CLINICAL NURSE FACULTY AND THE LIVED EXPERIENCE OF CLINICAL GRADING

by

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ABSTRACT

Clinical Nurse Faculty and the Lived Experience of Clinical Grading

by

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Clinical grading is one approach to assure that future nurses have the knowledge and skills to provide safe patient care. The phenomenon being explored for this study was the experience of clinical grading for clinical nurse faculty. Through the use of a qualitative phenomenological method, the lived experience of grading nursing student clinical performance for experienced clinical nurse faculty in pre-licensure programs is described. Eleven full-time nursing faculty were recruited using a purposive technique to obtain a convenience sample. Each participant first underwent an initial in-depth personal interview followed by a brief follow-up interview a few weeks later. The van Manen method of hermeneutic phenomenology was applied to describe and interpret the data while developing an understanding of the experience for the participants. Findings from this study revealed five essential themes. These essential themes were collated to form a textual interpretive statement which illuminated the meaning of the experience of clinical grading for the participants. Barrett's theory of Power as Knowing Participation in Change emerged as one way to reflect on the findings in a way that was meaningful to

nursing. Recommendations for future research and implications for nursing are identified.

Keywords: nursing education, clinical, grading, evaluation, faculty, power as knowing participation in change (PKPC), phenomenology, van Manen

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I wanted to share the following poem with all of you. It gave me inspiration as I was spinning through the final stages of this process.

Prepare while others are daydreaming.

Listen while others are talking.

Begin while others are procrastinating.

Work while others are wishing.

Believe while others are doubtful.

Decide while others are delaying.

Save while others are wasting.

Smile while others are frowning.

Persist while others are quitting.

Commend while others are criticizing.

by Guild Fetridge

DEDICATION

This work is dedicated to my parents Connie and Nick DeNisco.

Mom and Dad you are both gone from this world but you are never far from my heart.

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CHAPTER I

AIM OF THE STUDY

Introduction

It was an exceptionally chaotic day on the hospital unit. The staffing on the unit was down and there had been a cardiac arrest just as the nursing instructor met the students to start the day. An hour and a half into the students' clinical day, there was medication that needed to be administered; however, the student assigned to the patient could not be found. As she glanced down the hall, the instructor saw the student with the medication form in her hand. With a racing heart, sweaty palms and a sick feeling in her stomach, the nursing instructor ran to the patient's room. The instructor feared that this student, one of the nine student nurses in her clinical group, had independently prepared and administered medications without her supervision. This was in spite of all students having been instructed repeatedly, never to give medications without the instructor being by their side. The student had not waited to review or administer the medications with the instructor as she had been directed. What medications were administered? How much did she give? Trying to maintain a calm demeanor, the nursing instructor asked how the patient was feeling. She took the patient's blood pressure, pulse, respiratory rate and blood glucose level herself. So far, so good, she thought; maybe everything would be okay.

Sitting in her office reviewing this experience, the clinical instructor realized that this was a grievous breach in patient safety. This event would place the student at risk for clinical failure. Even with this realization, the instructor began to experience uncertainty.

It was now up to her to make a grading decision that could result in the student not being able to graduate. If this event had happened at the beginning of the semester, there would be opportunity for remediation and improvement; however, if this event had occurred toward the end of the semester, it might be grounds for failing the clinical component of the course, failing the entire course, delay graduation or possibly result in the student's dismissal from the program.

This vignette provides an example of the experiences and uncertainty that nursing faculty must address when assigning clinical grades. The vignette also demonstrates the complexity and ambiguity of clinical grading in nursing.

The aim of this phenomenological study was to shed light on the experience of clinical grading for nursing faculty in pre-licensure nursing programs. Determining whether a student's clinical performance on a given day or with a specific skill has been satisfactory is not so much the problem for nursing faculty; however, evaluation of a series of clinical performance behaviors resulting in a final grade and/or progression within the program is a much greater challenge (Billings & Halstead, 2008).

The objective of nursing education is to prepare nurses who have both the knowledge and skill to care for patients safely and with quality. In order to achieve this goal, nursing curricula include classes from the sciences and liberal arts as well as nursing classes with companion clinical experiences. Clinical nursing education has historically been an integral part of nursing curricula for students at all levels. At every level of nursing education, assignments in clinical settings are required to enable students to develop clinical skills as they gain knowledge in the classroom (Rogers & Vinten,

2009). Students first learn nursing theory and implications for practice in the classroom and then must apply that knowledge in the clinical setting.

The aim of this study was to develop an understanding of the lived experience of clinical grading for nursing faculty. This understanding will contribute knowledge to clinical nursing education, evaluation and grading methods as well as have potential impact on patient safety.

The Phenomenon

The phenomenon for this study is the experience of clinical grading for nursing faculty. The context will be the clinical setting and the need for maintaining patient safety. The population being for which the phenomenon occur is clinical nurse faculty.

The term clinical nurse faculty, or CNF, was selected for use in this study for a number of reasons. I wanted to recruit clinical instructors who were part of the full-time nursing faculty in their schools of nursing, and not clinical adjuncts, for this study. I did not want to use the term clinical nurse educator because of the possible association with staff development titles in nursing. In addition, the abbreviation CNE is reserved for certified nurse educators, and I did not want to misuse this as an abbreviation for clinical nurse educators without this certification.

I had researched the word faculty because of my concern with its use as a singular or plural noun. According to the Merriam-Webster dictionary, faculty can be used to describe all the teachers of a school or of one of its departments; it remains a singular noun but also denotes a group of people. I discussed the use of the word faculty, and the term clinical nurse faculty or CNF, with English teachers, nursing education colleagues and my dissertation sponsor before making a final decision about the term. I ask for your

tolerance and acceptance of this term as you read this dissertation. Please understand that I wrote, edited, rewrote, and researched its use and believed that it was the best term to describe the specific role that I was seeking to explore in this study.

Clinical nurse faculty (CNF) must be confident that students have an adequate understanding of their nursing care responsibilities and skills at each level of education in order to maintain safe practice (Emerson, 2007). The CNF must decide if a student's performance achieves a rating of satisfactory for a clinical nursing course separate and apart from the student's grade in the didactic or classroom component. This creates a complex situation as it may be difficult for a CNF to assign a grade of failure for clinical when the student has received a passing didactic grade. Therefore, in most cases, the student would receive a failing grade for the course even with a passing grade in the classroom theory component (DeYoung, 2009). This could vary however, based on an individual nursing program's policy and course syllabi.

Regardless of the type of evaluation or grading system in place, clinical grading requires faculty to make a subjective judgment about a student's performance (Seldomridge & Walsh, 2006). Few clinical evaluation tools in use have actually been formally tested for reliability and validity (DeYoung, 2009); however, if they have not been tested, faculty cannot be sure that student outcomes would be similar if evaluated by a different faculty member (Oermann & Gaberson, 2006). This lack of consistency in grading can impact the CNF who are responsible for teaching the student at the next level; they would have the expectation that previous clinical course objectives had been met by the students who have been moved on to the next level of coursework. Likewise, without consistent clinical evaluation tools, CNF may have concerns with their

colleagues' ability to objectively evaluate students' clinical performance (Scanlan, Care & Gessler, 2001; Seldomridge & Walsh, 2006). In summary, faculty have a responsibility to determine a student's ability to apply knowledge in the clinical setting yet have no common consistent criteria to use to determine whether or not students are performing at the appropriate level.

The purpose of understanding the lived experience of clinical grading for nursing faculty was to contribute knowledge to clinical nursing education, evaluation and grading methods and assess the potential impact on patient safety.

Justification for the Study of the Phenomenon of Choice

The review of the existing literature revealed a lack of substantive data on how nursing faculty grade nursing student clinical performance. Although the literature identified clinical evaluation as an important role of the clinical nursing faculty, there is no body of knowledge on grading and faculty experiences. In the absence of such data, it was appropriate to begin with a qualitative study because the question seeks to gain meaning and understanding of the phenomenon. Qualitative research is known for hearing people's own personal narratives and developing an understanding of the phenomenon being explored (Munhall, 2007) through their descriptions.

Clinical grading is one approach to assure that future nurses have the knowledge and skills to provide safe patient care. Patient safety has understandably been at the forefront of health care policy agendas. Since 1999, the Institute of Medicine (IOM) has published three separate reports discussing the safety concerns in healthcare settings (Thompson, et al., 2007). New nurse graduates who have passed the National Council Licensure Examination for Registered Nurses (NCLEX-RN) are hired by health care

agencies. Although the NCLEX-RN certifies minimal nursing knowledge it does not certify a minimum standard of clinical practice ability. The public is therefore relying on the CNF to act as a safeguard to graduate a safe novice nurse. The importance of nursing education was addressed in 2003 by the Institute of Medicine (IOM) when it released a report regarding health professions' education which identified the need to reform healthcare education in order to achieve national quality and safety goals (Hernandez, 2003).

In response to this 2003 IOM report, the Quality and Safety Education for Nursing (QSEN) project was designed to advance quality and safety across all nursing programs. The QSEN project resulted in the identification of knowledge, skill and attitude (KSA) for clinical competencies that are considered appropriate for all pre-licensure nursing education programs (Cronenwett et al., 2007). One way to increase safety is to accurately evaluate whether or not students have achieved these competencies.

The CNF evaluates students by observing student performance and collecting written data; together, these strategies provide the CNF with varying amounts of information from which to make an evaluative judgment. A clinical grade must then be given as the symbol to represent the evaluation. Typically the student must receive a passing grade in the clinical component in order to be successful in the course and either progress in the nursing program or be allowed to graduate (Oermann & Gaberson, 2006). It is the responsibility of the CNF to assign a clinical grade which is an accurate appraisal of the student's clinical performance since these students will ultimately be entering the healthcare system in the roles of professional nurses.

Nursing faculty has a professional responsibility to the public, academic and healthcare institutions, and also to the nursing profession, to promote safe and knowledgeable clinical nursing practice. The individual CNF must have the courage to insist on minimum student practice standards as well as the integrity to grade them consistently (Lachman, 2008). Nurse faculty is frequently put in situations of conflict arising from competing loyalties, loyalty to students and education as well as loyalty to the patients (the public) and their safety (American Nurses Association [ANA], 2001). As a group of professionals for whom caring is a basic principle of their practice, CNF tend to develop close alliances with, and care for, students in their clinical groups as they would care for patients; this caring can result in a possible distortion of the students clinical abilities which in turn could distort the clinical grades (Scanlan, et al., 2001). In order to assign a clinical grade, the CNF must make a definite decision about the effectiveness of a student's overall clinical performance.

Leniency in grading is one common error that has been identified in rating student performance across disciplines (Briscoe, Carlson, Fore-Arcand, Levine, & Cohen, 2006; Berube, 2004; Kamber & Biggs, 2002). This problem of grading leniency has also been identified as a problem in nursing clinical education (Seldomridge & Walsh, 2006; Walsh & Seldomridge, 2005). Criteria for student clinical performances do not provide specificity to differentiate how much nursing judgment is enough for a student to be successful (Walsh & Seldomridge, 2005) and provide one explanation for this leniency. The unwillingness of faculty to assign a failing grade to students due to their relationship with their clinical group or fear of litigation provides an additional explanation for the problem of leniency in clinical grading of nursing students (Scanlan et al., 2001).

The purpose of this phenomenological study was to understand the experience of clinical grading for clinical nursing faculty in pre-licensure nursing programs. This understanding may provide insight on ways to increase the confidence and ability of nursing faculty with this difficult role. This research also provides nursing education with a better understanding of the challenges of clinical evaluation and the potential for guidelines and orientation plans for new clinical nursing faculty. Illuminating the experience of clinical grading for nursing faculty will impact nursing education as well as professional nursing practice.

Phenomenon Discussed Within Specific Context

Clinical Settings

Clinical settings provide the environments for nursing students to apply their knowledge and practice nursing care. The purpose of their experiences in these settings is for the student to evolve from a novice learner to a beginning nurse and transfer cognitive knowledge into practice (O'Connor, 2006; Rogers & Vinten, 2009). These experiences are required for skill development and clinical decision making competence (Benner, Tanner & Chesla, 2009).

In order to promote skill and knowledge development, clinical sites are selected. These sites include in-patient care settings, ambulatory care centers and community health centers. Most of the clinical experiences take place in acute care in-patient settings. Although it may sound ideal, the acute care setting is one where there is a lack of predictability due to changes in patient condition, staffing irregularities and expectations of multiple health care providers, which all contributes to an exceptionally chaotic system. This acute care setting is one with high levels of responsibility and low

levels of control for the CNF. The CNF is then placed in this system with eight to 12 novice student nurses and is expected to teach and evaluate while maintaining patient safety. Ambulatory and community health centers provide additional patient care experiences; however, the environmental challenges do not approximate the sense of life-threatening issues that are present in the acute care setting but do require more holistic and contextual approaches for student care experiences.

Laboratory settings within the schools of nursing also provide an arena for clinical nursing education in a more controlled environment. Human patient simulator mannequins can be used in the laboratory milieu in an attempt to simulate realistic patient care experiences without jeopardizing safety (Rogers & Vinten, 2009). However, recommendations from the National Council of State Boards of Nursing (NCSBN, 2005) stated that a sufficient number of clinical experiences with actual patients must be included. According to the NCSBN "deliberate, controlled practice with simulators is an important asset for clinical learning, but…cannot take the place of learning in the authentic setting" (pg. 9).

While in these clinical sites, the nursing student is supervised by a CNF. This CNF can be a full or part-time faculty member who may have responsibilities with both clinical and classroom teaching, or a clinical adjunct who has only clinical instruction responsibilities. The CNF is responsible for providing students with patient situations that both relate to the ongoing topics in the course, and also are appropriate for the level of the student. Assigning patients requires the CNF to be attentive to the students' learning needs and comfort level, as well as the patient's condition and clinical site fluctuations.

Education in clinical settings.

Clinical learning experiences have always been an important part of nursing education (Ard & Valiga, 2009). Students learn a variety of concepts and skills in the classroom and lab settings that must then be transferred to the clinical setting (Ard & Valiga, 2009). In the clinical setting of nursing education, student nurses are required to actively participate in patient care. Students are required to assess patients, formulate plans of care, perform treatments, administer medications and then evaluate outcomes of care for assigned patients. The CNF has the responsibility to ensure that clinical experiences facilitate student learning as well as the responsibility to evaluate that learning has been achieved (Ard & Valiga, 2009). Faculty often struggle with having sufficient data for clinical grading to support a decision of satisfactory or unsatisfactory performance, providing necessary remediation, and then following through if the CNF determines that a student is unsatisfactory (Emerson, 2007). CNF make the final decision in the evaluation of his or her students' clinical performance and must choose pass/fail or satisfactory/unsatisfactory in most cases (DeYoung, 2009) although some schools do use letter grades for clinical.

Novice CNF are often ambivalent about wanting to provide students with enough opportunities for success in clinical experiences and their sense of responsibility to both the nursing profession as well as the public to whom they provide care (Emerson, 2007). The CNF may care about the student but cannot allow that care to impede judgment about the student's clinical performance.

Human simulators can assist the CNF in providing additional clinical experiences for students in a controlled laboratory setting, but should not replace all patient care

experiences. No simulated experience prepares nursing students with organizational skills as well as real clinical practice because of the ever-changing circumstances that present themselves (DeYoung, 2009). In a 2005 position paper, the National Council of State Boards of Nursing (NCSBN) reported that student experiences with actual patients were necessary, and needed to be of sufficient quality, in all pre-licensure nursing programs and should not be completely replaced by simulation.

Clinical groups.

CNF who supervise students in clinical settings are responsible for an increasing number of very ill patients as well as the students in their clinical group. Students are assigned to these clinical groups, which in some states can include as many as 12 students (American Association of Colleges of Nursing [AACN], 2005). In any clinical group of students, the CNF assumes responsibility for the supervision of the students as well as having an understanding of all the patients to whom the students have been assigned. This means that despite the student to instructor ratio, each student is assigned to care for one or more ill patients. As a result, the CNF with twelve students would be supervising the students as well as overseeing the care of 12 or more sick patients. This expectation for clinical supervision is rather unique to nursing faculty as compared to many other disciplines (AACN, 2005).

In one recent study on clinical education in pre-licensure programs conducted by the National League of Nursing (NLN, 2010), the increase in size of clinical groups was identified as one of the top five barriers to student learning by 45% of the nursing faculty respondents. The respondents further identified that some measures used to address this barrier included hiring more part-time and under-prepared faculty to work with the

students, as well as having full-time faculty teach clinical courses in addition to their regular class and clinical workload (Ard & Valiga, 2009). These measures were reported to be only minimally or somewhat effective by the faculty surveyed in addressing this clinical group size issue.

