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Unsafe student nurse behaviours: The perspectives of expert clinical nurse educators

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ABSTRACT

Clinical evaluation of undergraduate nursing students is one of the most challenging aspects of baccalaureate nursing education, especially for novice clinical instructors. Early identification of unsafe student behaviours is necessary to ensure students obtain adequate support and guidance. The degree to which clinical instructors are certain about what is safe and unsafe varies, and greatly influences their decisions about evaluative processes and which patients to assign to students. The purpose of this study was to gain consensus from a panel of sixteen nurse educator experts on particular student nurse behaviours that represent unsafe clinical practices and provide a hierarchy of unsafe behaviours from their perspectives. Using the Delphi technique, a series of four online surveys were administered to the panel: exploratory (open-ended questions), evaluative (responses to Likert statements with level of agreement), reconsidering (revising or confirming), and ranking. Thirty-eight unsafe student behaviours with respect to patients and seventeen unsafe behaviours with respect to others reached 80% or more consensus as being very unsafe. Two themes emerged from a cognitive perspective: the value of honesty and the expectation of knowledge. Two themes emerged from a behaviorist perspective: the value of control and the expectation of scrupulousness and precision.

1. Introduction

Clinical instructors typically hold a bachelor's degree in nursing and are hired by universities and colleges to supervise students in clinical practice settings. They assign patients to undergraduate students, teach them how to perform patient care, and evaluate the students' clinical practices. Instructors have dual obligations and responsibilities: they must facilitate student learning by incrementally challenging students, but at the same time they must ensure patient safety. Clinical evaluation of nursing students is one of the most challenging aspects of baccalaureate nursing education, especially for novice clinical instructors. Novice clinical instructors lack experience and often lack adequate preparation for their evaluative role. A novice instructor may perceive that a student's behaviour is unsafe but may not be able to make a judgement about the severity of the behaviour because of lack of experiential knowledge. Novice instructors may wonder “is the behaviour somewhat unsafe, is the behaviour borderline, or is this behaviour intolerable?” Some instructors pass students when in fact, they are doubtful about the students' clinical competencies and safety (Gainsbury, 2010; Hughes et al., 2016). Inability to make a decision or take action due to lack of experience, confidence or preparation for the role has historically been termed ‘failure to fail’ (Gainsbury, 2010; Montgomery et al., 2014; Killam et al., 2010). ‘Failure to fail’ can also be caused by contextual difficulties that obstruct an instructor's ability to act such as policies that allow nursing students an entire term to be successful in a course (Scanlan et al., 2001) or requirements for additional documentation that are extremely time consuming and burdensome for an instructor. Compounding the issue is a socialization process which can lead to close relationships between a clinical instructor and the students (Scanlan et al., 2001). Caring is an integral part of the nursing profession, and some instructors view the failing process as an uncaring practice (Scanlan et al., 2001). According to Brown et al. (2007) some instructors may decide to take the students' personal circumstances into account when evaluating them (which may or may not be appropriate).

Authors consistently agree that there is a need for early identification of unsafe student behaviours in order to ensure students obtain adequate support and guidance (Killam et al., 2010; Lewallen & Kayler

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DeBrew, 2012; Luhanga et al., 2008). When novice clinical instructors are unable to clearly identify unsafe behaviours, students do not receive the support and guidance they need to fulfill competencies for success and some student's progress when they are not ready to progress or they are unsuitable for nursing (Hughes et al., 2016). It is imperative that clear and consistent definitions of unsafe behaviours that constitute unsafe practices are established to guide novice instructors in their assessment and evaluation of student clinical performance. Although seminal authors agree about the educational circumstances surrounding 'failure to fail' it can be difficult for novice instructors to identify specific unsafe behaviours by interpreting vague terms for questionable student behaviours contained in extant literature. Vague terms include poor work ethic, inconsistent clinical performance, or poor communication skills (Duffy and Hardicre, 2007; Killam et al., 2010; Scanlan et al., 2001). When definitions of unsafe or questionable behaviours are vague, it is ultimately left up to the instructor to decide whether a student is safe or unsafe (Killam et al., 2010; Scanlan et al., 2001).

Novice clinical instructors must make judgments and decisions based on evidence and our aim was to develop more explicit evidence on this topic. The purpose of this study was two-fold. First, to gain consensus from a panel of expert clinical nurse educators on specific student nurse behaviours that represent unsafe clinical practices. Second, to provide a hierarchy of the unsafe behaviours, from the perspective of the nurse educators. Clinical nurse educators teach in both classroom and practice settings. Their role is to ensure nursing students receive theoretical knowledge as well as the skills they need to succeed in clinical settings. Clinical nurse educators typically hold either a Master's degree or PhD in nursing. Our results may be useful to guide novice instructors who must make judgments about whether a student nurse is safe or unsafe.

2. Methodological framework

Two concepts within clinical education in nursing were of primary importance in this study: the cognitive perspectives and behavioral/materialist perspectives of expert nurse educators (Barroso and Cameron, 2013). Cognitive perspectives are the "beliefs, knowledge, and ideas" that experts use when they teach in clinical settings (Barroso and Cameron, 2013, p. 179) while behavioral/materialist perspectives are the "patterns of behaviour and customs" of expert clinical nurse educators (Barroso and Cameron, 2013, p. 179).

The primary research question was: According to experts, what specific student nurse behaviours constitute unsafe clinical practices? Secondary research questions were:

1. From the perspective of experts, what specific student nurse behaviours reflect a) lack of knowledge, skills, or clinical judgment, b) unprofessional or unethical conduct that threatens or has the potential to threaten the physical, emotional, mental, or environmental safety of the patient or others, or c) a problem related to student attitude?
2. After consensus is reached, how will the experts rank unsafe student nurse behaviours?

In this study, the Delphi technique was the method used to collect data. The term Delphi means to receive good judgement on an issue and the underlying assumption is that group opinion of experts is more valid than individual opinion (Keeney et al., 2011). The method is useful to improve decision-making in health care and is often employed when there is limited or conflicting evidence in a particular area (Vernon, 2009). Using the Delphi technique, we followed a prescribed set of survey procedures designed to enable a panel of expert clinical nurse educators to reach consensus on unsafe behaviours of student nurses (Fletcher and Marchildon, 2014; Keeney et al., 2011; Powell, 2003). These techniques are described in detail in the method section.

The study took place in two urban nursing schools in the province of British Columbia, Canada. School One (college) provides 26 seats for undergraduate nursing students for the first two years of study in a four-year program. Twenty-six seats means that 26 students are admitted into the nursing program every year. Approximately 60% (15) of the students in School One are aged 18–19 years on admission while 40% (11) are mature students who have some post-secondary education. Approximately 20% (5) of the students are male and 80% (21) are female. Seven clinical instructors provide direct supervision in clinical settings to students enrolled in School One. Of those, approximately 30% (2) have less than two years of teaching experience. School Two (university) provides 140 seats for undergraduate nursing students across four years of study. Approximately 50% (70) of the students in School Two are aged 18–19 years on admission; 50% (70) are university transfer students (students who have completed 24 credits of university level and are between the ages of 20–25 on admission); approximately 5–10% (7–14) are male, and 85–90% (119–126) are female. Thirty-five clinical instructors provide direct clinical supervision to undergraduate students in School Two. Of those, approximately 10% (3) have no teaching experience and another 25% (9) have less than two years of teaching experience.

3. Method

3.1. Recruitment of experts

After we received administrative support and approval from the Behavioural Research Ethics Boards at School One and Two, we employed purposive sampling (Strauss and Corbin, 1998) to recruit a panel of experienced clinical nurse educators from both schools. We did not contact potential participants directly. Instead, known experts who met the inclusion criteria were identified by the Dean or Director. To be eligible the clinical instructors had to have five or more years of teaching experience providing direct supervision in a clinical setting, willing and able to commit to the Delphi process, and currently or previously employed as clinical instructors in School One or School Two. They received our information letter and invitation to participate via school email and were instructed to contact us if they were interested in participating.

