Just how bad does it have to be? Industry and academic assessors' experiences of failing to fail – A descriptive study

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A B S T R A C T

Background: Failing to fail nursing students in clinical assessments is an internationally acknowledged issue that necessitates thorough examination. Despite the gravity of 'mis-grading' nursing students, current research exploring this subject is limited. Understanding the experiences of assessors when faced with an underperforming student may help illuminate some of the broad issues associated with failure to fail.
Objectives: To describe both tertiary and industry based assessors' experiences of grading nursing student performances in clinical courses when that performance was not a clear pass or fail.
Design: A pilot study using a descriptive survey design was employed.
Setting: Participants were drawn from all states and territories in Australia.
Participants: Academic and industry assessors of undergraduate nursing students across Australian universities participated in this study.
Methods: A newly developed and validated survey was conducted via an online platform. Descriptive data were collected on assessors' experiences across the domains of the Invitational Theory: people; processes; programmes; policies and places.
Results: Participants clearly had a strong duty of care to patients and the nursing profession. However, 23.5% of participants had given the benefit of the doubt to student performances. They reported failing student performances nevertheless reported passing students. Some participants experienced a number of coercive student behaviours. They perceived that the culture of the ward impacted on student performances in assessments. Inadequate time to assess students in clinical practice was reported by 44% of participants. Participants reported no differentiation between theoretical and clinical assessments in their organisations' assessment policies.
Conclusions: Assessors reported many challenges when assessing students who were not performing at requisite standards. This study furthered the extant literature around the impact of people and processes on assessors and failure to fail. For the first time, assessors' experiences of the assessment environment, programme design and organisational policies associated with grading marginal student performances are reported.

1. Background

Failure to fail is a recognised phenomenon that impacts on practice-based professions internationally (Hughes et al., 2016). Failure to fail allows student nurses to progress into the profession without meeting professional standards of practice. This may have significant impacts on students, assessors, organisations, the profession and most importantly, to vulnerable patients (Earle-Foley et al., 2012). Despite this, several researchers have identified that some nursing students pass assessments

in clinical courses despite not clearly demonstrating fitness for practice (Black et al., 2014; Butler et al., 2011; Duffy, 2003; Hughes et al., 2018a; Hunt et al., 2012; Kennedy and Chesser-Smyth, 2017). This is a significant concern as when a student achieves an accredited nursing qualification, they are deemed safe to practice independently at an acceptable professional, community and university standard (Cant et al., 2013; Hunt et al., 2012; Nursing and Midwifery Board of Australia (NMBA), 2016).

Assessing fitness for practice presents numerous challenges to

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nursing programme designers around the world (Franklin and Melville, 2015; Hughes et al., 2016; Luhanga et al., 2014a). Currently the literature is limited to northern hemisphere studies examining failure to fail from mentors' experiences (Hughes et al., 2016). Focusing solely on mentors overlooks other key stakeholders who have a significant role in assessment of students' clinical performances. In Australia, assessment of student performances can include a number of different stakeholders depending on the model employed by the university. There are several different clinical supervision models used as part of Australian tertiary nursing programmes with one of the most common being the group or facilitator model. This model involves a student nurse being placed with a preceptor or nurse buddy each shift (direct-care registered nurse [RN]), ideally (but infrequently) the same preceptor (Walker et al., 2013). The students may also have a clinical facilitator, often employed by the university, who is responsible for the overarching supervision of a group of students (numbers of which vary depending on the tertiary and clinical institution). Additionally, students will typically also have a tertiary supervisor who is responsible for the contribution of clinical practice to their programme of study.

Another model has a direct preceptor/mentor supervisory arrangement whereby students are placed with a direct-care RN on a one-on-one basis for the duration of their placement. Here the RN is responsible for supporting the student with their learning, experience and assessment (Walker et al., 2013). Another model of clinical supervision is the dedicated education unit, where it is often a combined approach to student supervision (Walker et al., 2013). There are varying degrees of responsibility for the clinical assessment across the different clinical supervision models. Regardless of the model of clinical supervision employed, all stakeholders have a role in ensuring only students who meet standards of practice progress through the programme (Health Workforce Australia, 2013) and conversely, those that do not meet standards of practice do not progress.

The nursing profession cannot adequately address failure to fail without a clear and broad understanding of the contributing factors for assessing student performances. Understanding failure to fail is vital to promoting the integrity of the profession and ultimately for patient safety. The aim of this study was to describe both tertiary and industry-based assessors' experiences of grading nursing student performances in clinical courses when that performance was not a clear pass or fail.

2. Methods

2.1. Study design

This descriptive survey was the final phase of a sequential exploratory mixed methods study exploring failure to fail. Results from a relevant integrative review (Hughes et al., 2016), coupled with findings from an associated qualitative study (Hughes et al., 2018a,b) were used to develop this survey. The survey was designed to explore assessors' experiences of grading student performances in clinical courses when that performance was not a clear pass or fail.

2.2. Setting and sample

The sample consisted of academic and industry based assessors of preregistration nursing students in clinical assessments in Australian undergraduate nursing programmes. Academic respondents included clinical facilitators, course convenors and lecturers who assessed student nurses as part of their role. Industry based assessors included direct-care registered nurses and preceptors from hospital or community who had a direct role in assessing student nurses.