The role of the CNF is laden with responsibility and possible effects on patient safety and professional practice. Developing an understanding of this experience for nursing faculty has provided this researcher with information that will benefit nursing education as well as nursing practice. The purpose of this phenomenological study was to understand the experience of clinical grading for CNF in pre-licensure nursing programs. This understanding provides insight into the experience of the nursing faculty with the process of clinical grading. The following research question guided this study: What is the lived experience of grading nursing student clinical performance for clinical nursing faculty?

Biases and Assumptions Related to the Study

The specific focus of this study was to reveal the meaning of the lived experience of grading nursing student clinical performance by nursing faculty. My bias was that nursing faculty would report feelings of anxiety and uncertainty with decision making during the process of clinical grading. I anticipated that faculty would report feelings of distress if they had decided that a failing clinical grade had been earned by the student. Nursing faculty feels a sense of empathy with their clinical students and often recalls their own inexperience and anxiety when they themselves were nursing students. Even when nursing faculty believe that a less than satisfactory grade has been earned by a student; they may experience a sense of personal failure. This sense of failure in

themselves as clinical faculty may cause them additional anxiety and uncertainty with their role.

Another bias that I have is that clinical nursing faculty are often wary of assigning an unsatisfactory clinical grade because of a lack of certainty with their decision. I have noted that there are periods of time during clinical experiences when students are not in direct observation by the faculty and this time cannot be accounted for as satisfactory or unsatisfactory. Oermann and Gaberson (2006) also commented on this and describe these times as clinical observation gaps which they said provided the basis for some degree of faculty uncertainty.

A few assumptions were made regarding this study. Clinical expertise does not mean clinical teaching expertise and yet clinical nursing faculty receives little or no preparation in the new academic role with respect to clinical grading. New clinical nursing faculty members are usually expert practitioners in their clinical areas and are regarded as well-prepared for the role even though they lack academic education or preparation.

Clinical grading is said to be objective and based on specific criteria; however, it will always contain some degree of subjectivity. The CNF can experience role stress and uncertainty because of the duality of the faculty role. In this role they are caught between the role of caregiver and teacher/evaluator. Nurses do not seek to be punitive when behaviors are not changed but rather seek to encourage their patients to make well-informed decisions and choices; CNF tend to care for their students, but they must also evaluate and grade the student based on present clinical performance without allowing for the potential for improvement. A clinical grading decision must be made in the present

which could negatively impact the student's future and the CNF may view this as an uncaring practice which is inconsistent with their professional role as a caring nurse.

Relevance for nursing.

Nursing faculty, including CNF, make decisions about which students to admit to programs, which students are able to progress through the programs, and ultimately which students will graduate (Oermann, Saewert, Charasika & Yarbrough, 2009). CNF must evaluate learners to determine how well they have met objectives as well as to certify that they are safe (DeYoung, 2009). These CNF collect information through a variety of clinical evaluation methods and make judgments about student performance; the concluding evaluation requires that a grade be assigned and is reflective of the outcomes met by the student (Oermann et al., 2009). Since this can prevent or facilitate the student nurse from becoming a graduate nurse, this role of the CNF can be viewed as one of gatekeeper to the profession of nursing as well as that of a guardian for patients' safety.

Clinical grading is required by faculty to identify if students are meeting the requirements for the individual nursing program as well as for the nursing profession to which they seek to belong. Clinical expertise is used as one basis for selecting a CNF but that alone is not adequate preparation for the role (O'Connor, 2006). Since nursing faculty are expected to facilitate students' development of clinical judgment necessary for safe practice (NCSBN, 2005), they require skills in teaching and evaluation methods in order to have less difficulty making judgments about students' clinical performance which result in a clinical grade (Scanlan et al., 2001; O'Connor, 2006).

Summary of the Chapter

Chapter one includes the aim and the purpose of the study which explored the lived experience of nursing faculty who are responsible for grading nursing student clinical performance. The role of the CNF was addressed in this section. The research question that guided the study was identified and the phenomenon of interest was described in the context of nursing education. Justification for the study included the vast responsibility within the role as a clinical nursing faculty as well as concern for patient safety. The relevance of clinical grading to both nursing education and the nursing profession was explained. Chapter one concluded with the researcher's personal biases and assumptions related to the study and relevance to nursing. Chapter two discusses the evolution of the study from the historical and experiential context.

CHAPTER II

EVOLUTION OF THE STUDY

This chapter will include relevant literature on nursing education and clinical grading from a historical perspective. Benner's Framework for the Development of Clinical Expertise (1982, 2004) was initially used to guide this study and will be discussed. My personal and professional experiences will conclude this chapter.

Historical Context

Apprenticeship model.

The historical context for clinical nursing evaluation begins with early nursing education and the clinical apprenticeship model. In the early years of nursing education (1860-1896) as an apprentice, the role of the student was to provide a service (Judd et al., 2010). Student nurses provided this service to the training hospital. Nursing students were regarded as the majority of the nursing staff and were counted when decisions were made about the staffing in the hospital (Rogers & Vinten, 2009). Routine student labor was considered to be normal in early hospital nurse training programs. Students learned nursing by doing nursing and were viewed as workers rather than students (Infante, 1975). In the early apprentice model, student nurses were called probationers. Probationers had very specific regulations that determined their progress. Their progress was evaluated based on two separate areas. The first area pertained to personal characteristics such as honesty, punctuality, truthfulness and sobriety. The second area

was concerned with the probationer's ability to perform specific nursing skills (Bradshaw, 2001).

The years 1860 to 1896 were historical years for nursing education (Bradshaw, 2001). The work of Florence Nightingale and her training school in Great Britain, as well as the establishment of a training school for nurses in Germany, provided the impetus for the nursing education movement. Formal nursing education began in the United States in 1862 when a nurse training program was established at the New England Hospital for Women and Children. Initially the length of time required to train to become a nurse was one year; this was increased to three years by 1880. Nursing students, or apprentices, worked many hours and provided much of the staffing for hospitals as a part of their education (Judd et al., 2010).

These training programs emphasized apprenticeship and training with no attention to any type of nursing science theory. It was the hospital nursing administrator who directed the school or training program and students were often taught by physicians. There was little control by nursing faculty over the training and instruction of student nurses (Infante, 1975). The nursing student was viewed as an additional worker and not as one who was engaged in learning a new professional role (Ard & Valiga, 2009). The very nature of the apprenticeship model was that students worked to learn. "During the early years of nursing education, decisions about one's potential candidacy for nursing and continued progression were based on perceptions about the person, such as appearance and personality" (Oermann, Yarbrough, Saewert, Ard & Charasika, 2009, p. 352). Woolley (1977) reported that judgments about nursing student competencies have been evident as early as 1900. In those early years, a student's progress was

documented by the head nurse on the hospital unit and consisted of procedures that were completed as well as personality traits and "neatness of person" (Woolley, 1977, p. 310).

Curricula developed.

In 1925 the American Nurses' Association sponsored a study to review the state of nursing schools in 10 states. A committee was formed which consisted of nurses, physicians and lay people. This committee encouraged nursing schools to maintain the apprenticeship system of training and advised them to refrain from trying to model nursing school programs after other academic programs without apprenticeships. As a first step, guidelines were developed as a result of this study which forced schools to change the way that nurses were trained. Theoretical and clinical curricula were established that changed the focus of training to be for the benefit of the nursing student (Judd et al., 2010). Although the curriculum was changed, the clinical component continued using the apprenticeship model.

The standardization of nursing education curricula facilitated the proliferation of hospital based diploma programs since the curriculum had been developed and could easily be adopted. Student nurses were still providing the majority of nursing care in many instances. Finally, around the mid 1900's, nursing education began to move into institutes of higher education such as universities and colleges (NLN, 2010). As nursing education evolved from solely hospital based diploma programs to academic degree programs in institutes of higher learning, clinical education has also evolved yet still remains grounded in tradition rather than research (DeYoung, 2009). Dr. Patricia Benner, a nursing scholar, described this transition:

> The nursing profession came late to mainstream academia making many accommodations in former apprenticeship hospital-based education programs. Along the way, classroom education became more and more separated from clinical practice and more and more focused on formal abstract theories and less focused on how this abstract knowledge-technology would be *used* in clinical practice (Benner et al., 2009, p. 383).

Nursing still remains a practice discipline and as such requires that students interact and provide care to human beings. Classroom teaching in nursing and clinical content have historically been separated in nursing education due in part to the tradition of diploma education (Benner et al., 2009). What has remained constant throughout history is the need for student learning to meet safe patient care standards even when the student is a novice (Judd et al., 2010).

Contemporary clinical education.

The clinical experience of the nursing student today is focused on the integration of cognitive skill, decision making ability and the acquisition of technical skills (Judd et al., 2010). Advances in technology and simulation now provide an additional clinical learning arena for today's nursing students. These advances allow students to practice psychomotor and cognitive skills but eliminate the immediate concern for patient safety that exists in the clinical setting. Complex psychomotor skills often still require a live patient care situation in order to be mastered rather than a simulated experience with a mannequin (DeYoung, 2009). Nursing faculty is in the position of teaching and evaluating students in both cognitive and psychomotor domains and is expected to assign independent grades for each learning domain.

Many supportive examples for the need to study the experience of the clinical nurse faculty (CNF) with clinical grading are provided in the literature. Clinical evaluation has been identified as one of the most difficult practices of clinical teaching (Scanlan et al., 2001). Clinical evaluation is the process of gathering information which results in a clinical grade (Oermann & Gaberson, 2006). This clinical grade is assigned as a result of the observation and evaluation of student behaviors in the clinical setting and is therefore subjective in nature. This subjectivity can result in distress for the nurse educator while trying to make a clinical grading decision. In all clinical situations, students are expected to demonstrate accountability and professionalism. The student clinical experiences should always meet safe clinical practice standards which are determined in advance by the nursing program; however, clear definitions of what constitutes safe or unsafe clinical practice is not easily accessible in the clinical nursing literature (Walsh & Seldomridge, 2005) or in nursing program guidelines.

In one article on grade disputes in nursing, the authors identify that grading students' performance in clinical settings with actual patients is a complex and subjective activity (Boley & Whitney, 2003). The responsibility for assigning clinical grades rests with the individual CNF; this role is laden with responsibility and possible effects on safety and professional practice. Developing an understanding of the experience of clinical grading for nursing faculty provides an increased understanding of one aspect of the CNF role that will be of benefit to nursing education as well as nursing practice.

Context of Clinical Nurse Faculty

Role Development

Clinical expert.

In the practice setting, nursing professionals have often developed into expert practitioners in their specialty area; however, these expert practitioners often lack any additional formal training in education. Nurses new to the role as a CNF may be regarded as experts in clinical practice, and nursing education programs expect them to be good clinical instructors. Schools of nursing that hire clinical faculty need to understand that this clinical expertise does not necessarily translate to an expert CNF. Clinical expertise alone is not sufficient preparation for being a CNF (O'Connor, 2006).

The American Association of Colleges of Nursing (AACN) identified that "In nursing, clinical expertise is essential to professional success, but clinical proficiency alone is not sufficient to convey nursing knowledge and practice to others in a meaningful, useful, appropriate way. Excellent nurses are not necessarily expert teachers" (AACN, 2005, p.21). Once the transition to academia occurs these same clinical experts are in the role of novice educators. These new educators are given clinical objectives and a group of students, and are then expected to teach clinical skills and critical thinking as well as provide feedback in the form of formative and summative evaluations. It is important to remember that in the clinical setting all teaching and evaluation needs to be accomplished while still maintaining a high level of patient safety in an often chaotic healthcare environment. The CNF must develop his or her own skill in education practices while facilitating the clinical learning of the students.

Supervisory role.

Clinical nurse faculties have academic, ethical, and legal responsibilities to guide the development of safe nursing students and ultimately, safe nurses. Clinical teaching and supervision are themselves professional skills that require preparation and education (Luhanga, Yonge, & Myrick, 2008). In addition, close supervision of students is required in clinical settings because the experience includes assuming responsibility for patient care by both the student and the CNF (AACN, 2005).

It is the responsibility of the CNF to also evaluate the clinical performance of each of their students in the clinical group. These evaluations should take place on an on-going basis in the form of formative evaluations as well as culminating with a summative evaluation for each student. Formative evaluation is essential to provide students with the opportunity to improve and requires time for additional practice experiences (Oermann & Gaberson, 2006). Clinical evaluation involves the CNF observing student performance and then making a judgment about the performance and recording it on a clinical evaluation tool (Oermann & Gaberson, 2006).

Clinical evaluation tools vary from school to school. These clinical evaluation tools should specify outcomes to be achieved, or objectives to be met, in clinical practice; however, there is a lack of clinical evaluation tools in nursing that have been formally tested for reliability and validity (DeYoung, 2009). Observations, anecdotal notes, checklists and rating scales are examples of some of the evaluation methods used in clinical nursing education (Oermann & Gaberson, 2006). One example of a tool which demonstrates the types of criteria that may be a part of a nursing clinical evaluation is included as Appendix A.

The predominant method for clinical evaluation is the observation of student performance in clinical practice. These observations reflect only a sample of the individual student's performance during any given clinical experience. This role of evaluator for the CNF is an especially difficult role since one CNF is assigned to teach, supervise, and evaluate up to 12 students while ensuring that patient safety is not compromised in the clinical setting.

Teaching role.

In all areas of education, faculty has the responsibility to reward students' successes and efforts, as well as document failures, in an equitable and fair manner (Woody, 2008). Nursing faculty's role in the clinical setting must ensure that clinical performance evaluations are treated as academic matters and must be graded accordingly (Chasens, DePew, Goudreau & Pierce, 2000). Nurses have a common commitment to care whether in clinical practice, education or research (Diekelmann, 1990). This commitment to care extends to nursing students as well as to the patients.

Faculty is expected to adhere to academic principles in both classroom and clinical settings; however, nursing faculty most often enters the world of academia after first having been only in clinical nursing practice. Some concerns that have been identified by new nursing faculty include a lack of understanding about the new role and a lack of confidence in their ability to do the job effectively (McArthur-Rouse, 2007).

Evaluator role.

In the novice role as faculty, these clinical experts may still lack the education in evaluation methods and adult teaching principles that are essential for clinical teaching and grading. Infante (1975) identified that in order to properly guide a student's learning

in the clinical laboratory, the CNF needs to have an understanding of both the subject matter being taught as well as be a specialist in the field of education. Academic institutions do not always provide the new nursing faculty member with a preceptor experience, or a support system, that has become the standard for orientation in healthcare facilities; many do not even provide a consistent process for new clinical nursing faculty to learn their role (Diekelmann, 2004). This lack of preparation for the role transition to academia can contribute to the CNF's uncertainty with clinical grading as well as many other academic issues.

Conceptual/Theoretical Context

Based on my previous work, I anticipated that Benner's Framework for the Development of Clinical Expertise would be used to guide this study. This framework was based on the Dreyfus Model of Skill Acquisition which posits that a person develops skills in a sequential progression through five levels of proficiency (Benner, 2004). Benner used this model and found evidence which supported that clinical nursing practice skill acquisition followed the same sequential progression beginning with the initial stage as novice and culminating in the expert stage (Benner, 1982). Benner's work involved nurses at all stages of their careers and has relevance for clinical instruction in nursing (O'Connor, 2006). Benner's work on the novice to expert levels of clinical practice was used to reflect on both nursing student clinical performance as well as clinical nursing faculties experiences with clinical grading for this study. As the data were analyzed however, it emerged that although Benner's framework was important, Barrett's model of Power as Knowing Participation in Change became the applicable framework for analysis.

Experiential Context

Nursing education has become the focus of my nursing practice following a lifetime of varied experiences in nursing. During the past twenty-nine years I have practiced nursing in a variety of settings including Intensive Care, Intermediate Care, Public Health Nursing, School Nursing, and Nursing Administration. In each of these roles I have engaged in educational programs to increase my knowledge and competency level. I began transitioning to a practice role in nursing education when I began graduate school in 2002. I completed my nursing education practice requirement teaching in an RN to BSN program in the evenings and on weekends.

Once I had completed my graduate degree in nursing as a Clinical Nurse Specialist, I began teaching in the same program as a clinical adjunct. This adjunct clinical teaching experience convinced me of two things: that I wanted to teach nursing on a full time basis, and that I needed more education about exactly what was required to be a nurse educator. I went on to complete a Post-Masters Certificate in Nursing Education. This coursework provided me with the cognitive knowledge I needed in adult education theory, course development and teaching skills that I felt was lacking from my clinical nursing graduate degree. This transition from a nurse in clinical practice to a nurse educator, and the accompanying realization of my own knowledge deficit, resulted in my research interest.

I have experience with clinical grading at both the associate and baccalaureate degree levels in nursing education and am certified as a nurse educator by the National League for Nursing. My experiences with clinical grading provided the motivation for examining the lived experience in other clinical nursing faculty.

My initial experience as a clinical instructor caused me great anxiety. I saw all the mistakes students were making and wondered when I should be evaluating them for proficiency. I knew that experiential learning was important for students to apply theoretical knowledge; however, I was also concerned with patient safety, professional responsibility, and personal liability.