Five clinical nurse educators at School One and twelve clinical nurse educators at School Two agreed to participate (N = 17). This sample size is consistent with average sample sizes of nine studies where researchers used the Delphi technique as the method of data collection. Fifteen of the participants had sixteen years of experience or more as a Registered Nurse; ten had more than eleven years of experience teaching undergraduate nursing students in clinical settings; thirteen had completed a Master of Science in Nursing; eight had clinical expertise in either general medicine, general surgery, or community health (Table 1).

3.2. Overview of the delphi technique

The Delphi technique consists of a series of surveys (four rounds): The Exploration Phase which is qualitative, followed by three quantitative rounds: The Evaluative Phase, The Reconsidering Phase and The Ranking Phase. Experts who contacted us received an electronic link to the first survey which contained the consent form, demographic questionnaire and first questionnaire. Although we knew who had agreed to receive the electronic link, we were not able to match participants' responses to their identities.

To create the first questionnaire (The Exploration Phase), we extracted twenty-two vague descriptors of unsafe student nurse behaviours from extant literature. For each vague descriptor, we asked, "Thinking back, have you ever observed this behaviour? Yes or No?" (Table 2). If "Yes", the participant was prompted to provide as many details as possible about the incident without specifying the name of the student or agency involved. All affirmative responses were in the form

Table 1
Characteristics of participants.

Highest Level of Completed Education	
Master of Science in Nursing	75% (13)
Bachelor of Science in Nursing	25% (4)
Years of Experience as a Registered Nurse	
11–15 Years	12% (2)
16–20 Years	40% (7)
21–25 Years	18% (3)
26–30 Years	12% (2)
More than 30 Years	18% (3)
Years of Experience Teaching Undergraduate Nursing Students in Clinical Settings	
5 Years	12% (2)
6–10 Years	30% (5)
11–15 Years	46% (8)
16–20 Years	12% (2)
Areas of Clinical Expertise	
Oncology	1
General Medicine	3
Critical Care/Coronary Care	1
Case-Room/Post-Partum	1
Palliative Care	1
General Surgery	3
Orthopedics	1
Community Health	2
Pediatrics/Neonatal	1
Emergency	2
Women's Health	1
Residential Care	2

of unlimited text. We received 233 descriptions of unsafe practices. For example:

> Student making gross breaches in sterile technique with wound care- placing hand in center of the dressing field, placing hand into the garbage and then going back to the dressing field to continue the dressing, student picking up a used rose bud that fell onto the bed with the sterile forceps and then going back to the field to pick up the next gauze.

> A couple of students have taken on the “Doctor knows best” approach in the clinical setting when patients have asked questions. One student had a difficult time understanding that it was important to explain medication information that the patient questioned. The patient had doubts about medication timing and necessity. The student thought that the patient should trust the doctor and did not see her role in educating and supporting the patient.

We also asked the experts if they felt any student behaviours were missing in the questionnaire or if they had anything else they would like to add. We received additional descriptors, for example:

> One of my biggest issues is students not being prepared to take responsibility for their actions; there is often a level of justification or defensiveness in many students rather than accepting some responsibility.

> The super shy introverted student is one I find challenging. To get them to do an assessment when they can barely speak out loud or touch another person's body when they are so uncomfortable. Nursing is all about touching and talking, how to make the student more comfortable so they do not miss anything important.

After analysis of all descriptors (closely related responses were combined), we identified 136 potentially unsafe behaviours (Appendix).

In round two (The Evaluative Phase), all 136 potentially unsafe behaviours were returned to the participants with instructions to evaluate the level of threat to safety for patients and others based on their expert knowledge of undergraduate nursing students. For each behaviour, experts responded to a five-point Likert scale (very unsafe, somewhat unsafe, neutral, somewhat safe, safe) which allowed us to investigate not only their opinions, but also the intensity of those opinions. Others were defined as friends, family, visitors and hospital staff. Sixteen of the 17 experts completed round two (response rate 94%). Round two resulted in 55 behaviours that reached a 70% (± 5%) consensus threshold as unsafe for patients and 28 behaviours that reached a 70% (± 5%) consensus threshold as unsafe for others (Table 3). Previous researchers have considered this threshold acceptable for small panels (Graham et al., 2003; Naidoo and Joubert, 2013).

In round three (The Reconsidering Phase), we returned behaviours that did not reach the consensus threshold with instructions for experts to revise or confirm their previous responses (Fletcher and Marchildon, 2014; Hsu and Sandford, 2007). The collective group opinions were also provided to the experts in the form of percentage of agreement. The purpose of this round was to provide the experts with an opportunity to compare their individual opinions to that of the collective group (Vernon, 2009). Thirteen of the 16 remaining experts completed round three (response rate 81%). After round three results were

Table 2
Round one exploration phase.

#	Descriptors
1	Have you ever observed overconfidence in your students in the clinical setting?
2	Have you ever observed poor work ethic in your students in the clinical setting?
3	Have you ever observed lack of confidence- extreme nervousness in your students in the clinical setting?
4	Have you ever observed your students exhibiting verbal abuse towards patients in the clinical setting?
5	Have you ever observed your students exhibiting physical abuse towards patients in the clinical setting?
6	Have you ever observed your students interacting inappropriately with patients in the clinical setting?
7	Have you ever observed attitude problems with your students in the clinical setting?
8	Have you ever observed your students exhibiting poor verbal communication skills with patients in the clinical setting?
9	Have you ever observed your students exhibiting poor non-verbal communication skills with patients in the clinical setting?
10	Have you ever observed your students exhibiting poor verbal communication skills with staff in the clinical setting?
11	Have you ever observed your students exhibiting poor non-verbal communication skills with staff in the clinical setting?
12	Have you ever observed your students exhibiting uncaring behaviors in the clinical setting?
13	Have you ever observed your students exhibiting lack of knowledge in the clinical setting?
14	Have you ever observed your students exhibiting lack of practical skills in the clinical setting?
15	Have you ever observed your students exhibiting disrespect for the rights of patients in the clinical setting?
16	Have you ever observed impaired cognition in your students in the clinical setting? (for example, due to stress, drugs, alcohol, lack of sleep).
17	Have you ever observed your students exhibiting any illegal activities in the clinical setting?
18	Have you ever had any students who were unprepared for the clinical experience?
19	Have you ever observed students who were unable to think critically in the clinical setting?
20	Have you ever observed students who exhibited lack of organizational skills in the clinical setting?
21	Have you ever had a student who failed to disclose or discuss a clinical error with you?
22	Have you ever had a student who practiced outside the scope of practice for a nursing student?

Table 3
Round two behaviours that reached 70% (± 5%) agreement.

