that's a real pity that it has changed.
>
> **Terri:** The primary way I assess student's competency because I am not there with them, so we are doing this by video... I am counting on the staff in that hospital to tell me if there is an issue. We are getting further away from the actual action, more and more we are not allowed in these areas and the preceptors have to tell us, but they are not the ones trained in assessment.

> **Wilma:** As an educator I don't often see them working. So, it's really difficult for me to be able to assess them developing because I haven't been able to see that in action.

Clinical educators also recognised how important it was for all involved to engage in the mitigation strategies if these were to be successful. Support from supervising RNs, including the CSC and senior nursing staff, was considered pivotal. Clinical educators reported that they would employ strategies they had used previously to ensure support for Mary, including buddying her alongside one or two supportive RNs to help develop her practice.

> **Chris:** I'd put her with certain staff members of a higher skill level, so competent RN's that would ask her questions that would enquire about why she's doing what she's doing, what's her reasoning for things as well.

> **Marilyn:** I would ensure that she's buddied with a staff member that the CSC and I would agree with is a good supportive staff member. I'd be in consultation with the buddy RN, and the CSC, to assess that she's progressing sufficiently...

> **Robbie:** One thing I do that is really important is continuity of preceptors so Mary would get allocated two - three preceptors [rural/remote setting] and remain with them. Then they don't have to prove their ability every single shift and they can actually be developed rather than having to start from scratch every day.

In addition to the need for staff to be engaged, the success of mitigation also required the student to be prepared to engage, and to welcome feedback and use it to improve their practice. Participants' reflections on prior incidents with other students highlighted engagement by the student as important.

> **Betty:** I had a student who was really struggling with that "not quick enough doing medications" and it had been highlighted by some staff, and she decided that she was going to quit. I got her to start writing down medications and accessing resources. Every time I would come in she would come and tell me about the patient she was looking after, what medications they were on, why they were on those medications, any special administration requirements and the kinds of reactions that she needed to be aware of. I started getting positive feedback on how she was going with her medication management. Taking those steps to improve clearly made a significant difference to her, I suppose she felt and believed that she was capable of doing it.

> **Kitty:** I remember that when I first sat down and told her she had some things to work on that she was actually quite shocked, and it took her back a little bit, and then she started improving. We both worked hard she was definitely a student that wanted to improve. It was good.

> **Viola:** I need to have a plan about how and when and what will be improved. If the student isn't willing to engage in that learning and practicing, then I would pull them from placement.

Clinical educators reported that support from the university academic coordinator and university sector was also necessary to ensure successful outcomes with mitigation. When facing difficulties in managing and mitigating TtR students' practice, especially when unprofessional attitudes or behaviours were the challenge, support provided by the academic coordinator could make a

difference. The need for ongoing support from the academic sector, especially when managing and mitigating unprofessional behaviours, was clearly evident in these excerpts.

> **Chris:** The male student needed to actually be removed from placement because he was just unsafe and dangerous. The topic coordinator came across to the clinical placement and we had a meeting with the student and explained what was happening. It was brilliant.
>
> **Heidi:** One student very early on failed to turn up for a number of shifts and she would ring me every night. It was unprofessional practice, but I got a lot of support from the topic coordinator to deal with that, because I was fairly new to the job. I spoke with her (the coordinator) on a number of occasions. The student ended up being withdrawn, she eventually got through after sorting out her health issues.
>
> **Robbie:** I did fail a student like that last week. It was a lengthy process - it was recognised in week three so it was basically a five-week process of trying to get this student to the point where she could pass but we weren't able to. It involved a lot of additional time, and negotiation with the university.

Review

Clinical educators identified a common approach for developing TtR students' practice to the required beginning-level RN standard that was based on their past experiences with TtR students. Consideration of their management and mitigation of the case vignette revealed that they would implement a common series of strategies. An initial approach was meeting with all the key informants and assessing Mary's clinical practice to determine the risk to patient safety. Those who could, conducted this assessment by directly observing Mary's provision of nursing care. Clinical educators for whom observation was no longer an option, due to changes in facilitation models, were left to rely on the testimony of RNs. The next step was to develop a plan of action, including a professional learning plan or contract. Another common strategy was gathering evidence of progress through daily feedback from the supervising RNs. Engagement of all involved, including the university sector, was considered paramount for achieving successful outcomes of mitigation strategies.

In these deliberations about how to manage and mitigate Mary's practice, clinical educators raised several practice-situated factors they considered would impact the success of achieving better outcomes for the student. This was investigated further and findings regarding these factors are now presented as the next sub-theme.

5.2.2.2 "Where is the RN in all of this?"

This sub-theme explains how practice-situated factors impede management and mitigation of TtR students' progress toward the required standard. Whilst it is the clinical educator who will make the judgement about TtR students' progress, appraisal of their clinical nursing practice is mostly the

responsibility of supervising RNs, who observe and assess students' provision of patient care. The previous sub-theme findings established a common approach to mitigation strategies included engagement by all those involved, including supervising RNs. The following examples illustrate and establish how the quality of supervision provided by RNs, and other practice-situated factors, limited clinical educators' ability to ensure successful outcomes with mitigation. Clinical educators identified TtR students were not always afforded the professional courtesy extended to RNs when they made a mistake.

> **Chris:** I've worked with staff who've made wrong checking, wrong things and they are RNs, and some of them are experienced RNs as well.
>
> **Kitty:** The RNs are making mistakes and doing the same thing the student is doing but the student is being held accountable and that is unfair.

Several practice-situated factors, including inadequate supervision, were raised by clinical educators that they believed impacted on the success of mitigation strategies. As these excerpts illustrate, in the deliberation of the vignette, clinical educators questioned why staff concerns that Mary was unsafe had not been raised until week five.

> **Ann:** She's on her fifth week for placement and they're just telling me now. Even if he [the CSC] was on holiday for two weeks, I'm not sure why they left it until he'd come back. The earlier you pick these up, it gives you more time to work on them, which is fairer for the student.
>
> **Chris:** The fact that Mary is five weeks into a placement and only now they're bringing up some issues does concern me.
>
> **Robbie:** The fact that it's the fifth week of an eight-week placement, and this is the first time I have been made aware of any issues. That gets me very upset.
>
> **Viola:** I'd be concerned that I haven't been advised of this up till now - it's week five.

When these clinical educators reflected on the case vignette, they also questioned where the RN was when the problematic situations arose, especially the medication administration incident. They noted that TtR students must still be directly supervised when providing aspects of clinical care that, by law, must be undertaken by a registered nurse.

> **Chris:** The two issues that they have brought up about Mary, the blood pressure and the medications, she did rectify both of those situations and my thinking is, where is the RN in all of this? I want to look at the nursing staff.
>
> **Deb:** With this medication incident I'd be thinking "where's her supervising RN in all that." So yes, it is the student's fault but what's happening with the RN…

> **Grace:** Where was the RN? So as a third-year student she should still have an RN next to her because they should never be giving anything without a registered nurse standing right by their shoulder as they need to check the medication.

Clinical educators identified that a lack of support and encouragement from RNs could affect the success of mitigation strategies when seeking to develop TtR students' competence and confidence in their practice. Furthermore, a lack of confidence could increase the chance of TtR students making an error, as illustrated in these excerpts.

> **Deb:** Sometimes they're working with someone that makes them feel really uncomfortable, they lose their confidence and their ability to think, speak, do everything, as soon as they're with this nurse…

> **Jayne:** By third year if their confidence goes it is usually because of the environment. Just cos we can do it (provide nursing care) with our eyes closed, the students still need to gain confidence. Most of the time the lack of confidence is who they are working with, not being supportive or encouraging. I observed one RN dictating to the student do this, do this, do this. The student was getting all fingers and thumbs and getting stressed and when you do that you will make mistakes.

> **Robbie:** It wasn't that she didn't know what to do, she wasn't confident in it and she was one of those people who was quite nervous. It was a busy medical ward, and the nurses were going come on hurry up and she'd rush and the more she rushed the more she got it wrong.

The quality of supervisory practices of RNs was not just identified as a concern when raising issues within the case vignette. Several clinical educators recalled examples of how they had witnessed firsthand, supervising RNs allowing, and even encouraging TtR students to implement nursing interventions unsupervised, including administration of medications.

> **Betty:** I have witnessed RNs saying, "You just keep giving that IV antibiotic and I'll go over here and do such-and-such with this patient" or "You just keep doing that, you'll be fine". Oral medications they'll do that too, or "You're okay, you go and set up that IV" It's unsafe.

> **Deb:** Staff thinking that students could give medications unsupervised especially the final practicum students. Students are feeling confident, they know the routine, they know the staff, the staff are feeling confident with the students and that's the real danger time. That's when someone will say something like "you can go and give that medication, I trust you" and they do it. I had that happen.

> **Kitty:** I have seen third year students giving medications without supervision and often because it says even on the topic expectations these students need to be independent it literally gets taken that they can go and do it independently.

Clinical educators shared many examples of inadequate supervision that had repercussions for TtR students. Inadequate supervision by RNs had resulted in increasing the risk of harm for patients. For one student, this had resulted in her failing to redeem her clinical contract and, consequently, she was removed from the placement and, subsequently failed the topic.

> **Betty:** It would be so much easier as a facilitator if you didn't have to deal with any of that, or had a way to report it, but there is no SLS forms to fill out because the student got left unsupervised and it was a near miss. There is no process for that.

> **Terri:** They phoned me and said the student was with an RN and neither of them checked the patient's name and gave the medications meant for the patient in the next bed. The student wasn't working unsupervised but neither of them checked. It shouldn't happen, but it keeps happening. The student was issued with a PLP.

> **Wilma:** The student was on a learning plan that required she was always supervised closely I went in on a late shift and she was all by herself with three patients doing the meds and the nurse had left to go and get something and I thought "no, that's just too dangerous because you just don't know what she might do or could do being unsupervised." So that's when I had to ask her to leave. She was failed outright.

Clinical educators were concerned that inadequate supervisory practices also impeded provision of feedback from supervising RNs to TtR students who still needed to improve their practice.

> **Ann:** I suppose some of them don't know how to give examples as feedback, and that's always traditionally avoided by all nurses. Even if they think the student did have a bad day, they tell them they had a good day. Then, they'll come to say, me and they go "Oh, such and such didn't do a very good job" and I go "Have you told them? Do they know about it" and they go "Oh no!"

> **Betty:** I understand that people feel uncomfortable sometimes in providing this feedback, but I think in all fairness to students we have to provide them with timely feedback so that they can respond to that feedback, rather than be left with no time to be able to respond.

Clinical educators also reported concerns that, at times, the staff failed to report any concerns about student's performance directly to the students themselves. This omission left the clinical educators entirely alone in dealing with situations that they had not had the opportunity to observe firsthand. These reflections of past experience illustrate that clinical educators recognised not informing or denigrating students could have consequences.

> **Betty:** I want to know what feedback she has received from the staff. Has anybody addressed this with her or am I going to be blind-sided when I say that there's been some concerns raised? That happens. I had one student; staff had been saying to him that he was doing really well. He was getting lots of lovely feedback and then he's almost due to finish, I think he had maybe a week and a half to go, and they came and said, "We don't think he's ready to be a registered nurse." I felt that was unfair.

> **Heidi:** It has also been my experience that staff members are really good at denigrating students but will never put up the goods and so I have actually had to in the past ask the person making the allegations to sit down with us. It's a negotiation process, so maybe the communication issue isn't the student's - it's the staff members. It's a lot of that whispers and talking behind the student's back and rolling of eyes.

Clinical educators also perceived that, in the case of the vignette, there might be racism or bullying, which they recognised as having a potential impact on TtR students' practice development.

> **Ann:** Facing challenges with them and helping to support them, like with the bullying culture. Are students actually getting the support they need from the RN's?

Grace: We have racism and bullying on some wards that contributes to difficulty with communication and student confidence. I had one student who needed reinforcing and feeding back to cos then she started stepping up and she had confidence in herself.

Lucille: Again, it's that unsupportive environment, bullying, some nurses don't offer support, they even make students cry. There is a culture like this. Unfortunately.

Robbie: There were some bullying issues going on with that student as well, so I had to deal with the bullying issues.

Wilma: He had no confidence in communicating with the staff, he was really shy but they were going on and on and on about him and I thought "no, you've got to give him a chance" because we're eating our young instead of encouraging and supporting them. We're just chewing them up. Sometimes it's so frustrating,

Bullying and racism were so customary in some venues, that clinical educators reported that they just resigned themselves to being powerless to do anything to change what they saw as ingrained issues within the wider culture of nursing.

Ann: Quietly, there's a culture of nurses that don't mind that there's a bully on their ward … it's really difficult, that person, the RN, is not under you.

Betty: I suppose those areas where students have found that staff aren't supportive, it's very much about the culture. It's really difficult to say no to somebody that you feel is senior to you and is also responsible for part of your assessment whilst on placement.

Heidi: Unfortunately, students do have to learn to deal with bullies in the workplace cos they are everywhere in nursing.

Kitty: There was a very senior nurse on one of the wards and it always ended badly with students in tears… Unfortunately, it was like it was expected that she would be like that… it's not good, but students just have to get used of it.

Lucille: As a profession there is definitely acceptance of that culture, nurses eat their young - we're still saying it. They told me that in my first week of nursing. I don't know how to fix that. I'd love to but I can't.

In some venues, the clinical educators described the practice environment culture that was so toxic to students' wellbeing that the clinical educators had to advocate for the students to be removed from these hostile environments.

Grace: When the environment is unfriendly, like really unfriendly and they are submissively hostile toward students it wasn't fair for the student to stay in that situation. One student had to be removed because the staff were just horrendous with him and bullying really badly…

Kitty: I have had to remove students from hostile environments for their own mental health**.** Students had terrible experiences where they were not treated fairly and needed to know their place in nursing was at the bottom. It would have been great to have a reporting mechanism or even just to get to say that nurse is not to work with the students, but you don't have that power.

The clinical educators reported that safeguarding the practice environment to ensure it was a learning space for TtR students was not possible when the culture of the practice environment was not conducive to promoting TtR students' learning that would develop their practice.

> **Deb:** In private the staff/patient ratios are higher, they're often a lot more rushed, stressed and for those reasons sometimes they might have a shorter fuse. Sometimes staff attitude was that students were there to be slaves rather than to develop their knowledge and skills as a beginning registered nurse.

> **Eric:** I know that in some places there is a power interplay, a clique environment, and all this. It impacts students' learning.

> **Grace:** Students, especially final placement, are used as fill in for sick leave and they they're not given a chance to actually think about what they're doing. They're just told to go do obs, go do this. They're actually not encouraged to understand and learn…

Clinical educators identified the impact on learning when students were unable to cope within particular types of clinical environments. Whilst details of the data cannot be presented due to the risk of identifying the venue or clinical educator, they described the venues as sharing common features. These 'hot-learning environments' were the busy, often chaotic, constantly changing environments with a high turnover of acutely ill patients. They were located in R&R settings, speciality wards, and busy medical/surgical units within the large metropolitan public and private hospitals. This somewhat surprising finding has significance to the context of this study. The following excerpts illustrate that these venues could impact TtR students' practice progress and development. Such environments exposed students to inadequate supervision, including with medication administration, thus, increasing risk of error or potential for harm to patients.

> **Deb:** The ward I had for a long time was a really, really busy surgical ward in a private hospital, so sometimes the staff got so bogged down in their work that the students would sometimes turn into slaves. "I'm too busy to do the meds with you, can you just quickly go and do that" and I would have to say to them, look I know it's really hard, but the students are here to learn…

> **Kitty:** Yes, probably one student a year doing final placement - not that you should be picking them up that late, but I would have students having their first time on a busy ward (a public hospital – high turnover of acutely ill patients). So, it's a really unfamiliar environment and they struggle to meet the patient load and time manage.