The nursing programs I was hired to teach in provided me with no formal orientation. I was hired because of my clinical experience and my education as a Masters prepared nurse. Those were the only criteria that mattered at the time. I knew little about what was important to look for in a novice nursing student in terms of clinical skills or clinical judgment. I knew little about clinical evaluation or clinical grading. I was a novice.

One of my early experiences with clinical grading stimulated my thinking about the preparation and education that are needed for the role of CNF. A senior level nursing student was assigned to administer medication. One of the medications required reconstitution, which is adding fluid to a powder and making a liquid mixture. Instead of first reconstituting the powder, the student attempted repeatedly to withdraw the powder into the syringe. The student was not able to identify what the missing step in the procedure actually was. Even with additional experiences, this student could not verbalize or demonstrate the correct procedure for administering this medication. I wondered how this student had successfully met the requirements of the previous clinical nursing courses. This was the last clinical course before graduation. I felt disappointed in my colleagues when they verbalized that they had concerns with this student in earlier clinical courses. Why was nothing done earlier? This student did not pass the didactic

component of this course which then relieved me of the burden of assigning an unsatisfactory clinical grade; he had already failed the course.

I was unprepared for the possibility of having a student with such poor clinical skills at this level. Would I have been prepared to assign this student an unsatisfactory grade resulting in a course failure and subsequent delay in graduation if he had not failed on his own? I cannot honestly say that I would have been able to do so at that early stage of my role development as a CNF. This was only one example of my early personal uncertainty with clinical grading.

My beliefs about nursing education have evolved because of my personal experiences. It is my experience that student nurses work exceptionally hard both in class and during their clinical experiences. I believe that clinical experiences should provide a learning environment for students. Nursing scholars need to better prepare new faculty for their role. Faculty will then be able to better educate and support students to become the best professional nurses that they can be.

By conducting this qualitative, phenomenological research, it was my hope to illuminate the lived experience of clinical grading for clinical nursing faculty. By understanding this experience, I hope to contribute knowledge that will impact nursing education as well as nursing practice. It is my hope that this knowledge will be used to improve faculty development and clinical grading methods in pre-licensure nursing programs.

Summary of the Chapter

This chapter described the evolution of the study from the historical, conceptual/ theoretical, and experiential contexts. The historical context described the movement of nursing education from an apprenticeship model to one of academia with clinical experiences. This provided the context for the dichotomy between theoretical nursing knowledge and clinical knowledge or skill. The chapter concludes with my experiences as a nurse and subsequent transition to the role of clinical nurse faculty. Chapter three describes the phenomenological method of research that was used for this study.

CHAPTER III

METHODOLOGY

The purpose of this study was to describe the lived experience of nurse faculty with grading nursing student clinical performance. A qualitative design was used to examine this experience. Van Manen's (1997) qualitative method of phenomenology was used to guide the study. In this chapter, the phenomenological approach is discussed.

Phenomenology

Phenomenology as a philosophical perspective and a research method is focused on describing and understanding phenomena as they are experienced by an individual (Wojnar & Swanson, 2007). Phenomenology looks at any phenomenon as a possible human experience; phenomenological research questions the way in which one experiences the world (van Manen, 1997). Phenomenology's methods assume that there exists a structure to all human experience and refers to the totality of the lived experiences that belong to a single person (Thorne, Kirkham & MacDonald-Emes, 1997). Phenomenological research is done to question the way we as humans experience the world (van Manen, 1997).

Edmund Husserl.

Edmund Husserl (1859-1938) is considered to be the founder of phenomenology as a philosophy. Husserl (Husserl, trans. 1999) defined phenomenology as a science of human consciousness. Husserl believed that the meaning of lived experience could only

be elicited from a first-person point of view by the research subject. The Husserlian approach to phenomenology was one of description. The lived experience as described by the research participant is used to provide the complete description of the phenomenon being studied (Husserl, trans. 1999).

Husserl described the main characteristic of consciousness as being intentionality. Intentionality can be described as the relationship between one's mental acts and the external world. Husserl's beliefs expanded to include that the researcher would have to suspend previous beliefs about the phenomenon in question and employ a process of bracketing. Bracketing can be described as separating the phenomenon, analyzing it, and suspending previously held assumptions about it while analyzing the data from the research participants (Wojnar & Swanson, 2007). The intent of this bracketing would be to acknowledge and limit personal bias of the researcher while analyzing the phenomenon.

One successor of Husserlian phenomenology was Merleau-Ponty (1908-1961). Merleau-Ponty's belief was that at the aim of phenomenology was a search for meanings or essences (Merleau-Ponty, trans. 1962). In order to find the essences, Merleau-Ponty suggested returning to the things themselves. The object, or thing, being described in Merleau-Ponty's phenomenology is the world as we meet it in our immediate experience (Smith, 2005; van Manen, 1997).

Merleau-Ponty.

Merleau-Ponty's phenomenology of perception described the world as one which is revealed to us by our senses in our everyday life. According to Merleau-Ponty we are always prone to forget the world as we experience it, and we need to rediscover the

perceived world (Merleau-Ponty, trans. 2004). It is through this rediscovery of the perceived world that a person has the ability to find meaning and understanding in life. Merleau-Ponty suggested that one must return to the lived experience and search for the essences that underscore and provide meaning for that experience. At the core of his phenomenology, was the idea that human understanding results ultimately from our experience of the world as we perceive it (Merleau-Ponty, trans. 2004). The aim of Merleau-Ponty's phenomenology was to give a description of the lived experience of human beings in their world. Merleau-Ponty explained that humans cannot conceive of anything that is not perceived or perceptible (Merleau-Ponty, trans. 2004). According to Merleau-Ponty:

> It is our 'bodily' intentionality which brings the possibility of meaning into our experience by ensuring that its content, the things presented in experience, are surrounded with references to the past and future, to other places and things, to human possibilities and situations (p. 9).

Hermeneutic phenomenology.

Integral to Merleau-Ponty's philosophy is the distinction between the researcher's interaction with the participant, and the interpretation of the description of the phenomenon. Together the interaction and the interpretation co-create an understanding of the phenomenon being studied (Merleau-Ponty, trans. 1962). This constitutes the hermeneutic approach to phenomenological inquiry to which Merleau-Ponty subscribed. This philosophy of Merleau-Ponty provided the basis for van Manen's methodical structure of human science research which will be used by this researcher.

Aim of hermeneutic phenomenology.

The aim of the hermeneutic approach is to gain an understanding and co-creation of a phenomenon by the researcher and participants. This co-creation and interpretation will reveal what is meaningful in the phenomenon to the participants (Wojnar & Swanson, 2007). Hermeneutic phenomenology will be useful to examine contextual features of the lived experience of clinical grading that will be obtained by blending meanings and interpretations articulated by the researcher and the research participants (Wojnar & Swanson, 2007).

Summary of the Chapter

Chapter three presented a description of phenomenology as a research design and method. The method was presented from the perspective of Edmund Husserl (1859-1938), Merleau-Ponty (1962; 2004) and van Manen (1997). Both descriptive and hermeneutic approaches to phenomenology were explained. The applicability of the hermeneutic method to the specific phenomenon of nursing faculty and clinical grading was identified. Chapter four describes the methodology and the application to the research phenomenon.

CHAPTER IV

METHODOLOGY APPLIED

Chapter four introduces van Manen's phenomenological approach. The application of van Manen's approach to the phenomenon of the lived experience of clinical nurse faculty (CNF) with clinical grading will be discussed.

van Manen

Van Manen believed that the lived experience provided a place only to begin phenomenological research; it must then be transformed into a textual expression which can be reflected upon and relived by the reader (van Manen, 1997). This alternative method of phenomenology is one of interpretation rather than merely description and is known as hermeneutics. The aim of hermeneutic phenomenology according to van Manen, is to first conduct an analysis and then create a description in writing of a given experience. According to van Manen (1997):

> Phenomenology appeals to our immediate common experience in order to conduct a structural analysis of what is most common, most familiar, most self-evident to us. The aim is to construct an animating, evocative description (text) of human actions, behaviors, intentions, and experiences as we meet them in the lifeworld (p. 19).

Van Manen's method of hermeneutic phenomenology uses both the description given by the individual, as well as an interpretation of the interview data obtained by the researcher, to give meaning to the lived experiences. The interpretation of data enables

the researcher to come to an understanding of the meaning and significance of the phenomena being studied as it has been experienced by the research subjects, and results in a text or narrative written by the researcher (Kleiman, 2004). According to van Manen (1997), the human experience needs to be interpreted and captured in textual language.

Research activities.

Van Manen (1997) introduced a practical approach which can be used as a guide in conducting phenomenological human science research but warns against using the approach in a mechanistic, or fragmented way. The six research activities are:

1. Turning to a phenomenon which seriously interests us and commits us to the world;
2. Investigating experience as we live it rather than as we conceptualize it;
3. Reflecting on the essential themes which characterize the phenomenon;
4. Describing the phenomenon through the art of writing and rewriting;
5. Maintaining a strong and oriented pedagogical relation to the phenomenon; and
6. Balancing the research context by considering parts and whole (pp. 30-31).

In the first activity the researcher commits to a phenomenon and becomes unwavering in the practice of thoughtfulness concerning the phenomenon. Van Manen described this commitment as a project of someone to make sense out of a certain aspect of an experience (1997). This phenomenological description of the experience will always be one interpretation and will never eliminate the possibility for further exploration and discovery. In this research, the commitment of the researcher is to the role of the CNF and their experiences of assigning a clinical grade.

In the second activity the researcher aimed to become full of the world experience of the participants in order to gain greater understanding of the phenomenon. My background as a CNF has provided me with the comfort to interview the participants to explore their experiences as lived and described.

Reflecting on essential themes, the third research activity, requires a thoughtful reflection by the researcher to understand what is significant about the particular experiences for the participants. Thoughtful reflection was needed to illuminate the very essence or nature of the experience. Reflecting on essential themes was accomplished first by reading the transcripts and listening to the audio tapes. I then reflected on the raw data, including any notes I had made in my journal which documented body language of the participants and feelings I had during the data collection process.

Writing and rewriting was necessary to bring the spoken words of the participants to life in the fourth research activity. The application of language and thoughtfulness helps to reveal the phenomenon in question (van Manen, 1997). I composed texts of the sections of the transcripts that had hinted at themes when I reflected on them. By giving text to these themes I was able to review and interpret the intensity of the meaning that I first identified.

The fifth activity required the maintenance of a strong and oriented relation to the fundamental question being asked. It was important to maintain a strong relation and commitment to the question and not become distracted or put off-course. Van Manen (1997) warned that to do phenomenological research one must be strong in his or her orientation and cannot accept falsities in place of the true experience of the participants.

I remained focused on the phenomenon being explored during data collection and formulated related follow-up questions as the interviews unfolded. During analysis, I extracted the data that was obtained which was not related to the phenomenon being studied. I closely examined the data that was relevant in order to maintain my commitment to the research question.

The sixth and final research activity is balancing the research context by considering the parts and the whole. In this step the researcher needs to constantly review the study and look for the significance that each part of the experience brings to the whole. I reviewed the information obtained to determine if it actually illuminated the phenomenon being studied. I considered and re-considered effects on the phenomenon that would result by removing a part of the experience being described. If the phenomenon was unchanged as a result, I determined that the experience was not essential and did not keep it as a theme.

These six research activities are outlined and described by van Manen; however, he stated that there is no prescribed set of procedures that one should blindly follow. I attempted to use thoughtful reflection and interpretation on a continual basis while giving written text to the phenomena that were being described by the participants. To accomplish this, I read and reread the narratives and the themes, as well as listened to the audiotapes, to revisit the phenomena that were being described and to validate what I was hearing and interpreting.

Bracketing.

Bracketing was used to facilitate awareness of preconceived assumptions and assist with remaining engaged in self-reflection. This helped to limit bias during the

analysis of data that was collected. I worked to bracket my past experiences while analyzing the data and identifying essences that emerged from other nursing faculty experiences. Bracketing was achieved by maintaining an on-going personal journal to record experiences and feelings about the descriptions offered. In addition, the writing of the experiential context, assumptions and biases also assisted with bracketing.

Two doctoral prepared nurse experts were asked to review the transcripts in an attempt to maintain rigor with the interpretation of data collected. I remained cognizant that past experience can lead to over identification with the phenomenon and the context described by participants; it was therefore necessary for me to examine personal values and beliefs throughout the research process (Lincoln & Guba, 1985).

Protection of human subjects.

The protection of human subjects was achieved, written informed consent was obtained prior to conducting the research, and confidentiality was maintained throughout the research process. With the approval of the CUNY Institutional Review Board, I studied the lived experiences of a sample of experienced clinical nursing faculty who teach in pre-licensure nursing programs.

The informed consent identified the focus of the research as well as a promise of confidentiality for the participants and their institution (see Appendix B). Research participants were encouraged to ask questions and were informed that they were able to terminate participation at any time.

Sample selection.

Participants were selected using a purposive sampling process. This type of sampling was used to define a homogeneous sample which was determined by

informational considerations. Sampling was not terminated until there was no new information being obtained from additional participants. A final sample size of 11 participants was recruited; the number was increased from the projected number of six to 10 because of the rapid response that I received from potential participants. Lincoln and Guba (1985) termed this lack of new information that is received as redundancy and it is this redundancy which results in data saturation. Data saturation was achieved after eight participants but I felt it was important to give voice to the additional three CNF who had also volunteered to participate in this study. The data from these additional participants was consistent with the first eight I had interviewed.

Contact was made through email and word of mouth using a printed recruitment sheet (see Appendix C) to engage nursing faculty in pre-licensure programs as research participants. The recruitment sheet was first sent to nurse faculty colleagues known to me, with a request to send the sheet to other nurse faculty contacts. Faculty was all informed of the research topic and was then invited to contact me via email or cell phone if they wished to participate. Faculty was also informed of the need to schedule two separate interview times with me at a private location of their choice.

Data collection.

Data collection began during the first meeting with each of the participants. At that time initial demographic data was collected which described the participant's level of education and years of experience with clinical nursing education (see Appendix D). Participants consisted of full-time nursing faculty members in pre-licensure nursing programs that had at least two years of experience with clinical teaching and grading. All faculty members that participated in this study had at least a Masters level of educational

preparation. Adjunct clinical faculty was not enlisted as participants for this study in order to maintain consistency of the experience.

Unstructured interviews were conducted with each of the research participants and were used as the primary method of data collection. Unstructured interviews allowed the researcher to become an active listener during the data collection in this phenomenological study (Munhall, 2007). These interviews were scheduled in advance at a specified time and location that did not conflict with the participants' places of work. The purpose of these interviews was to delve deeply into the phenomenon being explored which was the lived experience of clinical grading for clinical nurse faculty. A schedule of meetings was established with each participant to allow for the initial in-depth interview as well as a follow-up interview to review the textual interpretation of the transcript with me and verify its accuracy.

In addition, I also purposefully sought shadowed data during the interviews. Shadowed data has been defined as information that participants give about the characteristics, perceptions and opinions of others in relation to the experience (Morse, 2001). I maintained a journal to record personal notes from the encounters that added to the data which was collected. As each interview was completed, I returned to my car immediately and wrote down notes in the journal for accuracy.

All interviews were audio taped and then professionally transcribed. Transcription was done by an individual with experience and knowledge of phenomenological studies. This individual had completed the Human Subjects Research in Social and Behavioral Sciences module as well as a Research Integrity module from the Qualitative Data Analysis Program (QDAP) of the University Center for Social and

Urban research affiliated with the University of Pittsburgh. Hard copies of the certificates are stored in the office of the Assistant Director and Research Specialist of the QDAP. Audiotapes were individually downloaded to a secure server at the QDAP. Identifying information was removed immediately after transcription of the interviews and pseudonyms were assigned. Transcriptions are being maintained in a locked cabinet in my home as well as on a secured computer drive at the Graduate Center.

Initially it was proposed to utilize ATLAS ti (version 6) [Computer program] to assist me with coding and data analysis; however given my closeness to the data and the interviews, ATLAS was not necessary as a form of data analysis. The primary method of analysis involved my repeated listening to the audio tapes as well as reading and re-creating texts of the data obtained from the depth interviews.

Research question.

The research question used to guide this study was: What is the lived experience of clinical nurse faculty with clinical grading? In order to understand the experience of clinical grading for the research participants, the following initial interview question was asked: Would you describe what it is like for you to grade your nursing students' clinical performance?

This question was tested with two nurse faculty to check for its effectiveness with eliciting information about the phenomenon of interest (DiCicco-Bloom & Crabtree, 2006). One faculty from an associate degree program and one from a baccalaureate degree program were approached and given the question as a pilot. Both indicated to me that the question was focused enough that each could describe their own personal experience with clinical grading in response.