#	Patient	Others
1	A student has not been taught how to remove an intravenous (IV). In the clinical setting, a staff nurse asks the student to remove an IV and the student does so, without seeking guidance from the clinical instructor.	A student fabricates a blood glucose reading for an insulin dependent patient.
2	A student removes an arterial line and is unaware that an arterial line is not the same as an intravenous catheter.	A student appears sedated when preparing medications in the clinical setting.
3	A student exhibits a cavalier attitude about a skill learned in lab but is unable to demonstrate the same skill in the clinical setting.	A student enthusiastically offers to teach a skill to a peer. The same student, however, has not received instruction on that particular skill.
4	A student is showering a hemiplegic patient and leaves the patient alone in the shower in order to complete another task.	A student has not completed all aspects of a head to toe assessment, but to demonstrate capability, the student reports fictitious data.
5	A student fabricates a blood glucose reading for an insulin dependent patient.	A student assesses a patient's blood pressure and reports it as 120/80. The instructor is suspicious so assesses the same patient's blood pressure and the result is 190/110.
6	A student appears sedated when preparing medications in the clinical setting.	A student flushes a peripherally inserted central catheter (PICC) line without supervision. When questioned, the student states “Everyone was busy”.
7	A student has not been taught how to perform a dermatome assessment. In the clinical setting, the student performs a dermatome assessment on a patient, and when questioned, the student states she had watched the nurse and “it wasn't hard to figure out”.	A student finds a patient halfway fallen out of bed. Instead of asking for help from the nurse who is in the room, the student asks another student to find the instructor while holding the patient to keep him from falling out of bed.
8	A student rushes through medication administration and omits some of the medication checks.	A student is unable to perform mathematical calculations necessary for medication administration.
9	A student enthusiastically offers to teach a skill to a peer. The same student, however, has not received instruction on that particular skill.	A student administers a larger than normal dose of medication to a patient without questioning or reviewing appropriate lab values.
10	A student has not completed all aspects of a head to toe assessment, but to demonstrate capability, the student reports fictitious data.	A student is unable to describe the implications of administering a heparin injection to a patient who is already receiving oral anticoagulants.
11	A student assesses a patient's blood pressure and reports it as 120/80. The instructor is suspicious so assesses the same patient's blood pressure and the result is 190/110.	A student is assigned to a patient with a fractured hip. The student does not know what activity level has been ordered for this patient.
12	A student complains about repetitious classroom content and does not complete assignments. The same student is unable to apply the theory in the clinical setting.	A student begins to lift a patient with a mechanical lift. The instructor notices that the sling is not properly placed and that the patient is slipping out.
13	A student is assigned to look up information in preparation for clinical practice. It is obvious to the instructor that the student hasn't looked up the information. When questioned, the student states, she is planning on “winging it”.	A student leaves the keys in the narcotic drawer of the medication cart and the drawer is left open.
14	A student flushes a peripherally inserted central catheter (PICC) line without supervision. When questioned, the student states “Everyone was busy”.	A student is assigned to patient A but looks up medications for patient B. The student begins to administer patient B's medications to patient A.
15	A student finds a patient halfway fallen out of bed. Instead of asking for help from the nurse who is in the room, the student asks another student to find the instructor while holding the patient to keep him from falling out of bed.	A student arrives at the clinical setting the evening before clinical practice in order to look up details about her assigned patients. The nursing staff notice that this student smells of alcohol.
16	A student is unable to perform mathematical calculations necessary for medication administration.	A student in the clinical practice setting is lethargic, has dilated pupils, and slurred speech. The student admits to consuming sedatives the evening prior and states that she is “still feeling the effects”.
17	An adult patient has a resting pulse rate of 130 beats/minute. The student assigned to this patient is unable to interpret the meaning of the patient's pulse rate.	A student performs an assessment and documents the patient's resting heart rate of 140 beats/minute without telling the instructor or nurse of the findings.
18	A student doesn't know what to expect or what interventions to perform if a patient's condition worsens.	A student documents administering a medication to a patient, but in fact, the medication wasn't administered. When questioned, it becomes obvious to the instructor that the student is dishonest and misleading.
19	A student administers a larger than normal dose of medication to a patient without questioning or reviewing appropriate lab values.	For two consecutive days, a student administers a high alert medication without having the medication co-signed. When questioned, the student responds that she was too rushed to find the nurse to co-sign the medication administration record.
20	A student is unable to describe the implications of administering a heparin injection to a patient who is already receiving oral anticoagulants.	A student reports to her instructor that her patient has an epidural infusion of fentanyl. In reality, the patient has an intravenous PCA (patient-controlled analgesia) of Dilaudid.
21	A student does not check medication administration records throughout the day for new orders and misses orders.	A student flushes a central line independently before having this skill checked and approved in lab or the clinical setting.
22	When looking at a patient's lab values a student is unable to identify significant laboratory values.	A student removes a chest tube without supervision.
23	A student is assigned to a surgical patient and is unable to describe the surgery, other than saying “It is some kind of head surgery”.	A student fails to disclose a clinical error with her instructor. When questioned, she states that she withheld the information due to fear of failure and/or consequences (a learning contract, not able to go to Africa or out of region).
24	A student is assigned to a patient with a fractured hip. The student does not know what activity level has been ordered for this patient.	A student completes a 12-h night shift as a licensed practical nurse (LPN). The student arrives at the clinical practice setting still wearing her uniform from the night before. The student appears very tired and says she has not retrieved any information about her assigned patient's because she has been working all night.
25	A student is assigned to administer an ACE inhibitor to a patient. The student is unable to explain the reason for the prescription or how ACE inhibitors work.	A student writes in her reflective journal that she had an exciting day in the emergency department. A patient presented with an irregular heart rhythm and required cardio-version. When the attending physician asked the student if she would like to hold the paddles, she did so.
26	A student places her hand in the center of a sterile dressing field, places her hand in the garbage, and then goes back to the sterile field to continue the dressing.	A student hangs a new total parenteral nutrition (TPN) bag without performing any of the checks. She has been taught in class that TPN needs to be checked by an RN but stated that she couldn't find anyone. The IV pump alarm was ringing, and she knew how to change a regular IV bag, so she went ahead and did it independently.
27	A student begins to lift a patient with a mechanical lift. The instructor notices that the sling is not properly placed and that the patient is slipping out.	A student administers intravenous morphine and the patient's respiratory rate slows drastically. The patient becomes unresponsive. The student is unable to identify what is happening or what to do.
28	A student washes a patient's perineum first, and then uses the same cloth to wash the patient's face.	A student who is assigned to a post-operative patient ambulates this patient incorrectly and too soon after surgery.

(*continued on next page*)

Table 3 (*continued*)

#	Patient	Others
29	A student administers medications to a patient without checking the patient's identity by reading the patient's arm band.	
30	A student leaves the keys in the narcotic drawer of the medication cart and the drawer is left open.	
31	A student is assigned to patient A but looks up medications for patient B. The student begins to administer patient B's medications to patient A.	
32	A student works at another job until midnight. In the morning, the instructor notices that the student is tired during clinical practice.	
33	A student arrives at the clinical setting the evening before clinical practice in order to look up details about her assigned patients. The nursing staff notice that this student smells of alcohol.	
34	A student is assigned to a patient who does not want his prescribed medication. The student hides the prescribed medication in the patient's food while the patient is sleeping.	
35	A student in the clinical practice setting is lethargic, has dilated pupils, and slurred speech. The student admits to consuming sedatives the evening prior and states that she is “still feeling the effects”.	
36	A student is asked by the cardiologist who the patient's responsible nurse is, and the student responds that she is.	
37	A student performs an assessment and documents the patient's resting heart rate of 140 beats/minute without telling the instructor or nurse of the findings.	
38	Over three consecutive weeks, a student is assigned to three patients who have all had the same surgery- transurethral resection of the prostate (TURP). This student is unable to retain information previously learned and discussed.	
39	A student is unable to verbalize required nursing care for a patient with an epidural infusion.	
40	A patient's oxygen saturation reading is 85%. The student assigned to this patient does not identify the patient's need for oxygen.	
41	A student documents administering a medication to a patient, but in fact, the medication wasn't administered. When questioned, it becomes obvious to the instructor that the student is dishonest and misleading.	
42	For two consecutive days, a student administers a high alert medication without having the medication co-signed. When questioned, the student responds that she was too rushed to find the nurse to co-sign the medication administration record.	
43	A student reports to her instructor that her patient has an epidural infusion of fentanyl. In reality, the patient has an intravenous PCA (patient-controlled analgesia) of dilaudid.	
44	A student flushes a central line independently before having this skill checked and approved in lab or the clinical setting.	
45	A student removes a chest tube without supervision.	
46	A student fails to disclose a clinical error with her instructor. When questioned, she states that she withheld the information due to fear of failure and/or consequences (a learning contract, not able to go to Africa or out of region).	
47	A student completes a 12-h night shift as a licensed practical nurse (LPN). The student arrives at the clinical practice setting still wearing her uniform from the night before. The student appears very tired and says she has not retrieved any information about her assigned patient's because she has been working all night.	
48	A student writes in her reflective journal that she had an exciting day in the emergency department. A patient presented with an irregular heart rhythm and required cardio-version. When the attending physician asked the student if she would like to hold the paddles, she did so.	
49	A student inserts an endotracheal tube during her operating room (OR) observational experience.	
50	A student hangs a new total parenteral nutrition (TPN) bag without performing any of the checks. She has been taught in class that TPN needs to be checked by an RN but stated that she couldn't find anyone. The IV pump alarm was ringing, and she knew how to change a regular IV bag, so she went ahead and did it independently.	
51	A student administers intravenous morphine and the patient's respiratory rate slows drastically. The patient becomes unresponsive. The student is unable to identify what is happening or what to do.	
52	A student's assigned patient has a low oxygen saturation level. The student is unable to suggest any interventions to improve the patient's oxygenation.	
53	A student is assigned to a patient with dysphagia. At meal time, the student feeds this patient even though she has not had any previous training on this skill.	
54	A student who is assigned to a post-operative patient ambulates this patient incorrectly and too soon after surgery.	
55	A student is unable to perform a skill in the clinical setting. The instructor asks, “Have you practiced this skill in the lab?” Student replies “No”.	

analyzed, a total of 62 behaviours that were unsafe for patients and 46 behaviours that were unsafe for others reached the 70% (± 5%) consensus threshold (too numerous for experts to rank easily). After we increased the consensus threshold to 80% we had a more reasonable number of unsafe behaviours for experts to rank during the fourth and final round: 38 unsafe behaviours for patients and 17 unsafe behaviours for others (Tables 4 and 5).