> **Marilyn:** He had a degree in something else that was completely unrelated to nursing so time management was very poor and that combined with his communication where he needed time to translate and understand. It just all took time and in a very busy learning environment, a hot learning environment like it was, there wasn't time…

> **Robbie:** It was a busy medical ward, and the nurses were going come on hurry up and she'd rush and the more she rushed the more she got it wrong.

Review

Socio-political and cultural issues affect the quality of supervision provided in the practice environment and, as a consequence, impede the success of mitigation. Practice-situated factors, including the environment itself, were shown to impact development of TtR students' practice progress to the required standard. In their decision-making and interpretation around the vignette and their sharing of personal experiences, clinical educators brought to the fore example after example of times they witnessed, firsthand, TtR students left unsupervised, even when administering medications. Inadequate supervision and the culture of bullying and racism were not only practice-situated factors that impeded TtR students' progress but were responsible for some students' involvement in near-miss events and situations that increased the potential for harm to patients. Clinical educators identified that, in some venues, this culture was so toxic that students needed to be removed for their own welfare. Creating a learning space for TtR students was not always possible, especially in venues where the factor most impeding these students' practice progress was the busy, often chaotic, ever-changing environment itself. Despite their recognition of the impact of these challenging practice-situated factors, the clinical educators had, at times, felt overwhelmed and unable to bring about changes to promote the students' learning. It emerged that dealing with these situations required them to have a set of diverse skills that went beyond that of being a registered nurse.

Clinical educators themselves recognised the diversity of their capacities required to perform their role and that broader issues, including the tools and wider curriculum, affected their assessment and their judgements regarding TtR students' readiness for professional practice. The emerging findings from exploring of these and other factors are presented for the final theme.

5.2.3 "When they start to become independent and show they're comfortable in the role of the RN, I'm happy they are competent and ready to work alongside me"

This theme explains broader education issues relating to clinical educators' assessment of TtR students' practice performance that was failing to meet the required standard, and how this impacted their judgement of readiness for professional practice. Clinical educators were cognisant of the responsibilities entrusted to them in making an accurate judgement as to whether the TtR students' practice has reached the required beginning-level RN standard. Conducting assessment of TtR students requires clinical educators to have the necessary skills and knowledge to make the final judgement. The next sub-theme explores how their skills and knowledge are acquired and the impact on their undertaking the role, and diverse responsibilities necessary for ensuring and assuring TtR students have the confidence and competence to meet the required standard.

5.2.3.1 "Simply being a registered nurse does not make you a facilitator, simply being a registered nurse does not make you an educator"

This sub-theme explains the necessary skills and multi-faceted role the clinical educators need to assess, manage, and mitigate TtR students' practice when it does not meet the required standard. It establishes that the role of clinical educator goes beyond that of being a registered nurse. Clinical educators must have education and assessment expertise necessary to conduct complex assessment of practice performance of TtR students. Analysis identified that clinical educators were largely left to rely on their past experiences with how to conduct assessment of practice of TtR students. Based on that experience, they performed the diverse responsibilities that were much broader than that of principal assessor. Experience enabled clinical educators to be aware of how their role could shape TtR students' understanding of clinical nursing practice as registered nurses as they approached and prepared for imminent entry into the profession.

> **Ann:** My role is to prepare them during final third-year placement for the role of registered nurse. I help them put the picture together about what clinical nursing is. I'm assessing them, their knowledge; and developing that knowledge to be an RN.
>
> **Chris:** To be able to inspire them to work out where they're place might be in the nursing world.
>
> **Heidi:** As the clinical facilitator my role is an educator, a support person and a liaison between the university and the hospital. I'm there to support all of that and make the final judgement as to whether or not the student is capable of succeeding.
>
> **Jayne:** I enjoy teaching which involves assessing what your student already knows. One of my students said that I encourage them to expand themselves, I like to give them enough support to take those steps. I try to give them as much confidence as I can or even have the confidence to identify when there may be a problem. I am not talking about with a patient but the way that we as nurses do things.

Like all specialised nursing roles, clinical educators' decision-making about assessment could be seen in the context of Benner's (1984) five-stage framework of competence from novice to expert. For the more novice clinical educator, the focus was on professional regulations, most notably, students' clinical skills capabilities that included time management. More experienced clinical educators exhibited a shift towards being what Benner (1984) would consider an expert in which the focus changed to be more about educating and ensuring students' development and practice progress. As identified by Benner (1984), their decision-making and assessment of TtR students' was influenced by tacit intuition and innate expertise.

> **Ann:** You see it, in final placement, she took the position of observer and lacked confidence. She didn't really want to take that step to transition from EN to RN.
>
> **Chris:** I knew when I said "Well, you're now a third year, final placement student. You need to be linking this and this. What would you tell me? What would you do? What would be your steps for

this patient now?" There was no links, there was no steps. There was no reasoning there. This student just had nothing.

Pauline: You've seen where they have missed cues. It's cognitive inference - you just pick up something. Something just doesn't seem right. They have no connection whatsoever. I had a student in final placement, she could do tasks, but she couldn't work out why she was doing them, and she couldn't assess the patients, or change things when needed. She just wasn't safe.

Clinical educators' expertise in conducting assessment was not, however, a result of the number of years undertaking the role. Rather, this knowledge and understanding of how to conduct assessment of practice was embedded in undertaking tutoring roles, or of holding postgraduate qualifications in education and teaching in other disciplines (Table 5.2). These clinical educators applied purposeful strategies to support learning and, when conducting assessment, sought out, for example, TtR students' ability to 'make the links', as they described it, between classroom learning and their actual patients.

Chris: The links that they make between knowledge they've learnt at university and then seeing that put into practice in the clinical setting. I would teach in their topic and be able to say so in class, you have been going through this, you've got this type of patient I now get it; this is the patient we went through in the lab at uni. This is the one. I've got the one."

Deb: Obviously, the PEP topics build on their knowledge and their skills so I would be questioning to assess their knowledge and their understanding of their patient every time I met with them. I'd be looking at how they're linking concepts together when they're talking, how they're prioritising things.

Kitty: In terms of final placement I found it easier as a facilitator teaching casually at the university because I knew how to help them translate their learning into practice, I knew what they had been learning.

Robbie: I have been a tutor in their topic so I know what they have been studying and seen the theory they have done and then they relate it to a real person and go oh my God yeah, it was so hard to learn in class but it makes sense now.

Expertise in assessment, that had been derived from their understanding as tutors, was also found to translate to knowledge of the wider curriculum. This was found to influence their teaching and learning approach within the practice environment. As illustrated, these clinical educators had high expectations because they knew the depth of knowledge TtR students should be applying and articulating when discussing their patients.

Chris: I need them to link their medication and know the pharmacology and by that, I want them to know the pharmacokinetics and the pharmacodynamics. How does it work through the body? What does it do? How is it eliminated? How does the drugs, you know these eight or ten medications they're on, how do they interact and effect things? Are these the best medications for them?

> **Grace:** Some students are very good at giving surface answers but when you actually go in to ask them to apply it to and transfer that knowledge to a different situation they're lost because they actually don't understand it.

> **Heidi:** I have a very clear understanding of what the curriculum expected from them especially in terms of pathophysiology and pharmacology and I would tie that back to their handovers of patients. I always had a clear idea of how to assess final placement students' knowledge base by getting them to explain why a patient was on a certain family [category] of drugs. It was a trigger for them to discuss how certain body systems work and to give an opportunity to illustrate how much they knew.

Clinical educators who had undertaken classroom tutoring demonstrated that they were able to facilitate the integration of knowledge with practice by engaging TtR students in the learning process. This was illustrated through the application of adult learning principles, such as scaffolding of learning and incorporation of different learning styles to help students link theory to develop their nursing practice knowledge.

> **Chris:** Knowing the student's learning style when they are telling me what's happening with patients, if they're a visual learner, they learn more if we draw a picture. I had this girl who was from Korea and her learning style was very much a visual learner. I had to discuss with her about furosemide and about other diuretics and the nephron and she just couldn't bring it all together. So, I just drew the nephron and said furosemide works on this part, spironolactone works on this part. The lightbulb went on and she went "Oh! Oh, that all makes sense now. I understand."

> **Grace:** Knowledge building all comes back to scaffolding and being able to modify, watching the way they react, and you adapt. I really like Vygotsky's zone of proximal development. If students are too stressed, they're not going to be engaged. If they're too bored, they're not going to engage. You need to find that middle zone.

> **Viola:** I always try if they are struggling to make it smaller so bring it back down and try therefore to make it achievable - small steps. Sometimes prompts are needed, and I weigh up am I prompting them less or more as the weeks goes on.

In addition to the role of classroom tutor, some clinical educators reported that they had provided remedial coaching or facilitated simulation sessions within the skills laboratories. These clinical educators not only demonstrated expertise when conducting assessment but employed other strategies to teach the RNs how they could better support TtR students' practice development. These strategies included fostering TtR students' independence; debriefing and questioning techniques; and conducting staff training sessions on how to provide difficult feedback.

> **Deb:** It was sometimes about education for the staff – teaching them to let the student do everything for their patients within their scope of practice. The RN standing back, the student has to come and say "right, I've got medications due now, I need you to come and watch me give them, supervise me give them".

> **Grace:** I give them all training on how to debrief and how to question to actually find out their [student's] knowledge in a way that's non-threatening. So, they'll know how to do that, to get past the emotional stuff and get to the cognitive level to actually find out where they (students) are at and that they (students) have got to feel safe.

> **Heidi:** I was fed up with trying to explain how to write feedback, so I got the staff together with students and gave them a group of scenarios we'd had, and I gave them cue cards. I reversed the roles about how to communicate over a difficult thing. Then I got them to share with the group, it was enlightening - the staff had forgotten what it was like to be a student and the students realised how hard it was to be the staff.

Clinical educators who had specifically tutored in nursing practice topics that incorporate problem-based scenario learning and practice-based skills sessions, exhibited a degree of expertise regarding assessment of practice performance that was not evident with everyone. When appraising the case vignette, despite the lateness of the notification, these clinical educators were confident that they could ensure Mary would meet the required standard within the remaining three-week timeframe.

> **Deb:** If I put in extra support, extra supervision, extra strategies, she definitely needs a learning plan, all those strategies in place, I'm confident that she will be ready.

> **Robbie:** She'll have a learning plan that makes clear where the deficits are, and I'll give some techniques to get there and then follow up to evaluate how she is travelling. I am confident I can get Mary through and pass her.

> **Wilma:** She is marginal and yeah, she's in the fifth week, but she's still got three weeks to build up to it. You can do a lot in three weeks.

Managing and mitigating TtR students' practice also required the clinical educators to demonstrate more than just assessment skills. Clinical educators recognised the need to provide pastoral care and support when dealing with these TtR students who were not meeting the required standard.

> **Lucille:** Our role is quite multipurpose, multi levelled. My role is to support and help develop students in order to be ready for their practicing role as registered nurses. I'm there to assess clinical competence, absolutely, but I'm are also there to help support and guide students through what can be quite traumatic situations.

> **Robbie:** Up in the remote areas there is a lot of pastoral care as well making sure they are not isolated, making sure they are doing self-care, introducing them to community events because part of our role is getting them involved in the community, so they will want to come back so there is a lot of that as well.

> **Terri:** I'm also a wellbeing supervisor, so I need to be checking that there are no factors confounding the students' ability to take part in the placement.

Clinical educators recognised that counselling skills enabled them to deal with TtR students whose practice was not meeting the required standard due to issues of unprofessional behaviours, including mental health, or if they were trying to cope with difficult situations.

> **Ann:** Mental health, is a big issue today. Some people have mental health issues and if they're not well, they can be very unsafe. I've had to take some off the ward.

> **Eric:** This final clinical placement is a stress, especially because they are in an eight - week block placement, and it's five days a week so I have to be prepared to manage situations, they will have emotional stuff or there could be situations where you just need to be there because they need you.
>
> **Heidi:** I've had students who've had family issues or struggled because of mental health illness. There are lots of these issues that are why students don't succeed.
>
> **Robbie:** Our students in R&R have no family, no friends, no support, they are away from them and their normal counsellors or people they would normally talk to so being aware of all that stuff. I have needed to ring them on their days off, making sure they are OK and all that stuff.

Clinical educators understood they were required to act as a liaison between supervising RNs, the student, and the academic coordinator when managing and mitigating TtR students' practice that was not meeting the required standard.

> **Betty:** Being the person that liaises between the student, the clinical setting, and the university, and provides guidance and support to the student.
>
> **Marilyn:** It's a liaising role with the staff on placement, the topic coordinator at the university and the student.
>
> **Robbie:** The key things are the assessment of the student, but also support of the student and the liaison between the health facility, the preceptors, the student, the university, the topic coordinator so there is that liaison role.
>
> **Terri:** I'm also a liaison between the university and the establishment, and the establishment and the student and sometimes the student and particular people.

Clinical educators recognised performing the diverse responsibilities of their role required additional knowledge and understanding beyond that of being a registered nurse.

> **Betty:** Simply being a registered nurse does not make you a facilitator. Simply being a registered nurse does not make you an educator. They're complementary but you need additional knowledge and understanding.
>
> **Viola:** Facilitators have to be very knowledgeable and very skilled.

It was evident that there was a lack of preparation by the university to ensure that all clinical educators have the necessary skills to perform the multi-faceted role. Clinical educators identified poor quality assessment by previous clinical educators impacted on TtR students' expectations regarding marking and their performance.

> **Betty:** I sometimes wonder, particularly when you see them filled out, whether the people that are filling them out understand what they're supposed to be doing. You get people going through and they'll just say, "fabulous, fabulous, fabulous" for everything, "performing at an independent level" and, well it is pretty unlikely that they were completely independent with everything in previous placements.

> **Deb:** Some students get really high marks from facilitators or if they've got seconded staff looking after them, just because they've gone around and done everyone's obs and made everyone's beds. Maybe facilitators haven't had a lot to do with their students which we know still happens or haven't been assessing students appropriately but give great marks for the PEPR anyway.
>
> **Kitty:** Students have an expectation with the new PEPRs that they will improve their results every time you do an assessment and each time, they expect to go up a level.
>
> **Robbie:** I take a lot of time determining if they are a 3, 4 or 5 in each area and students come back and say - on my last placement they gave me all fives so how come you can't give me all fives.

Clinical educators did not all feel adequately prepared for assessment of practice, and they recognised the need for education and training to prepare them to conduct assessment of practice performance. Clinical educators wanted support from the university sector, and training and education to improve their assessment capabilities. More importantly, these clinical educators considered this essential for ensuring consistent and equitable assessment of TtR students' practice performance by all clinical educators.

> **Betty:** A lot of students are done a great disservice by the fact that not only clinical facilitators, but in some cases tutors, pass them because that's easier. I think we need to have more rigorous standards in place for facilitating and we need to have more training about assessment.
>
> **Jayne:** I think even though we work under the competency standards, nurses don't understand them. Facilitators interpret it the way they understand it and so each facilitator may have different interpretations making it difficult for all students to be assessed in the same way.
>
> **Pauline:** The tools are only as good as the person interpreting them. The topic coordinators ensuring consistency of doing it [assessing] properly is vital to this.
>
> **Wilma:** When you become a facilitator, you don't get any training, you just do the job and often you don't even meet the course coordinator or have much contact with them. One coordinator had us all in the office and had a meeting before we started facilitation and that was fabulous, she talked about what she expected. It would be really good to have more support. I've had no process of what we need to do, and things change with assessment all the time. I think we need to be taught more. It's very much like you just go out there, we just need someone to cover these people.

