Slide 1

Mentoring through Performance Failure – Classroom to Clinic to Residency

Tara J. Manal, PT, DPT, OCS, SCS, FAPTA
Laura A. Schmidt, PT, DPT, OCS, SCS, ATC
Leslie O’Neill, PT, DPT, NCS

Slide 2

INTRODUCTION

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Slide 3

Clinical Competence

• “Degree to which an individual can use the knowledge skills and judgment associated with the profession to perform effectively in the domain of possible encounters defining the scope of professional practice.”

Kane Eval Health Prof 1992
Miller G Research in Med Ed 1990

• Competence – Retrospective, multi sources of information “knows how”
  – Didactic coursework
  – Answers well

• Performance – Assessed concurrently with feedback provided, “shows how”
Definitions of Safe vs Unsafe Clinical Practice

Safe Clinical Practice:
- Students are expected to demonstrate growth in clinical practice through the acquisition of knowledge and skills. Formulation and documentation of clinical practice outcomes must be consistent with the primary health care needs of the patient. Practitioner must consider potential adverse effects of the interventions. Evaluation is used to enhance practice. (From PNAC: Accreditation Standards for Nurse Education Programs in Primary Care, 1993; Nursing Outcomes Classification: The Language of Nursing Practice, 1996.)

Unsafe Clinical Practice
- The historical setting within a hospital or the health care setting where the patient is being cared for must be considered. The environment must be safe and free from potential hazards. The practitioner must consider the patient’s overall health status and the potential effects of the interventions. Evaluation is used to enhance practice.

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Where are ....... ?
- Your Faculty?
- Academic
- Residency/Fellowship
- Your Clinical Ed Team?
- Your Clinical Instructors/Mentors?
- Community Partners?
- You?

Clinical Performance Failure
- Not a topic typically discussed
- Recognition that not all students will be successful
- Share clinical instructors' challenges and examples
- Suggest ideas to consider to improve the collaboration between CI/mentors and faculty liaison
- Protect the public from unsafe practitioners
- Maintain minimal standard (Residency/Fellowship)

Hrobsky receptors Perceptions of clinical performance failure J of Nursing Ed 2002
Slide 7

Slide 8

Legal Issues in Evaluation

- University of Missouri v. Horowitz, Supreme Court 1978
- Upheld dismissal for clinical performance, poor progression and interpersonal issues
- Explicit written procedures given before entering program
- All students treated equally
- Evaluations have detailed records with examples
- Student was provided feedback throughout and ultimately given notice and shown results of evaluation
- Right to confront the evaluator and if fails the formal review process exists

Kapp Legal issues in Faculty evaluation of student clinical performance J of Med Ed 1981

Slide 9

Rights

Faculty

- Evaluate students
- Determine a grade
- Remove student from clinical area when they are judged to be unsafe
- Question professional suitability

Students

- Expect timely receipt of information about clinical performance
- See and hear supporting evidence of their evaluation
- Receive oral and/or written specific reasons for failure or debarment from practice
- Receive reasonable notice of decision
- Be assisted by person of their choice in appeal or professional unsuitability hearing
- Have objections of process included as part of the permanent written records

- Be assisted by person of their choice in appeal or professional unsuitability hearing
- Have objections of process included as part of the permanent written records
Slide 10

### Duties

<table>
<thead>
<tr>
<th>Faculty</th>
<th>Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adequately prepare students</td>
<td>• Provide safe care</td>
</tr>
<tr>
<td>• Treat students fairly</td>
<td>• Understand expectations for safe practice</td>
</tr>
<tr>
<td>• Adequate exam of evidence and ability to practice</td>
<td>• Prepare for practice</td>
</tr>
<tr>
<td>• Apply evaluation criteria and standards</td>
<td>• Know personal limitation in practice</td>
</tr>
<tr>
<td>• Clarify criteria to students</td>
<td>• Maintain appropriate documentation</td>
</tr>
<tr>
<td>• Document decisions to fail, dismiss, judge unstable</td>
<td>• Ensure safe and professional patient care</td>
</tr>
<tr>
<td>• Provide information to student on performance and appeal</td>
<td>• Provide information to student on performance and appeal</td>
</tr>
</tbody>
</table>

Slide 11

### Instructor/Mentor Administrative Pitfalls

- Common Rating Errors
  - Leniency/Severity (doves/hawks)
  - Range Restriction (central tendency around avg.)
  - Halo Effect – tendency of rater to give similar evaluations to separate aspects of person’s performance
- Documentation/Procedure Errors
  - Unwillingness to record – evaluations
  - Dilution of negative assessments
  - Insufficient feedback to resident/student
  - Failure on supervisor to use evaluation criteria