During the final round (The Ranking Phase), the experts were instructed to rank order the unsafe behaviours by dragging and dropping items until they were satisfied that they had ranked the items in the way

Table 4
38 Behaviours That Reached 80% or more Consensus as Most Unsafe for Patients.

Student Behaviour (#1 = most unsafe)	Rank	Tally
Student fabricates a blood glucose reading for an insulin dependent patient	1	433
Student removes a chest tube without supervision	2	398
Student documents administering medication, but in fact, medication wasn't administered.	3	358
Student administers IV morphine, patient becomes unresponsive, student unable to identify what is happening or intervene	4	357
Student documents adult resting heart rate of 140 bpm but fails to report the finding	5	355
Student removes an arterial line unaware that it is not the same as an intravenous catheter	6	354
Student reports fictitious data on a head to toe assessment	7	351
Student assesses and reports patient's blood pressure as 120/80 when it is actually 190/110	8	345
Patient's oxygen saturation reading is 85%. Student does not identify patient's need for oxygen	9	344
Student using mechanical lift does not notice that it is not properly placed and patient is sliding out	10	325
Student fails to disclose a clinical error due to fear of failure or other consequences	11	304
Student assigned to patient A but looks up medications for patient B. Begins to administer patient B's medication to patient A	12	304
Student flushes central line independently before having skill checked and approved	13	298
Student appears sedated when preparing medications in clinical	14	291
Student hangs TPN bag independently and without performing any checks	15	268
Student flushes a PICC without supervision, stating “everyone was busy”	16	268
Student administers larger than normal dose of medication without reviewing lab values	17	257
Student unaware of implications of administering heparin injection to patient on oral anticoagulants	18	252
Student rushes through medication administration omitting some checks	19	251
Student consumes sedatives on evening prior to clinical practice and states she is “still feeling the effects”	20	248
Student administers medications to patient without checking patient's identity arm band	21	245
Student not prepared for patient assignment, stating she is “planning on winging it”	22	243
Student without prior training on dysphagia feeds patient who has dysphagia	23	243
Student unaware of what to expect, or how to intervene when patient condition worsens	24	242
Student unable to perform mathematical calculations necessary for medication administration	25	241
Student assigned to patient with low oxygen saturation but unable to suggest interventions to improve oxygen levels	26	212
Student fails to get high alert medication co-signed 2 days in a row. Student states that she was “too rushed to find the nurse”	27	203
Student breaks sterile technique several times and continues dressing change	28	187
Halfway through clinical shift student leaves facility without telling instructor	29	176
Student ambulates patient incorrectly and too soon after surgery	30	175
Student unable to retain information previously learned and discussed	31	174
Student works a 12-h night shift as an LPN, and arrives to clinical practice still in her uniform and hasn't retrieved any information about assigned patients	32	170
Student unaware of prescribed activity level for a patient with a fractured hip	33	169
A student inserts an endotracheal tube during her operating room observational experience	34	145
Cardiologist asks student who the patient's nurse is, and student responds that she is	35	119
RN tells student to ignore patient request for analgesia and withhold analgesia. Student does so without checking with instructor	36	118
Student attends clinical practice when he is obviously sick	37	114
An attending physician asks student if she would like to hold the paddles to cardio-vert patient and student does so	38	101

Table 5
17 Behaviours That Reached 80% or more Consensus as Most Unsafe for Others.

Student Behaviour (#1 = most unsafe)	Rank	Tally
Student documents administering medication, but in fact, medication wasn't administered.	1	195
Student administers IV morphine, patient becomes unresponsive, student unable to identify what is happening or intervene	2	184
Student works at another job until midnight. Instructor notices that student is tired during clinical practice	3	182
Student fails to disclose a clinical error due to fear of failure or other consequences	4	168
Student using mechanical lift does not notice that it is not properly placed and patient is sliding out	5	148
Patient's oxygen saturation reading is 85%. Student does not identify patient's need for oxygen	6	143
Student works a 12-h night shift as an LPN, and arrives to clinical practice still in her uniform and hasn't retrieved any information about assigned patients	7	122
Student rushes through medication administration omitting some checks	8	120
Student administers medications to patient without checking patient's identity arm band	9	114
An attending physician asks student if she would like to hold the paddles to cardio-vert patient and student does so	10	108
Student without prior training on dysphagia feeds patient who has dysphagia	11	103
A student inserts an endotracheal tube during her operating room observational experience	12	102
Student breaks sterile technique several times and continues dressing change	13	87
Cardiologist asks student who the patient's nurse is, and student responds that she is	14	84
Student unable to retain information previously learned and discussed	15	83
RN tells student to ignore patient request for analgesia and withhold analgesia. Student does so without checking with instructor	16	75
Student misses large number of clinical hours, minimizes importance of attendance, objects to additional clinical hours	17	70

they wanted (placing the most unsafe behaviour in the #1 spot). Fourteen of the 16 remaining participants completed round four (response rate at 88%).

4. Results

To calculate our results, we assigned 38 points to the behaviour ranked number 1 as most unsafe for patients, 37 points to the behaviour ranked number 2, 36 points to the behaviour ranked number 3 and so on for each expert. The procedure was repeated for the 17 unsafe behaviours for others; 17 points to the behaviour ranked number 1 as most unsafe for others, 16 points to the behaviour ranked number 2, and so on. The points for each item/behaviour were tallied (Tables 4 and 5) and displayed as bar graphs (Figs. 1 and 2).

During a reflective and deliberative process, the ranked unsafe behaviours were reviewed to determine what the ranked behaviours (founded on the personal experiences of expert clinical nurse educators) conveyed about their values, beliefs, and expectations, and linked them