Review

Analysis of clinical educators' decision-making regarding the assessment of TtR students' readiness for professional practice established that it required skills that went beyond the role of registered nurse and, yet it was grounded in their past experience and expertise as a clinical supervisor in nursing. A significant feature of expert assessors was their ability to conduct assessment that was based on knowledge gained from prior experience in classroom tutoring. Teaching patho-physiology and pharmacology meant these clinical educators' knowledge and understanding of contextual-based learning raised their expectations of TtR students' application and articulation of such knowledge. Those who tutored nursing practice topics had a level of confidence and know-

how that others, who did not have these experiences, lacked. Management and mitigating of TtR students' practice required the clinical educators to do more than just conduct assessment. Clinical educators recognised that dealing with challenging behaviours, including those stemming from mental health issues, required diversity within the role to provide pastoral care and to liaise between the practice environment and university sector. A responsibility of the university sector to provide education and preparation of all clinical educators to ensure consistency and accuracy in assessment of practice performance of TtR students was crucial. Analysis to understand the consequences regarding the assessment of TtR students' readiness for practice is now presented for this final sub-theme.

5.2.3.2 "Facilitation is so variable and it's so subjective and some facilitators are just not invested in the whole process"

Ensuring validity and reliability of assessment for TtR students is paramount to stop any risk of awarding borderline passes to students whose practice does not quite yet meet beginning-level RN standard. Looking beyond already established factors that impact assessment, such as human influence and wisdom of practice, awarding of borderline passes for TtR students was challenged by the design of the assessment tool itself, the wider curriculum, and university decisions including several new processes, all of which had implications on this assessment. When TtR students' practice performances could meet the required standard, making the judgement of their readiness for professional practice as a beginning-level RN, was simple and straightforward.

> **Wilma:** When they start to become independent and show they're comfortable in the role of the RN, I'm happy they are competent and ready to work alongside me.

Conversely, when TtR students' practice performance did not meet the required beginning-level RN standard, the judgement was challenging for clinical educators. Their shared examples showed that it was personally difficult to fail these students, even when they understood why it had to be done.

> **Deb:** Sometimes you had students out there that were challenging and difficult, and it wasn't very nice when you had students that had failed, and you had to tell them that they've failed, and even though it's necessary, it was difficult.

> **Pauline:** No one enjoys failing anyone. But I felt that one was particularly hard because naturally the student was angry, and they didn't understand why they failed.

> **Viola:** People don't like failing students, I had to fail a student who breached everything when doing a wound dressing. Had no knowledge and knew nothing. She was completely distraught because she was an international student, and her visa would be cancelled if she failed the topic but that is not an issue for me. This was about her practice, her safety against the standards here in Australia.

Informing TtR students that their practice was not meeting the required standard was made more difficult when former clinical educators had not performed their role satisfactorily. Clinical educators considered that this contributed to an ethos in which TtR students only became aware of their practice deficits during their very final clinical placement.

> **Betty:** I notice between facilitators, between tutors, that there's this huge array from people that are really quite committed and provide lots of feedback, but it really depends on who the student ends up with, and I don't think that that's satisfactory. It's not fair and then those are the students that fail, and that's not a deficit on their behalf, that is the lack of support.

> **Eric:** For third years, if they are not at the standard it's really a failure for the school. If there hasn't been a problem until year three, I'm sorry, it's been overlooked by previous clinical facilitators.

> **Robbie:** Facilitation is so variable and it's so subjective and some facilitators are just not invested in the whole process.

In seeking to gain understanding of why awarding of borderline pass grades might be occurring, it emerged that these clinical educators themselves were sometimes inclined to give TtR students 'the benefit of the doubt' and give them a borderline pass.

> **Pauline:** I always think with these students like Mary, you have to give them the benefit of the doubt.

> **Robbie:** I do tend to give the students a little bit of benefit of the doubt sometimes because I think nurses have high expectations of students and don't recognise how difficult that can be for them.

> **Terri:** He cared about how people were treated so I took that into account, even if he was a bit slow right now, this guy is going to get to a ward in his grad year and that was the call I made, they are going to whip him into shape. It's difficult, those decisions are difficult, but I passed him.

The clinical educators recognised that recently introduced changes to curriculum and facilitation models made by the university had made it more difficult for them to fail these TtR students.

> **Eric:** I had a student I really wanted to fail, but it's getting more bureaucratic and it's getting harder. If you put them on the new learning plan there is no way you can fail them.

> **Robbie:** In terms of being able to assess whether they are borderline or not, needs shadowing and working with students as much as possible which you have to get permission from every man and his dog for. In the old days you use to be able to come and spend an hour with the student do a shower or the med round with them…

Of greater concern and noted in several of the cases in Study 1, was the frustration for the clinical educators who questioned, as these excerpts illustrate, why their professional judgement could be so easily overturned by the university.

> **Grace:** What frustrates me though, and I know I'm not alone in this, we will fail a student on clinical because of an assortment of reasons and we'd have documented proof and then back here they're given another go or they appeal so it's overturned and they're kind of like put back in again when you're sitting there thinking, actually no, they need to come back and do the whole topic again because they haven't got the knowledge and they need the time to consolidate that knowledge not just get put back out into another placement when it's knowledge they're lacking in. We're actually harming them. We're harming the profession and we're harming our reputation.
>
> **Pauline:** If they're borderline why bother failing them because they're going to get passed anyway and you've got to go through a lot of detail because you know they're going to be saying, why are you failing this student? I can see though why a lot of people don't bother. I still fail them, but I do that knowing they will pass anyway.

Further analysis to understand why clinical educators might be inclined to award borderline pass grades identified that the assessment tool itself was a contributing factor. Clinical educators who make this final judgement were seeking documentation that could provide clear indicators describing TtR students' readiness for professional practice. The recent curriculum changes within the SoNM in which this study was situated, had seen the introduction of the Australian Nursing Standards Assessment Tool (ANSAT) (Appendix 15) that replaced the PEPR as the tool for rating practice performance against the profession's standards. The new standards for the registered nurse (NMBA, 2016) had changed from the former competency-based framework to a quality and safety framework (Appendix 7).

Clinical educators were cognisant, as principal assessors, that the ANSAT did not provide demarcation to indicate when TtR students' practice did not meet their expectations of these professional requirements. Whilst the ANSAT provides pre-set criteria, further analysis of the clinical educators' interpretation when completing the document revealed gaps in the tool that relied on greater subjectivity in assessment, as illustrated in these considered reflections detailing clinical educators' concerns with the ANSAT assessment form (Appendix 15).

> **Betty:** The way these tools are designed I don't know if they particularly capture the student experience …
>
> **Eric:** This new PEPR, it's very subjective and all this scaling doesn't provide a very good grasp of what the student is really like, that's why I put lengthy comments in.
>
> **Robbie:** So, the ANSAT was written with the NMBA [2010] competency standards, and all they've done is whack the new ones in, not recognising how differently the new standards have been written. All of that interconnectedness of the old competency standards is not in this new ANSAT tool.
>
> **Terri:** There is one thing about the ANSAT is that it doesn't give any scope for specifically measuring clinical practice, it doesn't even talk about it really.

Furthermore, clinical educators raised concerns that the ANSAT did not enable them to indicate that progress was being made from one level to another or reflect deficits that had required improvement and development for TtR students' practice progress.

> **Grace:** I think the written comments can be a lot more valuable than the ranking system, but you've got to be able to write the truth. They've had issues and you read the new form and it doesn't reflect any of the issues whatsoever and doesn't allow for the areas of improvement.

> **Robbie:** I am conscious of the student's right to appeal and I didn't want her saying I only failed because I was bullied so documentation becomes so important. It's really important to be able to make the distinction between what is lack of knowledge or lack of communication and what is unsafe as well and then when the lack of knowledge becomes unsafe then it has been made clear.

This meant their assessment decisions of TtR students' performance were limited to whether they have or have not met the required standard. In the interviews, the clinical educators considered there was no other alternative. The ANSAT documentation, as illustrated in these excerpts, did not allow for the clinical educators to reflect on their assessment of TtR students' level of knowledge.

> **Eric:** I can't establish the link between the first standard and the subheadings. Critical thinking it's all about their analysis. It's all about assessment of patients. There has to be a link somewhere. I struggled with this seriously. Professional experience objectives and outcomes and aims, it doesn't say anywhere about the knowledge base. What's the standard of their knowledge? They need to know this. I know they need to know this but what's the minimum where I can fail them or not fail them.

> **Lucille:** I find that where they (tools) fall down is with assessing the students' basic knowledge of A&P, pathophysiology, medication knowledge. It's not a separate box. It's incorporated into many different areas. I find that that's difficult especially as a new facilitator.

> **Robbie:** With the student I ended up failing, the very first section of the ANSAT is thinks critically and evaluates nursing practice but the behavioural cues are all around professional behaviour and ethics and it's not around their knowledge and their critical thinking skills… She wasn't willing to admit when she didn't understand something. I do think we also need something about professional behaviour.

Clinical educators were mindful that the ANSAT and guidelines did not make clear if TtR students' practice should be measured as students or as graduate beginning-level RNs.

> **Robbie:** The other thing about the ANSAT is that some people assess them as a student and others as a graduate. Even the manual, the guide is not clear, so there is confusion. It is not clear.

As these clinical educators identified, to assess whether students were capable of working independently as an autonomous RN was not possible, because TtR students are not permitted to independently undertake aspects of nursing care responsibilities that only a registered nurse can perform. This contributed to difficulty assessing TtR students as meeting the required standard, as illustrated in these excerpts.

> **Betty:** They certainly can't be independent with medications; they can't be independent with IVs. I think that people struggle with how to assess this.
>
> **Eric:** They're not independent. We cannot judge that. We cannot assess this.
>
> **Kitty:** One issue I have had is that you are marking students as meeting the standards, but they can't be independent. It's complex with all the different issues.

From the clinical educators' perspective, the design of the tool did not enable them to identify the particular factors they attribute to whether the required standard of practice had or had not been met by TtR students. Importantly, the participants claimed that the lack of a standardised approach to TtR students' assessment across all institutions contributed to confusion that led to indecisiveness in making judgements about TtR students' readiness regarding practice. This was especially true for those clinical educators in R&R settings, and smaller private hospitals, as they have TtR students from more than one university simultaneously attending placements.

> **Grace:** How we can do it so it's systematic with a large number of people and that it's consistent given we have 40 nursing schools in Australia and every single one can assess their students in a different way.
>
> **Heidi:** There are a lot of tools out there. I like the feedback sheets if they were done properly, I had the evidence then and I could march down and say please explain to the student. They were valuable, the ones that were useless was the 1s and 2s during the first week, despite all the input I put into the staff…
>
> **Terri:** I hate the paperwork, the different kinds of paperwork. There is assessment paperwork that I do with them, I don't understand all the forms, it's just another job, it takes me from engaging with students so is it really necessary?

In addition to the newly introduced ANSAT assessment form and RN standards of practice (NMBA, 2016), the school in this study had also recently introduced a new curriculum with a different structure for delivery of curriculum content using an intensive approach. Clinical educators identified this more condensed, intense curriculum style impacted TtR students' ability to synthesise and consolidate their knowledge and apply it at the level they were seeking.

> **Deb:** Their level of knowledge, their level of understanding and their ability to put the pieces of the puzzle together was better in the old curriculum than now because now we don't give them enough time to develop those skills. Now the topics are condensed and quick intensive style. The old curriculum gave them a longer time to consolidate that knowledge and we covered topics to a greater depth.
>
> **Grace:** I think we are missing consolidation. We're not giving them, especially in our current curriculum format, of intensive three-week topics, we're not giving them time to consolidate the knowledge and apply the knowledge.
>
> **Kitty:** I really don't like the intensive style; students are not getting through the study plan before they go to the intensive class and then it's hard to develop their critical thinking out there.

> **Lucille:** I think we could benefit from having more extensive placements, more varied. It seems a lot of them come out at third year and that's where they're trying to put all the pieces together. We really should be starting to do that earlier.

> **Viola:** I have seen a change with this curriculum. I am noticing that students don't have the knowledge and if they do it is very superficial, and they need more time to practice and do skills. I had to fail a student when she couldn't do a wound dressing. She was completely distraught because she was an international student, and her visa would be cancelled if she failed the topic but that is not an issue for me. This was about her practice, her safety against the standards in Australia.

Clinical educators were concerned that TtR students could now pass this curriculum and not be clinically competent.

> **Grace:** They need to be safe. I think there are students that actually pass this curriculum that aren't competent. Look, I've mentioned this to people before that I've got concerns that we're passing students who aren't competent...

> **Pauline:** It's a production line and we're not encouraging that depth of learning. They're getting through second year, then they're getting through third year. At a lower level which is not the student's fault. It's the system. We're getting more coming through that aren't meeting the criteria.

Clinical educators also recognised wider curriculum issues, particularly the different entry pathways with high numbers of international students, increased the workload for them and the supervising RNs.

> **Jayne:** He was a graduate entry. The students that come in at graduate level should probably be assessed before they hit the ward as expectations are high and they need to meet them. I couldn't pass him because it would have been unfair to his patients, staff he had to work with, him, I had to fail him for everybody's safety.

> **Marilyn:** I see with students that have come through as the grad entries [degree] without a medical or nursing background and English is their second language, they are the ones that really struggle. It's unfair. They've got such a steep learning curve. I'm not sure if it's setting them up to fail, but they're disadvantaged by it.

> **Viola:** I have concerns about the graduate entry students who come in at second year level. I have had architects and horticulturalists and they don't have anything to bring, whereas I have had ENs who will have that knowledge they bring as a second year because they have some background. If they are a pharmacist, they are great, they have background knowledge, but not if they have done IT degree. We need to better support them, so they are ready.

Clinical educators recognised this, as it meant that TtR students could now find themselves in busy medical/surgical venues for the first time during their degrees.

> **Kitty:** Over the years I have noticed that their placements have changed, and some students weren't having a typical ward placement until they came into their final placement and they couldn't do a wash on a patient and they would be picked up and staff would say they were unsafe asking why can't they do a wash.

> **Lucille:** Some of our students, and certainly I've had them, have never had an acute care placement before and all of a sudden, we throw them into a busy environment. We're asking for

> trouble. We're not only poorly supporting that student by throwing them into an overwhelming environment but we're not giving them any foundations to build on. Placement structure, I think, needs an overhaul.
>
> **Viola:** They might actually finish now and never have had an acute care placement. That is not fair for the student. If you ask where you have done your placements and they say aged care, community, GP practice and they want to work in acute care, the hospital will say just leave us your resume and we will let you know.

Another issue contributing to changes within clinical education for TtR nursing students was the increasing move by hospitals to appoint their own staff into the role of clinical educator. Seconded staff are not required to hold formal education qualifications or to undertake any training about the conducting of assessment. They do not undertake additional classroom tutoring. They have no access to the learning systems and platforms available to university appointed clinical educators. Clinical educators considered the primary responsibilities of these seconded staff were to their colleagues, not the student, and this disadvantaged TtR students, particularly when practice was not meeting the required standard and the RNs raised concerns.

> **Deb:** There are venues that have seconded staff, and well the students haven't got anyone else that they can confide in or talk to if they're having issues and like we've said that sometimes the issues are the staff but that poor student is trapped in that environment and all we've got to go by is what the staff are saying.
>
> **Grace:** If you have a clinical facilitator who – and I think this one of the big problems we have with seconded facilitators, is that their loyalty can be put to the test because they're employed by that venue – so, if there is an issue they need to keep being paid and have a job. Are they going to go against what's being said about students then?

In exploring other issues contributing to the tension between the two sectors, a difference in expectations regarding what constitutes meeting the required standard and how such practice should be exhibited by TtR students, emerged. Clinical educators recognised this disconnect.