2.3. Theoretical framework

Underpinning this survey is the Invitational Theory which provides a comprehensive theory around creating an environment that enriches key stakeholders' learning (Purkey and Novak, 2016). There are five domains which are central to this educational theory: people; processes; programmes; policies; and places, and if these domains work together, people can reach their full potential (Purkey and Novak, 2016). This framework has been applied to a small number of nursing education studies, with only one identified study exploring its use in nursing student assessment (Cook, 2005; Finger and Pape, 2002; Green et al., 2018; Pai et al., 2017). Theoretically, the domains contribute to the success and/or failure of each individual, therefore this framework was deemed appropriate to broaden the understanding of assessors' experiences of grading marginal student performances in clinical assessments when that performance was not a clear pass or fail.

2.4. Survey

The survey was developed using DeVellis' (2017) staged model of tool development. Item development evolved from an integrative review (Hughes et al., 2016) and qualitative data (Hughes et al., 2018a,b) derived from interviews and focus groups. Modification, removal and/ or refinement of items via an 8-person expert panel review to ensure relevance, validity and comprehensibility, resulted in a survey that included 76 items grouped into the five domains of the Invitational Theory: i People (29 items); ii Processes (26 items); iii Programmes (15 items); iv Policies (3 items); and v Places (3 items) (Purkey and Novak, 2016). There were 11 demographic items added to the survey. A five-point Likert response scale was used with two different sets of descriptors. One ranged from 1 = strongly disagree to 5 = strongly agree and the others from 1 = never to 5 = always. Survey items also contained other response options such as 'not applicable', checklist responses and free text options where appropriate.

2.5. Data collection

The survey was distributed via email link through the Australian Nurse Teachers Society (ANTS), with additional purposeful and snow-balling sampling approaches through collegial networks. ANTS is an autonomous, professional organisation that provides education and support to educators who provide education and learning to nurses and midwives in Australia. Members of ANTS are highly motivated nurse educators from across the education spectrum, who engage in free exchange of professional and educational ideas across all states and territories in Australia. Participants completed the survey via a secure online survey platform (Limesurvey).

2.6. Ethical considerations

We received human research ethics committee approval (GU-HREC Approval number 2016/948). An information sheet outlining the study background and aims accompanied the survey. The return of a completed survey implied consent. All data were collected anonymously with no possible linking of IP addresses to surveys. Digital data were stored securely with password protection at the university. The data were collected in March 2018. One reminder email with the survey link was sent.

2.7. Data analysis

Data analyses were performed using the Statistical Package for the Social Sciences (SPSS), version 25. All responses provided by participants were included in the analysis, such that there are different response numbers for each domain, as indicated in relevant tables. The distribution of data was skewed and therefore non-parametric methods of description were employed (Field, 2013). Frequencies and summary statistics were used to describe the sample in terms of demographic characteristics and participant responses (Mills and Gay, 2015).

Table 1
Summary of participants' demographic characteristics.

Variable	
Years as RN, median years (IQR) [Range: 3–47]	22 (17.8)
Years as assessor, median years (IQR) [Range: 0–33]	10 (10.0)
Gender, n (%)	
Female	133 (89.0)
Male	15 (10.0)
Missing data	1 (0.7)
Background, n (%)	
Industry	107 (72.0)
Industry and tertiary	33 (22.0)
Tertiary	9 (6.0)
Current employment, n (%)	
Industry	86 (58.0)
Tertiary	31 (21.0)
Industry and Tertiary	31 (21.0)
Missing data	1 (0.7)
Year level assessed, n (%)	
1st year	3 (2.0)
2nd year	1 (1.0)
3rd year	9 (6.0)
Multiple years	131 (88.0)
No year level specified	5 (3.0)
State of employment, n (%)	
Queensland	83 (56.0)
New South Wales	30 (20.0)
Victoria	15 (10.0)
Western Australia	10 (7.0)
Tasmania	5 (3.0)
Australian Capital Territory	3 (2.0)
Northern Territory	1 (0.7)
South Australia	1 (0.7)
Missing data	1 (0.7)
Area of practice, n (%)	
City	122 (82.0)
Rural	20 (13.5)
Remote	2 (1.5)
No area of employment specified/missing data	5 (3.0)
Self-Assessed Expertise, n (%)	
Expert	59 (40.0)
Proficient	73 (49.0)
Competent	11 (7.0)
Advanced Beginner	3 (2.0)
Novice	1 (0.7)
Unsure	1 (0.7)
Missing data	1 (0.7)
Highest Degree Completed, n (%)	
Diploma	4 (2.0)
Degree	31 (21.0)
Hospital based training	1 (0.7)
Graduate Certificate	33 (22.0)
Graduate diploma	14 (9.0)
Honours	4 (3.0)
Masters	50 (34.0)
Current PhD student	1 (0.7)
Doctorate/PhD	11 (7.0)

3. Results

A total of 149 participants completed the online survey. The typical respondent was female, from the industry setting, with 10 years of experience in assessing students across all year levels. All Australian states and territories were represented. Most respondents self-assessed their expertise as either expert or proficient with a high proportion having completed post-graduate qualifications (Table 1). Of the 149 participants, 40 wrote comments in the free text item. Some responses were detailed exemplars of the participant experiences, with one participant completing a 720 word response.