Follow-up questions were determined by the flow and direction that developed during the interview. These questions emerged as a result of the description of the phenomenon by the research participants (DiCicco-Bloom & Crabtree, 2006). I asked these follow-up questions without interrupting the flow of the narrative that was given by the participant (Munhall, 2007).

Data analysis.

Van Manen's method of data analysis was applied. Research interviews were transcribed and transcriptions were circulated to each participant for validation. This was then reviewed with the participant during a second shorter interview, and revised with the participant's assistance. Transcripts were reviewed and preliminary essential themes were identified. These themes were then validated by a sample of five of the research participants. The preliminary themes were reviewed again and refined and consolidated to identify the essential themes. Accuracy of the themes was substantiated with the raw interview data that were collected (Kleiman, 2004). A textual interpretive statement was constructed as a result of these themes. This textual phenomenological description is one that was gathered by lived experience, recalls lived experience and is validated by lived experience (van Manen, 1997).

Given the personal nature of both clinical grading and phenomenological interviewing, the processes indicated by van Manen were expanded for this study. In developing themes, I wrote about the themes I saw and shared them with colleagues. I debated the name of the themes and the strengths of the essential themes and then rewrote the themes and prioritized elements of the experience. This process of analysis

and interpretation was strengthened because many of my colleagues with whom I shared the themes also had experience with clinical teaching and grading.

Summary of the Chapter

In chapter four, van Manen's phenomenological approach, including the application of the recommended six research activities, was identified and explained. The sample selection process that was used to enlist a homogenous group was outlined. The steps involved with the protection of human subjects including the process of obtaining informed consent and securing data were identified. Interviewing as a method of data collection in phenomenology was explained. Measures to maintain security and confidentiality with electronic information were included. The process of data analysis was described, as well as the importance of confirming accuracy of the research findings.

CHAPTER V

FINDINGS

The purpose of this study was to explore and describe the lived experience of clinical grading for full-time nursing faculty, with at least two years of clinical teaching and grading experience in pre-licensure nursing programs. Max van Manen's (1990, 1997) hermeneutic phenomenological method was used to describe and interpret these lived experiences in a scholarly attempt to transform them into textual meanings and themes. This chapter presents a comprehensive description of the study sample and a discussion of the research findings.

Research Setting

Study sample

Eleven full-time nursing faculty participated in this study. All participants had at least two years of clinical teaching and grading experience in a pre-licensure nursing program. Nine of the participants were female and two were male. Participants ranged in age from 38 to 62 years. Faculty ranged in years of teaching experience from four to 25 years. Six of the faculty taught in associate degree nursing programs and five in baccalaureate or higher degree programs. Seven participants taught in public institutions and four in private institutions. Clinical areas of nursing specialization included medical-surgical, maternal-child health, psychiatric, and community nursing.

Data collection took place over two months during the summer. I anticipated having difficulty with scheduling due to this vacation period in the academic calendar;

however, a majority of the participants were employed in summer session classes. The remaining participants were able to schedule times that were convenient for them.

Study Findings

This section of the chapter presents study findings as they were revealed using van Manen's hermeneutic method of phenomenology. Van Manen (1997) described his methodical structure for hermeneutic phenomenology as six activities which can be interchanged and may evolve as the phenomenon is explored. I completed the first activity as the researcher by selecting a phenomenon that was of real interest to me as well as being a part of the world in which I lived and practiced.

The second research activity involved investigating the experience of the participants with the phenomenon of interest (van Manen, 1997). The question posed to each participant was: Would you describe what it is like for you to grade your nursing students' clinical performance? This question was initially used to elicit the experience of clinical grading by each of the research participants.

All of the participants were assigned a pseudonym by the researcher to maintain anonymity. I have introduced each participant by their pseudonym and then with a quote that personified the experience of clinical grading as they described it.

The Participants' Experiences

Kaydee

"…it's such a process of becoming, and I just believe in the process so much and when you're in the process of doing anything, should you be graded? It's just so difficult"

Kaydee welcomed me into her private office dressed in a cream colored skirt and jacket. Sun was spilling into the windows and illuminated all the adornments in her office. Pictures of Kaydee with groups of past students in clinical uniforms were framed

and hanging on the wall, while pictures of her with her children and family were on her desk. Posters about nursing were on a bulletin board which also added to the wall décor. We sat facing each other, with her behind the desk and I seated in the side chair next to her.

Kaydee explained that she had been in nursing education for the past 19 years. She has taught primarily in associate degree nursing programs. She spoke with sincerity and thoughtful consideration when she described her experiences and feelings about clinical grading. Kaydee spoke often about her role as a mother and how that experience influenced her interactions with nursing students in the clinical setting stating "I'm big into role- modeling". She described wanting to give students "the benefit of the doubt" while they are learning and credits her own clinical instructors with framing that thought process. She described her clinical education in the following way:

> I've also had myself wonderful clinical instructors, and I think that's why I'm in teaching today, because I just always had the best support. I was always allowed to make those mistakes and come back and fix it and make it better. I had people believe in me, and that's why I am where I am today.

Kaydee described her experiences with clinical grading as being difficult at times, but stated "Usually I'm really at peace with people that have not been successful, clinically, and in the classroom." She described one instance where she knew that the student was not going to pass the didactic component but had been extremely compassionate and caring in the clinical setting. She acknowledged that "that was a struggle….but I knew right on that that's not going to make her a good nurse". Kaydee

then counseled the student to explore other paths where she could utilize her compassion and caring to care for people.

Kaydee described subjectivity as being characteristic of her experience with clinical grading, stating "I do think it's a little bit subjective, clinical grading, how can it not be?" She described assigning a grade as the "grey area" which affords the clinical faculty "a little autonomy, and a little more personalization with the student" but did describe her concern that at times it can be "a little too grey".

As Kaydee spoke, I found myself thinking that I would have loved to have her as a clinical instructor when I was a student! Her passion for nursing education, her students, patient safety, and the profession was evident in everything she shared. About clinical grading, Kaydee stated

> I'm not a great fan about grading them in clinical; I do it, and I do it, I'll be honest, with some subjectivity. But I do think I hold up the standards. And I just want good nurses; I want good nurses out there to take care of me and my family….I love it; I hope I got that across. I love, I absolutely love it. I love being there for them.

Allison

"I think clinical grading can be [the most] challenging and yet the most rewarding."

Allison, a tall, attractive, middle-aged, well dressed woman, greeted me when I got off the elevator in her school building. We walked to her office. Her office contained two desks but she assured me that we would have privacy and closed the door behind us. The room was inviting with beach themed decorations and pictures of

Allison's family arranged on her desk as well as on a large windowsill. The hum of the air conditioner provided us with a low soothing background hum while we talked.

Allison had more than five years of experience with clinical teaching and grading in nursing education along with many years of experience in the role of staff development. She gave me the impression that she was confident in her professional role and comfortable with discussing her experiences. She sat semi-reclining in her chair and sipped a cup of coffee while she talked with me.

As we began, Allison's description of clinical grading was focused on safety and whether or not a student was meeting clinical objectives. She described her experience with clinical grading as sometimes being a struggle. She spoke of using self-reflection and asking herself the questions "Should I pass him/her or not?" and "Am I expecting too much?" when she felt unclear on exactly which grade should be assigned. As the interview progressed Allison became more comfortable and revealed more about her experience.

Allison revealed that she would "like to say it's objective, but there's a subjective component" in clinical grading. She spoke of her earliest experiences with clinical grading with regret due to her own inexperience. She gave this statement as one example: "I passed her, but I didn't have a confidence level like this chick is going to take care of me."

Allison described the challenge of looking at each student individually while maintaining the course and program standards. She used the example of one student who had difficulty in clinical. When she had met with the student to discuss her clinical concerns, she learned that the student had just completed chemotherapy and was anxious

and stressed. Allison described her concern with this student's life issues but explained "I couldn't lower the standard, I couldn't lower what the expectation was, but we helped her get help and she's doing quite well." She explained that the student was able to meet the course objectives and ultimately complete the program.

Her comfort with objective grading was made apparent when she said "Classroom is pretty black and white, but I think clinical is more of a grey area". Allison described professional behavior and communication as important attributes for a student in clinical, but admitted that those things were hard to objectify and therefore assign a grade.

> How does that (clinical grading) make me feel? I actually relish it. I think it makes me feel as though I've seen it, a growth, a growth from beginning green students to senior, right before graduation. So it's scary, but it comes along with some accomplishment as well. You feel you made a product, a good quality product.

Lindsay

"I would say it's an emotional process, it's a subjective process. I think it takes experience; I think it takes a level head…I think it's something that is qualitative, really, I think it varies from instructor to instructor…"

Lindsay invited me to meet with her at her family home for our interview. She greeted me at the door in a scrub suit and looked very relaxed. We sat together outside since it had been a beautiful summer day. We chatted socially for a few minutes and then began our discussion about her experience.

Lindsay shared that she had initially entered nursing education more than 10 years ago as an adjunct in the clinical setting. She later became a full-time faculty member at

the same school in a baccalaureate nursing program. Lindsay spoke with confidence about her ability to assign a clinical grade based on the course objectives. She was firm in her conviction that a student who was not doing well in the classroom would also not be performing up to expectations in the clinical setting. She explained:

> The one thing that stands out is that clinical, the good news about clinical grading is that it's always validated in testing grading. And what I mean by that is when I have those students who …eek out a pass in clinical, meaning they haven't killed anyone over the rotation, so I really can't fail them in clinical….the good news is their testing scores are low enough that they're not progressing.

Lindsay spoke easily and with confidence about her belief that clinical grading is a subjective process. She explained that there is a big difference in clinical performance between someone who "passes really well and one who passes right on the borderline", but related this to similarities with a really good nurse versus "the one who comes in the room and you don't want to wake up to". She credits her years of teaching experience as having provided her with the ability to "perfect my clinical grading through observation and through mental rubrics in my head". She explained that it is her belief that using a pass/fail system is the only way to assign a clinical grade; however, identified that many students have stated their preference to receive a letter grade in clinical.

Lisa

"And I tell the students this all the time, no matter where I am, I have an obligation to protect the public, it's not just that I'm your teacher and I'm giving you a grade or not, but as a nurse, as a faculty person, we're responsible to make sure that you're safe when you leave here and practice."

Lisa had an open face and eyes that crinkled at the corners when she smiled to greet me. She had agreed to meet me at a site I the city that we were both familiar with. We walked together and were able to find a quiet room. We then sat across from each other at a table with our arms resting in front of us. The room was quiet, private and conducive to our discussion. Lisa and I spoke about the summer and she explained that she was teaching during the (summer) semester even though she was off from her full-time faculty job.

Lisa was a seasoned nurse educator with 18 years of clinical teaching and grading experience. She was currently teaching in a baccalaureate nursing completion program for Registered Nurse students. I explained that the focus of my study was on her experience with clinical grading in pre-licensure nursing programs. She said that she understood this and would describe those experiences during our interview.

"Stressful" was the word that Lisa used to describe her experiences with clinical grading. She explained that she took clinical grading very seriously and referred to "protecting the public" as one of her responsibilities. Lisa described spending "hours and hours and hours" completing the clinical evaluation tool that was used for a course and then assigning a clinical grade at the end.

Lisa described one particular experience with clinical grading as having been very stressful. She had assigned a failing clinical grade to a student which then resulted in the student being dismissed from the program. She explained;

> "I knew it was my moral and ethical responsibility to do it, so I was comfortable with that" but elaborated stating "…it was stressful; it's hard to do, because you realize that you're affecting people's lives and their financial status."

Lisa spoke of having experienced an awareness that she could personally be at risk for physical violence if the student had responded in that way when she had delivered the news of the clinical failure. Her compassion for the student was obvious when she laughed and stated "And the funny thing is, do you know what I remember now what I did with that student? I drove him home after that because I was so upset; I felt so bad for him!"

Harriett

"I mean sometimes I say to myself all right, as long they're not absolutely terrible and detrimental…who am I to be so judgmental? You know, we're not God. It is a job. Are they gonna at least do the job and not kill anybody? So am I gonna pass them? Am I happy about it? No, not always. I'm really not. I really would prefer they did not come into nursing."

Harriett and I met at a site she had requested in a school of nursing in a large city. She requested I meet her at the end of the clinical lab day. She was smiling and chatting with a colleague, seated behind a desk in the front of the classroom when I arrived. Her colleague left when I arrived and we stayed in the room which was a nursing skills lab in the school. Harriett and I were alone except for the human mannequins lying on the beds in the room. We were interrupted on two occasions, once by a student, and once by a colleague, during our interview. Harriett quickly resumed our conversation and continued after each of these interruptions.

Harriett was a middle-aged woman who laughed frequently and spoke rapidly as she described her experiences with clinical grading. She informed me that she had 10 years of experience with clinical teaching and grading in programs ranging from

associate to masters level nursing programs. She kept me laughing throughout our interview with her animated descriptions of some of her experiences. Beneath the laughter, Harriett spoke about the compassion she had for many of the students and described the difference she felt that existed between classroom and clinical grading.

> So I mean a lot of people will say well, if they're really bad in theory, they're often really bad in clinical. That's not always true. I have some students that are very good in the clinical area, and have just a little bit of trouble making it in the theory portion, and I always feel kind of bad that I can't give a couple of extra points to those that are sitting on the borderline.

At times Harriett's descriptions sounded harsh, describing a student as "dumb" or "just awful". She raised her voice and became very loud when she related the story about one student who incorrectly calculated a medication dose and then argued with her that it was correct. Her compassion for the student and her concern with maintaining patient safety and professionalism though, softened any of the earlier harshness.

Harriett described her feeling that it was difficult to grade students in the final semester when she felt that they were unprepared and not meeting expectations. She explained that she was disappointed and felt frustrated with her colleagues who did not report these concerns throughout the earlier clinical courses stating "You'll look and nobody wrote anything about the student, like 'can't do drug calculation'."

Harriett felt strongly about her responsibility to the nursing profession. She summed it up by saying "We do want to bring nurses into the field; and people can become good nurses, and not everyone's gonna move at the same pace at the same time, and there has to be a way to encourage people."

Deb

"I really want to be sure that the student is safe, and even though I'm there, that they, if I wasn't there, they would be able to make good decisions independently."

Deb had invited me to her home to conduct our interview. Her apartment was cool and provided a fresh relief from the outside heat. We sat at her kitchen table with the sun shining in on us through the windows. Deb told me that she was in her late fifties which I found hard to believe! She looked much younger with her smooth brown skin and clear brown eyes. She was dressed for the summer in a relaxed outfit of shorts and a top. Her computer was on the table and she said she had been doing some work right before I arrived. Deb informed me that she had seven years of experience with clinical teaching and grading in an associate degree nursing program.

Deb stated that she never had a student who was unsuccessful in clinical. She described her belief that most students are able to reach the level of performance required to meet the objectives even though "not everybody has the natural feel for nursing." Deb described her role as one where she has a more personal interaction with the students and is able to facilitate them to pass in clinical. She describes being able to work with the weak students and help them to meet the level of clinical competency that is needed to pass the course. Deb compared clinical grading and didactic grading in this way:

> It's more; it's not like you're reading a book and you take a test, and you either pass or fail, there's much more…if the student is a little slow or they don't quite get it, then I'm going to say, direct them more, and even, maybe, my grading might be a little biased, because I'll say this student is really bright, I know she can get it.

Lance

"Unfortunately I think the way it works within the U.S. is that there's a pass or fail with most of the healthcare disciplines with respect to clinical. So either you make it or you don't make it. And it's a very subjective measure on the part of the instructor."

Lance and I met at a neighborhood restaurant one afternoon after his last clinical day before his summer break. He came from his car looking like a real clinical nursing faculty wearing a scrub suit and a lab coat! We sat at a booth and ordered a soft drink as we began our interview in a relaxed setting.

Lance was in his late thirties and had more than seven years of experience with clinical teaching and grading as a full-time faculty member. His voice was soothing and he spoke with confidence as he described his experience with clinical grading. In his experience, Lance reported using a pass/fail system of grading for clinical. A clinical pass was defined as a student who met the minimum safety standards for the level of the course they were in. A failure was reserved for the student who did not meet the minimum safety standard.

Reflecting on his experiences, Lance described his wish that he had more of a mentoring process as a new clinical faculty. He described not feeling comfortable in making clinical grading decisions as a new faculty member and attributes his present confidence to his years of experience. He said about his present experience with clinical grading that "It's easy. It's so much easier now because I lay it out on them from the very beginning, and the approach I use is its business. Business is business."

When asked about what could be improved with clinical grading, Lance explained that he would like more objective measures. He described this in the following

statement, “I just wish that there were more objective measures (for clinical grading) rather than subjective measures. If there were, that’d be a better thing. A good thing.”

Teresa

“I don’t like failing students; I’ve probably in ten years, four students have not passed my clinical and while I don’t like doing it, I feel I’m morally obligated to do it, because we can’t pass students that aren’t safe.”