> **Ann:** Sometimes I think with ward staff we can make sure that their expectations of the student is realistic.
>
> **Betty:** We need to have a more consistent approach. Often, they (staff) have differing expectations than maybe the university or the student themselves.
>
> **Chris:** What are the expectations for that placement. What are the university's expectations of what does that student need to complete and to what level? What are the ward's expectations of the student? Do they all meet? Does the ward have a higher standard than needed? Does the ward have a lower standard than needed?
>
> **Jayne:** Sometimes the environment undermines the student, RNs can have high expectations and make the student uncomfortable and they then don't have the confidence to step forward.
>
> **Kitty:** I have had staff members running to me telling me a student is terrible but sometimes that is only one perspective and the nurse just had harsh expectations.

Clinical educators identified the onus that once was on the university sector was now on them to assess, manage, and mitigate these TtR students' practice, as evidenced in this excerpt.

> **Wilma:** I did contact the university when I thought I was going to have to put a student on a contract, I spoke to the coordinator and she basically said – 'just be aware that she's international, be careful because she's Asian, it's a shame for her family because they're paying for it, make sure that the decision that you make is correct, however it does sound like she's unsafe but it's up to you in the long run.'

This shift in responsibility for managing and mitigating poor practice for these TtR students contributes to the tensions surrounding clinical education and assessment of TtR students. A lack of direction and process from the university sector left the more novice clinical educator wanting support through independent assessment, and more experienced clinical educators uncertain about how to proceed, so they sometimes just failed students because they perceived there was no other option.

> **Lucille:** If it became a real concern a student was not safe in their practice or their knowledge, or simply wasn't where they should be to be able to qualify as a safe, competent registered nurse, I would want to have them reassessed by somebody else.

> **Wilma:** I did end up failing her. I had no idea what to do, so I ended up just writing fail on the report and emailed it to the topic coordinator and the student but I really had no idea, I was like "is this the right thing to do, do I need evidence", it was a bit tricky. It was hard enough to fail a student when they are on placement and especially when they are international students.

Clinical educators wanted their judgement regarding students' practice performance to be valued. These considered responses when identifying their concerns with assessment show why that request should be heard.

> **Lucille:** The facilitator role is somewhat undervalued. We're out there as often as we can with these students in real time dealing with real situations with real patients…

> **Pauline:** Just putting it on one person to make the final decision, that judgement is not fair on the student or on the person who is having to say to them, you're not actually meeting the standard yet.

> **Wilma:** I've had no process of what we need to do, and things change all the time and how am I meant to know all this. I find it's not very supportive.

Review

Clinical educators' insightful perceptions confirmed the findings from Study 1 and provided meaning of the context of assessment that safe, quality, competent nursing practice informs their understanding and identification that TtR students' practice was meeting the required standard. When dealing with the challenges of those TtR students' whose practice does not meet the required standard, clinical educators were found to sometimes give the benefit of the doubt and to award

borderline pass grades. Analysis of clinical educators' concerns with the assessment tools and the curriculum, established that assessment of practice performance of TtR students to ensure they were ready for professional practice, may not always have occurred accurately and/or consistently.

Design issues with the ANSAT assessment tool regarding clinical educators' considerations of how safe, quality, competent nursing care is exhibited for the beginning-level RN standard meant their expectations of required practice were not always able to be reflected. Particular degree pathways were identified as a contributing factor in why TtR students might not be attaining the required standard. Such issues contributed to the tension between the two sectors and to subsequently have implications on assessment outcomes for TtR students. The inconsistency and randomness regarding the types of placements TtR students had, their previous clinical educators, the increasing use of seconded staff, and other changes beyond the clinical educators' scope, were all found to generate consequences for TtR students' preparedness, and to even inhibit some students' progression towards the required standard.

5.3 Conclusion

Guided by the three unanswered questions from the first study, analysis and interpretation of clinical educators' perceptions, interpretations, and meaning of TtR students' readiness for professional practice has established how clinical educators assess, manage, and mitigate practice development when the practice performance does not meet the expected standard. Clinical educators, in consultation with supervising RNs, make the final judgement of TtR students meeting the required beginning-level RN standard against their interpretation of benchmark measures that govern professional nursing practice. Assessment of the required standard being achieved necessitated provision of safe, quality, competent clinical nursing practice. Instrumental to this was students' application of knowledge, specifically aspects of conceptual-based learning, articulated in discussions regarding the provision of patient care, and found to inform clinical educators' judgement of readiness for professional practice.

Conversely, when this required standard was not being met, the second study established that a shared understanding exists amongst clinical educators about the ways in which they identify TtR students' practice performance that does not meet the required standard. Clinical educators were unified in their deliberation that when TtR students' practice performance meets the criteria of unsafe, dependent practice, they should be removed from placement to reduce the risk to patients' safety. This intent of keeping their patients safe, even if unsure what to do next, was a fundamental difference between unsafe practice and TtR students whose practice was not meeting the required

standard though their practice was safe, but marginal. Identifying what were specific hallmarks of this safe, but marginal practice created conditions that enabled the clinical educators to provide opportunity to improve and develop these TtR students' practice to the required standard.

Embedded in past experience, clinical educators' identification of common strategies for the management and mitigation of these TtR students included meeting with the key informants, assessing provision of care to determine if patient safety was at risk, developing a plan of action, gathering evidence to evaluate their practice progress towards the required standard, and engagement by all involved to ensure success of mitigation strategies. Practice-situated factors, including quality of supervision and socio-political and cultural issues in practice environments, influenced clinical educators' ability to ensure development of TtR students' practice progress. Quality supervision from supportive RNs was regarded by the clinical educators as especially important for ensuring TtR students requiring mitigation could improve to the required standard. Wider cultural issues, including bullying and racism, were contributing factors creating a practice environment that was not a safe learning space for students to develop their competence or confidence in readiness for professional practice.

Clinical educators recognised their role was multi-faceted and required a diverse set of skills to meet the many responsibilities that went beyond simply being a registered nurse. However, clinical educators' conduct of assessment identified that this expertise largely relied on them having to draw on past experience and, for many, from their experience of classroom tutoring. Not all clinical educators felt adequately prepared for their role of assessor when making a judgement about TtR students' readiness for professional practice, especially with TtR students whose practice was not meeting the required standard.

The weaknesses with the design of the ANSAT, and wider curriculum factors confronting clinical educators when assessing TtR students' practice not meeting the required standard, contributed to the continuing practice of awarding borderline pass grades. Differing expectations regarding achievement of the required standard, and other factors, create a disconnect between the university and practice environment sectors that compounded assessment challenges facing clinical educators.

Chapter 6 will now explore these key integrated findings emanating from this study. It will establish why these results are important, and how they contribute to the clinical education outcomes for TtR students, especially those whose practice does not yet meet the required standard. The results will be compared and contrasted with existing knowledge, together with discussion of why the new findings are similar or different to those of previous research.

CHAPTER 6 INTEGRATION AND DISCUSSION OF STUDY 1 AND STUDY 2

6.1 Introduction

This chapter will discuss the integrated key findings and establish why these results are important, especially for those TtR students whose practice does not meet the required standard. The results will be compared and contrasted with existing knowledge and their implications for future practice will be discussed.

The practice performance of TtR students requires students to be ready for professional practice as a beginning-level RN on completion of their degree. Unlike earlier clinical placements in the degree program in which students can anticipate using their next clinical placement to address deficits in their practice performance, final placement has little opportunity for this. By the completion of final placement, TtR nursing students' practice is expected by clinical educators to meet the profession's benchmark measures and expectations of what is safe, quality, competent practice. This study sought to gain greater understanding of what happens when TtR students do not meet the required standard and lack the competence and confidence required in readiness for professional practice.

This study identified a previously unarticulated phenomenon of TtR students' practice that does not meet the required standard of practice, but meets the specific hallmarks of what is safe, but marginal practice in contrast to unsafe, dependent practice. Furthermore, this safe, but marginal practice can be improved when clinical educators implement commonly understood mitigating strategies, thus, enabling these students to gain the competence and confidence required for professional practice.

This chapter presents a 'fusion' (Regan, 2012; Schneider et al., 2016) of the integrated key findings emanating from the content analysis of clinical and academic documents for nine cases and the thematic analysis and interpretation of semi-structured interviews with sixteen clinical educators. Identified through the application of the hermeneutic lens, probing findings of both studies, the five integrated findings that will be presented and discussed are:

- Assessment of practice performance of TtR students as not meeting the required standard occurs when the integration between knowledge and practice does not align with clinical educators' interpretation of how safe, quality, competent nursing practice is exhibited.

- Clinical educators apply specific criterion hallmarks using meanings and descriptors applicable to the assessment of nursing practice that differentiate ‘safe, but marginal practice’ from ‘unsafe, dependent practice’ and/or ‘unprofessional behaviours’ when TtR students’ practice performance is not meeting the required standard.

- Identification of safe, but marginal practice performance of TtR students facilitates the application of appropriate and directed mitigation strategies to ensure their competence and confidence required for professional practice when the approach is not impeded by practice-situated factors beyond the control of clinical educators.

- A lack of deliberateness in assessment and management of practice performance when TtR students are not meeting the required standard contributes to failure to fail/failure to pass.

- The multi-faceted role of clinical educators requires additional knowledge and skills beyond that of the registered nurse and necessitates understanding of educational interventions to safeguard assessment of practice in accordance with curriculum requirements.

The relationship between these key findings and the existing literature, together with illumination of identified gaps that the new findings seek to close in relation to the research question and aims are addressed. Furthermore, the implications of these findings going forward, including models and interventions to address these, are also presented in the following sections.

6.2 Section 1: Research findings, Supporting Evidence and Literature

While there is an abundance of literature relating to assessment of clinical practice of nursing students, little of it focussed specifically on the assessment of TtR students undertaking their final clinical placement. A gap was shown to exist regarding assessment, management, and mitigation of TtR students whose practice was not meeting the required standard. Both studies identified findings relating to how clinical educators assess, manage, and mitigate TtR students when practice performance does not meet the required standard and development expected in readiness for professional practice. This section presents the key findings that capture the essence of the text in relation to closing this gap and answering the principal question and aims of this study. Each integrated finding will be presented in relation to what literature had already established, and the significance of new findings creating knowledge by closing the gap in relation to the phenomenon of how clinical educators’ assess, manage, and mitigate TtR students’ practice not meeting the required standard. Reference to tables from Study 1 (S1) or page numbers from Study 2 (S2) are included where appropriate, to present a link back to the relevant finding.

6.2.1 Factors that influenced clinical educators' judgement about TtR students' readiness for practice

This study has established that assessment of TtR students' readiness for professional practice is complex and involves much more than merely deciding that the student is either ready or not to become a registered nurse. Assessment of TtR students' ability to implement skills and integrate learning with practice (Cooper et al., 2010) occurs within the context of clinical practice (Stuart, 2007). Factors considered by clinical educators when assessing practice performance of TtR students showed this formed part of a complex, interconnected assessment process that influenced their judgement about readiness for professional practice. Integration, demonstrated through a synthesis of experiences, theory, and practice (Cooper et al., 2010), informs clinical educators' judgement of TtR students' readiness for professional practice. When synthesis of knowledge became the foundation of the nursing care that TtR students provided, clinical educators could assess they demonstrated attainment of the benchmark measures indicating safe, quality, competent nursing practice was being provided. Conversely, when TtR students did not demonstrate this integration, clinical educators in both Study 1 and Study 2 judged the TtR students' practice as not meeting the required standard. The ways in which these findings relate to the principal question, existing literature, and creation of new knowledge are now presented.

Core factors that influenced clinical educators' judgement about TtR students' readiness for practice occurred through observation (S2: p. 94) of the nursing care they provided to patients.

Clinical educators also looked for the application of contextual-based learning (S2: p. 84), as well as students' ability to perform within the socio-political context (S2: p. 101) of the practice environment.

Other research has established that organisational factors (Hughes et al., 2018; Killam & Heerschap, 2013) and positive supportive relationships that enhance learning (Henderson et al., 2012a; Pront et al., 2013) have an impact on placement outcomes for students. Types of supervision, including preceptorship (Luhanga et al., 2008a; Luhanga et al., 2014) and mentoring (Helminen et al., 2014; Kaihlanen et al., 2013) and models of placement including the DEU (Edgecombe et al., 1999; Edgecombe & Bowden, 2009; Gonda et al., 1999; Moscato et al., 2013; Ranse & Grealish, 2007) have all been shown to enhance learning outcomes of clinical placement. Critical reflection (Cooper et al., 2005; Levett-Jones et al., 2011) and the provision of clinical rationales that demonstrate use of clinical reasoning (Brookfield, 2008) have been shown to inform clinical assessors' judgement of students meeting assessment requirements in preparation for professional practice. The findings of this study concur with these factors but establish that, when the focus is on judging TtR students'

readiness for professional practice, clinical educators in the role of principal assessor, employed a layered process including formal and informal assessment modalities, to identify the indicators of the synthesis of knowledge (S2: p. 85) they were seeking.

New knowledge generated in this study identified that TtR students' knowledge assessed as meeting benchmark measures that clinical educators seek becomes evident when TtR students exhibit initiative and effort to seek out relevant information about patient care. Clinical educators perceived this as an indication of students applying an evidence-based framework (S2: p. 85) to clinical practice in which they:

- synthesise knowledge by applying theory-in-action of the benchmark measures including contextual-based learning;
- respond appropriately to the deteriorating patient;
- work within their scope of practice; and,
- reflect on and critique their clinical nursing practice through critical reflection.

These benchmark measures ensure delivery of safe, quality, competent nursing practice, commensurate with the required beginning-level RN standard, served as the indication to clinical educators the required standard was being attained. Use of the term 'benchmark measures' is deliberate in this study, as studies using tools to measure 'objectivity' have been questioned as to their validity and reliability (Cant et al., 2013; Cassidy et al., 2017). Conversely, when integration of knowledge and context was not evident during assessment, clinical educators perceived students to fail to notice vital links and cues and assess the TtR student's practice performance as not meeting the required standard.

In Study 1, a deficit in knowledge integration included students' inability to demonstrate:

- integration of knowledge to ensure patient safety;
- assessment of patient's clinical needs on which to base a care plan; and,
- integration of hospital policies and procedures and recognizing the deteriorating status of patients.

These concrete observable practice factors that were identified in the Study 1 assessment reports of TtR marginal students' practice were also evident in the Study 2 exploration of clinical educators'

perceptions and meanings about students who were not meeting the expected standard in readiness for professional practice.

Emotional intelligence (Foster et al., 2017) and resilience (Hart et al., 2012; Thomas & Revell, 2016) have been shown to impact student's transition (Phillips et al., 2014) towards professional practice. Prior research has established that student engagement in professional practice requires them to feel included (Thrysoe et al., 2010) and to experience belongingness (Levett-Jones & Lathlean, 2008; Levett-Jones & Lathlean, 2009a) and relatedness that occur through meaningful interpersonal relationships (Mohamed et al., 2014). These have been shown to help enhance students' resilience and confidence, and reduce their anxiety associated with undertaking practice and assessment within the clinical environment (Melincavage, 2011; Pai, 2016). A positive learning culture was shown to impact the provision of patient-centred care (Borrott et al., 2016; Levett-Jones & Lathlean, 2008) that was further enhanced through social bonds (Malouf & West, 2011) by enabling students to feel they were a member of the nursing team (Henderson et al., 2012a). Relationships between students and clinical staff have been shown to impact nursing students' socialisation, professional role development, and imminent transition to practice (Curtis et al., 2007; Levett-Jones et al., 2009; MacIntyre et al., 2009; Pront et al., 2012; Thrysoe et al., 2010).