3.1. People

The majority of assessors found providing feedback rewarding (85.9%) with associated improved student performances following feedback (87.3%). Furthermore, most participants did not find providing feedback confronting (91.9%). Nonetheless, 29.5% of participants reported feeling intimidated *sometimes* or *often*. Furthermore, the participants were split as to whether they found it harder to give feedback if the student was 'likeable' (40.2% agreeing it is harder and 41% disagreeing).

Generally, participants (73.8%) did not believe that students should be given the benefit of the doubt. However, when asked whether they had given someone the benefit of the doubt 23.5% of participants had *sometimes* or *often* given the benefit of the doubt. The tolerance for passing different year levels when the students do not meet standards of practice decreased as the year levels increased. In the first year of the programme 12.0% had passed poorly performing students, 4.7% had passed a student in second year that was poorly performing and 1.3% of assessors have passed a completing student who was poorly performing.

Assessors typically have experienced positive (91.3%) and or student acceptance (96.6%) when providing feedback about student performances, however, the majority of assessors (91.3%) identified that student insight impacted on student responses. Despite the majority of participants experiencing positive responses from students during the assessment process, there were a number of responses that need to be taken into consideration in the context of assessors' experiences. Of the participants, 60.4% had students who expressed anger with 32.9% experiencing aggression from students. Violence was experienced by 10.1%. A number of assessors (35.6%) had experienced a student placing a formalised complaint about them after discussing the student's clinical performance. Assessors (61.1%) reported students trying to manipulate them into awarding a passing grade. This increased when students utilised their life factors (79.9%) like visa requirements or care responsibilities or had previous nursing experience (65.1%). Assessors did not find failing students challenging (64.5%) even when it was not a clear pass or fail (70.5%). However, some participants (27.5%) found assessing students challenging when they had developed a positive relationship with the student.

The notion of failing a student on their professional attitude alone if their skills and knowledge were satisfactory divided the participants. The largest proportion of participants (48.9%) believed that you can fail students on their attitude alone whilst fewer (40.3%) believed you cannot. The majority of assessors adapted their teaching (80.5%) and the way they managed assessments (85.9%) based on their previous experiences. Almost exclusively assessors had a strong duty of care both to the profession (97.3%) and patients (97.3%). In this study assessors reported feeling supported by their colleagues (79.2%) during difficult conversations (62.4%) and by the organisation (67.1%) (Table 2).

3.2. Processes

Assessors' reports of support were mixed. The majority of assessors (64.2%) *agreed* that there were adequate processes in place to support staff (see Table 3). Furthermore, whilst the majority of assessors (53.7%) received ongoing guidance in managing students whose performance was unclear, a small percentage either *never* (4.5%) or *rarely* (17.9%) received guidance. Likewise, most participants (50.8%) *agreed* that the university supported their role as gatekeeper to the profession. However, 68% of participants had experienced personal or psychological distress in their gatekeeping role from lack of support.

Participants (55.2%) were mostly satisfied with the amount of contact they had with the assessment team. Yet, only 30.9% rated collaboration between the industry and tertiary sector *good* or *excellent* (Item no. 9). The majority of participants (91.8%) were sure of themselves when assessing marginal performances. Whilst assessors generally (83.6%) felt adequately prepared in their role as assessor and in providing feedback about poor performances (67.9%), a similar percentage (68.7%) would like more professional development. Participants (42.5%) *agreed* that their employer provided adequate

Table 2
Summary of item responses from the domain 'People' grouped by Likert-response type.

Item no.	Item (N = 149) [missing data/%]	Always n (%)	Often n (%)	Sometimes n (%)	Rarely n (%)	Never n (%)	Median (IQR)
1	I find providing students with constructive feedback about their performance confronting? [1/0.7]	1 (0.7)	10 (6.7)	82 (55.0)	41 (27.5)	14 (9.4)	3.00 (1)
2	I find providing students with constructive feedback about their performances rewarding. [1/0.7]	1 (0.7)	19 (12.8)	95 (63.8)	33 (22.1)	1 (0.7)	4.00 (0)
3	I have had students improve their performance after feedback. [1/0.7]	8 (8.5)	122 (81.9)	18 (12.1)	0	0	4.00 (0)
4	I have felt intimidated whilst giving a student feedback on their performance. [1/0.7]	0	2 (1.3)	42 (28.2)	83 (55.7)	21 (14.1)	4.00 (1)
5	When providing constructive feedback to students about their performance in clinical assessments, their response has impacted my ability to provide feedback. [0]	0	11 (7.4)	65 (43.6)	56 (37.6)	17 (11.4)	3.00 (1)
6	When I have assessed a student performance, I have given the student the benefit of the doubt and passed them. [2/1.4]	0	5 (3.4)	30 (20.1)	63 (42.3)	49 (32.9)	4.00 (1)
7	I have experience of students attempting to use their personal circumstances in an attempt to excuse their performance deficits. [1/0.7]	3 (2.0)	46 (30.9)	70 (47.0)	26 (17.4)	3 (2.0)	3.00 (1)
8	I have had students with previous nursing experience who believe they should be passed even if their performance does not meet the Australian Registered Nurse Standards for Practice. [2/1.4]	3 (2.0)	23 (15.4)	71 (47.7)	33 (22.1)	17 (11.4)	3.00 (1)
9	I have experienced ongoing distress as consequence of recommending a failing grade. [4/2.7]	1 (0.7)	3 (2.0)	27 (18.1)	43 (28.9)	71 (47.7)	4.00 (1)
24	I feel supported in my assessment role by my colleagues. [1/0.7]a	53 (35.6)	65 (43.6)	23 (15.4)	7 (4.7)	0	4.00 (1)
25	When I have had a difficult conversation with a student, there was somebody there to provide support to me. [2/1.4]a	51 (34.2)	41 (27.5)	41 (27.5)	11 (7.4)	3 (2.0)	4.00 (2)
26	I feel supported as an assessor by my employer. [1/0.7]a	53 (35.6)	47 (31.5)	34 (22.8)	13 (8.7)	1 (0.7)	4.00 (2)