Teresa and I met after a workday in a small conference area in her school of nursing. She appeared to be a little rushed, having just come out of a meeting. Teresa was businesslike, brisk and efficient; she spoke with confidence about her experience with clinical grading which spanned over more than 10 years. She explained that the experience of clinical grading has become easier for her as the years have gone by, but maintains that meeting nursing competencies has always been the standard she upheld. Teresa’s concern for safety was clear when she stated “So I feel that, while we have to help the students, (that) we cannot pass somebody along that does not demonstrate the competencies.”

Clear communication, both verbal and written, were noted by Teresa to be very important in her experience with clinical grading. She stressed the need for good documentation in order to notify a student of what needed to be accomplished in order to succeed in the clinical setting. Teresa admitted that “didactic (grading) is just much easier because it’s all about numbers; and it’s very objective. However, clinical (grading) does have a subjective component….”

Teresa explained that although assigning an unsatisfactory to a student for clinical may be “uncomfortable”, it is something that needs to be done as a part of her job. She

was very sincere when she said "My goal is to graduate competent nurses, so I'm not trying to mess anybody up in clinical. I am absolutely trying to help them to be the best possible nurse they could be."

Lucia

"Theory grading is sort of black and white. There is a grade to achieve to pass. You either do pass or you don't pass. Clinical grading has shades of grey, so I think that's why I find, especially as a new instructor, that there are no very specific guidelines, at least to get you started in the beginning of what to look for and what not to look for."

Lucia met with me in a residential suburban setting that was convenient for both of us. We were relaxed in each other's company and had a cup of coffee while we had our discussion. Lucia exuded energy and seemed anxious to begin our interview. She spoke freely and offered many examples when she described each particular experience with grading. Her speech was rapid and at certain times she slowed down while she gave more thought to individual responses.

One source of concern for Lucia with regards to clinical grading was based on the specific course she taught and its placement in the nursing program. She stated "Since it is a senior level course I've always taught, I felt there was more pressure on myself, internally, to make sure that I was the gate-keeper for safe patient care." Lucia described that she often used self-reflection asking questions such as "Am I being too critical? Am I expecting too much? Am I implementing these objectives too specifically?" when she evaluated a student's clinical performance before assigning a grade. Her concerns for both patient safety and the integrity of the profession were obvious as she spoke and these guided her decision making.

Lucia identified administrative support as being a huge factor which contributed to her experience with clinical grading. She described one conversation and spoke with real emotion as she recounted to me:

> Very recently, I had dialogue with a senior member of the administrative staff for whom I had communicated the difficulties that I have with clinical students and she reminded me that this is a school, and that this was a learning environment, and that no one should fail clinical; everybody should pass because you're in school. And while there was something in me that said 'All right, I guess that does make some sense, that you're in a school'. But then I thought, 'But you're in a school and you fail tests, so wouldn't the same apply? Nobody should fail any tests?'

With a note of sadness, Lucia identified that the one thing she would change about clinical grading would actually be adding more support for the faculty who are making grading decisions. She hoped that administration would trust their faculty enough to support their decisions. She also advocated for more seasoned faculty to grade students clinically, identifying faculty inexperience as a real disadvantage with clinical grading.

Kitty

"Clinical grading is probably one of the most complicated things in nursing education, because there are so many variables that affect it."

Kitty asked to meet with me at an urban school of nursing where she was teaching for the summer. When I arrived we walked together to find a place where we could meet privately. We searched for a private area and found a small nursing skills lab/storage

area that Kitty thought would be conducive for our interview. We sat down in chairs facing each other and began to talk.

Kitty's area of clinical specialization was psychiatric nursing. She taught in both undergraduate and RN completion programs for more than twenty years. Kitty reported that she taught in many different nursing programs through the years and had made the professional acquaintance of many faculty, as well as administrators, in each of the programs.

Kitty identified that patient safety was her main consideration when she assigned a clinical grade. The problem with that, she stated, was "it's very difficult to determine who is unsafe." Kitty described becoming "fuzzier in terms of evaluating who's going to be good clinically" because of her many years of experience and subsequent follow-up with past students. In terms of students' experience, Kitty said she believed that most would improve with time. The students that she identified as being most problematic were the ones that did not care or those who had a poor attitude and did not accept responsibility for their actions.

Theory grades and clinical grades did not always match according to Kitty. She described one student who was very good in clinical but she described her as being "dangerous with a Scantron form, they can't pass a test". In an opposing example, she also described a student who was valedictorian of the class but was "a disaster in the clinical area". She said faculty could see it both ways and that sometimes there would be a real connection between theory and clinical grades but sometimes there were not.

Kitty described nurse educators as "basically nice people….a lot of them are nurturing types." She reflected back on the many faculty experiences with clinical

grading that she knew about and said "if you're ending someone's career, it's a pretty big deal, and so most nurse educators don't want to do that".

Franco

"…but I often wonder about the tools, and again, I've always had a tool that I'm using, and I know for some faculty, and I'll include myself here, that there is a propensity that unless something is overtly out of order, in terms of what the student is doing, that there's a kind of like, there's a straight line down the column under satisfactory."

Franco agreed to meet with me at the end of a clinical day he was teaching. We met in a classroom in the school of nursing where he was teaching. He closed the door behind us and we had a private space to conduct our interview. Franco appeared to be relaxed; we were facing each other and he was seated with his legs crossed. He reported that he was in his sixties but looked younger. His primary experience in nursing had been in clinical practice before transitioning to academia. He had less than five years of teaching experience and was responsible for students in an accelerated masters nursing program as well as having some responsibility in an undergraduate program. The students in the masters program were pre-licensure and therefore this clinical grading experience could be included in this research. Franco's areas of clinical grading responsibility were in psychiatric nursing and community health.

Franco described his feeling that the clinical evaluation tools being used were "ambiguous" and resulted in a less precise grade than he would have liked. His concerns with grading focused on the lack of specificity and sensitivity of the tools. He identified that his recommendation for improving clinical grading would to revise the evaluation tools and make them more course specific instead of standardized for all courses.

The clinical rotation that Franco has responsibility for grading is very brief. The psychiatric nursing clinical lasts only four weeks. He believes that this creates some difficulty with compiling adequate information about a student's clinical performance in order to assign a grade.

Thematic Analysis

Once the research interviews were transcribed, data reduction was performed according to van Manen's method of analysis. The first review was a holistic reading of the transcripts which I conducted as soon as the transcriptionist returned them to me. Next, I contacted each participant to schedule a second meeting to review the transcript for accuracy or to add or modify any part they felt was necessary. Initially as I listened to the audiotapes and read each transcript, I identified four implied dimensions with each of the participants. The participants described the experience of clinical grading in terms of each of these dimensions. I called these dimensions *the abouts*. The first dimension was about self, the next, about student, the third about patients, and finally about the profession. These dimensions provided me with a framework in which to place themes that I then identified from the data.

For the second interview, I met with five of the participants for a face-to-face review of the transcript. Two participants were interviewed by telephone at their request for the second interview; and four participants chose instead to read the texts, make any revisions that they felt were needed, and then returned them to me. Two of the participants who I met with personally elaborated on their experiences but did not change any of the content. One of these participants actually described an additional

clinical grading experience that had occurred since our initial interview. This interview was also transcribed and reviewed as part of my data analysis.

Once the follow-up interviews were completed, I conducted a holistic review which included selective highlighting. Then a detailed line by line review was conducted to determine themes that comprised the characteristics of the phenomenon (van Manen, 1997). As I read through the transcripts I sought to develop clusters of common characteristics that could be categorized as themes (van Manen, 1997). As themes were identified, I wrote them in a list for each participant's experience. I then reviewed each list and compiled a master list of all the themes that I had identified. Using this method of analysis with the transcripts, a total of 21 themes were initially extracted. These themes were:

1. Clinical grading is subjective
2. The process is emotional and can be anxiety producing
3. Experience is needed for grading; more confidence as years go by
4. Must maintain patient safety
5. Uncertainty: Could I be wrong? Am I missing something? Who am I to say?
6. Soft skills important (communication, professionalism) but hard to measure and grade
7. Do not want to assign a failing clinical grade. Last resort.
8. Belief that good classroom performance (test taking) usually equates to satisfactory clinical performance
9. Clinical objectives important
10. Discontent with clinical objectives/tools

11. Satisfaction with outcomes (making a difference in someone's life)
12. Feel like I'm making a difference-to student's life; to profession; both pass and/or fail
13. Able to effect change in grade due to qualitative nature of experience; Differs from classroom grading
14. Clinical grading requires more thoughtful consideration than classroom grading
15. Hope that students will improve; that they fail theory & therefore no worry about clinical; For administrative support; to improve the profession
16. Motivation of student matters
17. If it were my family member. "Would I want them to take care of my family member?"
18. Changes in clinical needed
19. Lack of numerical/letter grade devalues grading for student
20. Disappointment with colleagues (especially in final clinical courses) Inconsistent when reviewing past experiences
21. Student's process of learning, becoming

These 21 themes appeared in the data; however, phenomenological research distinguishes between what appears to be so, and what constitutes the real nature of the experience for the participants (van Manen, 1997). As van Manen eloquently stated, "a true reflection on lived experience is a thoughtful, reflective grasping of what it is that renders this or that particular experience its special significance" (p. 32). In accordance with van Manen's research activities, I reflected on these themes by listening again to the

experiences as they were described by the participants as well as by re-reading the transcripts as I listened to them. In this way I worked to keep myself oriented to the research question and the specific phenomenon of interest being explored.

Next I sought to group the themes by similar characteristics. I grouped themes together that seemed to reflect a common feeling or thought. Each grouping of collective themes is presented in Table 1. Some of the themes appear in more than one box since they also provide some of the description for another collective theme.

Table 1

Grouped Collective Themes

Grouped collective themes for analysis	
I.	(1) Clinical grading is subjective (3) Experience is needed for grading; more confidence in ability as years go by (4) Must maintain patient safety (5) Uncertainty: Could I be wrong? Am I missing something? Who am I to say? (6) Non-technical skills important but hard to measure (8) Belief that good classroom performance (test taking) usually equates to satisfactory clinical performance (13) Able to effect change in grade due to qualitative nature of experience; differs from classroom grading (14) Clinical grading requires more thoughtful consideration than classroom grading (16) Motivation of student matters (17) If it were my family member
II.	(4) Safety used as benchmark for grading (9) Clinical objectives important
III.	(7) Failing is a last resort (13) Able to effect change…..; differs from classroom (8) Belief that good classroom performance usually equates to satisfactory clinical performance (2) The process is emotional and can be anxiety producing (5) Uncertainty: Could I be wrong? Am I missing something? Who am I to say?
IV.	(11) Satisfaction with outcomes (12)Making a difference in someone's life: the student and the profession
V.	(15) Hope that students will improve, that they fail theory & no worry about clinical; for administrative support; to improve the profession (21) Process of becoming
VI.	(19) Lack of numerical/letter grade devalues grading for student (20) Disappointment with colleagues (especially in final clinical courses); Inconsistent when reviewing past experiences (10) Discontent with clinical objectives/tools

Determining essential themes.

Next, I needed to reflect on the themes that I had identified to determine what was essential to the phenomenon of the experience of clinical grading. Van Manen (1997) explained that in order to identify which themes are essential, we must ask ourselves if the phenomenon would still be the same if we were to imaginatively change or delete the theme from the phenomenon; other themes could then be categorized as incidental themes, or ones without having the ability to change the experience, if they were removed. Following this recommendation I reflected on the grouped themes and then re-considered the phenomenon removing each one individually.

As a result of this next level of analysis, I wrote and re-wrote what I interpreted and identified them as *preliminary essential themes* for the phenomenon. These themes are presented in Table 2.

Table 2

Preliminary Essential Themes

I	Clinical grading is subjective and requires thoughtful consideration
II	Safety as the benchmark
III	Failure is the last resort and is avoided whenever possible
IV	Making a difference in the lives of students and for the profession
V	Hope for the future
VI	If it was my family member
VII	Discontent and disappointment (negative feelings)

I reviewed these themes with two experts and determined that further refinement was needed. Then, I reviewed the raw data to revisit the lived experience of the phenomenon for the participants. I reflected on the preliminary themes and reconstructed the textual interpretation of some of them to broaden their scope and meaning. As a result the following essential themes emerged: (a) subjectivity and shades of grey, (b) safety as the benchmark, (c) opportunity for change, (d) wishful thinking, and (e) discontent and disappointment.

In accordance with van Manen's recommendation, a good phenomenological description is validated by lived experience (van Manen, 1997). Accuracy of essential themes was substantiated with the raw interview data that was collected (Kleiman, 2004) as well as by confirmatory statements received from a sample of the participants.

Essential theme I: Subjectivity and shades of grey.

This theme emerged from the two preliminary themes *clinical grading is subjective (and requires thoughtful consideration)* and *if it was my family member*. Both of these themes reflect the subjectivity and personal investment of the CNF that was described by the participants as being essential for the experience of clinical grading. The color grey was often used by the participants as one way to describe this subjectivity.

Subjectivity was identified by all participants as being a part of the experience of clinical grading. Subjectivity was both valued by the participants as well as being the cause for very thoughtful consideration. Kitty spoke about wanting to give students "the benefit of the doubt" and being able to do that with clinical grading. Allison described the need for self-reflection during clinical grading in the following statement:

> I'd like to say its objective, but there's a subjective component in that. If you don't recognize it, you say, why am I feeling this way about this student? So I need to say to myself. Ok, something makes me uncomfortable.

A few participants used the term qualitative to describe the experience of clinical grading and contrasted the experience with classroom grading which was described as quantitative (Franco, Lindsay). Many of the participants' used color to express the subjectivity of the experience. As one example, a participant, Kaydee, stated "Well I guess it's not as black and white sometimes in the clinical setting" and further described the experience as allowing for "that grey area". She spoke of the autonomy that this afforded her as a CNF, but did express concern that it can become "a little too grey sometimes".

The color grey was specifically used to describe the experience of clinical grading for nine of the eleven participants. Allison compared classroom and clinical grading by saying "Classroom is pretty black and white, but I think clinical is more of a grey area. A classroom, black and white, you answer the question, you look at your exam, right or wrong." She continued in her description and said that clinical grading "is a little bit more subjective" but also added that it "can be the most challenging and yet the most rewarding" part of her job as a CNF. Lucia had a similar description when she explained "theory grading is sort of black and white" and added that "clinical grading has shades of grey". Because of the subjectivity, or greyness, Lucia stated that "I am very much more thoughtful when I grade clinical evaluations, than I do theory".

Years of experience as a CNF was identified by half of the participants as being an important factor related to confidence with clinical grading. The following are some

comments made by the participants: “I wasn’t as attuned to the clinical competency and how to handle it” (Allison); “I’ve been doing clinical a long time so I feel like I’ve come a long way too with my students and expectations” (Kaydee); “But generally speaking, now, while I have a clearer sense of what’s safe and appropriate clinical performance, I have more expertise in getting that performance out of the student” and “especially as a new instructor, that there are no very specific guidelines to get you started in the beginning: of what to look for and what not to look for” (Lucia); “I guess maybe when I was a new instructor I didn’t feel as comfortable as I feel now in the decisions that I made regarding my students” (Lance); and finally “I think that each time I do it, it gets a little bit easier, just because I try to make it as objective as possible” (Teresa).

Almost all of the participants used a form of the expression “if it was me or my family member” when they described evaluating a student’s clinical performance. In addition to meeting safety standards, the participants reported reflecting on the question “Would I want this person taking care of me or a member of my family?” when they considered a student’s clinical performance. Lindsay considered it this way: “If it was my sibling, or my mother, I would like someone to sort of intervene….I would want someone to take account of that if it was my family member…” when she described the experience.

Other participants expressed the theme in a similar way. Lucia explained that she stayed focused on the patient and safety when she framed the following question to herself: “If I could say to myself, ok, if this was your mother, or your father, or your brother, would it be ok with you that the nurse left the room when he had chest pain; would that be ok?” Kaydee reflected on a time when she had assigned an unsatisfactory

grade in the following way: “You know what I always say, is, do I want this person taking care of my family member? So I was ok with it… .”

Essential theme II: Safety as the benchmark.

Safety was identified by all participants as the benchmark they used for clinical grading. It provided each participant with an anchor; returning to safety as the measurement criteria to be used when they described having the ability to make a grading decision. As Deb described “What do I look for when I’m going to grade a student in the clinical area? I want to be really sure that the student is safe”. Teresa spoke with conviction when she said “We can’t pass students that aren’t safe.” Several participants gave specific examples of unsafe practice that impacted a clinical grading experience, but some did not. Kitty told me that “it’s very difficult to determine who is unsafe”, and recalled that many students often improve dramatically as the years go by. Lance explained that he uses meeting the minimum safety standards as well as the clinical objectives for the course as his own personal benchmark with clinical grading. Kaydee stated “I follow my clinical objectives very closely”.