Nursing students' engagement in patient care and their interactions with patients and staff (Levett-Jones & Lathlean, 2008; Levett-Jones & Lathlean, 2009a) have been shown to provide indicators of good practice when conducting assessment. This study has produced evidence that shows when TtR students approach their own learning with the desire to know more and to learn about their patients' conditions and the relationship of that to the nursing interventions and care they implement, (S2: p. 85) it indicates to clinical educators that they are adopting an evidence-based practice approach to their practice that is required of the beginning-level RN.

These indicators of expected practice, that have been identified in this study, provide tangible evidence of how clinical educators judge the practice performance of TtR students are or are not meeting the required standard. When TtR students do not demonstrate clinical educators' interpretation of safe, quality, competent nursing practice, however, challenges are presented for clinical educators to conclusively and confidently form a judgment that the TtR student is or is not ready for professional practice. This quandary lies at the heart of this study. It particularly arises when TtR students' practice performance is not unsafe, nor unprofessional, but neither is it able to be assessed as safe, quality, competent nursing care and, therefore, a demonstration of readiness for professional practice.

6.2.2 Drawing the distinctions between safe, but marginal practice performance of TtR students from unsafe, dependent practice and/or unprofessional behaviours

Some TtR students do not meet the typology or hallmarks of unsafe, dependent clinical practice as described within the literature (Henderson et al., 2012a; Killam et al., 2011; Killam et al., 2012; Luhanga et al., 2008a), neither are they able to be assessed as safe and competent and, as such, ready for professional practice. Questioning their readiness for professional practice occurred as a direct consequence of the clinical educator judging their practice performance as not at the required standard. This study established that a more elaborated set of criteria assisted clinical educators to identify safe, but marginal practice, and differentiate it from unsafe and unprofessional practice. The need for these distinctions in assessment of practice of TtR students is the second integrated finding to emerge from this study.

The need for, and impact of, differentiating criteria has not been previously identified in the literature. Prior research has described the practice performance of nursing students during clinical placement when it does not meet assessment requirements and expectations, using terms such as 'unsafe' (Killam et al., 2011; Killam et al., 2012; Luhanga et al., 2008b; Luhanga et al., 2014; Mossey et al., 2012), 'unsuccessful' (Lewallen & DeBrew, 2012) and 'underperformance' (Elliott, 2016; Yepes-Rios et al., 2016). Most of these studies have investigated unsafe practice from the student perspective, using published hallmarks, or typologies of unsafe practice of nursing students during clinical placement (Henderson et al., 2010; Killam et al., 2011; Luhanga et al., 2008b; Luhanga et al., 2014; Mossey et al., 2012).

This study's findings concur with the published hallmarks of unsafe practice of TtR nursing students, including acting outside the student scope of practice and placing patients' safety at risk or a pattern of near-miss events in which harm is only avoided due to staff intervention (Killam et al., 2012). Deficits in performing fundamental skills (Killam et al., 2012) and a lack of knowledge including critical thinking (Henderson et al., 2010; Killam et al., 2012) are also identified criteria. This study has identified two additional hallmarks, not previously included, that represent TtR students' practice that is unsafe and dependent. These are: (1) not able to safely meet the required workload without close supervision and input by RNs; and (2) failing to take responsibility for their practice deficits and behaviours.

This study proposes that assessment is more trustworthy when clinical educators are provided with specific identifiable criteria to identify if the TtR students' practice is unsafe or unprofessional so that clinical educators are able to fail these TtR students. Establishing the ways that clinical educators differentiated unsafe, dependent practice and unprofessional practice is important to the

context of this study. Studies that did explore third-year students' practice in relation to the hallmarks of unsafe practice (Killam et al., 2011; Luhanga et al., 2008a, 2008b; Luhanga et al., 2014) did not differentiate between unsafe practice and unprofessional practice of TtR students.

Findings in this study concur with the Q-methodology study by Killam et al. (2012) that recommended that, as unsafe practice poses a threat to public safety and/or threatens the nursing profession's professional standards, these students should be failed. Clinical educators were adamant these TtR students should be removed to ensure patient safety, as found in Study 2. Clinical educators also considered that, when TtR students resorted to unprofessional behaviours, such as swearing (S2: p. 88) or begging to be passed (S2: p. 88), they were not meeting expected standards of professional behaviour and, as such, were not ready for professional practice.

This study also made a concerning discovery that when TtR students display unprofessional attitudes and behaviours and the clinical educators failed them, that judgement could be overturned by the university on appeal (Study 1, Table 4.5). In particular, clinical educators found it more difficult to fail TtR students whose practice was not meeting the required standard due to their unprofessional behaviours and attitudes (S2; p. 88).

Clinical educators' ability to draw distinguishable criteria between TtR students' practice as unsafe, unprofessional, and safe, but marginal, was pivotal to meeting the aims of this study. Making this differentiation for students, who are so close to completion of their degree, and when their practice was not meeting the required standard, was important because, as this study found, these students' practice was sometimes being unfairly labelled (S2: p. 88) as unsafe by supervising RNs. For TtR students, having their practice incorrectly labelled as unsafe could have serious ramifications and result in their immediate removal from the venue, often without any mitigation (Study 1, Table 4.5).

More importantly, this study has established that clinical educators could, however, differentiate TtR students' practice performance as safe, but marginal when using the additional criteria that were not included in the standard assessment tool (Appendix 13) and this contributed to their capacity to distinguish it from practice that was unsafe or unprofessional. Safe, but marginal TtR students kept themselves and their patients safe by not acting outside the student scope of practice and self-correcting. They could be slow with skills, but it would be to accommodate a need for a task that required a degree of caution. These students, who are assessed as marginal but safe, understand their practice needs to improve because they have insight that non-nursing clinical education studies previously identified as being 'consciously incompetent' (Lake & Hamdorf, 2004, p. 327; Peyton, 1998, p. 17). These TtR students wanted to improve their practice deficits (S2: p.

93) and, more importantly, were willing to work hard to overcome them. They should, therefore, be afforded mitigation and failed if remediation is unsuccessful (Chunta, 2016).

6.2.3 Management of practice that does not meet the required standard

Identification of safe, but marginal practice performance of TtR students requires a deliberate use of appropriate mitigation strategies to ensure that they develop the competence and confidence required for professional practice. This step is possible only when it is not impeded by contextual factors beyond clinical educators' control. Despite the long history of the use of mitigation strategies within nursing programs to provide support and assist nursing students to meet assessment requirements, a gap in literature exists in identification and evaluation of mitigation strategies for TtR students. Prior studies have established that mitigation, or remediation, as it is often referred to, risks being a 'band-aid' approach for students when it occurs so late in the degree (Custer, 2016; Maize et al, 2010; Pennington & Spurlock, 2010). This study proposed that TtR students whose performance meets the criteria of safe, but marginal practice should be afforded mitigation strategies because it is more likely that they would be willing to work hard to develop their practice.

The identification and analysis of mitigation approaches and interventions, an aim of this study, established that, in Study 1, mitigation strategies were ad hoc and variable and, therefore, set up conditions that could be subject to student appeal (Study 1, Table 4.5). These finding were pivotal in the research approach used for Study 2 including the design of both the case vignette and the questions. The findings in Study 2 revealed clinical educators' application of commonly used strategies when making decisions regarding the management and mitigation of the case vignette. The common strategies included:

- meeting with the key informants;
- assessing the TtR students' practice;
- determining a plan of action;
- gathering evidence including written daily feedback reports to evaluate progress towards readiness for professional practice; and,
- engagement by all involved in the mitigation process, including the student, supervising RNs, clinical educator, and the university sector.

Analysis of the individual approaches for managing and mitigating the practice performance of TtR students that fails to meet the required standard provides a foundation for the development of a more deliberate and structured approach that could go some way to lessen the confusion that currently exists. Clinical educators described this confusion as being caused by variations across the institutions, that especially impacted in those venues where TtR students from multiple institutions would undertake clinical placement at the same time.

This study has identified that an assessment of TtR students' practice that is not meeting the required standard should generate a 'decision trail' that identified the mitigation strategies implemented. This would go some way to eliminate the failure to provide mitigation in some cases that was exposed in Study 1. The failure to afford mitigation was grounds for student appeals (Study 1, Table 4.5) and resulted in the overturning of their fail grade because their practice limitations had not been addressed. Alarmingly, this created situations in which these students could seek employment, thus posing a significant risk to patient care and other staff.

When nursing students pose a risk to patient safety (Killam et al., 2011; Killam et al., 2012; Luhanga et al., 2008b; Luhanga et al., 2014; Montgomery et al., 2014; Mossey et al., 2012), it has been found that mitigation was less likely to have been implemented (Lynn & Twigg, 2011). This study demonstrated through comparing nine cases, that an inconsistent approach had occurred with clinical contracts being implemented for some of the nine TtR students whose practice had placed patients' safety at risk, while others were removed without any mitigation. Clinical educators concurred with prior studies that identified communication deficits were common (Lewallen & DeBrew, 2012) especially amongst international students (Kelton, 2014) and male students (Gregory, et al., 2009), and a critical factor in why they had implemented mitigation for TtR students (S2: p. 102). A recent wider WIL study concluded that the responsibility for mitigation of students who are close to completion of their degree is the responsibility of the university sector (Ajjawi et al., 2020). Whilst this may be the ideal, this study identified this does not always occur and in fact, that there had been a shift in which the onus to mitigate poor practice, could now rest entirely with the clinical educator (S2: p 117).

Mitigation, in relation to TtR students specifically, has not previously been explored. This study has established that when clinical educators were able to distinguish criteria for safe, but marginal practice, when assessing TtR students, they could make more accurate judgements (Study 2, Table 5.4). Providing these specific criteria using a tool that enabled TtR students' practice to be assessed as safe, but marginal meant clinical educators were more inclined to implement mitigation and/or remediation processes.

6.2.4 Lack of deliberateness contributing to failure to fail/failure to pass

A lack of deliberateness in assessment and management of practice performance when TtR students are not meeting the required standard contributes to failure to fail and failure to pass. This study has contributed a framework to distinguish the three levels of practice performance, namely, safe, but marginal, unsafe and dependent, and unprofessional practice. This framework supports sound judgements and reduces incidence of students being given the 'benefit of the doubt' to overcome the risks associated with a failure to fail culture (Hughes et al., 2018) or of being failed unfairly. Assessing practice against identified criteria could enable clinical educators to make judgements that are beyond a reasonable doubt.

The impact of failing to fail the unsafe nursing student cannot be overstated (Killam et al., 2012; Luhanga et al., 2014; Mossey et al., 2012). The issue of failure to fail has been a contentious and ongoing issue for those involved in clinical nursing education. It was raised by Duffy (2003) to better support mentors to fail incompetent students. Research has explored such factors as the impact of assessors' willingness to assign the fail grade (Chunta, 2016; Couper, 2018; DeBrew & Lewallen, 2014; Docherty, 2018; Duffy, 2003; Hughes et al., 2018; Larocque & Luhanga, 2013; Lewallen & DeBrew, 2012;). Emotional consequences, for both student and assessors, were also identified as causing a reluctance to fail students (Couper, 2018; DeBrew & Lewallen, 2014; Duffy, 2003). The lack of willingness to fail students, especially towards the end of their degree, raises the question of whether students deserve to pass, having been able to pass up to this stage, or are being passed because nobody wanted to fail them (Killam & Heerschap, 2013; Luhanga et al., 2008a).

Hughes et al. (2018a) undertook a qualitative study to examine the human influences and organisational processes within the university sector to provide explanation of how the culture of failure to fail (Hughes et al., 2019a) continues to occur. Prior studies identified that the practice environments are 'hot-learning environments', replete with unpredictability (Cooper et al., 2003; Eraut, 1994). As a result, individual students' success in placement environments can be highly variable so that they can be quite successful in one and not in another (Cooper et al., 2005; Henderson et al., 2010; Pront et al., 2013) especially if they lack resilience (Delgado et al., 2017; Hart et al., 2014; Thomas & Revell, 2016). Clinical educators were identified in this study to be more likely to afford TtR students the benefit of the doubt when they factored in the impact of poor quality supervision by RNs or bullying cultures within venues when making their judgement of TtR students' readiness for professional practice. Findings from both Study 1 and Study 2 established that clinical educators do award borderline pass grades (S2: p. 111) and they do give these students the benefit of the doubt.

Having concrete criteria to assess and determine TtR students' practice is safe, but marginal provides a means to reduce the likelihood of assessors not only failing to fail but also failing to pass that occurs when TtR students are failed unfairly and removed from practice, sometimes without mitigation, as was seen in Study 1 (Table 4.5).

This study described two conditions of judgements of practice performance. One was recorded in text and submitted to the university with a rationale and conduced in the messiness of everyday practice. This first context was for real students with real consequences. The other, was thoughtful, considered, and risk free, because the student was 'fictitious' and there would be no associated consequences for the student. Time was put aside during the interview in which to make and discuss this judgement. The only risk was the fact that the clinical educators' judgements were being directly observed in the research interview process so their descriptions may have reflected what they thought were ideals related to the assessment of students' competence to practice. Thus, these two research conditions are quite contextually different, but both provide information to help question the ways that TtR students are assessed as being capable to practice safely as professionals. The questions raised are not only about the capabilities of the assessors or the accuracy of how they assessed, but also about critical analysis regarding the taken for granted assumptions that shape the processes and the systems by which these judgements are made regarding readiness for practice of those about to complete their degrees.

This study has demonstrated that the kinds of thinking that occur when clinical educators are making judgements about the capabilities of TtR students to be safe and competent practitioners is messy. In the actual act, clinical educators weighed up the safety of patients, their compiled impressions of the students along with all their other responsibilities and made a judgement in the midst of managing multiple demands and then justified that decision to the university. In the clinical setting these judgements can be influenced by personal relationships or be quite impersonal if the clinical educators have had little student contact. It is almost impossible to capture this thinking while assessing in the clinical context, but the evidence used in Study 1 was comprehensive documentation and records of the decisions about the performance about each of the nine students that were made over time.

This study has provided evidence that, to avoid overturning of grades and/or awarding of borderline pass grades, clinical educators must assess TtR students' application of knowledge to practice. Their capacity to do this was shown to deepen when clinical educators understand and draw from their knowledge of the wider curriculum (S2: p. 106). Clinical educators' level of confidence in conducting assessment of practice, most evident in the analysis of their assessment of the case

vignette, was found to be embedded in a level of expertise that was shaped by thinking–in–action (Cooper, et al,, 2005) and the wisdom of experience that leads to tacit knowledge (Benner et al., 2009) of learning and teaching, and the wisdom of practice (Shulman, 1987). This knowledge, being tacit, is difficult for educators to express explicitly yet at the same time it helps them to decide in such complex situations what actions should be taken.

Clinical placement develops TtR students' capacity for critical thinking and becoming socialised to meet the expectations regarding professional and ethical behaviour (Henderson et al., 2010; MacIntyre et al., 2009; McCarthy & Murphy, 2008). Practice of TtR students that was meeting the required beginning-level RN standard was shown to incorporate critical reflection through the application of a clinical reasoning approach (Brookfield, 2008; Hunter & Arthur, 2016; Levett-Jones et al., 2011) and reflection in, on, and before action (Edwards et al., 2017; Levett-Jones et al., 2011). Clinical educators reported that observations of student capacity to critically reflect on their own practice was critical in making judgements about the TtR students' transition towards readiness for professional practice.

The evidence that fail grades awarded by the clinical educators were being overturned on appeal so readily at the university (Study 1, Table 4.5) was concerning. In Study 2, clinical educators voiced their frustration (S2: p. 112) with this as a lack of regard for their professional judgement. By contrast, the failure to pass TtR students whose practice is neither unsafe nor unprofessional, but may not have yet attained the required standard, (S2: p. 100) was recognised and labelled by the clinical educators as unfair.