Item no.	Item (N = 149) [missing data/%]	Strongly disagree n (%)	Disagree n (%)	Neither agree or disagree n (%)	Somewhat Agree n (%)	Agree n (%)	Median (IQR)
10	I think assessing student performances that are not a clear fail is one of the most challenging aspects of my role. [4/2.7]a	49 (32.9)	56 (37.6)	24 (16.1)	11 (7.4)	5 (3.4)	4.00 (2)
11	I find failing poorly performing students in clinical assessments one of the most challenging aspects of my role. [6/4.1]a	39 (26.2)	55 (36.9)	15 (10.1)	27 (18.1)	7 (4.7)	4.00 (2)
12	I find it harder to give constructive negative feedback if a student is 'likeable'. [1/0.7]a	22 (14.8)	39 (26.2)	27 (18.1)	51 (34.2)	9 (6.0)	3.00 (2)
13	I find it more difficult to assess a student's performance if I have developed a positive relationship with that student. [5/3.4]a	36 (24.2)	43 (28.9)	24 (16.1)	39 (26.2)	2 (1.3)	4.00 (2.75)
14	I find student's insight impacts their responses to feedback. [1/0.7]	2 (1.3)	0	10 (6.7)	28 (18.8)	108 (72.5)	5.00 (1)
15	I have changed the way I teach based on my experiences with assessing student performances. [3/2.0]	3 (2.0)	3 (2.0)	21 (14.1)	60 (40.3)	59 (39.6)	4.00 (1)
16	I have changed the way I manage assessments based on my previous experiences. [1/0.7]	3 (2.0)	4 (2.7)	13 (8.7)	54 (36.2)	74 (49.7)	5.00 (1)
17	I believe you cannot fail a student's performance on their attitude alone. [1/0.7]a	26 (17.4)	47 (31.5)	15 (10.1)	39 (26.2)	21 (14.1)	3.00 (2)
18	I think students should be given the benefit of the doubt in clinical assessment. [3/2.1]a	56 (37.6)	54 (36.2)	21 (14.1)	14 (9.4)	1 (0.7)	4.00 (1)
19	I tend to pass poorly performing students in their first year of the nursing programme as they are new to the course and have time to improve. [3/2.1]a N/A 16/10.7%	61 (40.9)	39 (26.2)	12 (8.1)	16 (10.7)	2 (1.3)	5.00 (1)
20	Mid way through the nursing programme, students have more time to improve so I tend to pass them. [3/2.1]a N/A 5/3.4%	82 (55.0)	47 (31.5)	5 (3.4)	7 (4.7)	0	5.00 (1)
21	In the final year of the nursing programme, students are completing their degrees so I tend to pass them. [4/2.7]a	108 (72.5)	28 (18.8)	7 (4.7)	2 (1.3)	0	5.00 (1)
22	As an assessor of students in clinical assessments, I have a duty of care to the nursing profession. [4/2.7]	1 (0.7)	0	0	2 (1.3)	145 (97.3)	5.00 (0)
23	As an assessor of students in clinical assessments, I have a duty of care to patients. [0]	1 (0.7)	0	0	3 (2.0)	145 (97.3)	5.00 (0)
	Overall						4.00 (0)

NA not applicable.
a Indicates reverse coding of item.

Table 3
Summary of item responses from the domain 'Process' grouped by Likert-response type.

Item no.	Item N = 134 [missing data/%]	Always n (%)	Often n (%)	Sometimes n (%)	Rarely n (%)	Never n (%)	Median (IQR)
1	I receive ongoing guidance in managing students whose performance is not a clear pass or fail. [2/1.5]^a	27 (20.1)	45 (33.6)	30 (22.4)	24 (17.9)	6 (4.5)	4.00 (1)
2	I am unsure of myself as an assessor of students when their performance is borderline. [1/0.7]	0	10 (7.5)	47 (35.1)	62 (46.3)	14 (10.4)	4.00 (1)