Slide 12

### Administrative Solutions

- Enhance Data
  - Standardizing observation of behavior (get 2nd observer)
  - Common nomenclature/evaluative definitions
  - Inter-rater agreement
- Frame of Reference training
  - Senior person reviews with less experienced their rating
  - Samples of good and unacceptable provided
  - Discuss strategies to improve performance together
- Modules
  - Videos
Slide 13

Clinical Educator Stress

- Failing a student is ranked as 1st or 2nd most onerous responsibility
  - Dread and stress of making decision
  - Not influenced by training course

- Time is next
  - Preparation
  - Program planning
  - Supervision
  - Feedback

Ilott Ranking the problems of Fieldwork supervision reveals a new problem: Failing students Br J of OT 1996

Slide 14

CI Perspective on Failure

- Medicine
  - Lack of documentation
  - Inadequate or concrete evidence
  - No day-to-day record of performance
  - Lack of knowledge of what to document or time to observe behaviors
  - Anticipation of appeal and legal action or even time needed for appeal process
  - Lack of remediation options (knowledge and overestimation of impact on trainee future)

- Lack of faculty support with appeal process

- Faculty who pass students even when provided information from the onsite CI/Mentor
  - Message received by CI/Mentor “It doesn’t matter what you think”

Dudek Failure to Fail: The perspectives of Clinical Supervisors Academic Medicine 2005

Slide 15

CI Personal Factors

- CI/Mentor belief students need time to learn and failure early in training does not give them a chance to succeed
- Reticence on part of CI’s to identify or resolve student problems early
- Lack of conviction in decision

- Caring profession
  - Perceived as uncaring/guilty
  - Their failure reflects my failure in teaching
  - Student personal cost
  - Killing career
- Threat of University appeals system

Luhanga F Failure to Assign Failing Grades; Issues with Grading the Unsafe Student 2008
Scanlan Dealing with the Unsafe student in clinical practice Nurse Educator 2001
Slide 16

Responsibility Conflict

• CI’s as gatekeepers of the profession
• Stop borderline students who engage in unsafe practice from becoming licensed practitioners
• In nursing, noted in multiple studies that clinical educators are not trained and reluctant to assign a failing grade
• (Boley & Whitney, 2003; Cowburn, Nelson & Williams, 2005; Dudek, Marks & Regehr, 2005; Duffy, 2004; Heavey, 2003;Scanlan et al. 2001)

Duffy 2004

Slide 17

Is our message clear?

• The main motive to fail a trainee ....
  – Public to ensure safety
  – Profession to protect it’s reputation
  – Allow trainee the opportunity for remediation and success
• Clinicians over estimate the impact

Slide 18

Empowering Instructors/Mentors to Act

• Institution Faculty role
  – Listening
  – Being supportive
  – Following up after the experience
• “I kept thinking about it over and over in my head and I remember you called me perhaps it was a few days later. Well it was just the last thing I needed to know. I was okay. I didn’t kill somebody. I killed somebody’s career. When you called back a few days later, it was like I did the right thing’’
Slide 19

Instructor/Mentor Pearls to Remember When Dealing with a Failing Student

• CI’s provide students with opportunities to demonstrate and practice
  • If performance is not acceptable, progression is not possible
  • Students may deny that they are struggling. Focus on the facts.
  • “This one is not a fail; This is a test”
  • Struggling student may express external opinions despite performance consistency
  - Am the student’s expectations Unrealistic?
  • CI’s do not “fail” students. Students “fail” to meet the standards.
  • CI’s have a professional obligation to accurately assess students who do not have the skills and behaviors reflective of safe clinical practice
  • Most students who do not pass, successfully complete remediation and ultimately succeed. Many are appreciative because they recognize the difference in their skill level and career potential.

Diekelmann Students who fail clinical courses: Keeping an Open future of New Possibilities J of Nursing Ed 2003

Slide 20

Personality Traits in Clinical Failure

• Rigidity of thinking
  - Inability to cease using strategies that do not produce desired results and adopt new, more functional strategies (also increased stress with schedule and supervisor changes)
• Lack of psychological insight
  - Inability to identify and interpret one’s emotions, motivations and personality traits. Difficulty interpreting and understanding one’s own response to environmental demands. Difficulty in the ability to create ability to meet clinical and professional challenges
• Difficulty interpreting feedback
  - Understand other’s responses in relation to one’s own behavior and modify inappropriate behaviors based on feedback alone (reported unfair treatment)

Gutman Student Level II Fieldwork Failure: Strategies for Intervention Am J of OT 1998

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Behavioral Styles of Clinical Failure

• Discomfort with the ambiguity that accompanies clinical reasoning
  - Difficulty accepting more than one treatment method is appropriate for the same clinical problem (not just correct answer). Increased frustration at trying to master alternative solutions to a single clinical problem
• Difficulty learning from mistakes
  - Students consistently implement the same ineffective cognitive/behaviors. (Wrong choices because could not rethink dysfunctional approach for functional and)
• Discomfort with the physical handling of patients
  - Insufficient patient safety with transfer, mobility, nursing. At’s are unable to be left unsupervised
• Dependence on external measures for self-esteem
  - Lapse of value to grades and clinical evaluations as criticisms of performance is seen as criticism of themselves.