A deliberate approach to clinical assessment, using differentiating criteria to arrive at an evidence-supported judgement, would benefit not only the students and clinical educators, but also the academic coordinator, who may have little choice but to overturn the clinical educator's judgement if it is not substantiated with evidence. Assessing TtR students' practice as safe, but marginal could prevent 'failure to pass' as these students would be automatically afforded mitigation. The provision of supporting evidence would enable the academic sector to analyse each case to ascertain that students are not in hostile environments and being unfairly labelled as unsafe. The current situation, in which grades are overturned without first establishing acceptability of TtR students' practice, is a case of the university sector's failure to fail. Overturning placement assessment outcomes without further assessment by the university sector carries no less risk of harm to these students' future patients than clinical educators awarding them borderline passes. This study posits that the provision of a set of criteria to form evidence-based, definitive judgements could reduce the dual

risks of failure to fail and failure to pass and enable the clinical and university sectors to work more harmoniously toward making these important judgements.

6.2.5 Educational interventions shaping assessment of practice performance

Expertise for clinical educators regarding assessment of practice performance was found to be derived not from intentional design but, rather, the undertaking of classroom-based tutoring (Table 5.2). These teaching roles were found to give clinical educators the necessary skills and knowledge that fostered confidence in their ability to assess and manage TtR students who were not meeting the standard.

However, it was found that not all clinical educators had this level of confidence, and that variation between assessors created problems. Günay & Kılınç (2018) identified that assessment of students' ability to apply theory to practice varied from one assessor to another. This study found that variation between assessors (S2: p. 108-9) was especially problematic with TtR students whose practice was not meeting the required standard who challenged clinical educators demanding higher grades. Better preparation and education of clinical educators regarding assessment would improve consistency between clinical educators and develop their capacity to gather sufficient evidence or implement early mitigation for less than satisfactory practice (Study 1). Gathering more evidence and generating records of decision trails would help reduce the overturning of grades for TtR students whose practice does not meet the required standard. Support from the university sector to provide preparation and education is essential for ensuring consistent, equitable assessment of students' practice performance.

The university sector has the responsibility for ensuring that clinical educators' assessment is valid and reliable, that is, it assesses what it intends to assess (Cassidy et al., 2017), and it is fair and characterises the expected learning in the practice setting (Price, 2012). Prior studies have questioned the requirement for nursing students to be at the beginning-level RN standard and consider it is only about ensuring a work-ready workforce (Windsor et al., 2011). Studies have also questioned whether it is fair to assess nursing students' competence development against the profession's standards (Almalkawi et al., 2018; Helminen et al., 2017) when TtR students cannot practice independently (S2: p. 113-4) and must act within the student scope of practice.

A study that previously explored problems with assessment tools (Levett-Jones & Lathlean, 2009a) questioned the veracity of self-appraisal assessment tools with students who were overconfident and acted outside their scope of practice. Although this study did not set out to focus on assessment

tools, it was able to establish that gaps in the ANSAT (S2: p. 112) created a dilemma for clinical educators. Knowledge and professional behaviours are also not specifically assessed.

Pedagogical problems inherent in wider curriculum issues were shown in this study to impact TtR students' clinical outcomes. A prior study by Elder et al. (2015) showed final-year students who received low scores for science-based topics were more likely to require remediation to pass the National Council Licensure Examination (NCLEX) for Registered Nurses. This study established that low scores for science-based topics (Table 4.4) were a curriculum issue that correlated with TtR students failing to demonstrate their capacity to apply knowledge to practice. Studies have explored the need to limit assessors' bias through assessment design (Price, 2012) and that assessing of TtR students' readiness for professional practice requires students to practice at a proficient skill level as a minimum (Helminen et al., 2014; Levett-Jones et al., 2011), and the need to demonstrate the skills for providing safe, effective nursing care (Fater, 2013; Helminen et al., 2014; Tanner, 2007). This study concurred with those findings and also identified that entry pathways that limit the number of previous placements TtR students have undertaken were an influencing factor (S2: p. 115) in why TtR students' practice development did not progress to the required standard

This study established that a difference in expectations between the supervising RNs and assessment requirements for TtR students was a contributing factor in the exposed tension between the university and practice environment sectors as identified by the clinical educators in Study 2. Clinical educators do not make judgements regarding TtR students' practice in isolation. That judgement was found to be informed by the testimony of supervising clinical staff who have observed students' practice in real time with real patients (Ha, 2015; McNeish et al., 2011). In overturning the judgement of the clinical educator, the university sector is also disregarding the directly observed assessment of the students' practice by the supervising RNs and as shown, this contributes to tension between the two sectors.

It also became apparent in this study that several clinical educators did not have opportunities to undertake firsthand observation of TtR students' engaging in the provision of nursing care. This meant these clinical educators were totally reliant on the testimony of the supervising RNs. Furthermore, the attitudes, behaviours and practices of the supervising clinical staff was shown to influence their ability to give feedback to students and to seek assistance, especially when dealing with students whose practice is not meeting the required standard (Henderson et al., 2010). It is important, therefore, that not only clinical educators, but also supervising RNs, need understand the ways that readiness for professional practice can be exhibited as well as curriculum requirements for TtR students. Previous research confirmed that education interventions conducted by the

academic sector through workshops on campus, or tutorials as conducted in the actual clinical setting of the DEU model (Edgecombe et al., 1999; Edgecombe, 2014), increased supervising RNs' understanding of the curriculum and students' learning needs. Such measures could also be utilised to close the gap in differing expectations as this might alleviate the tension exposed in this study between the two sectors.

The role of the clinical educator requires additional knowledge and skills. Education and training to equip clinical educators with the necessary assessment skills was shown as pivotal with assessing TtR students whose practice does not meet the required standard.

6.2.6 Summary

It was established that assessment of practice performance of TtR students that does not meet the required standard is enhanced when explicit differentiating criteria in an assessment tool were provided to clinical educators and promoted a consensus that had been previously absent. The current set of conditions regarding assessment of clinical performance of TtR students contributes to a failure to fail and a failure to pass. The implications of this finding include a need for rethinking the following: the design of the entry pathways to degree programs, design of the assessment tool itself, and the professional development regarding practice performance of TtR students required by all those who undertake the pivotal role of clinical educator. What was found to be particularly important is the need to explicitly distinguish identification and assessment of safe, but marginal clinical performance from what is unsafe and/or unprofessional TtR performance.

6.3 Implications

The analysis of nine cases of TtR students whose practice did not meet the required standard, and extensive analysis of clinical educators' accounts of managing and mitigating these students' practice, demonstrated that the implementation of mitigation, was inconsistent, individualised, and mostly ad hoc.

A more consistent approach to management and mitigation, however, was applied by clinical educators when assessing the standardised case vignette due to the availability of the specific criteria to rate TtR students' practice as safe, but marginal; unsafe, dependent; or unprofessional. The availability of a framework of criteria and processes could eliminate awarding of borderline pass grades. To illustrate what might be possible a framework (Appendix 17), has been developed that involves: management of the situation with all key informants; assessment of practice; development of a plan; gathering of evidence; and, engaging all key informants in mitigation (MADGE Process).

The MADGE process that has been generated is based on reflective strategies implemented by clinical educators and gained in this study. The results that led to the identification of the MADGE process (Appendix 17) may be open to different interpretation, as not all clinical educators identified each of the phases in precisely this same way. However, it is based on the general approach they all described as their management and mitigation of practice of these TtR students. The clinical educators with the most experience in dealing with these TtR students identified the phases, with one notable exception, and that was whether they identified the need to first report to the academic coordinator. Other studies that have evaluated mitigation or remediation (Chunta, 2016; Custer et al., 2016) questioned the effectiveness of remediation with unsafe, dependent practice. The MADGE process concurs with this, and has identified that TtR students who meet the unsafe, dependent criteria, or display behaviours and attitudes that meet the unprofessional criteria, should be removed to reduce the risk of harm to patient safety (Killam et al., 2012; Luhanga et al., 2014). Prior studies that explored specific approaches and strategies for mitigation or remediation (Gregory et al., 2009; Kelton, 2014; Ness et al., 2010) did not do so in relation to TtR students who must meet the required standard.

6.4 Conclusion

This chapter has presented the integrated findings emanating Study 1 and Study 2. The findings were compared and contrasted with existing knowledge, together with discussion of why new findings were similar or different to previous research, and the significance of this new knowledge. The fostering of the implications for developing TtR students' practice that does not meet the required standard and is assessed as safe, but marginal, is significant for shifting the persisting culture of failure to fail and overturning of grades for TtR students, and failing to pass TtR students whose practice is safe but marginal. The MADGE process (Appendix 17) that emerged from the study's established findings for the management and mitigation of TtR students' practice that has been assessed and distinguished as safe, but marginal has been discussed.

The final chapter will summarise the outcomes of this study and present an overview of this thesis in relation to the principal question and aims, and the purpose and significance of this investigative study. It will present a set of guidelines for assessment of TtR students when their practice performance does not meet the required standard to ensure and assure graduates' competence and readiness for professional practice. It will address the limitations of the study and discuss future research implications.

CHAPTER 7 CONCLUSION

7.1 Introduction

This study sought to provide greater understanding of the practice performance of transition to registration (TtR) nursing students that does not meet the required standard when undertaking final clinical placement. Using a phenomenological approach to the research, two separate studies were undertaken to achieve the three intended aims, answer the key research question and address the three aims. These are each listed and discussed in the sections that follow.

7.2 Research Question

How do clinical educators assess, manage, and mitigate Transition to Registration (TtR) students when clinical practice does not meet the required standard and development expected in readiness for professional practice.

7.3 Research Aims

1. To critically examine and identify the perceptions and meanings held by clinical educators that is evidenced in the assessment history of selected TtR nursing students whose practice performance is judged as not meeting the required standard.

2. To identify and analyse the mitigating approaches and interventions commonly used by clinical educators to assess and support TtR students when their practice performance does not meet required standard to enable students to gain the clinical competence and confidence required for beginning-level RN practice.

3.To identify the changes needed to nursing education curriculum and professional learning for clinical educators to improve and enhance their management and assessment of practice performance of TtR students who do not meet the required standard.

Study 1 used content analysis (Elo & Kyngãs, 2008) to critically examine the historical documentation pertaining to the clinical and academic performance history of the practice performance of nine TtR students, all of whom were assessed by their clinical educators as not meeting the required standard. To identify the selected cases, this study used indicators in the clinical reports that had been submitted by clinical educators in recording their assessment of students' readiness for practice. The problematic nature of these records was that they failed to provide any reasoning and justification for the assessment and subsequent judgement. As a result,

this first study was not able to provide a comprehensive answer to the principal research question but went some way towards meeting the first aim. The three unanswered questions that emerged following the analysis of the existing historical documents held by the university prompted the undertaking of a second study and shaped its design.

Study 2 involved critical examination of interviews with clinical educators using thematic analysis (Braun & Clarke, 2006) to elicit and critically examine the perceptions and interpretations of meanings held by sixteen clinical educators to distinguish how they assessed, managed, and mitigated practice performance of TtR nursing students whose practice was not meeting the required standard. This study generated valuable insight into how clinical educators identify and analyse practice progress. The study also generated insights into the mitigating approaches and interventions they applied to provide remedial support in enabling these TtR students to gain the requisite level of clinical competence and confidence required for professional practice.

7.4 Outcomes of this Study

This study began with an assumption that there are flaws in the assessment of TtR students in their final clinical placement. This assumption was based on my own experiences gained over the many years of my professional practices as a learning coach for nursing students who were failing to meet practice expectations in their final year of study. While it is clear that most students are competent and confident to transition into practice as graduates, a small but significant group are not. Some will need more time to improve their knowledge, skills, and professional behaviour. Others are unsafe, and/or unprofessional, and it is a commonly held assumption that it would be irresponsible to pass them as they would put patients and other staff at risk. The differences between these three states are often difficult to discern and have largely failed to be explicitly articulated for both the TtR students and the clinicians who assess them.

In relation to the principal question, discussion of the integrated findings has addressed how clinical educators assess, manage, and mitigate TtR students when their clinical practice does not meet the required standard and the development expected in readiness for professional practice. What has been established, and supported through evidence, is that clinical educators assess practice performance as not meeting the required standard when TtR students do not demonstrate safe, quality, competent nursing practice at the beginning-level RN standard during their final clinical placement.

Common, causal factors identified in the first study indicated that clinical educators' decision-making about students who did not demonstrate expected standards included knowledge deficits,

skills deficits, and unprofessional behaviours. The second study established the judgement of whether the required standard had been met was based on clinical educators' interpretation of the required standard of safety, quality care, and practice competence exhibited in the students' nursing practice.

Clinical educators' assessment, management, and mitigation of TtR students whose practice performance was not meeting the required standard was based on their experience gained over time with similar TtR students' performances. This could be referred to as clinicians' wisdom of experience (Shulman, 1987). Expertise in conducting assessment to judge TtR students' integration of knowledge with practice was found to be enhanced when clinical educators had experience in tutoring in the classroom. This finding pointed to a lack of an intentional and purposeful program conducted by the university to ensure clinical educators had been inducted and prepared to conduct assessment of TtR students' readiness for professional practice.

Study 2 found that clinical educators were constrained in the assessment of TtR students who were not meeting the required standard because the current assessment tool failed to provide explicit demarcations of students' performance that went beyond indicating that the standard had or had not been attained. The analysis of data regarding how clinical educators form and act on judgements about practice performance of TtR students that does not meet the required standard indicates that a tacit, shared understanding exists among those responsible for assessing readiness for professional practice, which was evident when they were provided with an assessment tool that included additional measurable criteria.

A shift in clinical educators' judgements was evident when they were provided with more differentiated criteria that described safe, but marginal practice, and resulted in them all identifying the practice as safe, but marginal for the TtR student presented in the standardised case vignette. Such understanding was not evident in their prior assessment of the same case vignette without this tool. Furthermore, the clinical educators identified additional hallmarks of safe, but marginal practice to distinguish this for assessment purposes from unsafe, dependent practice, or unprofessional practice (Appendix 16). This new capability in discerning and distinguishing performance competence and safety advanced a more detailed understanding of how such safe, but marginal practice is exhibited by TtR students which has significant implications for universities to consider for clinical education in the future.

When using the tool developed for the study, clinical educators differentiated between the qualities of TtR students' clinical performances, particularly noting the performances that were marginal but

not safe as being in a different category from performances that they found to be unprofessional or unsafe and dependent practice. Their rationale was that these students whose practice was marginal but safe might not always pose the risk of harm to patients or demonstrate unprofessional behaviours. The impact on the clinical education outcomes for TtR students who have such a judgement made about their practice is profound because, in such a situation, they would not be removed from their placement, nor be failed so close to completion of the degree. This alternative assessment could also influence clinical educators' decision to implement remediation measures.

The clinical educators identified strategies that they employed which they attributed to past successes in mitigating students' performance weaknesses that enabled TtR students to gain the competence and confidence required for professional practice. The result of the analysis of the two studies culminated in the development of the structured MADGE process (described in the previous chapter). This process is intended to guide the assessment, management, and mitigation of TtR students when their practice could be judged as safe, but marginal, using the new criteria. These new criteria and the structured evidence-based process could go some way in reducing the problem of failure to pass TtR students who might just need more time or guidance to prepare for transition to registration standard.