Item no.	Item N = 134 [missing data/%]	Strongly disagree n (%)	Disagree n (%)	Neither agree or disagree n (%)	Somewhat agree n (%)	Strongly agree n (%)	Median (IQR)
3	I believe there are processes in place to provide support for staff when managing a student's performance when it is not a clear pass or fail. [0]	10 (7.5)	18 (13.4)	20 (14.9)	47 (35.1)	39 (29.1)	4.00 (2)
4	I felt adequately prepared for my role as an assessor of nursing students' clinical performances. [1/0.7]	4 (3.0)	7 (5.2)	10 (7.5)	46 (34.3)	66 (49.3)	4.00 (1)
5	I would like more professional development around assessing students' clinical performance. [5/3.7]^a	6 (4.5)	7 (5.2)	24 (17.9)	49 (36.6)	43 (32.1)	2.00 (2)
6	I think my employer provides sufficient professional development around managing student's whose performance is not clear in clinical assessments. [1/0.7]	23 (17.2)	27 (20.1)	26 (19.4)	44 (32.8)	13 (9.7)	3.00 (2)
7	I feel I have been prepared to provide feedback to nursing students about their poor performance. [1/0.7]	8 (6.0)	17 (12.3)	17 (12.3)	55 (41.0)	36 (26.9)	4.00 (1)
8	I find unless a student's performance is a clear safety issue, it takes too much time to giving a failing grade. [3/2.2]^a	67 (50.0)	27 (20.1)	12 (9.0)	19 (14.2)	6 (4.5)	5.00 (2)
10	I believe the university supports assessors in their role as gatekeeper to the nursing profession. [6/4.5]	10 (7.5)	29 (21.6)	21 (15.7)	45 (33.6)	23 (17.2)	4.00 (2)
11	I believe university appeals processes tend to favour the student. [12/9.0]^a N/A 5/3.7%	2 (1.5)	6 (4.5)	34 (25.4)	38 (28.4)	37 (27.6)	2.00 (2)
12	I believe the university appeals process does not support the assessor. [13/9.7]^a N/A 6/4.5%	4 (3.0)	10 (7.5)	44 (32.8)	33 (24.6)	24 (17.9)	3.00 (1)
13	I only recommend a fail if I have enough evidence even if I am worried about the student's performance. [4/3.0]^a	25 (18.7)	48 (35.8)	10 (7.5)	32 (23.9)	15 (11.2)	4.00 (2)
14	I have experienced personal/psychological distress in my role as the professional gatekeeper from lack of support. [5/3.7]^a	1 (0.7)	6 (4.5)	31 (23.1)	53 (39.6)	38 (28.4)	2.00 (2)
15	I have had my recommendation/decision to fail a student performance overturned by the appeals process. [30/22.4]^a	44 (32.8)	20 (14.9)	28 (20.9)	12 (9.0)	0	4.00 (2)
16	I have failed a student but then seen them progress anyway. [16/11.9]^a	1 (0.7)	20 (14.9)	49 (36.6)	19 (14.2)	29 (21.6)	3.00 (1)
17	There is a process whereby I can make sure I assess student performance in the same way other assessors are. [9/6.67]	21 (15.7)	39 (29.1)	28 (20.9)	25 (18.7)	12 (9.0)	3.00 (2)
18	In my experience all students in their final, completing year of their programme are successful in appealing failing grades. [24/17.9]^a NA 19/14.2%	6 (4.5)	15 (11.2)	42 (31.3)	19 (14.2)	9 (6.7)	3.00 (1.75)
19	I believe it is unfair to students if I know about their previous clinical assessment performances. [3/2.2]^a	34 (25.4)	51 (38.1)	16 (11.9)	23 (17.2)	7 (5.2)	4.00 (2)
20	If I was aware of students' previous performance in clinical courses it would assist me with planning learning opportunities. [2/1.5]	5 (3.7)	6 (4.5)	4 (3.0)	41 (30.6)	76 (56.7)	5.00 (1)
21	I would find it useful to know in advance the students in my group who previously have just managed to pass. [2/1.5]	5 (3.7)	10 (7.5)	14 (10.4)	43 (32.1)	60 (44.8)	4.00 (1)
22	I am satisfied with the amount of contact I have with the assessment team. [3/2.2]	9 (6.7)	33 (24.6)	15 (11.2)	50 (37.3)	24 (17.9)	4.00 (2)
23	I use intuition to grade a student's clinical performance. [1/0.7]^a	55 (41.0)	29 (21.6)	20 (14.9)	28 (20.9)	1 (0.7)	4.00 (2)
24	I use criteria to grade a student's clinical performance. [1/0.7]	2 (1.5)	0	1 (0.7)	22 (16.4)	108 (80.6)	5.00 (0)
25	I find marking rubrics help discriminate between a pass and a fail in clinical assessments. [4/3.0] N/A 3/2.2%	4 (3.0)	9 (6.7)	14 (10.4)	38 (28.4)	62 (46.3)	4.50 (1)
	Overall median						4.00 (1)

NA not applicable.
^a Indicates reverse coding of item.

Table 4
Summary of item responses from the domain 'Programme' grouped by Likert-response type.