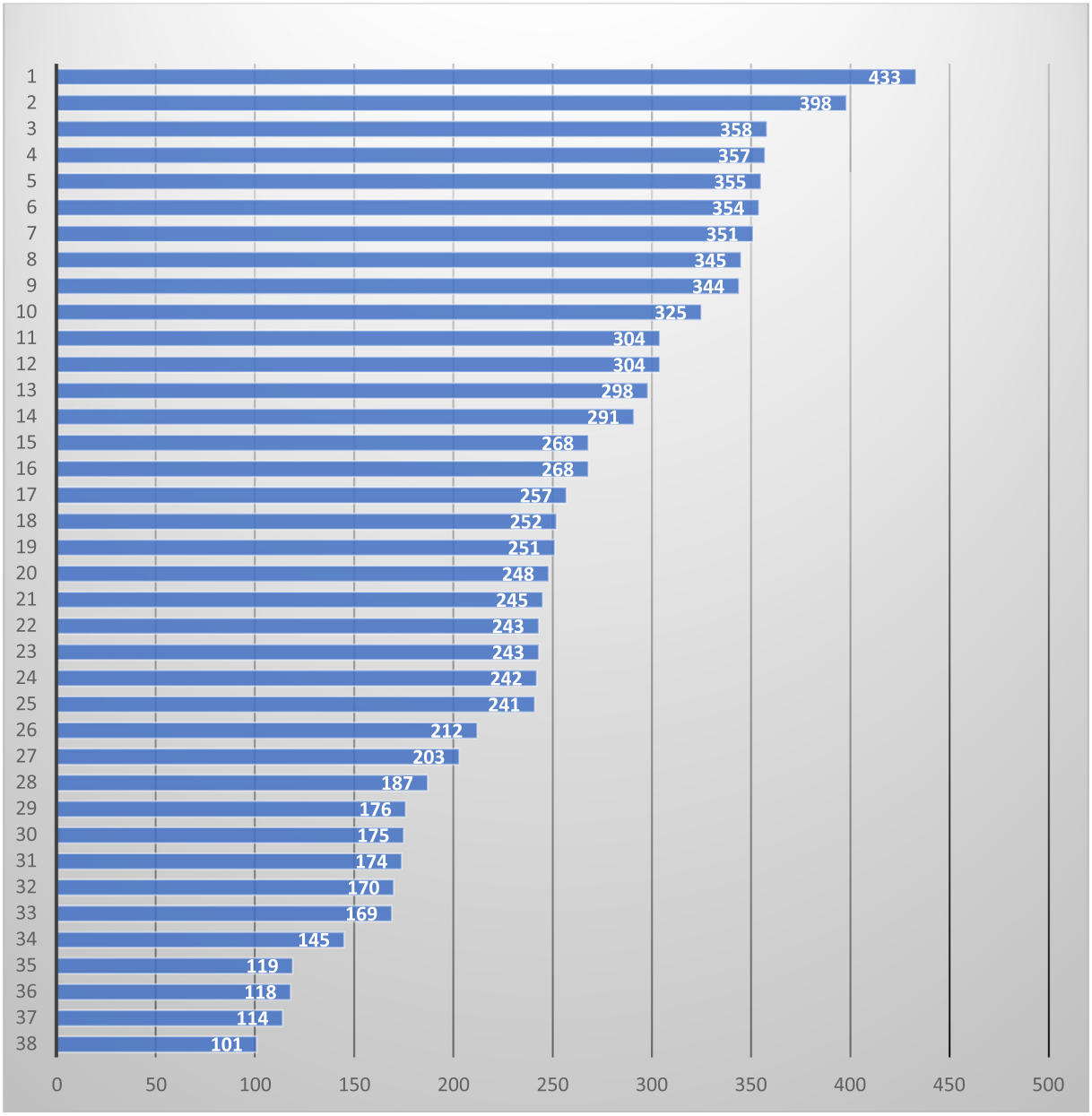

Fig. 1. 38 Behaviours That Reached 80% or more Consensus as Most Unsafe for Patients.
1. Student fabricates a blood glucose reading for an insulin dependent patient.
2. Student removes a chest tube without supervision.
3. Student documents administering medication, but in fact, medication wasn't administered.
4. Student administers IV morphine, patient becomes unresponsive, student unable to identify what is happening or intervene.
5. Student documents adult resting heart rate of 140 bpm but fails to report the finding.
6. Student removes an arterial line unaware that it is not the same as an intravenous catheter.
7. Student reports fictitious data on a head to toe assessment.
8. Student assesses and reports patient's blood pressure as 120/80 when it is actually 190/110.
9. Patient's oxygen saturation reading is 85%. Student does not identify patient's need for oxygen.
10. Student using mechanical lift does not notice that it is not properly placed and patient is sliding out.
11. Student fails to disclose a clinical error due to fear of failure or other consequences.
12. Student is assigned to patient A but looks up medications for patient B. Begins to administer patient B's medication to patient A.
13. Student flushes central line independently before having skill checked and approved.
14. Student appears sedated when preparing medications.
15. Student hangs TPN bag independently and without performing any checks.
16. Student flushes a PICC without supervision, stating “everyone was busy”.
17. Student administers larger than normal dose of medication without reviewing lab values.
18. Student unaware of implications of administering heparin injection to patient on oral anticoagulants.
19. Student rushes through medication administration omitting some checks.
20. Student consumes sedatives during evening prior to clinical practice and states she is “still feeling the effects”.
21. Student administers medications to patient without checking patient's identity arm band.
22. Student not prepared for patient assignment, stating she is “planning on winging it”.

23. Student without prior training on dysphagia feeds patient who has dysphagia.
24. Student unaware of what to expect, or how to intervene when patient condition worsens.
25. Student unable to perform mathematical calculations necessary for medication administration.
26. Student assigned to patient with low oxygen saturation but unable to suggest interventions to improve oxygen saturation levels.
27. Student fails to get high alert medication co-signed 2 days in a row. Student states that she was “too rushed to find the nurse”.
28. Student breaks sterile technique several times and continues dressing change.
29. Halfway through clinical shift student leaves facility without telling instructor.
30. Student ambulates patient incorrectly and too soon after surgery.
31. Student unable to retain information previously learned and discussed.
32. Student works a 12-h night shift as an LPN, and arrives to clinical practice still in her uniform and hasn't retrieved any information about assigned patients.
33. Student unaware of prescribed activity level for a patient with a fractured hip.
34. A student inserts an endotracheal tube during her operating room observational experience.
35. Cardiologist asks student who the patient's nurse is, and student responds that she is.
36. RN tells student to ignore patient request for analgesia and withhold analgesia. Student does so without checking with instructor.
37. Student attends clinical practice when he is obviously sick.
38. An attending physician asks student if she would like to hold the paddles to cardio-vert patient and student does so.

as a group. Four themes emerged: two from a cognitive perspective (the value of honesty and expectation of knowledge) and two from a behavioral/materialist perspective (the value of control and expectation of precision and scrupulousness). Our results suggest that expert clinical nurse educators, above all else, value honesty in their interactions with undergraduate nursing students and control in the clinical teaching/learning environment. They also expect student nurses to possess a certain amount of theoretical knowledge prior to arrival in the clinical setting and they expect scrupulousness and precision in the clinical setting and in the students’ personal lives.

4.1. The value of honesty

Dishonest behaviour was ranked highest or most unsafe for patients and others. While failure of a student to disclose or discuss clinical errors has been previously identified as an unsafe student behaviour (Luhanga et al., 2008; Killam et al., 2010; Tanicala et al., 2011), failure to disclose or discuss is not the same as deceitfulness. In this study, the panel of expert clinical nurse educators agreed that if a student is deliberately deceitful (for example, enters false information in a legal document or fabricates the results of a patient assessment) this type of behaviour is terminal. A terminal behaviour would result in failure, is considered a non-negotiable behaviour or a “breach of contract”, and