Allison had described her concern with safety to me but explained that she would also give students an opportunity to improve. She gave the following description as an example “I watched him very closely. He had to demonstrate his concern for safety in every other clinical experience.” Allison explained that even though this student had demonstrated an unsafe practice initially, he was able to demonstrate improvement and ultimately be successful in clinical.

The most extreme measure for safety was described using “they haven’t killed anyone” as the criteria. Four of the participants described this as being the reason many

students would continue to progress since there were no specific glaring safety infractions to be cited; however, all of the participants described student competency as the goal. They used the aforementioned statement with me only to give a more vibrant example knowing that I am also a CNF and am familiar with the experience. Lindsay also gave an example where she struggled with clinical grading because "it wasn't a life or death situation, it's more of a patient comfort and an initiative kind of situation…"

Essential theme III: Opportunity for change.

This theme emerged from the two preliminary themes *failure is the last resort* and *making a difference in the lives of students and for the profession.* As I reflected on each of these themes I was struck by the opportunity for change that the CNF has in the life of the student and for the quality of the profession. In addition, reserving a grade of clinical failure as a last resort provides the CNF with an opportunity to change the students' educational trajectory based on the grading decision. As my thoughts evolved and unfolded, I decided that opportunity for change was both a more descriptive and abstract title to denote this theme.

All participants reported that in their schools of nursing a clinical failure for a student would result in a course failure. Participants varied from those with the least experience having had no students who had ever failed clinical, to those with the most experience who had a total of four fail in their academic career. More years of experience changed the perspective of the CNF; those with more experience were more definite about what it is that they expect when assigning a clinical grade.

Participants responded with different levels of emotion about the experience of assigning an unsatisfactory clinical grade. Teresa explained "While I don't like doing it,

I feel I'm morally obligated to do it, because we can't pass students that aren't safe". Lance told me that "the approach I use is it's just business. Business is business…And you have to perform."

Kitty described "I mean most people; they really do not want to fail somebody". She explains the impact of a clinical failure in this way "if you're ending someone's career, it's a pretty big deal. And so most nurse educators don't want to do that." Kaydee described "I'm being honest, because I give them that chance. I always think I want somebody to give me that chance, especially in a learning situation." Lindsay explained:

> Like the students who get the basic pass or the low pass in my mind, the ones that eek out a pass in clinical, meaning they haven't killed anyone over the rotation, so I really can't fail them in clinical, they've come the whole rotation, they've shown up on time, they haven't done any severe errors, they haven't performed any horrible mistakes, they've been a basic clinical student, so they're going to pass clinical…

Lisa described her feelings after assigning a failing grade many years before to me in the following way: "so yeah it was stressful, it's hard to do, because you realize you're affecting people's life and their financial status, and today I think it's even harder because many students have family responsibilities and all that.."

The participants were able to define specific clinical days when they assigned an unsatisfactory grade to a student, but also identified that one unsatisfactory did not necessarily equate to a clinical failure for the course. Harriett described this in the following way:

> Cause I did fail her for that day. And the thing is that you have to have three failures, two failures in meds and a failure in something else for me to fail you in clinical. That's what I tell them at the beginning of the semester. So you can have a couple of off days.

Participants described the relationship between classroom performance and clinical performance in similar ways. Harriet explained "a lot of people will say well, if they're really bad in theory they're often really bad in clinical. That's not always true". Lucia had similar comments stating "My experience most of the time, was that if they were performing poorly in the classroom, they were performing poorly clinically, generally speaking. But there were times when that was not the case, but it just wasn't often."

Lucia explained steps that she has taken to avoid assigning an unsatisfactory grade in the following example:

> The only thing that I can honestly say to you is I never passed anyone clinically who was dangerous because I was afraid of repercussions to me. What did happen is that student was, I willingly passed that student on to another instructor (at mid-semester). Not as much to avoid consequences to me, as to give the student a fair shake with a different instructor.

Teresa explained that she had given additional clinical experiences to students in an attempt to have them meet the requirements to pass clinical. She said it didn't usually work but she had done it in an effort to "try to help them." Kaydee also reported giving students a "second chance", and added "you can't fail somebody on not being

compassionate, although it is one of our objectives, but it's always melded in with something else."

Having the ability to assign a clinical grade and make a difference in the lives of students and ultimately to the nursing profession was often cited as a reason for satisfaction with the role of CNF by the participants. Kaydee described her love of the role in the following example: "I love to see them grow, and I love to see them just become nurses, you know the whole process, I love to watch it." She later smiled when she described her long term goal as being "I just want good nurses; I want good nurses out there to take care of me and my family."

Allison described making a difference when she stated "I think clinical grading can be the most challenging and yet the most rewarding, because you can see how they put theory into practice." Allison then used the term "contributing to our future, the future of caring nurses" when she shared her experience with clinical grading and its impact on the nursing profession. She shared a particular student experience where she felt she made a difference in a student's life when she explained:

> So she finally muddled through it and I got her later on and I said "Can we talk? Is something going on, you know are you stressed out? Tell me." Well the flood gates opened! She was stressed out, she was post-chemo, I mean horrible, horrible things that we worked together how she could maybe manage the stress part of it.

Lisa spoke with sincerity when she talked about the responsibility to the nursing profession by saying "But faculty have a big responsibility in preparing people for practice. I like to think that most faculty take it very seriously [laughter], but not

everybody is as neurotic as I am and that's just how it is." When she described her impact on individual students she said "You have to think of all those things as the words you use in terms of praising or criticizing…Because you don't want to crush people, you want them to develop." Lisa also spoke about affecting peoples' lives, their families and their financial status when she talked about her experiences with clinical grading. She spoke about the students "who were trying to better themselves" and her involvement as a CNF in that process.

Lindsay described feeling satisfied with her role when she explained "Umm…it makes me feel competent to know that I'm putting out qualified nurses that I know are not going to hurt anybody's children." Lance described his feelings at the end of a clinical semester in the following way:

> "I'm feeling, I'm feeling good. I'm feeling as though the students came away with a good learning experience. I'm coming away feeling that maybe you know, maybe certain things could have been changed, been different with the actual clinical itself…So for the most part I'm feeling pretty good about, you know, the you know, the pass or the fail that I've assigned."

Essential theme IV: Wishful thinking.

This preliminary theme was called *hope* but with further reflection, I decided that wishful thinking more accurately represented the data that was obtained and interpreted. Wishful thinking was expressed by all participants but did not always pertain to the same thing. Hope for improvement, hope for administrative support and hope for the student's classroom grade to reflect clinical performance were areas where hope was identified by many participants.

I interpreted wishful thinking as a theme from those participants who shared their beliefs that students would improve. Participants described "working with those students to get them to pass" (Lisa) and "maybe with a couple of more weeks, maybe a few more hours, that they could get to a certain level of functioning that they are very fluid in their movements" (Lance) as examples of hoping, or wishing, for improvement. Harriett expressed her hope that students would improve when she asked the following: "I mean sometimes I say to myself, all right as long as they're not absolutely terrible and detrimental who am I to be so judgmental?"

Kitty explained how she has hope for students because of her past experiences in the following statement:

> As I've gotten older I've become, you know my experience with seeing people who were kind of average, that story I told you before, and then fifteen years later they're like superstars, and so I feel like it's hard to know who's going to be….yeah, I mean most people are going to get better.

Wishing for administrative support was expressed by the participants with respect to assigning an unsatisfactory clinical grade. Kitty described one experience talking about the lack of administrative support in the following way: "And the dean at the time wasn't having any part of it, because she didn't want to fail anybody, that particular dean, this was at another institution, fifteen, twenty years ago."

Wishful thinking was also expressed when participants spoke about the relationship between classroom and clinical performance. Harriett laughed when she explained "We all hope that they just flunk out so that it goes away…you know, that's really what everybody hopes, that they'll just fail and then it'll go away." Other

participants explained this further saying it was easier if the student who was performing poorly in clinical was also unsuccessful in class; the classroom failure would then result in an overall course failure. Lindsay expanded on this with her own description:

> So, mid-semester when I'm having problems with a student in clinical, I look at their testing grades, and low and behold, they're failing miserably in the lecture portion of the class. And it's like, such a sigh of relief for me that I'm validated in my assessment in the clinical portion of the class. So it's almost like, ok, I can calm down a little bit because they're not going to progress at this point, because they're never going to pass the lecture part of the class.

Essential theme V: Discontent and disappointment.

All participants expressed some negative feeling about the experience of clinical grading; however, the type and frequency of the feelings differed among them. Kaydee described a feeling of discontent when she shared her thoughts about the number of students she had in her clinical group. This discontent was evident when she explained:

> I wish, deep down, I didn't have so many students, so that I could spend more time with them, and I think I could grade them, probably knowing them better in clinical; I might have a better grip on grading them. Sometimes I'm just so busy….

Kitty expressed similar discontent with clinical group size and the ratio of 10 students to one CNF that is currently used at her school in the following statement:

> The ratio is ridiculous and I think that it's really important that we work towards the new preceptorship models that some schools have adopted, that's like the new thing. And I think that that actually will really be helpful in nursing education,

> because I think with the ten-to-one, some faculty members have, sort of let students observe because there's only so many clinical people that they can actually safely precept…plus they're like switching rotations every few weeks, they're here and by the time they get organized and figure out what hospital they're in, they're on to the next one…

Lindsay spoke with a tone of disappointment when she described the students' lack of effort in trying to achieve a clinical grade. She stated

> This is a student that just meets the standards, that doesn't really go above and beyond anywhere. A lot of our students strive to that point, that's where they want to be; they just want to meet the standards and that's it. They don't want to go above and beyond…That's all they're going to aspire to regretfully….

Allison also spoke about disappointment with students' motivation and performance when she related one student interaction, saying "But it's true, I said, you really let me down. You're not fulfilling your role in this thing."

Franco and Harriett expressed disappointment with the clinical evaluation tools that are used as a basis for determining the clinical grade. Franco explained that the first thing needed to be done to improve the experience of clinical grading is to develop a new tool. He explained "And so I sort of, I would sort of beg for something that I think really gives me something that's more concrete about evaluating a student in the clinical area." Harriett expressed her disappointment when she said "Cause all there is, is a stupid checklist. Satisfactory, unsatisfactory, not observed." Teresa described the "need to shorten the competency list, for what, how we're evaluating students because it's very long on everybody."

Lack of support was also identified as an area that resulted in disappointment for many participants. Lucia described the lack of past supportive documentation as being a source of negative feelings when she explained:

> The clinical instructor would say to me that the student was horrible, she didn't do this, he didn't do that, he didn't know this, couldn't understand that, and I would go back to the paperwork. No I would never evaluate based on what anybody else said, but if I was looking for supportive documentation, very rarely could I find it…So there were times I felt I was starting from scratch.

Harriett reported a similar disappointment when she said:

> You'll look and nobody wrote anything about the student, like 'can't do a drug calculation'…and then they get to the fourth semester, and they can't figure out a drug calculation, or they tell me they've never hung an IV piggyback, and I want to cry!

Lucia also spoke with sadness and disappointment about the lack of support she felt from administration in her school when it came to assigning an unsatisfactory clinical grade. She described the second time she assigned an unsatisfactory grade and said "This decision wasn't supported, so the student got to continue and go on."

Many participants described a sense of disappointment with the experience of clinical grading when they were new to the role of CNF. As an example, Lance described:

> When I was a new educator I wish I had more of a mentoring experience such that I guess maybe when I was a new instructor I didn't feel as comfortable as I feel now in the decisions I made regarding my students.

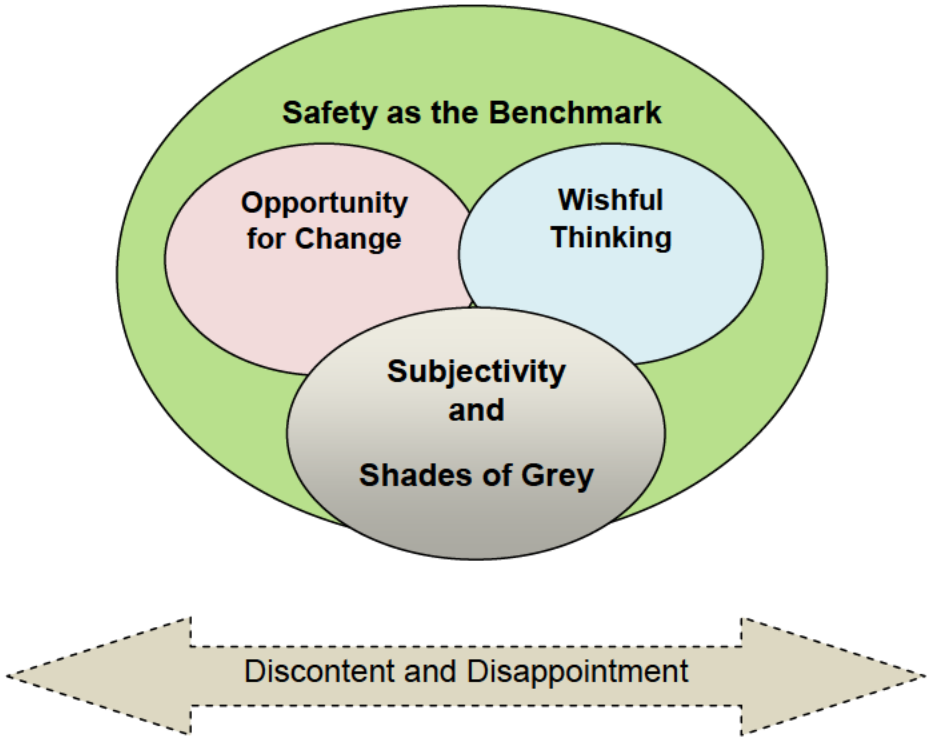
Lucia described "losing all hope" when it came to support for clinical grading decisions. She spoke with real disappointment when she said:

> So I've lost the hope that someone will feel, someone in authority will feel as altruistic as I do, and won't have any qualms about a blanket support, will know their faculty and trust their faculty enough to say 'what she says is the way that it is.'…I've lost the hope that that could be there.

Dissonance was described by some participants as an additional negative feeling surrounding the experience of clinical grading. Lisa described a time when she experienced dissonance when she had the realization that a college was a business that was supported by tuition. She talked about wishing for administration to support the faculty instead of "asking you to compromise your values" in order to run the business. This feeling sometimes resulted in disappointment and discontent.

I constructed a model to demonstrate my understanding of the essential themes as well as their relationship to each other. This model is displayed as Figure 1 and illustrates the lived experience of clinical grading for the CNF in this study.

Figure 1: Thematic model of the lived experience of clinical grading for CNF



Establishing rigor.

In qualitative research, rigor is concerned with the relevance of the research question, adherence to methodology, thoroughness of data collection, consideration of all data during analysis, and finally the self-reflection and understanding of the researcher during the process (Burns & Grove, 2009). Multiple dimensions of the phenomenon being studied must be explored and new ideas are formed as a consequence of the rigor.

According to van Manen (1997), it is important to maintain a strong relation and commitment to the research question and not become distracted or put off-course. He warned that to do phenomenological research one must be strong in his or her orientation and cannot accept falsities in place of the true experience of the participants. Lincoln and Guba (1985) used the term trustworthiness to describe what needs to be achieved as a

result of qualitative research. The four criteria of truth value, applicability, consistency and neutrality comprise trustworthiness (Lincoln & Guba, 1985, p. 290). I studied each transcript with these criteria in mind and identified consistent and essential themes. I then selected sections from the transcripts that illuminated each theme to establish research rigor.

Once I had identified the essential themes, I reviewed them with two doctoral prepared nurse experts in an attempt to maintain rigor with the interpretation of data collected. Both of these experts agreed with my thematic analysis based upon the transcripts and the data that was obtained.

As an additional step in determining research rigor, I had a sampling of the research participants review the themes that I had identified and determined to be essential. This sample of participants was in agreement that the themes reflected the nature of their experiences with clinical grading.

Textual interpretive statement.

According to van Manen, creating a phenomenological text is actually the objective of the research process and it is this text which enables us to make visible the phenomenon being studied (1997, p. 130). Writing and re-writing the themes that were revealed were the first steps in creating a textual interpretive statement of the experience of clinical grading.

When I combined the five essential themes to develop a textual interpretive statement, I came up with the following to describe the experience for the CNF: *The experience of clinical grading is subjective and colored in shades of grey; uses safety as a benchmark; has the opportunity for change in the lives of students as well as the*

nursing profession; often involves wishful thinking for a positive outcome, and can sometimes be clouded by feelings of discontent and disappointment.

Summary of the Chapter

This chapter presented descriptions of the eleven CNF who participated in this study. Each description included a quote that was selected which personified the experience of clinical grading for each of them. The participants' transcripts were analyzed according to the hermeneutic method described by van Manen. Five essential themes were identified by the researcher and then supported with selections from the transcripts as a testament to research rigor. These themes were used to construct a conceptual model of the experience. A textual interpretive statement was then provided as a result of the integration of the five essential themes.