Item no.	Item N = 127 [missing data/%]	Always n (%)	Often n (%)	Sometimes n (%)	Rarely n (%)	Never n (%)	Median (IQR)
1	I believe I have adequate time to assess student performances during clinical assessments. [2/1.6][a]	1 (0.7)	18 (14.2)	50 (39.4)	43 (33.9)	13 (10.2)	3.00 (1)
2	I feel overwhelmed by the amount of work associated with my role as assessor of nursing students. [4/3.1]	4 (3.1)	29 (22.8)	58 (45.7)	21 (16.5)	11 (8.9)	3.00 (2)

Item no.	Item N = 127 [missing data/%]	Strongly disagree n (%)	Disagree n (%)	Neither disagreed or agree n (%)	Somewhat agree n (%)	Strongly agree n (%)	Median (IQR)
4	I feel it takes longer to fail a student's clinical performance than it does to pass it. [1/0.7][a]	5 (3.9)	7 (5.5)	12 (9.4)	42 (33.1)	60 (47.2)	2.00 (1)
5	I find that on short clinical placements, there is not enough time to give feedback to students about their performance. [1/0.7][a]	7 (5.5)	10 (7.9)	8 (6.3)	53 (41.7)	48 (37.8)	2.00 (1)
6	I believe the design of the programme doesn't allow for students who need more time to master clinical practice. [4/3.1][a]	50 (39.4)	46 (36.2)	9 (7.1)	13 (10.2)	5 (3.9)	4.00 (1)
7	I don't have enough time to support students who need extra help developing clinical skills. [2/1.6][a]	34 (26.8)	56 (44.1)	9 (7.1)	19 (15.0)	7 (5.5)	4.00 (2)
8	I believe if a student passes all theoretical subjects, they will be passed in the clinical course regardless of their performances. [11/8.9][a]	1 (0.7)	14 (11.0)	37 (29.1)	27 (21.3)	37 (29.1)	2.00 (2)
9	I believe if I fail too many nursing students, it will affect my job prospects. [3/2.4][a]	10 (7.9)	21 (16.5)	19 (15.0)	24 (18.9)	50 (39.4)	4.00 (2.75)
10	I believe if I receive a complaint, it will affect my job prospects. [3/2.4][a]	30 (23.6)	25 (19.7)	20 (14.9)	36 (28.3)	13 (10.2)	3.00 (2)
11	Short term contractual employment makes it harder to retain staff in the role of assessor. [6/4.7][a] NA 5/3.9%	49 (38.6)	43 (33.9)	15 (11.8)	4 (3.1)	5 (3.9)	4.00 (1)
12	The diversity of clinical experiences challenges my capacity to determine if students meet the professional standards of practice. [7/5.5][a]	29 (22.8)	22 (17.3)	24 (18.9)	38 (29.9)	7 (5.5)	3.00 (2.5)
13	Clinical safety errors in OSCE should be fed back prior to clinical placement. [12/9.4] NA 6/4.7%	5 (3.9)	6 (4.7)	7 (5.5)	21 (16.5)	70 (55.1)	5.00 (1)
14	I believe it is hard to moderate OSCE's. [17/13.4] NA 19/15.0%	8 (6.3)	24 (18.9)	30 (23.6)	26 (20.5)	3 (2.4)	3.00 (2.25)
	Overall median						3.00 (1)

NA not applicable.
[a] Indicates reverse coding of item.

Table 5
Summary of item responses from the domain 'Policies'.

Item no.	Item N = 120 [missing data/%]	Strongly disagree n (%)	Disagree n (%)	Neither agree or disagree n (%)	Somewhat agree n (%)	Strongly agree n (%)	Median (IQR)
1	I find policies don't take into account the differences between theoretical assessment and clinical assessment. [2/1.7][a] NA 6/5%	9 (7.5)	20 (16.7)	35 (29.2)	40 (33.3)	8 (6.7)	3.00 (2)
2	In my organisation I am unaware of policies specifically covering assessment of nursing students. [4/3.3][a]	33 (27.5)	29 (24.2)	8 (6.7)	26 (21.7)	20 (16.7)	4.00 (3)
3	I have found my organisations' (health care facility or university) assessment policies helpful when differentiating between a passing or failing grade. [5/4.2] NA 6/5%	8 (6.7)	22 (18.3)	20 (16.7)	38 (31.7)	21 (17.5)	4.00 (2)
	Overall median						3.00 (2)

NA not applicable.
[a] Indicates reverse coding of item.

professional development around marginal performances. Participants (70.1%) reported that it did not take too much time to fail student performances. Assessors believed that the appeals process favours students (56.0%) and did not support assessors (42.5%). Many participants (47.7%) reported that they had not had their grade overturned by the appeals process. However, participants (35.8%) had failed a student yet seen them progress regardless, with 20.9% of participants having had third year students successfully appeal a failing grade.

The vast majority (97%) of participants used criteria to grade a student's performance rather than intuition (21.6%) and found marking rubrics helpful discriminators (74.7%). Most assessors (76.9%) would find it useful to know in advance students who have previously just managed to pass and did not believe it was unfair to know about a student's previous clinical performances (63.5%). Many participants (44.8%) did not believe there was an adequate moderation process.

3.3. Programmes

Table 4 presents a summary of the individual item responses around aspects of the academic programme. The domain of programme included elements such as workload, time constraints in terms of clinical practice time as well as the time it takes to fail student performances. Participants (71.5%) typically believed they have adequate time to support students. However, only 12.8% of participants believed they *often* or *always* had adequate time to assess student performances. Many (63.8%) participants felt overwhelmed by their workload with most participants (71.1%) believing it took longer to fail a student than pass them. Whilst generally participants (68.4%) believed the programme design accommodated students who require extra time, 69.0% of participants believed that three weeks or longer is the minimum length of time in order to adequately assess student performances. Many respondents (68.4%) reported forgoing feedback in shorter placements due to time constraints. Just over half of the participants (58.3%) believed that if they fail too many students or if they were the subject of a student complaint (38.5%), it would impact on their job prospects. However, the majority of participants (72.5%) did not feel that short-term contractual employment impacted on assessor retention.