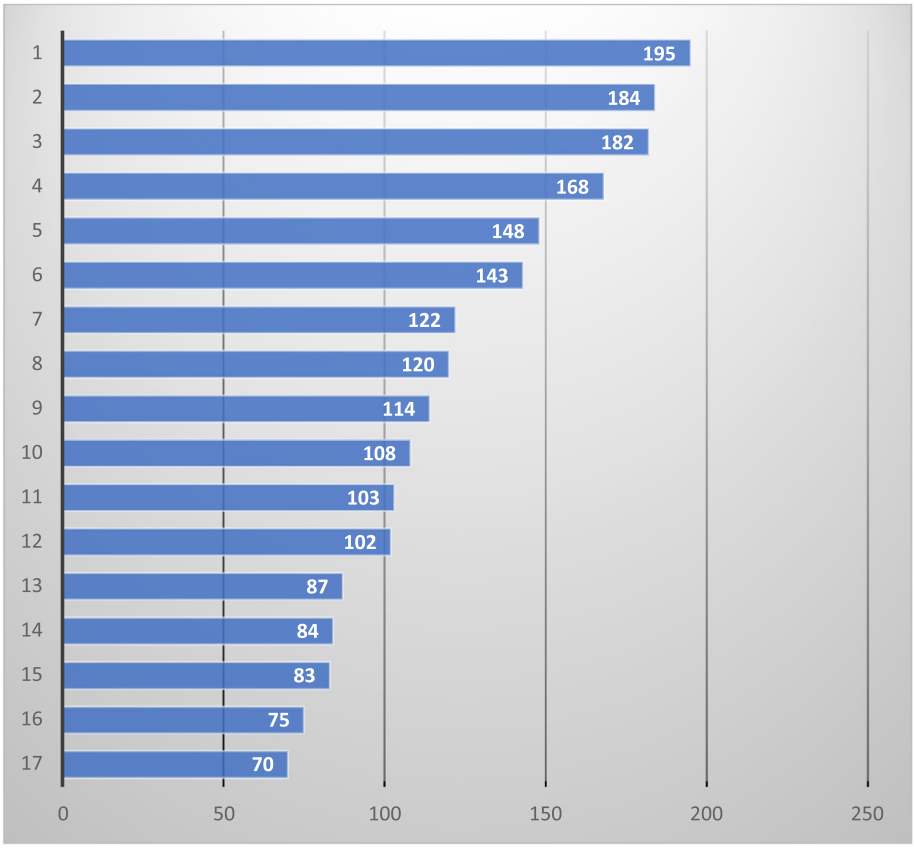

Fig. 2. 17 Behaviours That Reached 80% or more Consensus as Most Unsafe for Others.
1. Student documents administering medication, but in fact, medication wasn't administered.
2. Student administers IV morphine, patient becomes unresponsive, student unable to identify what is happening or intervene.
3. Student works at another job until midnight. Instructor notices that student is tired during clinical practice.
4. Student fails to disclose a clinical error due to fear of failure or other consequences.
5. Student using mechanical lift does not notice that it is not properly placed and patient is sliding out.
6. Patient's oxygen saturation is 85%. Student does not identify patient's need for oxygen.
7. Student works a 12-h night shift as an LPN, and arrives to clinical practice still in her uniform and hasn't retrieved any information about assigned patients.
8. Student rushes through medication administration omitting some checks.
9. Student administers medications to patient without checking patient's identity arm band.
10. An attending physician asks student if she would like to hold the paddles to cardio-vert patient and student does so.
11. Student without prior training on dysphagia feeds patient who has dysphagia.
12. A student inserts an endotracheal tube during her operating room observational experience.
13. Student breaks sterile technique several times and continues dressing change.
14. Cardiologist asks student who the patient's nurse is, and student responds that she is.
15. Student unable to retain information previously learned and discussed.
16. RN tells student to ignore patient request for analgesia and withhold analgesia. Student does so without checking with instructor.
17. Student misses large number of clinical hours, minimizes importance of attendance, objects to additional clinical hours.

cannot be tolerated. Expert clinical educators value morality and expect that all undergraduate students will be moral agents who behave in an honest and ethical manner.

4.2. Expectations of knowledge

The expert clinical nurse educators who participated in this study expect that students will possess a certain amount of knowledge. This knowledge is required to provide safe, competent, and ethical care. When students do not demonstrate the expected knowledge in the clinical setting, their behaviours are considered to be a "breach of contract" and cannot be tolerated. Three types of expected knowledge were evident in the results:

1. Expected theoretical knowledge acquired before students enter the clinical setting
2. Expected theoretical knowledge specific to safe medication administration
3. Expected ability to retain information previously learned and discussed.

An example of expected theoretical knowledge acquired before students enter the clinical setting is that students will know how to accurately measure vital signs in an average healthy adult and will know the parameters of normal vital signs. When students demonstrate that they are unable to accurately measure vital signs or fail to recognize abnormal vital signs, these behaviours are considered to be a "breach of contract".

An example of expected theoretical knowledge specific to safe medication administration is the belief that students who are ready to begin administering intravenous narcotic medication in the clinical setting will possess knowledge about narcotic pharmacodynamics and interventions for adverse effects, that they will be able to perform mathematical calculations necessary for medication administration and will apply pharmokinetic principles.

Finally, expert clinical nurse educators assume that students will be able to retain information previously learned and discussed. When students repetitively break sterile technique, do not have some knowledge of the therapeutic devices used in their clinical settings, or ambulate patients incorrectly or too soon after surgery, these behaviours are not tolerable because students are demonstrating that they have been unable to retain information previously learned and discussed. These behaviours are considered to be a "breach of contract" and unsafe for both patients and others.

4.3. The value of control

Clinical instructors who are employed by a college or university are not usually employed on the nursing units where they teach. Therefore, they are usually outsiders, not part of the nursing unit social culture, and may not be intimately familiar with cultural routines and rituals that include tacit procedures and processes. In order to maintain safety of the patients assigned to their students and their own safety, the expert clinical nurse educators in this study demonstrated that they valued tight control over student activities. Safety for clinical instructors can mean freedom from being chastised or reprimanded (sometimes in front of students) by personnel employed on the nursing unit. For example, an instructor loses control when students perform skills independently but without permission (even if there is no negative outcome), or skills they simply have not learned. An example of a highly ranked unsafe behaviour that illustrates the significance of maintaining control was removal of a chest tube without supervision. This unsafe behaviour was ranked #2.

Most expert clinical nurse educators also value their own choices for student experiences. They hope to choose appropriate experiences that will link theory to practice, and most want to be present to support and mentor students throughout the learning process. Therefore, when students perform skills independently with another health care professional and without preparation or permission, instructors are not in control and not fulfilling a desired and valued role. For example, when an attending physician asked a student if she would like to hold the paddles to cardio-vert a patient and the student did so without permission, the panel of expert nurse educators in this study considered this behaviour to be very unsafe for the patient even though a physician was present. Similarly, when a student inserted an endotracheal tube in the operating room during an observational experience, even though the surgeons were present, the experts in this study clearly ranked the behaviour as unsafe. Expert clinical nurse educators may be more tolerant of extraneous student experiences when they know in advance, are present to supervise the student, are able to mold the learning activity, and could intervene if necessary.

4.4. Expectations of scrupulousness and precision

Expert nurse educators in this study expected scrupulousness and precision in two domains: in the clinical setting when students are performing technical skills associated with medication administration and in the students' personal lives. For example, students who are not scrupulous and precise will omit some checks while administering medications, fail to check a patient's identity band, or neglect to obtain co-signatures before administering high alert medications.

The expert clinical nurse educators also expected that nursing students would have high standards in their personal lives and act with moral integrity. For example, when a student appeared tired on arrival in the clinical practice setting, was still in her uniform from working the previous night and had not retrieved any information about her assigned patients, the experts agreed that his/her behaviours were unsafe and not tolerable. When a student appeared sedated when preparing medications in the clinical setting, or a student admitted to consuming sedatives the evening prior to clinical practice and stated that she was "still feeling the effects", these behaviours were also not tolerable. Finally, when a student left the clinical setting halfway through a clinical shift without telling the clinical instructor, the student's behaviours most likely demonstrated not only lack of moral obligations for patient safety but lack of respect for the instructor's need to know.

5. Discussion

Most clinical nurse educators value their role in helping nursing students become successful practitioners. This study highlighted how important it is for clinical instructors to review their values and expectations with undergraduate nursing students at the very beginning of a clinical rotation: the value of honesty during interactions, the expectation of a certain amount of theoretical knowledge prior to arrival in the clinical setting, the need to maintain a level of control, and the expectation of scrupulousness and precision. For example, while acknowledging that many students feel overwhelmed with the large amount of theory content generally delivered to them over short periods of time, clinical instructors can also point out that it is extremely difficult to help students link theory to practice in a clinical setting if students do not have the theoretical knowledge prior to practice. Clinical instructors may also wish to review patient diagnoses and conditions commonly seen on particular nursing units to help students become familiar with the nursing assessments and interventions required for particular patients. After a review of commonly occurring practical skills, students who are still struggling should be offered extra time in a nursing laboratory to practice skills.

Promoting a culture of honesty was also highlighted in the results. Clinical instructors may wish to inform students that some mistakes are expected, that it is okay to make mistakes, but that mistakes should be discussed openly. A relationship between student and instructor that is built on trust is a way of lessening fear of disclosure (Gillespie, 2005)

and reducing the need for fabrication. Clinical instructors play an integral role in creating a safe space for learning.

It is also important to be clear about guidelines and policies, especially pertaining to the scope of practice for students. Clinical instructors may wish to review student guidelines, scope of practice for students, and unit specific routines and policies with the nursing students more than once. Finally, clinical instructors must role model appropriate behaviours that support scope of practice and uphold nursing standards.

6. Conclusion

Ongoing support and guidance for novice instructors is becoming increasingly important as the size of student clinical groups at some nursing schools expand due to fiscal constraints.

As safety gatekeepers, novice clinical instructors need to be prepared with up-to-date information about potentially unsafe student nurse behaviours. Our results of potentially unsafe behaviours may be useful during educational/professional development workshops. Ongoing support and guidance and frank discussions about specific unsafe behaviours that experts find intolerable may also help to foster the retention of new clinical instructors.