7.5 Contribution to the Body of Knowledge

At the time this study was undertaken, limited research focussed specifically on outcomes for TtR students, with much of the literature addressing nursing students' practice performance in general and not specifically in relation to the final TtR clinical placement. Much of the research that was examined in the literature review focused on broader assessment factors, thus, leaving a gap in establishing how the clinical educators make the judgement and assess that TtR students' practice performance is at the required standard. This research has limited its analysis to TtR students' practice performance during their final clinical placement, although historical documentation, including former clinical reports and academic grades as recorded on academic transcript records, were taken into consideration. Whilst there is research that has investigated failure to fail of students whose practice is unsafe (Chunta, 2016; Couper, 2018; DeBrew & Lewallen, 2014; Docherty, 2018; Duffy, 2003; Hughes et al., 2018; Larocque & Luhanga, 2013; Lewallen & DeBrew, 2012; Tanicala et al., 2011) and the hallmarks of how unsafe practice is exhibited (Killam et al., 2011; Killam et al., 2012; Luhanga et al., 2008b; Luhanga et al., 2014; Mossey et al., 2012), no studies were uncovered that identified how judgements were made regarding safe, but marginal practice of TtR students and its potential to result in a failure to pass so late in their course of studies. This study also elaborated on why making this differentiation is important as, until now,

unsatisfactory assessment conditions have prevailed. Either clinical educators have had to rely on tacit, unscrutinised ‘wisdom of experience’, in which it seems that some students have been given ‘the benefit of doubt’ (Hughes et al., 2018) when perhaps they should have been failed. Clinical educators have also been frustrated by the overturning of grades by the academic sector. This practice has contributed to tension between the clinical and university sectors, as exposed by this study.

7.6 Significance of this Work

This study has established several significant key integrated findings relating to how clinical educators assess, manage, and mitigate the practice performance of TtR students that was not meeting the required standard. It has established what clinical educators seek as benchmark measures to judge TtR students’ readiness for professional practice. It is critical that practice performance of TtR nursing students who are about to complete their degree is rigorously assessed. Confidence in the accuracy of this assessment and demonstration of the standard, as mandated by the profession’s governing body, ensures the safety of the students themselves, the staff they will work with, and the public for whom they will provide nursing care once they become registered to practice as a professional RN.

This study has identified criteria that distinguish practice performance of TtR students as unsafe, dependent practice, or as unprofessional practice. More important, it makes a distinction between TtR students whose practice performance is safe, but marginal from those whose practice performance is unsafe and/or unprofessional. Making the distinctions against researched criteria will enable a reduction in decisions that result in failure to fail and failure to pass. Furthermore, to reduce the risk of borderline passes occurring, the study has identified a structured assessment process, such as the MADGE process, for approaching the management, assessment, and mitigation of TtR students whose practice does not meet the required standard.

7.7 Limitations

Limitations of this study include the decision to conduct this research in two campuses within just one school of nursing and midwifery. This was intentional to limit variables during the interviewing of the clinical educators (facilitators) that might arise due to differences relating to curriculums, placement objectives, and assessment processes or tools. The use of one SoNM across multiple campuses was common in other literature exploring similar issues and factors using qualitative research (Hughes et al., 2018).

The findings may have been enriched by interviewing hospital-based RNs, who have been seconded to undertake the clinical educator role by their employers, in addition to those who interviewed who had been appointed by the university. This limitation was imposed by the SoNM in which this research is situated. Approval was denied for this research to access seconded, hospital-based clinical educators. Conditional ethics approval was granted on abiding by this limitation. However, it is worth noting that, in process, data saturation was reached and, therefore, rather than viewing this as a limitation of the study, further research options have been identified related to this issue.

The design of the case vignette, whilst based on data contained within the nine cases of actual students who had not passed their TtR placement because they did not meet the required standard, could present a limitation and needs to be acknowledged. Clinical educators were asked to rate the scenario, using the assessment rating tool, that by design intentionally also included the practice meanings and descriptors of safe, but marginal practice. Furthermore, the MADGE process that emanated from this rating of the scenario using that tool, could be seen as a potential limitation that as such needs to be acknowledged, given this intentional design for assessing the scenario as part of the research approach used in this study.

Students are clearly stakeholders in this assessment process, but the decision not to interview them was purposeful. In the main, studies around practice performance and clinical education of nursing students involve the student perspective. Little value would be gained in relation to the research question in asking students whether their practice satisfactorily meets expected standards and was safe. Research shows “unconsciously incompetent” students (Lake & Hamdorf, 2004, p. 327; Peyton, 1998, p. 16) who lack the requisite level of competence required for professional practice, are often unaware of their practice performance deficits (Lake & Hamdorf, 2004; Peyton, 1998). Self-efficacy through awareness of practice deficits was shown in this study to be a recognisable, distinguishing difference between the unsafe and the safe, but marginal practice performer.

Finally, the profession’s mandating body currently requires assessment of competence of nursing students be undertaken by those who assess, supervise, and observe such practice. A significant finding of this study was identifying that the clinical educators do not always engage in direct observation of TtR students when they are providing patient care. This raises questions as to whether the governing body’s requirement is being, or can be, met. This was an unintended finding of this study and, as such, it has not identified ways to overcome this disjunction between policy and practice. However, the study has shown how clinical educators modify the assessment process when they are unable to observe. Bearing these limitations in mind, and based on the overall

findings of this research, the next section will propose a set of guidelines, derived from analysis of data for recommendations of consideration and areas for potential future research.

7.8 Proposed Guidelines for Future Practice

Having established several factors that impacted and impeded the practice progress of TtR students, especially when their practice was not meeting the required standard, it is clear that some changes to common practices are required. The following set of guidelines, based on this study's findings, may help to address and overcome some of these identified challenges. These guidelines begin with an assumption that responsibility should be shared amongst all key stakeholders.

1. Labelling of TtR students' practice performance that does not meet the required standard as unsafe has not always been shown to be accurate. To reduce safe but marginal practice performance from being unfairly labelled as unsafe or unprofessional, there needs to be a process and criteria for assessing, managing, and mitigating TtR students' practice that does not meet the required standard. A global classification of judgements could be identifying practice as: safe, but marginal; unsafe, dependent; and/or, unprofessional.

2. TtR students whose practice performance is unsafe and/or unprofessional should be suspended and an investigation conducted. Should their practice be deemed as unsafe or unprofessional, then they should be removed from clinical placement by the academic staff to reduce any further risk to patient safety and a fail grade awarded.

3. For TtR students whose practice is not meeting the required standard, but who cannot be rated as unsafe or unprofessional and who meet the criteria for safe, but marginal practice, mitigation strategies should be implemented that may include an extended final placement.

4. Assessment of TtR students' readiness for professional practice should be undertaken against a fair and defensible assessment process using a national TtR student assessment tool that aligns with the professional practice standards for the registered nurse, and also incorporates demonstration of more explicit descriptions of learning outcomes that include a satisfactory level of knowledge, mastery of psychomotor/technical clinical skill set, and professional disposition behaviours and values. A good example for consideration of a new assessment tool design is the Compass tool developed for speech pathology.

5. All clinical educators should be provided with additional education and training to ensure that they possess an understanding of how to conduct fair and defensible assessment of clinical practice and are capable of making an informed judgement of TtR students' readiness for professional

practice. This requirement for competent assessment skills should occur regardless of whether the clinical educators are appointed by the university or are seconded hospital staff who undertake this role within their organisation. The responsibility for providing and regulating this education should rest with the university sector.

6. The university sector should work collaboratively with the profession's governing body (NMBA) to develop guidelines for curricula that stipulate the required minimum number of hours of clinical placement for all entry pathway programs that lead to registration. A percentage of these nominated hours should be required to occur within specific environments so that students do not encounter 'hot-learning', high-risk environments for the first time during their TtR placement. Approval of curricula could be granted dependent on the higher education sector outlining for every program the ways it would meet these stipulated requirements.

7. The university sector should provide clinical educators with a reporting mechanism that has a dual purpose. Firstly, clinical educators could nominate RNs whose teaching and supervisory practices have enhanced TtR students' learning and this information should be passed on to the host organisations. Secondly, where quality of supervision was inadequate, or a pattern of a less than satisfactory culture emerged, the university sector should provide onsite education to develop those supervisory practices of the RNs and improve placement outcomes for students or cease to use that venue.

8. The governing body and university sector should review the role of clinical educator and acknowledge the valuable contribution it makes to clinical education of nursing students. In this process, consideration should be given to introducing compulsory national qualifications in clinical nursing education. This strategy would close the loophole that currently allows seconded hospital RNs to be appointed to the role of clinical educator without holding a Bachelor of Nursing degree.

7.9 Implications for Future Research

This investigative study resulted in some significant findings to improve current outcomes for TtR nursing students when their practice performance does not meet the required standard. It has also proposed a way to assess, manage, and mitigate such practice for those TtR students who meet the criteria of safe, but marginal practice performance. The assessment tool and the structured process that emerged from this study have not been trialled but need to be. With this in mind, the following suggestions for further research are made.

1. Research should be undertaken to evaluate the value of the MADGE process for more accurate and defensible assessment and management of the practice performance of TtR students that does not meeting the required standard and is assessed as safe, but marginal.

2. The assessment tool identifying practice performance of TtR students as safe, but marginal; unsafe, dependent practice; or unprofessional practice be reviewed, tested, and amended for accuracy and feasibility of application by clinical educators.

3. Research should be conducted to determine what education and training programs could promote best-practice assessment to ensure clinical educators have the required understanding for judging TtR students' readiness for professional practice. This research might also investigate how being employed as a casual tutor in higher education impacts clinical educators' capacity to conduct assessment of TtR students' knowledge and practice performance.

4. Associated with the previous recommended research is the need to generate evidence to articulate what fair and defensible assessment is, and how to apply cardinal criteria for rating the practice performance of TtR students aligned with the required standard.

5. Research should be undertaken to determine alternative methods for the clinical educator to directly observe TtR students engaging in patient care. Outcomes could be used to initiate change to the practice itself, or to provide impetus to update the governing body's regulations to reflect this shift has occurred and to establish some alternatives.

6. Research should be undertaken to explore whether a move towards a four-year Bachelor of Nursing degree is required to ascertain whether potential benefits exist providing the capacity for:

- Undertaking additional study of topics/courses that have been identified by clinical educators in this study, including pathophysiology and pharmacology, to support integration of theory and practice so that, by completion of the TtR placement, students are able to demonstrate a deeper application of contextual-based learning.
- Ensuring mastery of skill sets, including communication skills, that are assessed through simulation-based objective structured clinical evaluations (OSCEs) across all four years.
- Increasing the required clinical placement hours.

7.10 **Conclusion**

This investigative study, undertaken using Gadamer's philosophical hermeneutics (Gadamer, 1989; Davey, 2006) as the selected methodology, has answered the principal question by establishing how clinical educators assess, manage, and mitigate the practice performance of TtR students that does not meet the required standard. It critically examined and identified the perceptions and meanings

held by clinical educators that was evidenced in the assessment history of nine selected TtR nursing students whose practice performance was not meeting the required standard. It has identified and analysed mitigating approaches and interventions including purposeful strategies used by clinical educators to assess and support TtR students when their practice performance does not meet required standards so they will gain the clinical competence and confidence required for beginning-level RN practice. It has identified changes for nursing education curriculum and professional learning for clinical educators for the purpose of improving and enhancing their management and assessment of practice of TtR students that does not meet the required standard.

In conclusion, final clinical placement gives TtR students an opportunity to engage in an authentic learning space with maximum exposure, but a final clinical placement should not be limited to having a workplace experience to learn about nursing work. Students need to understand that they are required to demonstrate achievement of the professional practice standards for registered nurses at the beginning-level RN standard that involves critical reflection, clinical reasoning, and application of evidence-based practice. This is necessary to avoid their clinical practice becoming ritualised and task-oriented. At this stage of their degree, TtR students themselves have a responsibility to ensure that they engage with their curriculum and actively seek to achieve outcomes connected to learning in and through workplace clinical placement experience. Students who cannot do this risk finding their TtR practice performance rated as not meeting the required standard.

Practice performance of TtR students that does not meet the required standard needs to lead to explicit consequences. These consequences need to be governed by a clear process that needs to involve assessment of performance that is fair and defensible. The process needs to be followed by the student, the supervising RNs, and the clinical educator, and involve the academic sector staff. It must involve the gathering of evidence to substantiate and support the assessment decision that can be evidenced should there be an appeal against it.

Clinical educators have a responsibility to ensure the accuracy and the fairness of their assessment. ANMAC (2012) states that the responsibility rests with the university sector to ensure that those who assess nursing students on clinical placement are sufficiently informed and skilled to carry out this assessment. Preparation through education and training is critical, therefore, for ensuring those who undertake assessment of TtR students' readiness for professional practice have the requisite skills. However, universities have often failed to provide the programs and enabling resources that can support the acquisition of sound assessment skills for clinical educators involved in the assessment of that practice performance of final-year students.

Whilst the two studies in this thesis set out to examine the assessment of nursing TtR students' readiness and competence to practice, the findings lend themselves to consideration by other health professions. It is critical that assessment be accurate and be defensible in any education for practice program of study. This especially the case where students are not yet demonstrating safe and satisfactory practice performance because not to do so can result in either putting the community at risk or being unjust for students by delaying their opportunities for employment. Furthermore, students' practices at this late stage in their program of study, where there has been considerable investment by many stakeholders, should be carefully managed, poor practice mitigated where possible, and failed where necessary. The results from this investigative study provide a way forward to inform universities and clinical venues of what is needed to change to ensure that clinical educators' assessment of practice performance, and subsequent judgement of TtR students' readiness for professional practice, can ensure and assure it is beyond a reasonable doubt.

TABLE OF APPENDICES

Appendix 1: Letter of Introduction

Professor Janice Orrell
School of Education
Flinders University
GPO Box 2100, Adelaide S A 5001
janice.orrell@flinders.edu.au
www.flinders.edu.au
CRICOS Provider No. 00114A

LETTER OF INTRODUCTION

Dear Sir/Madam,

This letter is to introduce Mrs Moira Kelton who is a PhD student in the Faculty of Education, Humanities & Law from the School of Education here at Flinders University. She will produce her student card, which carries a photograph, as proof of identity if you require it.

She is undertaking research leading to the production of a thesis or other publications on the subject of marginal clinical practice performance and the interventions used to assure final semester nursing students' readiness for professional practice. She would like to invite you to assist with this project by agreeing to be involved in an interview which covers certain aspects of this topic. No more than 1 hour on 1 occasion would be required.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Since she intends to make a tape recording of the interview, she will seek your consent, on the attached form, to record the interview, to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed, and to make the recording available to other researchers on the same conditions. It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be asked to sign a confidentiality agreement which outlines the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

Any enquiries you may have concerning this project should be directed to me at the address listed above or e-mail Janice.orrell@flinders.edu.au Thank you for your attention and assistance.

Yours sincerely

Professor, Higher Education
School of Education
Flinders University, Bedford Park, SA 5042 janice.orrell@flinders.edu.au www.flinders.edu.au
Higher Education Consultant Adjunct: Charles Sturt University, Education for Practice Institute

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7037). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 2: Information Sheet

Professor Janice Orrell
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INFORMATION SHEET

Title: An enquiry into the identification of marginal clinical practice performance and the interventions used to assure final semester nursing students' competence and confidence for professional practice.

Researcher:
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Email: moira.kelton@flinders.edu.au

Ph: 08 82013273

Supervisor(s):
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Associate Professor Lily Xiao
School of Nursing & Midwifery
Flinders University
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Description of the study:
This study is part of the project entitled: An enquiry into the identification of marginal clinical practice performance and the interventions used to assure final semester nursing students' competence and confidence for professional practice.

This project will investigate what prompts clinical educators to determine that some nursing students are 'at risk' of failing to meet the required level of competence during their final clinical placement and subsequently being failed. The study seeks to create understanding around the meanings attributed by the clinical educators who supervise and assess student's practice to the notion of 'at risk' of failing if a student does not demonstrate a beginning Registered Nurse (RN) level of competence by completion of the placement. This study seeks to determine what interventional measures and or processes are considered important for mitigating such risk and assisting the 'at risk' of failing final

placement nursing student to ensure they demonstrate the competence and confidence required for professional practice. This project is supported by Flinders University School of Education.