CHAPTER VI

REFLECTION ON THE FINDINGS

The findings from this study led to the development of the following textual interpretation of the experience of clinical grading for clinical nurse faculty (CNF): *The experience of clinical grading is subjective and colored in shades of grey; uses safety as a benchmark; has the opportunity for change in the lives of students as well as the nursing profession; often involves wishful thinking for a positive outcome, and can sometimes be clouded by feelings of discontent and disappointment.* In order to illuminate this phenomenon, existing literature sources were reviewed. Results of the literature review supported the need for a phenomenological exploration of the experience of clinical grading since this particular aspect of the role of the CNF had not been previously addressed.

Synthesis of Data and Literature

A search of nursing, health care, and academic literature provided many supportive examples for the need to study the experience of nursing faculty with clinical grading. Clinical evaluation has been identified as one of the most difficult practices of clinical teaching and assigning a clinical grade is an outcome of clinical evaluation (Scanlan, Care & Gessler, 2001). The review of the literature addressed the following areas: (a) concerns with teaching effectiveness; (b) grading disparities; (c) judgment concerns; and (d) clinical grading experience in other practice disciplines.

Concerns with teaching effectiveness.

The major themes in the literature surrounding clinical nursing education were focused on the effectiveness of teaching, and the clinical faculty, as perceived by students. The perceptions of students and faculty regarding effective clinical teachers were studied in the early 1980's but focused on looking at the congruency of students and teachers perceptions (Brown, 1981). The Nursing Clinical Teaching Effectiveness Inventory or NCTEI was developed and implemented to identify characteristics of clinical teachers that students believed to be important (Mogan & Knox, 1986; Lee, Cholowski &Williams, 2002). Using this same tool, two researchers carried out an additional study that compared the teaching effectiveness of part-time and full-time clinical nurse faculty as perceived by nursing students. Faculty also participated in this study and was asked if there were differences in the way they perceived the effectiveness of their own clinical teaching; no significant differences had been found (Allison-Jones & Hirt, 2004).

In one quantitative study on clinical education, the Self-Efficacy for Clinical Evaluation Scale (SECS) was developed and used (Clark, Owen, & Tholcken, 2004). This study looked at the students' perceptions of clinical competence as a means to improve the course content based on identified areas of importance by the students.

Recent literature regarding clinical performance grades in nursing education is divided between clinical experiences (Boley & Whitney, 2003; Walsh & Seldomridge, 2005) and undergraduate student preceptorship experiences (Luhanga, Yonge, & Myrick, 2008; Seldomridge & Walsh, 2006). Clinical experiences are described as those experiences that are directly supervised by nursing faculty. Preceptorship

experiences utilize clinical staff, not nursing faculty, to supervise students' learning experiences. Clinical nursing faculty have an ethical responsibility to recognize substandard clinical practice, consistently apply clinical grading standards, and give a failing clinical grade if one is warranted (Boley & Whitney, 2003). Preceptors have the same responsibility but have little experience and instruction in evaluations and therefore lack confidence in clinical grading.

In a 2007 study by the Evaluation of Learning Advisory Council of the NLN, the majority of nurse faculty surveyed, or 83%, reported using a pass/fail approach for grading in clinical courses rather than a letter or numerical grade. This study also reported that while associate degree programs required students to pass both theory and clinical components in order to pass the entire course this was not the case in some of the other program types (Oermann, Yarbrough, Saewert, Ard & Charasika, 2009). This study did not however, address the possible consequences for the students who may not pass the clinical component in these other program types.

Grading disparities.

Grading disparities were identified in one study by Luhanga, Yonge and Myrick (2008), which examined the process of precepting nursing students. The researchers found that preceptors did assign passing grades to students whom they felt were unsafe in clinical practice. Some of the reasons given by the study participants for assigning passing grades included their own lack of experience as a preceptor, a reluctance to cause students personal cost, reluctance to assume the extra workload, lack of time to evaluate sufficiently and pressure of the perceived nursing shortage to create graduates.

In a study by Walsh and Seldomridge (2005), data were collected from 10 required paired theory and clinical courses at one university from 1997 to 2002. The data showed a marked disparity between didactic and clinical grades, with clinical grades being much higher. The researchers identified that criteria for clinical grading were not clear and were open to a great deal of subjectivity.

In one article on grade disputes in nursing, the authors identified that grading students' performance in clinical settings with actual patients was a complex and subjective activity (Boley & Whitney, 2003). The responsibility for assigning clinical grades rests with the individual clinical faculty member. It has been noted that when it comes to clinical grading, faculty will sometimes second guess their evaluations and may give students the benefit of the doubt and give a higher grade than was actually earned (Boley & Whitney, 2003; Walsh & Seldomridge, 2005).

Judgment concerns.

An essential theme that was revealed in this study was that clinical grading is subjective and requires thoughtful consideration. This was consistent with the theme of subjectivity, shades of grey in my study. Since clinical grading is open to subjectivity, assigning a failing grade may present the CNF with some legal concerns. Courts have said that nursing faculty possesses the expertise to evaluate student performance and assign clinical grades; however, documentation is essential in the event of grade appeal litigation. CNF are urged to be confident in their decisions especially when patient safety is the reason for a clinical failure (Boley & Whitney, 2003). Confidence in decision making is difficult when many CNF lack the expertise in clinical grading that comes as a

result of inexperience with clinical grading as reported by many of the participants in this 2003 study.

While observation of students in the clinical setting does allow the nursing faculty to identify areas of learning, it also allows for time when the student is left unobserved (Oermann & Gaberson, 2006). These practice time gaps are the cause for some distress in clinical nursing education. This reticence to generalize the evaluation to unsupervised behaviors can lead CNF to assign a passing grade. The instructor has no way of knowing if this student would improve in the future; as grading is based on the observed behaviors in the present. Clinical evaluation requires that the instructor make a judgment about a student's performance in the present and not at some future point in time (Seldomridge & Walsh, 2006). The theme of hope that was revealed by the participants contradicts this; participants reported having hoped that students would improve in the future as one reason to assign a passing grade in cases where they were uncertain.

Other practice disciplines.

In a review of other practice discipline's experiences with clinical evaluation and grading, similar research gaps were found to exist. Factors that influence the passing of underperforming students was the basis for one qualitative focus group study with medical student clinical faculty (Cleland, Knight, Rees, Tracy & Bond, 2008). In this study of 10 focus groups, it was identified that medical educators expressed conflict about clinical grading of students. Medical educators were reluctant to fail undergraduate medical students and identified uncertainty of the standards expected at different levels of clinical training as one area of concern. The researchers described a human gap in the clinical assessment process which they report has not been addressed by the development

of evaluation tools for medical students, and discuss the need to look at the psychological factors that are involved with clinical grading. One theme that was identified related to the medical educators' attitude toward an individual student. The authors identified positive and negative individual student factors which influenced the educators when they completed clinical assessments. This finding is consistent with a theme of subjectivity similar to the findings in my study.

In another qualitative study on medical students and clinical evaluation, clinical supervisors identified four major areas that acted as barriers to clinical grading (Dudek, Marks, & Regehr, 2005). These barriers included a lack of documentation, a lack of knowledge of what specifically needed to be documented, the anticipation of a grade appeal, and a lack of remediation options for the clinical faculty. The researchers found that clinical faculty did not lack the ability to use evaluation tools, but rather lacked the willingness to use them due to the sense of obligation they felt to the students (Dudek, Marks, & Regehr, 2005).

The lived experiences of clinical educators in speech pathology were also explored in a qualitative study in a program in Australia (Higgs & McAllister, 2005). The researchers identified that there is a limited amount of research about what it is like to be a clinical educator. This study utilized in-depth interviews with clinical educators in speech pathology as the participants. The research participants described a personal investment in their relationships with students in the clinical setting. They described connectedness and caring as important characteristics of their interpersonal relationships with their students.

A key issue that was identified by these participants was the challenge of being responsible for student assessments. A particular area that was identified as needing more research and attention in the clinical education literature was regarding the growth and development required in becoming a clinical educator. This finding is consistent with statements given by participants in my study describing lack of experience as being a problem when making a clinical grading decision (Higgs & McAllister, 2005). The researchers identified that future research with clinical educators in other professions is needed.

Nursing faculty.

Areas of concern have also been identified in nursing education related to clinical assessment and grading (Walsh & Seldomridge, 2005). Evaluation in the clinical setting requires that faculty measure a student's knowledge, preparation, judgment, ability to perform psychomotor skills, as well as the student's ability to be flexible in an ever-changing clinical environment (Walsh & Seldomridge, 2005). CNF are often reluctant to give negative feedback to students in writing yet still identify that it is their responsibility to ensure that the student is safe to practice in the clinical setting (Dolan, 2003).

Tanicala, Scheffer and Roberts (in press) are currently involved in a multi-phase research project to develop protocols for nursing student evaluations in clinical settings. This research is needed due to the dearth of information that currently exists to define safe patient care by nursing students. Specific student behaviors which impact safety and would result in a clinical failure will be identified and tested in one phase of this project. This research addresses the theme of safety as a benchmark that was revealed in my study

and will provide specific behaviors that would need to be identified as unsafe by the CNF when making a decision about assigning a clinical grade.

In a phenomenological study that explored the experience of being a full-time nursing faculty member in a baccalaureate nursing education program, Gazza (2009) identified five themes that were uncovered among the eight participants. This study explored the experience of being a faculty member but did not focus on any particular aspect of the role. Four of the themes identified by Gazza had similarities with my study's findings on the experience of clinical nursing faculty regarding clinical grading. The themes of making a difference; being a gatekeeper to the profession; support; and workplace relationships, were also uncovered in varying degrees in my study. The fifth theme, trying ways to balance multiple roles, was not identified possibly due to the focused nature of the phenomenon being studied with the experience of clinical grading.

Reflections Using a Nursing Model Perspective

The interpretive textual statement of CNF with the experience of clinical grading is *The experience of clinical grading is subjective and colored in shades of grey; uses safety as a benchmark; has the opportunity for change in the lives of students as well as the nursing profession; often involves wishful thinking for a positive outcome, and can sometimes be clouded by feelings of discontent and disappointment.* I reviewed the textual interpretation as well as the raw data collected in the form of audio files and transcripts. After reflecting on the tone and the essential themes from the data, Power as Knowing Participation in Change emerged as a theoretical construct consistent with my findings. I then decided to utilize Dr. Elizabeth Barrett's Power as Knowing

Participation in Change theory to interpret and elucidate the experience of clinical grading.

The Power as Knowing Participation in Change theory (PKPC) was derived from Rogers' Science of Unitary Human Beings. Continuous change is a premise of Rogerian methodology (Barrett, 1988), and "power is a theme in the continuous flow of life experiences whereby some potentials for unitary change are actualized" (Caroselli & Barrett, 1998, p. 9). PKPC offers that power as knowing participation in change is being aware of what one is choosing to do, feeling free to do it, and doing it intentionally (Barrett, 1986/2010). PKPC consists of four dimensions: awareness, choices, freedom to act intentionally, and involvement in creating change. Barrett regards these four dimensions as inseparable from each other (Barrett, 2010).

Barrett describes power as being *power-as-freedom,* unlike the more common view of *power-as-control*. Power has commonly been described as having the ability to influence and cause change by using dominance or force (Caroselli & Barrett, 1998); however, in PKPC theory, power is not causal, deterministic or hierarchical in nature (Polifroni, 2010). The freedom to act with intention and make choices from those that are available is then considered to be power as knowing participation in change.

For this study, the results of assigning a clinical grade in a pass/fail system of grading fit with the power-as-freedom and as knowing participation in change (E. Barrett, personal communication, September 6, 2010). In this process, the CNF allows for an array of student behaviors and achievement of objectives in the power-as-freedom they exercise when assigning a grade. The CNF has the freedom to utilize his or her own judgment, with thoughtful consideration being given, to the possible changes that result

from a grading decision. The CNF-student relationship can be viewed as the relation between an individual (the CNF) and the environment (student, clinical setting). In this worldview, where power is seen as freedom, the relationship is one of mutual process and trust (Barrett, 2010).

Using the PKPC as a structure for organizing my thinking, I studied each essential theme and reflected on its applicability to the theory. These essential themes do not exist in only one dimension of the theoretical framework, but may be reflected in two or more. This structure and organization were then placed in a table to be reviewed. Table 3 illustrates this reflective activity.

Table 3

Reflection on Themes Using Four Dimensions of PKPC Theory

Awareness	**Choices**	**Freedom to act intentionally**	**Involvement in creating change**
Subjective and shades of grey Opportunity for change Discontent and disappointment	Subjective and shades of grey Safety as the benchmark Opportunity for change Discontent and disappointment	Safety as the benchmark Opportunity for change Wishful thinking	Subjective and shades of grey Safety as the benchmark Opportunity for change Wishful thinking Discontent, and disappointment

Even though I had reflected and found congruence between the essential themes and the four dimensions of PKPC, I was concerned about the presence of negative feelings in essential theme V. I wondered if their presence would contradict my interpretation that the participants were engaging in PKPC within the experience of clinical grading. In a dialogue with Dr. Barrett (personal communication, September 6,

2010), she explained that although there is really no such thing as powerlessness, it is possible for people, in this case CNF, to experience feelings of powerlessness. These transient feelings of powerlessness, in certain situations, were the cause for the discontent and disappointment that was described by some of the participants. The participants however, still retained a full awareness, as well as the ability to make intentional choices, when they assigned a clinical grade and thereby knowingly participated in change.

In summary, Barrett's theory of Power as Knowing Participation in Change (PKPC) emerged from the data as one way to explain the participants' lived experience of clinical grading. The participants were *aware* of the *choices* they had, were *free to act intentionally* and *were involved in creating the change* that would come as a result, both for the student and for the nursing profession.

Discussion and Implications for Nursing

Discussion.

The purpose of this study was to use a phenomenological approach to illuminate the lived experience of clinical grading for clinical nursing faculty. My goal was to achieve a greater understanding of the meaning of the experience for the 11 clinical nurse faculty who participated in my study. As I engaged in this research, my own personal views about clinical grading, as well as my thoughts about the meaning of the experience for my colleagues, were challenged. My assumptions included a belief that the need for experience would emerge as a prevalent theme with all participants. Because of this, Benner's Framework for the Development of Clinical Expertise was first used to guide this study. This theoretical context was used for reflection during the study, but I identified that alternate themes emerged which caused me to reconstruct my initial

thoughts about the theoretical framework. Some participants had identified that experience was important, but the data was not rife with it as a theme. Experience was discussed more in the context of needing to use thoughtful consideration and spending more time when determining a grade especially in the early years of the CNF role.

The need for support from administration and colleagues was another theme I expected to prevail through the lived experiences of the participants. Although this was not a prevalent theme, it needs to be noted that the participants who described this as a part of their experience had negative feelings of discontent and disappointment, as well as real emotion, about the lack of support they had received. They described wishing that someone had helped them or supported them in their role with clinical grading.

All participants made the comparison between assigning a grade in the clinical setting and assigning a grade in the didactic component of a nursing course when they described their experiences. Participants were very definite when they reported that classroom grading was objective and based primarily on test grades. They identified that there was nothing that could be done to improve an unsatisfactory grade that a student had achieved based on poor test grades; they referred to this as being black and white as opposed to grey. This grading in the didactic component of a course was described as decisive, but clinical grading was described as more subjective and malleable by all participants. Grading practices based on testing have been given the most weight and value in nursing because of the need to have students pass the NCLEX-RN at the completion of the program (Oermann et al., 2009).

In a recent report, the IOM identified the need for the nursing education system to be improved to ensure the delivery of safe patient care in all health care settings. It

identified that "nurses need to attain requisite competencies to deliver high-quality care" (IOM, 2010). By assigning a clinical grade to students in pre-licensure programs, CNF have an important role in safeguarding patient safety by determining whether or not these competencies have been achieved.

Limitations of the study.

Qualitative research findings cannot be generalized; therefore, the findings of my study can only be said to represent the lived experience of the 11 participants who were involved. I engaged in a research study which was very meaningful to me because of my own knowledge of the experience. While I worked to bracket my biases and assumptions, the possibility remains that my interpretations could have been colored by my own experience and could be a limitation of the study. This interpretation of the findings provided one way to reconstruct the phenomena as it was described (Burns & Grove, 2009); others may consider alternate ways as they read about the experience.

Implications for research.

This research revealed one possible meaning of the lived experience of clinical grading for clinical nursing faculty that has interesting and meaningful implications for further research. Further research is needed to explore clinical nursing education in general, with an important focus on CNF and their experiences in this role. The existing literature in this area needs to be expanded with findings from new research.