It is theoretically possible to use the results of this study to create a standardized tool such as a check list that could be used by clinical novice instructors during evaluations of students who are potentially unsafe. Novice instructors may also wish to extrapolate from the list of identified unsafe student behaviours to fit their own clinical situations. For example, the descriptor about total parenteral nutrition is equally relevant to chemotherapy or heparin infusions. The results could be featured in video-recorded vignettes of unsafe behaviours. Students could watch the videos and create their own lists of all the unsafe behaviours they have observed.

Researchers may also wish to use the findings in other studies aimed at illuminating the motivations behind unsafe behaviours. Additional suggestions for future research include: another study using the same Delphi techniques but aimed at seeking the perceptions of preceptors who are employed in facilities where nursing students are present, a Q methodology study with students or clinical nurse educators using the ranked items, or the development of a questionnaire for students or nurse educators using the ranked items.

7. Limitations

The expert participants in this study were recruited from one Canadian urban college and one Canadian university. All were women, and most were Caucasian. The results, therefore, may not reflect the views of male clinical nurse educators, rural educators, or educators from other cultural backgrounds. In addition, the results reveal the cultural perspectives of clinical nurse educators who taught only undergraduate baccalaureate nursing students. The cultural perspectives of clinical nurse educators who teach in diploma or associate nursing programs, or who teach practicing nurses may differ. Furthermore, clinical nurse educators were the only participants. Baccalaureate nursing students, preceptors, and staff nurses were not invited to contribute their perspectives of unsafe student practices. Therefore, while the results may be transferable to similar settings, they are not generalizable. The purpose of this study was to develop new knowledge about unsafe student nurse behaviors from the perspective of nurse educator experts. The hierarchy of unsafe behaviors developed using a consensus panel may provide a valuable foundation for further research and development of educational practices on this topic.

Funding

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Appendix

List of 136 Potentially Unsafe Behaviours Identified During the Exploration Phase.

1. A student has not been taught how to remove an intravenous (IV). In the clinical setting, a staff nurse asks the student to remove an IV and the student does so, without seeking guidance from the clinical instructor.
2. Just before removing an indwelling urinary catheter, a student tells the patient that the catheter is 3 feet long.
3. A student removes an arterial line and is unaware that an arterial line is not the same as an intravenous catheter.
4. A student is employed as a care aide and transfers a patient before being taught the skill in the undergraduate program.
5. A student does not ask any questions in the clinical setting but at the same time, exhibits a cavalier attitude.
6. A student exhibits a cavalier attitude about a skill learned in lab but is unable to demonstrate the same skill in the clinical setting.
7. A student is showering a hemiplegic patient and leaves the patient alone in the shower in order to complete another task.
8. A student fabricates a blood glucose reading for an insulin dependent patient.
9. Half way through a clinical shift, the student leaves the clinical facility and goes home without informing the instructor.
10. A student appears sedated when preparing medications in the clinical setting.
11. A student appears inebriated in the lab when doing clinical skills testing.
12. A student has not been taught how to perform a dermatome assessment. In the clinical setting, the student performs a dermatome assessment on a patient, and when questioned, the student states she had watched the nurse and “it wasn't hard to figure out".
13. A student rushes through medication administration and omits some of the medication checks.
14. A student hangs out at the nurse's station talking with staff instead of engaging with the patients.
15. A student declines to perform a skill in the clinical setting when asked to perform it. When questioned, the student states he does not need any further practice.
16. A student enthusiastically offers to teach a skill to a peer. The same student, however, has not received instruction on that particular skill.
17. At the patient's bedside, a student contaminates the sterile field multiple times. The instructor has to take over and finish the procedure.
18. A student has not completed all aspects of a head to toe assessment, but to demonstrate capability, the student reports fictitious data.
19. A student assesses a patient's blood pressure and reports it as 120/80. The instructor is suspicious so assesses the same patient's blood pressure and the result is 190/110.
20. A student complains about repetitious classroom content and does not complete assignments. The same student is unable to apply the theory in the clinical setting.
21. A student sits at the nursing station and complains that there is nothing to do. The call bells are ringing and the student's assigned patient has not had personal hygiene performed.
22. A student arrives at the clinical setting 1 min prior to the start time or late with excuses.
23. A student does not lift the patient's gown to listen to heart and lung sounds.
24. A student hides from his or her instructor or staff.
25. A student is texting in the nursing station because she has “done everything” when in actuality patient care was not complete.
26. A student is offered an opportunity to practice urinary catheter

insertion and student states “been there-done that".

27. A student is assigned to look up information in preparation for clinical practice. It is obvious to the instructor that the student hasn't looked up the information. When questioned, the student states, she is planning on “winging it".
28. A student states he has given report of his patient assessment and care to the primary nurse. The primary nurse states that report was not received. The student responds that the primary nurse is not telling the truth.
29. A student is unable to perform a skill in the clinical setting. The instructor asks, “Have you practiced this skill in the lab?” Student replies “No".
30. A student cries and shakes and is unable to initiate a given task or communicate with patients.
31. A student avoids eye contact and fidgets when interacting with others.
32. A student exhibits self-loathing behaviour when unable to perform nursing care that has been previously taught.
33. A student reads and rereads the Medication Assessment Record without finding what he is looking for.
34. A patient has no bowel sounds, distended abdomen, and explosive vomiting. The student is unable to explain why this patient would require a nasogastric tube.
35. A patient states to the student, “I've lost lots of weight since my hospitalization”. The student does not perform a nutritional assessment.
36. A student has missed a large number of hours of clinical practice due to “illness".
37. A student is performing a procedure and describes aloud every step of the procedure in front of the patient.
38. A student is drawing up insulin but is unable to remove air bubbles, so reinserts the needle multiple times dulling the needle.
39. A student who has been assigned to a diabetic patient is unable to get enough blood from the patient's finger for the glucometer reading. Instead of seeking help, the student continues to poke repeatedly on the patient's finger.
40. A student is 15 min late administering medication and begins to cry in front of the patient. When asked by the patient “What is wrong?” the student begins to laugh inappropriately.
41. A male student on a maternity unit comments to the new mother who is breastfeeding that he likes to put his baby onto his breast so he knows what it feels like to have the baby suckle and to have sore nipples.
42. A student calls a patient who is in his sixties “dude".
43. A patient with dementia asks a student “Where am I?” The student says to the patient, “I just told you that you were in the hospital remember?"
44. A student is providing care to an older Aboriginal patient. The student repeatedly asks the patient to describe details about her time in residential school.
45. A student's negative demeanor impacts the mood of the entire clinical group.
46. A student repeatedly asks a patient in pain what his pain level is. The patient asks “Why do you keep asking me that?” The student replies, “Because I need to know - that's why".
47. A student who is having a meal in the hospital cafeteria is overheard speaking negatively about instructors, patients and staff.
48. A student flushes a peripherally inserted central catheter (PICC) line without supervision. When questioned, the student states “Everyone was busy".
49. A student texts her boyfriend during post-conference.
50. A student gives an instructor the middle finger and tells the instructor that she is the worst instructor ever and that she is not supportive.
51. A student uses medical terms when speaking with a patient instead of using plain language.
52. A student is performing a wound packing and states, “That looks so bad! What is that?"
53. Two students talk over a patient about the personal care they just completed on the same patient and discuss the patient's bowel movement.
54. An elderly patient is being transferred in a mechanical lift and begins to have a bowel movement. The student asks, “Is that supposed to happen?” (pointing at the patient and making sounds of disgust).
55. An older patient is hard of hearing and the student does not speak loudly enough for him to hear what she is saying.
56. A student is part of a dyad assigned to a patient. This student does not take part in the assessment and instead stares off into the distance the entire time.
57. Rather than providing patient education about medication timing and necessity, the student tells the patient that he should “Just trust the doctor".
58. A student needs continuous reminders to articulate assessment findings clearly and accurately.
59. A student pulls at a patient's wrist in order to look at the patient's name band, without explaining what she is doing.
60. When changing an incontinence pad for a patient with clostridium difficile, the student gags in front of the patient.
61. A student rolls her eyeballs and sighs with impatience as the patient moves slowly or hesitates.
62. A student sits on the side of a desk, running her hands through her hair, as she asks the physician to order something for her patient.
63. A student does not report to the nursing team. When questioned, the student states, “I'm afraid of the nurse".
64. A student enters a patient's room without asking for permission from the patient or the nurse, in order to watch procedures that the student deemed “cool to see".
65. A student exposes a patient's perineum and begins to wash the area without speaking to the patient about the procedure/process.
66. A student finds a patient halfway fallen out of bed. Instead of asking for help from the nurse who is in the room, the student asks another student to find the instructor while holding the patient to keep him from falling out of bed.
67. A patient rings her call bell frequently. The student assigned to this patient delays answering the call bell and becomes loud when providing the patient with explanations.
68. A student writes negative comments about a patient in her reflective journal.
69. Staff at the nursing station are overheard speaking disparagingly about a patient. A student assigned to the same patient also begins to speak disparagingly about the patient.
70. A nurse instructs a student to ignore a patient's request for analgesia and to withhold analgesics from this patient. The student follows these directions without questioning the instructor.
71. A student is unable to perform mathematical calculations necessary for medication administration.
72. An adult patient has a resting pulse rate of 130 beats/minute. The student assigned to this patient is unable to interpret the meaning of the patient's pulse rate.
73. A student doesn't know what to expect or what interventions to perform if a patient's condition worsens.
74. A student administers a larger than normal dose of medication to a patient without questioning or reviewing appropriate lab values.
75. A student is unable to describe the implications of administering a heparin injection to a patient who is already receiving oral anticoagulants.
76. A student does not check medication administration records throughout the day for new orders and misses orders.
77. When looking at a patient's lab values a student is unable to identify significant laboratory values.
78. A student is assigned to a surgical patient and is unable to describe