Participants were also asked to identify educationally sound methods of competence assessment. An overwhelming majority of participants (98.4%) reported that workplace-based assessment (clinical practice) was a good method to assess student performances. Simulation was considered a good method of assessing competence by 85.8% of participants, whilst Objective Structured Clinical Examinations (OSCE) were considered effective by 63.8% of respondents. The majority of participants (71.6%) believed that students should be told of their clinical safety errors in OSCE prior to their clinical placement. Some participants (22.9%) believed it was hard to moderate OSCEs. There were also a number of written options that were considered effective by a number of participants: case studies (60.6%); journaling (51.2%); care plans (41.7%); written assignments (33.1%); exams (32.2%); portfolios (21.3%) and checklists (19.7%). Many participants (51.2%) suggested self-assessment was a good method with 48.0% responding that peer-assessment was an effective method of assessing competence.

The majority of participants (50.4%) believed a student would pass a clinical course if they passed all theoretical courses, regardless of clinical performance. Responses were evenly split in terms of whether the diversity of clinical experiences impacted on the assessor's ability to determine standards of practice with 40.1% believing it did not and 35.4% believing it did.

3.4. Policies

There was a large variation in responses in the policy items. The majority of participants (51.7%) were aware of policies covering assessment of nursing students. However, only 25% of participants found

Table 6
Summary of item responses from the domain 'Place'.

Item no.	Item N = 120 [missing data/%]	Strongly disagree n (%)	Disagree	Neither agree or disagree n (%)	Somewhat agree n (%)	Strongly agree n (%)	Median (IQR)
1	I believe the culture of the clinical area impacts on student success in clinical assessments. [0]	4 (3.3)	4 (3.3)	3 (2.5)	52 (43.3)	57 (47.5)	4.00 (1)
2	I believe students should not go to specialist placements if their previous clinical performance has not demonstrated a clear pass. [0]	5 (4.2)	14 (11.7)	14 (11.7)	27 (22.5)	60 (50.0)	4.50 (2)
3	I would like to place the student in the most appropriate clinical area for them. [1/0.8]	9 (7.5)	19 (15.8)	14 (11.7)	29 (24.2)	48 (40.0)	4.00 (2)
	Overall median						4.00 (1)

their organisations policies helpful to differentiate between a passing and failing grade. Many participants (40%) *agreed* that policies do not consider the differences between theoretical assessment and practical assessment (Table 5).

3.5. Place

The majority of assessors (76.6%) *agreed* that student success was impacted upon by the culture of the clinical area. The participants *agreed* that students should be placed in the most appropriate place for that student (54.3%) and that this should not be in a specialty placement [for example the emergency department, paediatrics, intensive care setting or theatre], if the student's performance was not a clear pass or fail (60.4%) (Table 6).

4. Discussion

This is the first reported study to use a specifically designed survey to describe assessors' experiences of grading unclear student performances that may lead to understanding failure to fail. Overall, the participants in this study reported assessing student performances as a rewarding component of their role. Responses suggested however, that both industry and academic assessors had challenging, often negative, experiences when grading nursing student performances when that performance was not a clear pass or fail. The results also suggest that assessors take their duty of care to the profession and to the patient very seriously.

The role of gatekeeper to the profession was valued by assessors in principle yet many of the participants indicated this was harder to maintain in practice. Most participants suggested that assessors should not be giving students the benefit of the doubt, nevertheless, many had reported giving students the benefit of the doubt. The benefit of the doubt appears to be more prevalent when assessing first year students with decreasing tolerance as students' progress through the years of the programme. The notion of leniency for first year students has been reported in the literature previously with leniency causing grade inflation across all clinical courses being widely reported (Donaldson and Gray, 2012; Hughes et al., 2018a; Hunt et al., 2012; Paskausky and Simonelli, 2014; Yepes-Rios et al., 2016). It is important that assessors fulfil their role as gatekeeper to the profession throughout all stages of the programme to limit issues associated with students reaching third year with an expectation that they deserve to graduate. Moreover, not providing students with an accurate reflection of their level of fitness for practice limits opportunity for development of accurate self-reflection.

The appeals process appeared to be a barrier for assessors in fulfilling their gatekeeping role in this study. Our results align with the increasing body of work identifying the impact of university appeals systems on failure to fail (Brown et al., 2012; Duffy, 2003; Hughes et al., 2018a; Larocque and Luhanga, 2013; Luhanga et al., 2014a,b, 2008b). Assessors' experiences when the university does not support them in their role as gatekeeper may impact on their grading; nurturing the belief that failing marginal students may not be worth the time and increased workload. Programme design and organisational support play a crucial role in enabling assessors to feel comfortable in their role as gatekeepers for the profession, ensuring only those fit for practice progress through the programme (Chunta, 2016; Yepes-Rios et al., 2016). Given the moral, professional and ethical responsibility inherent in the role as assessor, the concepts of leniency, benefit of the doubt and the appeals process needs to be addressed as a matter of urgency.