Replicating this study with part-time adjunct clinical faculty should be considered due to the large number of adjuncts being used in clinical nursing education. Since full-time faculty has described negative feelings associated with a lack of support, the

experience of adjunct faculty needs also to be explored. The use of focus groups can provide one way to conduct a qualitative study with adjunct clinical faculty.

A quantitative study using the Power as Knowing Participation in Change Tool (PKPCT) should be conducted to reveal the *Power Profile* (Barrett, 1988) of the CNF within this role. Since the findings of this study led to the identification of PKPC, obtaining evidence to support this with the use of the tool would be helpful.

Research examining alternate systems for clinical grading should be conducted. Some participants in this study described students' desire for clinical grades that would impact their grade point average. This type of research would yield responses from both CNF and students that would provide evidence to support the use of a particular grading system.

Implications for nursing.

The findings from this study revealed that CNF are most concerned with patient safety and use that as their benchmark when a clinical grading decision is made. The CNF take their role very seriously and use thoughtful consideration when determining if clinical objectives have been met. The negative feelings that surrounded the experience of clinical grading often came as a result of a lack of support for the participants with the grading process. Administrators in nursing education need to reflect on these findings and provide support to the CNF in their schools. Clinical grading decisions which foster patient safety need to be promoted and supported within schools of nursing. Workshops should be conducted for the CNF to learn about the process of clinical grading as well as any documentation that would need to be completed.

Clinical objectives need to be clearly defined and made as objective as possible. The findings from this study identified that CNF believe having both clear objectives and clinical evaluation tools are important for them when assigning a clinical grade. Work needs to be done within schools of nursing to create evaluation tools that are course specific and clearly define expected behaviors and skills that need to be achieved.

Faculty takes their role in preparing nurses to deliver safe patient care very seriously, but in order to do this, "all of nursing education must embrace the need for change" (Cronenwett et al., 2007). Clinical grading is a challenging process for even the most experienced faculty; however, the most inexperienced faculty are often the ones who are responsible for assigning clinical grades. Nursing education needs to utilize experienced faculty in the clinical setting as well as in the classroom. Experienced faculty could work with the new CNF to increase both their confidence and ability to evaluate students' safe clinical performance and assign a clinical grade. If nurse clinicians are used for clinical teaching and evaluation, support must also be provided. Clinical expertise alone is not enough to transform an excellent nurse into an excellent teacher and evaluator, or one who can assign a clinical grade (AACN, 2005).

A few participants had offered suggestions for improving clinical grading practices during our interviews, while others expressed satisfaction with their current practice. One suggestion that was mentioned included the possibility of combining clinical and classroom grades to create a blended grade. This blended grade would integrate numerical values from classroom assessment strategies with a numerical grade for clinical.

Improvements in clinical nursing education will result in better performance by new graduate nurses and will have a positive effect on safe patient care. CNF play an important role in this education to practice continuum when they assign clinical grades. These clinical grades may either permit or prevent a student from progressing in a pre-licensure nursing program and will ultimately have an effect on patient safety and the nursing profession.

Summary

This phenomenological study described and interpreted the lived experiences of full-time CNF in pre-licensure programs with clinical grading. Eleven full-time CNF with a minimum of two years of experience, were recruited to obtain a purposive sample of convenience. Each participant first completed an initial in-depth personal interview followed by a brief follow-up interview a few weeks later. The van Manen method of hermeneutic phenomenology was applied to describe and interpret the data while developing an understanding of the experience for the participants. The five essential themes that emerged were: (a) *subjectivity and shades of grey*, (b) *safety as the benchmark*, (c) *opportunity for change,* (d) *wishful thinking*, and (e) *disappointment and discontent*. A textual interpretive statement was then created by using these essential themes.

Barrett's theory of Power as Knowing Participation in Change emerged as one way to explain the participants' lived experience of clinical grading. The participants were *aware* of the *choices* they had, were *free to act intentionally* and *were involved in creating the change* that would come as a result of the clinical grade both for the student and for the nursing profession.

APPENDIX A

Sample Clinical Evaluation Tool

NAME OF SCHOOL
DEPARTMENT OF NURSING
COURSE NAME

Course Number **CLINICAL EVALUATION TOOL** **Semester/Year**

Student Name: _____

Attendance: _____ **Punctuality:** _____

COURSE OBJECTIVES & BEHAVIORS	SOURCES OF DATA COLLECTION	CLINICAL ROTATION I		CLINICAL ROTATION II	
		PASS	FAIL	PASS	FAIL
I. Use the nursing process as the methodology to plan, implement, and evaluate the delivery of nursing care to adults and aged clients with acute and chronic illnesses. A. Acquires appropriate data to assess individual's health history, physical, functional and psychosocial assessments. B. Incorporates assessment findings when planning nursing care. C. Develops and prioritizes accurate nursing diagnoses in collaboration with clients, peers, and other health team members. D. Develops appropriate short-term and long-term outcomes that are client centered. E. Formulates nursing interventions that are pertinent to the achievement of the client outcomes. F. Safely performs nursing interventions including psychomotor skills while providing nursing care. G. Safely administers medications. H. Prioritizes nursing care delivery. I. Identifies evaluation criteria for client outcomes.	Clinical Observation Pre/Post Conference Nursing Care Plan Self-Mgt. Plan				

NAME OF SCHOOL
DEPARTMENT OF NURSING
COURSE NAME

Course Number **CLINICAL EVALUATION TOOL** **Semester/Year**

COURSE OBJECTIVES & BEHAVIORS	SOURCES OF DATA COLLECTION	CLINICAL ROTATION I		CLINICAL ROTATION II	
		PASS	FAIL	PASS	FAIL
J. Judges whether or not the nursing interventions facilitated the client's achievement of outcomes. K. Reassesses the client if outcomes were not achieved and revises plan of care based on the new assessment data. II. Discriminate among alternatives which promote health, prevent disease and enhance disease management for clients in their adult and later years. A. Collaborate with client, family and health care team to identify the client's health care needs. B. Provide anticipatory guidance to the adult and aged client. C. Promote and maintain functional health patterns. D. Prioritize nursing interventions pertinent to the achievement of client outcomes toward maximum health and function. III. Provide therapeutic nursing care which includes consideration of ethical and legal dimensions of practice. A. Maintains client's confidentiality utilizing HIPPA standards. B. Respects client's autonomy. C. Adheres to Patient's Bill of Rights D. Documents in accordance with facility's standards. E. Discusses ethical and legal concerns regarding care of acute & chronically ill persons.	Clinical Observation Pre/Post Conference Nursing Care Plan Self-Mgt. Plan				

NAME OF SCHOOL
DEPARTMENT OF NURSING
COURSE NAME

Course Number **CLINICAL EVALUATION TOOL** **Semester/Year**

COURSE OBJECTIVES & BEHAVIORS	SOURCES OF DATA COLLECTION	CLINICAL ROTATION I		CLINICAL ROTATION II	
		PASS	FAIL	PASS	FAIL
IV. Devises therapeutic interventions to provide culturally sensitive care to adult and aged clients with acute and chronic illnesses. A. Determines the health beliefs and practices of clients B. Recognizes own value system. C. Articulates sensitivity to the rights of clients from different cultures and socioeconomic levels D. Incorporates client's and family's cultural and ethnic beliefs into nursing care.	Clinical Observation Pre/Post Conference Nursing Care Plan Self-Mgt. Plan				
V. Collaborates with clients and health care members in providing care that is congruent with standards. A. Establishes a partnership relationship with clients and their families. B. Develops mutually respectful collegial relationships with members of the health care team. C. Correlates plan of nursing care with the multidisciplinary health care team.	Clinical Observation Pre/Post Conference Discussions Nursing Care Plan Self-Mgt. Plan				

NAME OF SCHOOL
DEPARTMENT OF NURSING
COURSE NAME

Course Number **CLINICAL EVALUATION TOOL** **Semester/Year**

COURSE OBJECTIVES & BEHAVIORS	SOURCES OF DATA COLLECTION	CLINICAL ROTATION I		CLINICAL ROTATION II	
		PASS	FAIL	PASS	FAIL
VI. Apply nursing and other related theories and research findings to address the needs of the adult and aged client. A. Applies nursing research into the delivery of nursing care. B. Describes nursing research questions relevant to the patient's nursing care. C. Identifies theoretical rationale related to nursing interventions. D. Applies relevant nursing and supporting theories and concepts into the delivery of nursing care. E. Evaluates the findings of nursing research studies for providing nursing care to acute and chronically ill clients.	Clinical Observation Pre/Post Conference Nursing Care Plan Self-Mgt. Plan				
VII. Communicate therapeutically to facilitate change in clients with acute and chronic illnesses. A. Utilizes therapeutic communication skills while providing nursing care to clients and when interacting with peers and members of the health care team. B. Communicates clearly to clients, families, health care team, peers, and instructor. C. Provide emotional support for clients & their families as they experience the grieving process. D. Reports changes or significant findings in the client's condition to appropriate members of the health care team and	Clinical Observation Pre/Post Conference Nursing Care Plan Self-Mgt. Plan				

NAME OF SCHOOL
DEPARTMENT OF NURSING
COURSE NAME

Course Number **CLINICAL EVALUATION TOOL** **Semester/Year**

clinical instructor. E. Documents clearly, accurately, and inclusively. F. Demonstrates beginning technological skills. G. Develops nursing care plans that are timely, organized and legible.					
VIII. Use teaching/learning principles to facilitate health promotion and health maintenance behavior for the adult and aged client. A. Collaborates with client and health care team to identify client teaching needs. B. Uses the principles of teaching and learning for instruction of clients. C. Develops a teaching plan for clients. D. Uses teaching aids/materials for instructing clients. E. Implements health teaching effectively. F. Evaluates the clients' learning outcomes.	Clinical Observation Pre/Post Conference Nursing Care Plan Self-Mgt. Plan Agency Documentation				
IX. Select community resources which will support care of the client after discharge from and acute care, chronic care or rehabilitation facility. A. Participates in discharge and/or interdisciplinary discussion meetings. B. Identifies appropriate community resources that will meet the health needs of the client.					

NAME OF SCHOOL
DEPARTMENT OF NURSING
COURSE NAME

Course Number **CLINICAL EVALUATION TOOL** **Semester/Year**

COURSE OBJECTIVES & BEHAVIORS	SOURCES OF DATA COLLECTION	CLINICAL ROTATION I		CLINICAL ROTATION II	
		PASS	FAIL	PASS	FAIL
C. Seeks out information on community resources from the internet, the health care team, and other information sources. D Collaborates with the health care team to provide information on community resources. X. Demonstrate responsibility for one's own learning and professional practice in the delivery of client care. A. Adequately prepares for clinical experience. B. Is punctual and has consistent attendance. C. Uses time management skills in planning and implementing nursing care. D. Applies critical thinking strategies in delivering nursing care. E. Dress and appearance is professional and consistent with the SCHOOL NAME policies. F. Identifies and seeks out own learning experiences. G. Identifies and uses appropriate learning resources. H. Seeks supervision from the clinical instructor when appropriate. I. Actively participates in clinical conferences.	Clinical Observation Pre/Post Conference Nursing Care Plan Self-Mgt. Plan				

APPENDIX B

Informed Consent

Health Sciences Doctoral Programs

Audiology (Au.D.) Nursing Science (DNS) Physical Therapy (DPT) Public Health (DPH)

The Graduate School and University Center
The City University of New York
365 Fifth Avenue
New York, NY 10016-4309
TEL 212.817.7980 FAX 212.817.1680

CONSENT FORM

My name is Bernadette Amicucci and I am a doctoral student in the Department of Nursing Science at the Graduate Center of the City University of New York (CUNY). I am conducting a study about nursing faculty and clinical grading. You are being asked to participate in a study which explores the experience of nursing faculty with clinical grading. You have been identified as a possible participant because you are a nursing faculty member with at least two years of experience in clinical grading of students in a pre-licensure nursing program. It is anticipated that 6 to 10 individuals will participate in this study. Participation in this study is voluntary, and refusal to participate will involve no penalty to you.

You are being asked to participate in an in-person interview which will last about one hour. During this interview you will be asked questions about your experiences with clinical grading. The interview will take place at a mutually agreed upon convenient location. This interview will be audio taped and transcribed. A second, shorter (approximately 30 minutes), follow up interview will also be necessary and will provide you with an opportunity to review the transcription and check for accuracy.

The risks from participating in this study are no more than encountered in everyday life; however, it is possible that the discussion could raise sensitive issues for you. In the event that this happens, the researcher has a resource that you will be able to contact for assistance. You may stop the interview process at any time without penalty.

There is no direct benefit to you by participating in this study. However, participating in this study may increase understanding of nursing faculty experiences which could improve nursing education and have an impact on professional nursing practice.

I will audio tape the interview with your permission. The tapes will use identifying codes and your name and school affiliation will not appear on the transcripts. Tapes will be destroyed after

Health Sciences Doctoral Programs

Audiology (Au.D.) Nursing Science (DNS) Physical Therapy (DPT) Public Health (DPH)

The Graduate School and University Center
The City University of New York
365 Fifth Avenue
New York, NY 10016-4309
TEL 212.817.7980 FAX 212.817.1690

the interviews are transcribed. No personal identifiers will be linked to the data. All materials will be kept in a locked cabinet and only my faculty advisor and I will have access. The data will be stored for a minimum of three years. After that time, all materials may be destroyed. As long as the data exists it will be kept secured. The information will be used to produce a doctoral dissertation. The results of this study may be published; however, all identifying information about you and others who participated will be omitted or disguised. The researcher is mandated only to report to the proper authorities if there is any concern of imminent danger of harming yourself or others.

You may discontinue participation at any time without penalty. If you have questions about the study, you can contact me, Bernadette Amicucci, at , bern41962@aol.com or my dissertation sponsor Dr. Keville Frederickson at (212) 817-7980, keville.frederickson@lehman.cuny.edu. A summary of results will be provided to you upon request. If you have questions about your rights as a participant in this study, you can contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York, (212) 817-7525, kpowell@gc.cuny.edu.

Thank you for your participation in the study.

I have read the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study. I have received a copy of this form for my records and future reference.

I agree to have these interviews audio-taped [please circle one]: **Yes** **No**

Health Sciences Doctoral Programs

Audiology (Au.D.) Nursing Science (DNS) Physical Therapy (DPT) Public Health (DPH)

The Graduate School and University Center
The City University of New York
365 Fifth Avenue
New York, NY 10016-4309
TEL 212.817.7980 FAX 212.817.1680

Participant's Name _____ Signature _____ Date _____

Researcher's Name _____ Signature _____ Date_____

APPENDIX C

Call for Participants

Health Sciences Doctoral Programs

Audiology (Au.D.) Nursing Science (DNS) Physical Therapy (DPT) Public Health (DPH)

The Graduate School and University Center
The City University of New York
365 Fifth Avenue
New York, NY 10016-4309
TEL 212.817.7980 FAX 212.817.1680

You are Invited to Take Part in a Nursing Research Study

- Hello! My name is Bernadette Amicucci and I am a doctoral student in the Doctor of Nursing Science program at the CUNY Graduate Center. You are being asked to participate in a study which explores the experience of nursing faculty with clinical grading. You have been identified as a possible participant because you are a nursing faculty member with at least two years of experience in clinical grading of students in a pre-licensure nursing program. This study will be used to complete the requirements for the researcher's doctoral dissertation.
- Your total time commitment would be about two hours. Your participation would require an initial in-person interview which would take approximately one hour. There will be a second, shorter in person interview lasting under an hour that would take place about a week or two after the first one. Your participation is completely voluntary.
- If you are a clinical nurse faculty who would like to participate and share your experiences with clinical grading, please contact the primary investigator. Please provide your contact information and availability.
- I would like to interview faculty in the next few months and would arrange to meet you wherever it would be most convenient for you. If you are interested in participating in this research study, please feel free to contact me either by phone or email.
- I would be very grateful for your time and the opportunity to hear about your experiences.

Thank you for your consideration.

Please contact:

Bernadette Amicucci RN, MS, CNE

Cell phone: , email: bern41962@aol.com Subject: Research study

APPENDIX D

Participant Information Sheet

Clinical Nurse Faculty and the Lived Experience of Clinical Grading

Participant Information

Dates of Interviews:_____

Gender (circle response): 1) Female 2) Male

Age (please specify age in years): _____

Educational Background (circle and fill in):

1) Masters degree in Nursing

2) Masters degree in other (Please indicate specialty _____)

3) Post Masters Certificate (Please indicate specialty _____)

4) Doctorate (Please specify which degree and specialty_____)

Specify number of years experience with clinical teaching and grading: _____

What type of facility do you currently teach in? 1) Public 2) Private

What level of clinical nursing education do you have responsibility to teach and grade?

1) Associate degree 2) Baccalaureate degree 3) Masters degree

List all specific clinical specialty areas in which you have responsibilities to teach and grade: (i.e. Med-Surg, Psych, Maternal-Child, etc.)

_____

_____

Contact Information:

Name_____ Phone_____

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