the surgery, other than saying “It is some kind of head surgery".

79. A student is assigned to a patient with a heart murmur. The student is not able to hear the murmur or articulate associated patient risks.
80. A student is assigned to administer an ACE inhibitor to a patient. The student is unable to explain the reason for the prescription or how ACE inhibitors work.
81. A student places her hand in the center of a sterile dressing field, places her hand in the garbage, and then goes back to the sterile field to continue the dressing.
82. A student begins to lift a patient with a mechanical lift. The instructor notices that the sling is not properly placed and that the patient is slipping out.
83. A student washes a patient's perineum first, and then uses the same cloth to wash the patient's face.
84. A student is unable to successfully draw up medications from vials or ampoules.
85. A student administers medications to a patient without checking the patient's identity by reading the patient's arm band.
86. A student leaves the keys in the narcotic drawer of the medication cart and the drawer is left open.
87. A student is assigned to patient A but looks up medications for patient B. The student begins to administer patient B's medications to patient A.
88. A student does not obtain consent from a patient before beginning to wash the patient's perineum.
89. A student works at another job until midnight. In the morning, the instructor notices that the student is tired during clinical practice.
90. A student arrives at the clinical setting the evening before clinical practice in order to look up details about her assigned patients. The nursing staff notice that this student smells of alcohol.
91. A student falls asleep during post-conference.
92. A student forces a patient to take a bath.
93. A student is assigned to a patient who does not want his prescribed medication. The student hides the prescribed medication in the patient's food while the patient is sleeping.
94. A student is assigned to a patient whose family do not want him to receive prescribed intravenous medication. The student administers the prescribed intravenous medication while the family is out of the room.
95. A student does not complete all required assignments on time.
96. A student attends clinical practice when he is obviously sick.
97. A student in the clinical practice setting is lethargic, has dilated pupils, and slurred speech. The student admits to consuming sedatives the evening prior and states that she is “still feeling the effects".
98. A student is unable to accurately transcribe medication changes into a patient's chart.
99. A student is asked by the cardiologist who the patient's responsible nurse is, and the student responds that she is.
100. A student shows up to clinical practice without student identification, a stethoscope, watch, pen, or flashlight.
101. A student performs an assessment and documents the patient's resting heart rate of 140 beats/minute without telling the instructor or nurse of the findings.
102. Over three consecutive weeks, a student is assigned to three patients who have all had the same surgery-transurethral resection of the prostate (TURP). This student is unable to retain information previously learned and discussed.
103. A student is preparing to perform a skill and makes several trips to the supply room to gather supplies.
104. A student is unable to verbalize required nursing care for a patient with an epidural infusion.
105. A patient's oxygen saturation reading is 85%. The student assigned to this patient does not identify the patient's need for oxygen.
106. A student documents administering a medication to a patient, but in fact, the medication wasn't administered. When questioned, it becomes obvious to the instructor that the student seems dishonest and misleading.
107. For two consecutive days, a student administers a high alert medication without having the medication co-signed. When questioned, the student responds that she was too rushed to find the nurse to co-sign the medication administration record.
108. A student reports to her instructor that her patient has an epidural infusion of fentanyl. In reality, the patient has an intravenous patient-controlled analgesia (PCA) of Hydromorphone.
109. A student flushes a central line independently before having this skill checked and approved in lab or the clinical setting.
110. A student removes a chest tube without supervision.
111. A student discusses her personal life and personal insecurities with others during clinical practice.
112. A student fails to disclose a clinical error with her instructor. When questioned, she states that she withheld the information due to fear of failure and/or consequences (a learning contract, not able to go to Africa or out of region).
113. A student completes a 12-h night shift as a licensed practical nurse (LPN). The student arrives at the clinical practice setting still wearing her uniform from the night before. The student appears very tired and says she has not retrieved any information about her assigned patient's because she has been working all night.
114. From a list of available analgesics, a student is unable to choose an appropriate analgesic for his patient.
115. A student is unable to decide whether or not to hold a blood pressure medication for her patient.
116. A student is told by her instructor to be prepared and have all supplies gathered by 10 o'clock to perform a dressing change. The student is not ready to go and misses out on the learning opportunity.
117. A student is unable to assess, provide personal care, or document on one patient before the end of a 7-h shift.
118. A student administers a medication late to a patient because the patient was away from the unit to receive an X-ray.
119. A student writes in her reflective journal that she had an exciting day in the emergency department. A patient presented with an irregular heart rhythm and required cardio-version. When the attending physician asked the student if she would like to hold the paddles, she did so.
120. A student inserts an endotracheal tube during her operating room (OR) observational experience.
121. A student hangs a new total parenteral nutrition (TPN) bag without performing any of the checks. She has been taught in class that TPN needs to be checked by an RN but stated that she couldn't find anyone. The IV pump alarm was ringing, and she knew how to change a regular IV bag, so she went ahead and did it independently.
122. A student removes an intravenous (IV) catheter independently. She has been taught the theory portion of the skill but has not practiced the skill in lab.
123. A student arrives in the clinical setting wearing street clothes. When questioned, the student states that he did not have time to wash his uniform.
124. A student applies a cream to a patient but does not recognize that it is a prescribed medication.
125. A student administers intravenous morphine and the patient's respiratory rate slows drastically. The patient becomes unresponsive. The student is unable to identify what is happening or what to do.
126. A student contaminates his forceps while performing a sterile dressing change and is unable to problem solve/decide what to do.
127. A student's assigned patient has a low oxygen saturation level. The student is unable to suggest any interventions to improve the patient's oxygenation.

128. A student is assigned to 2 patients. The student must perform full personal care, administer medications, and complete a simple dressing change. The student is late administering medications, late for charting, and has to delegate the dressing change to another student.
129. A student is assigned to a patient with dysphagia. At meal time, the student feeds this patient even though she has not had any previous training on this skill.
130. A student takes 45 min to perform a complete head to toe assessment on his patient.
131. A student routinely misses breaks or does not take any breaks during an entire shift.
132. A student has difficulty speaking with patients or touching patients' bodies to perform care.
133. A student leaves several pieces of paper-notes, cue cards, and a folder with patient information in a medication binder.
134. A student who is assigned to a post-operative patient ambulates this patient incorrectly and too soon after surgery.
135. A student is unable remember how to roll an immobile patient to change an incontinence brief, or place a sheet or sling under the patient.
136. A student who has missed a number of clinical hours minimizes the importance of attendance and objects to additional clinical hours.

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