Participants in this study experienced many positive student responses when discussing student performances, however, students' responses to delivery of their marginal grade included targeting, attacking, denigrating or undermining the assessor, personally and/or professionally. Such experiences are likely to contribute to the difficulties assessors reported with failing students who do not clearly

demonstrate fitness for practice, and align with findings reported in other studies (Black et al., 2014; DeBrew and Lewallen, 2014; Duffy, 2003; Hunt et al., 2016a; Larocque and Luhanga, 2013; Luhanga et al., 2014a,b, 2008a,b). Assessors' experiences of intimidation, manipulation, anger and violence by some students echo other emerging evidence indicating some nursing students use coercive and manipulative strategies in order to be awarded a passing grade (Hughes et al., 2018a; Hunt et al., 2016a,b; Luhanga et al., 2010). Indeed, given that 60% of assessors experienced student anger during feedback, 32.9% experienced aggression and 10.1% of violence, the need for more consideration and focused research in future studies and in the processes of developing supportive strategies for assessors is vital. These student responses often contributed to assessors' experiences of emotional and moral distress and requires further examination to explore this troubling issue (Black et al., 2014; Duffy, 2003; Hughes et al., 2018a; Pratt et al., 2013).

Consideration of the programme design as a contributing factor in failure to fail is a novel concept and one which warrants further attention. The notion of time and how it impacts on failure to fail was an issue in this study where many participants felt overwhelmed by the amount of work associated with their role as an assessor. Moreover, the majority of participants felt that there was insufficient time for feedback on shorter placements. It may be postulated that due to workload and time pressures, some assessors may pass students who are performing at a borderline level. Again, these findings are similar to other work in this area undertaken in differing geographical locations and using alternative methodologies (Duffy, 2003; Hughes et al., 2018b; Kennedy and Chesser-Smyth, 2017; Luhanga et al., 2008a; McCarthy and Murphy, 2010; Yepes-Rios et al., 2016). These studies did not, however, specifically explore the impact of the programme design on failure to fail.

There was wide variation in responses to the domain 'policies'. This could reflect the population being mainly based in the industry setting where the focus of policies is on clinical management and industry focused policies rather than student nurse performance. Participants were aware of assessment policies however, these related broadly to assessment policies rather than concrete exemplars or definitive guides that assessors utilised to help them differentiate between a pass or fail grade. A number of assessors were unaware if there were any policies on assessment in their organisation. It is the responsibility of the tertiary organisations to ensure all assessors, both industry and tertiary, know how to interpret the policies and their implications. Whilst it is imperative that schools of nursing have transparent policies (Chunta, 2016; Yepes-Rios et al., 2016) and processes (Hughes et al., 2016; Yepes-Rios et al., 2016) to guide assessment, this is the first study that reports policies may have a bearing on failure to fail. Further research on policies pertaining specifically to assessment of clinical performance, the application of these policies and how it may impact on failure to fail is required.

Whilst the impact of the clinical environment on learning has been explored (see for example, Flott and Linden, 2016; Levett-Jones and Lathlean, 2009), there has been no clear discussion of the impact of 'place' on failure to fail and this warrants further exploration. One challenge highlighted involved students who were not performing at a high standard being allocated specialty placements. Students are more often in the role of observer in specialty placements, making it more difficult to identify if they meet fitness for practice standards. Given the scarcity of clinical placements, speciality placements are a missed opportunity for those students who are performing at borderline level who would benefit from more 'hands on' time. This study's results suggest that the area the student is placed in may impact on their ability to succeed in their assessments due to institutional culture. Institutional culture has been reported as a barrier for students succeeding (Levett-Jones and Lathlean, 2009), however no study has explored this in terms of failure to fail. Whilst it was not specifically explored in this study, it may be pertinent to explore if the clinical place does indeed lead to

students passing clinical courses when they are not demonstrating fitness for practice.

4.1. Limitations

The results of the study need to be considered in light of its methodological limitations. Since members of ANTS form a group of highly engaged nurse educators, our recruitment sample may not be a true reflection of the experiences of all assessors. Data from these participants may be different to that from those who have less of an interest in education and yet are still assessing students as part of their role or those from another country. The length of the survey may have contributed to the drop in completion rates for the final two domains rather than the lack of relevance and needs to be considered when interpreting the results.

5. Conclusions

Assessors' experiences of grading student performances in clinical courses when that performance was not a clear pass or fail was the focus of this study. This was the first study that utilised the Invitational Theory to develop an exploratory survey to understand assessors' experiences of assessing student performances and failure to fail. The results further the extant literature on the contribution that people and processes make to enabling or creating barriers to assessing student performances and ensuring only students who are fit for practice pass clinical courses. Assessors take their role as gatekeeper to the profession seriously and endeavour to maintain high standards, however, personal and professional support is required to enable the assessor to fulfil this role. The domains of programmes, policies and places raised many noteworthy observations that require systematic exploration. For this reason, future studies should build on this broader understanding of failure to fail. The unique contribution of this study is the exploration of the failure to fail phenomenon from a broader more holistic lens that adds a new dimension to understanding the complexities associated with failure to fail. Developing an understanding of the issues assessors' experience when coming to a decision about whether to fail a student or not, enables a clearer path to mitigate this potential risk to institutional graduate quality and thus reputation, vulnerable patients and the quality of the nursing profession.

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