Purpose of the study:
This project aims to find out

1. If the approaches and the interventions that currently support students identified as ‘at risk’ of failing their final clinical placement helps them to gain the competence and confidence required for professional practice.
2. What the cues, conceptions and meaning are that are held by clinical educators when they identify final clinical placement nursing students as ‘at risk’ of failing.
3. If an intervention process using a guiding set of principles to support the ‘at risk’ of failing nursing student to demonstrate the competence and confidence required for professional practice by completion of the final placement should be designed / developed.

What will I be asked to do?
You are invited to attend a one-on-one interview with the researcher who is the topic coordinator for the final nursing practice topic to talk about your experiences of facilitating or supervising final semester nursing students identified as ‘at risk’ of failing. The interview will take approximately 60 minutes. The interview will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been finalised. This is voluntary.

What benefit will I gain from being involved in this study?
The sharing of your experiences will help to inform the education design of future nursing education programs. It will help to shape the process to enable clinical educators and supervising clinical staff to support the ‘at risk’ of failing final semester nursing student.

Will I be identifiable by being involved in this study?
Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed, and the typed-up file stored on a password protected computer that only the researcher will have access to. Your comments will not be linked directly to you. The researcher does plan to publish her findings. You will be allocated a pseudonym / code name so that your identity remains protected at all times.

Are there any risks or discomforts if I am involved?
The investigator anticipates very few risks from your involvement in this study. Speaking about failing a student so close to completion of their degree, however, might upset you. Should this happen the researcher will stop the interview and check that you so or do not wish to continue. You can stop your participation at any time. Should you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the researcher.

How do I agree to participate?
Participation is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the process at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form and send it back to me at <address>.

How will I receive feedback?
Outcomes from the project will be summarised and given to you by the investigator should you wish to see them.

Thank you for taking the time to read this information sheet and we hope that you will accept the invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7037). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 3: Consent form for participants

CONSENT FORM FOR PARTICIPATION IN RESEARCH (Interview)

An enquiry into the identification of marginal clinical practice performance and the efficacy of interventions used to assure final semester nursing students' competence and confidence for professional practice.

I ……

being over the age of 18 years hereby consent to participate as requested in the interview for the research project on direct care staff experiences of behaviours and psychotropic medications.

1. I have read the information provided (Information sheet and letter of Introduction)
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form
5. I understand that:
    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on any treatment, employment or service that is being provided to me.
    - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

Participant's signature……Date……..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….…….....

Researcher's signature…….. Date……

Appendix 4: Clinical Case Conference Presentation (CCCP) Mark Sheet

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Appendix 5: Professional Experience Placement Record (PEPR) Example

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Appendix 6: Final Nursing Practice Topic Information Summary

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Appendix 7: NMBA Nursing Competency Standards for the Registered Nurse

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Version 2010, Retired version: Registered nurse competency standards - January 2006 - rebranded* 1 July 2010 to 31 May 2016

Version 2016: Current version: Registered nurse standards for practice, 1 June 2016.

Footnote: These standards could not be reproduced in hard print for this thesis

Appendix 8: Clinical Placement Objectives–NURSXXXX Nursing Practice

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Appendix 9: Feedback Sheet NURSXXXX (Example)

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Appendix 10: PEPR Summaries – Tracey: Placement 1 and 2

Removed due to ethical considerations

Appendix 11: Semi-structured Interview Questions

Background

1. Could you tell me about the role of a clinical facilitator as you see it?
2. What aspects of the role do you enjoy the most?
3. Which aspects do you least enjoy?
4. After reading the scenario about final semester student Mary what issues were you most concerned about?
5. What actions would you have taken?
6. Do you have any other comments you would like to make about the scenario?
7. Have you encountered anything similar when facilitating final semester nursing students undertaking their transition to registration placement?

Competence assessment

8. How would you describe clinical competence to a final year nursing student?
9. What is important to you when undertaking competence assessment of a final semester nursing student?
10. What are your thoughts on clinical competence assessment tools (CERs / PEPRs) that you have used for final semester nursing students?
11. Have you ever encountered a student who you deemed not competent?
12. How did you recognise their lack of competence?
13. What action did you take?
14. What was the outcome?

Knowledge assessment

15. Could you describe for me what processes you go through to assess a final semester, transition to registration students' level of knowledge
16. What areas of nursing knowledge do you believe are most critical to measuring competent nursing practice?
17. If you encountered a final semester student who had a level of knowledge that resulted in you having to decide if the student was safe, but marginal or unsafe – how did you / would you make that determination?
18. What has been some of your best experience of facilitating students to apply their knowledge to their clinical practice?
19. When facilitating the transfer of theory to practice what teaching and learning strategies do you apply?
20. Could you describe which aspects of the curriculum you consider to be critical to facilitate final semester nursing students' readiness for practice?

Approaches to practice development

21. Could you describe the strategies you use when facilitating final – semester students to develop their nursing practice to that of the beginning level RN?
22. Could you tell me about a particular time you helped develop a final semester student who lacked confidence in their clinical practice?
23. Are there practices that you would highlight if educating staff about strategies that they can use to develop clinical practice?
24. Have you ever had the occasion to intervene in poor supervision and assessment practices by supervising clinical staff RNs? What did you do?
25. What advice would you give to a first-time clinical supervisor RN of a final year nursing student?

Scope of Practice

26. Have you encountered a final semester student who acted outside their scope of practice?
27. Could you please describe your approach to this situation and what concerned you the most?

Scenario Assessment

28. In relation to the scenario about Mary discussed at the beginning – using this Assessment Rating Tool how would you rate Mary? Why?

Other Comments

29. Is there anything you wish to discuss or add? Is there anything you wish to retract?
30. Do you wish to read your typed transcript?

'Thank you so much for your time and thoughtful response; it has been very valuable and insightful.

Again, thank you for your time.'

Appendix 12: Standardised Case Vignette Process:

Thank you very much for agreeing to be interviewed. Before I commence with the questions, I would ask you to please read the following scenario. You are welcome to make notes or ask questions and seek clarification at any point. I have set aside 15 minutes for this, but please let me know if you require longer.

Mary Cheng is a final semester nursing student. She has commenced the fifth week of her eight-week block placement on a busy surgical ward at a large metropolitan public hospital where you are the clinical (PEP) facilitator/educator.

The CSC who has been on leave for the past two weeks updated you today about your students' progress when you arrived at the venue and tells you that a couple of staff have expressed some concerns to him about Mary.

Mary received a credit (72%) for her Clinical Case Conference presentation to you last week and you have been happy with her progress. Mary is coping with 75% of the RN patient load (she needs to be doing 100% by the completion of this placement). She can be a bit slow at times when she is administering medications and documenting patient care. Last week she had a patient with a low BP (101/48) that she had recorded in the chart, but she failed to report it to the supervising RN. She followed up by taking a repeat BP that was within normal limits. Last evening, she took the right medications but wrong nursing chart to the bedside but on checking the patient's name band realized her error and corrected it. Whilst no adverse outcome resulted from these situations staff have expressed to the CSC today that they do not believe Mary is safe. It seems she is sometimes reluctant to answer staff's questions about new patients' medical conditions and/or medications. The CSC tells you that given this he cannot see Mary being ready by the end of the final placement, so he thinks it would be best if she was removed now.

Do you have any other questions about the scenario?

Appendix 13: Assessment Tool for Rating Scenario

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Appendix 14: Demographic Form

Demographic Information

Pseudonym Name _____

Education qualifications

_____

_____

Number of years of undertaking the Clinical Facilitator / Clinical Educator role

_____

Venues:

_____

_____

_____

_____

_____

Other tertiary teaching experience

_____

_____

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Appendix 15: Australian Nursing Standards Assessment Tool – Example

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Appendix 16: Distinguishing Criteria of TtR Students' Practice that is Not Meeting the Required Standard.

Safe, but marginal practice criteria for TtR students:

- Does not act outside the student scope of practice and adheres to practices and policies
- Does not place the patient in harm's way because the student identifies the problem and self – corrects before any harm occurs without intervention or prompting from staff.
- Is underpinned by a satisfactory level of knowledge that includes the ability to synthesis contextual-based learning that shows patient's safety is not at risk and understands how to keep their patients' safe, even when unsure about what to do next.
- Practice may manifest as slow with some skills and at times inefficient time management, but this correlates to provision of care where such caution is warranted, for example during administration of medications, the use of new equipment or if undertaking an unfamiliar procedure.
- Communication with the patient is always appropriate and effective interpersonal skills are demonstrated with patients, staff and others.
- When concerns are raised, there is acceptance of the need to improve any practice deficits and welcomes opportunity to develop to the required level by actively seeking feedback.

Unsafe, dependent practice criteria for TtR students:

- Requires constant verbal and physical prompts and direction to provide care
- Acts beyond their scope of practice resulting in their involvement in a critical incident.
- Places patient safety at risk through a pattern of near – miss events in which harm is only avoided due to staff intervention.
- Deficit in knowledge underpinning practice demonstrated through inability to provide clinical rationales for the nursing care implemented.
- Requires frequent prompting to elicit knowledge.
- Inability to synthesise theory and practice even with frequent prompting and cues.

- Uncoordinated, unconfident and lacks proficiency in basic technical clinical skills.
- Unable to meet required workload without input and close supervision by RNs.
- Unable to provide leadership or direction to others

Unprofessional practice criteria for TtR students:

- Professional conduct and caring not consistently demonstrated.
- Does not always recognise professional boundaries towards staff & others
- Frequently demonstrates ineffective interpersonal communication skills.
- Does not use reflective practice to identify own professional development needs
- Does not always seek clarification from supervising RNs if unsure
- Does not consider health and wellbeing in relation to being fit for practice
- Unable to discuss practice behaviours and avoids attempts to promote reflection
- Unwilling to engage in mitigation: examples include refusing to accept development plan; swearing or unprofessional reaction; begging; offering money to be passed.

Appendix 17: The MADGE Process for Managing, Assessing, and Mitigating TtR Students' Practice that Does Not Meet the Required Standard

The MADGE Process: A systematic guide for the assessing, managing, and mitigation phases when TtR students' practice performance is not meeting the required standard.

Manage reported situation by meeting with all key informants - Student; Supervising RN(s) who reported concerns; Senior nursing staff member to establish what has happened. Ideally the clinical educator meets with all key informants at the same time as this meeting provides opportunity for mediation that might sort the problem(s) without further intervention. This meeting can be conducted remotely.

Assess TtR student's' practice and prepare a report for the Academic Coordinator (Faculty representative):

- A critical incident (adverse event) that resulted from the TtR student acting outside the student scope of practice that did not result from staff instruction should result in immediate suspension pending further investigation by the clinical educator in consultation with the academic coordinator (faculty representative).

- A third near-miss event where patient harm has only been averted due to staff intervention will also result in immediate suspension pending further investigation by the clinical educator in consultation with the academic coordinator (faculty representative). Both prior near-miss events should have prompted a formal email warning from the clinical educator to the student.

- Unprofessional behaviour such as threatening or abusive behaviour; rudeness or disrespect towards patients, staff or the clinical educator will result in suspension pending further investigation by the academic coordinator (or faculty representative) in consultation with clinical educator and/or senior nursing staff member.

Outside the above specific situations, TtR student's practice performance that is not meeting the required standard must be assessed in the clinical venue by the clinical educator using the following assessment process against the criteria provided below.

1. Assessment of practice through direct observation of the TtR students' provision of nursing care under supervision of the RN for one shift. Where observation by the clinical educator is not possible, or if the clinical educator is not confident to conduct the assessment, the assessment could be conducted by an independent assessor (not the

reporting RN) as nominated by the clinical educator in consultation with the senior nursing staff member (or their nominee).

2. Assessment of knowledge must be undertaken by the clinical educator. This could be undertaken remotely, but the clinical educator must question the student with the nominated assessor present during the assessment. Clinical educator will question and assess the application and articulation of knowledge demonstrates the depth of knowledge and linking of contextual-based learning commensurate with beginning level RN practice for all allocated patients' condition, treatments and clinical care needs during the shift where provision of care was observed.

Safe, but marginal practice criteria for TtR students:

- Does not act outside the student scope of practice and adheres to practices and policies
- Does not place the patient in harm's way because the student identifies the problem and self – corrects before any harm occurs without intervention or prompting from staff.
- Is underpinned by a satisfactory level of knowledge that includes the ability to synthesis contextual-based learning that shows patient's safety is not at risk and understands how to keep their patients' safe, even when unsure about what to do next.
- Practice may manifest as slow with some skills and at times inefficient time management, but this correlates to provision of care where such caution is warranted, for example during administration of medications, the use of new equipment or if undertaking an unfamiliar procedure.
- Communication with the patient is always appropriate and effective interpersonal skills are demonstrated with patients, staff and others.
- When concerns are raised, there is acceptance of the need to improve any practice deficits and welcomes opportunity to develop to the required level by actively seeking feedback.

Unsafe, dependent practice criteria for TtR students:

- Requires constant verbal and physical prompts and direction to provide care

- Acts beyond their scope of practice resulting in their involvement in a critical incident.
- Places patient safety at risk through a pattern of near – miss events in which harm is only avoided due to staff intervention.
- Deficit in knowledge underpinning practice demonstrated through inability to provide clinical rationales for the nursing care implemented.
- Requires frequent prompting to elicit knowledge.
- Inability to synthesise theory and practice even with frequent prompting and cues.
- Uncoordinated, unconfident and lacks proficiency in basic technical clinical skills.
- Unable to meet required workload without input and close supervision by RNs.
- Unable to provide leadership or direction to others

Unprofessional practice criteria for TtR students:

- Professional conduct and caring not consistently demonstrated.
- Does not always recognise professional boundaries towards staff & others
- Frequently demonstrates ineffective interpersonal communication skills.
- Does not use reflective practice to identify own professional development needs
- Does not always seek clarification from supervising RNs if unsure
- Does not consider health and wellbeing in relation to being fit for practice
- Unable to discuss practice behaviours and avoids attempts to promote reflection
- Unwilling to engage in mitigation: examples include refusing to accept development plan; swearing or unprofessional reaction; begging; offering money to be passed.

Following the assessment, a detailed summary and recommendation is forwarded to the Academic Coordinator (or Faculty representative). A decision is made by the Academic Coordinator (Faculty representative) and emailed to Student (cc'd to the Clinical Educator) :

- Safe, but marginal practice = Implementation of mitigation strategies to improve practice using the mitigation phase as detailed below.

- Unsafe, dependent practice = Removal from the venue by academic staff.

- Unprofessional practice = Removal from the venue by academic staff

Mitigation Phase for Safe, but marginal practice performance by TtR students

Develop a plan for practice improvement (PPI) that states areas of concern and practice deficits; mitigation strategies for development of nursing practice to the required beginning level RN standard together with the timeframe by which the required standard needs to be attained.

Gather evidence, that should include a written daily feedback report that evaluates progress toward the required standard and a bi-weekly review of practice progress and development through consistent application of the strategies and review of the timeline by the student and the clinical educator in consultation with supervising RNs.

Engagement by all involved in the mitigation process including the student, the supervising RNs, the clinical educator and the academic coordinator (or faculty representative). A weekly report summarising evaluation of the TtR students' progress towards the required standard is emailed to the academic coordinator (faculty representative) each week for duration of the PPI. The academic coordinator informs student by email at conclusion of PPI timeframe of final outcome for placement grade.

During the mitigation phase should a TtR student demonstrate practice that meets the unsafe, dependent or unprofessional criteria; not actively engage in the mitigation process; act in an illegal or unlawful manner the clinical educator will inform the academic coordinator (or faculty representative) of what has happened to request that the TtR student be removed immediately from the placement. The student should not attend the venue until contacted by the academic coordinator.

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