Gutman Student Level II Fieldwork Failure: Strategies for Intervention Am J of OT 1998
Slide 22

Solutions to Identified Problems

• Professional behavior and interpersonal skill training
• Faculty feedback to students regarding problematic behaviors
• Clinician counseling with identified students
• Student remediation programs of community service
• Student learning contracts based on specific behavioral objectives

*Gutman Student Level II Fieldwork Failure: Strategies for Intervention. Am J of OT 1998*

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CLINICAL PERFORMANCE ASSESSMENT

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Clinical Performance Activities

• Examining information is needed to identify a patient’s problem
• Establishing data for the patient’s history, taking a physical examination, diagnostic tests
• Identifying, interpreting, and summarizing patient data to derive working diagnoses
• Establishing management goals and evaluating the effectiveness of treatment
• Establishing treatment plans, managing the patient’s care
• Communicating and relating effectively with patients and their families
• Working effectively with other health professionals under the range of conditions
• Critically appraising new information for adequacy, quality, and veracity
• Storing personal knowledge and skills and updating them in an efficient and effective manner
• Performing consistently in a dependable and irreversible manner

Slide 25

**Learning the Student**

**Watchful Listening**

- Watching how the student approaches the day and organizes
  - Timeliness
  - Demonstrates dependability
  - Respect for others
  - Liveliness
  - Approach and interaction with patients (facial and body language)

Rittman Interpretive Analysis of Precepting an Unsafe Student J of Nursing Ed 1995

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Slide 26

**Learning the Student**

**Assessing Dangerousness**

- Trust: the student will seek assistance when necessary (impacts level of independence)
- Completeness of care: student is “finished” but key components are missing (evaluative findings, treatment components, managing the clinical area)
- Performance consistency
  - Reporting accuracy
  - Notion that issues and changes in status
  - Priority setting for care and safety
  - Ability to critically question own practice and accurately determine what they know and do not know

Rittman Interpretive Analysis of Precepting an Unsafe Student J of Nursing Ed 1995

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Slide 27

**Early Warning Signs**

- Attitude/Behavior
  - Unenthusiastic
  - Unprofessional
- Not asking questions
- Inability to recognize difficulties and make changes
- Failure to seek help as needed

Tactical Pass/Fail Nursing Student Clinical Behaviors Phase 1: Moving Toward a Culture of Safety Nursing Ed Perspectives 2010
Other Early Warning Signs

- Profound content deficits identified
- Difficulty with basic skills
  - Introducing self
  - Room set up
  - Safety
- Lack of...
  - Accountability
  - Initiative
  - Empathy
  - Preparation
  - Not prepared, why?

Reasons for Poor Student Performance

- Sleeplessness
- Depression
- Learning disabilities
- Abusive relationships
- Childcare concerns
- Transportation difficulties
- Family stresses
- Financial limitations
- Academic Faculty
  - Facilitate referral for appropriate services

CI Assessment of Student Challenges

- Identify any and all components contributing to challenges the student is experiencing
- Differentiate content deficits from non-content deficits (emotional, affect, communication) impacting performance
- We have more confidence identifying and addressing objective deficits (knowledge, psychomotor skills, safety) but we need to be equally able to address any performance deficit as they occur.
Slide 31

You recognize there is a problem but what is/are the root problem(s)?

- Communication
- Professionalism

Once challenging component(s) can be addressed a plan can be set up

What help do you need and what is to be achieved in the clinical setting?

Slide 32

Content Problem

- Lack of retention of previously learned skills/knowledge
  - Inability to measure ROM
  - Inability to remember or reference specific tests and clinical prediction rules
  - Difficulty recalling anatomy
  - Difficulty recalling indications or contraindications
- Inability to process knowledge reviewed in clinic (acquisition)
  - Inability to apply knowledge from one patient to a similar novel patient
- Inability to provide differential diagnosis considerations

Slide 33

Content Activities

- Allow student time to practice on aide
- Provide student with “homework” to review content
- Guide the student to connect similar things to previous patients
- Provide verbal discussion on content specific challenges (e.g. body structure/patterns)
- If profound deficit, ability may be too low for safe practice to continue
Performance Problem

- Performance deficits
  - Unable to perform under real clinical conditions vs. classroom
  - Can describe but unable to observe movement including gait pattern, functional assessment, and recognizing substitution/compensation patterns
  - Difficulty with time management in clinic impacting doing what they can articulate is needed
  - Safety challenging with performance (poor or absent guarding) or recognition of status changes
  - Can say what to do but doesn’t do those things in the moment

Execution
- Basic skills (room set-up, safety)

Performance Activities

- Practice
- Paper cases/scenarios
- Case load reduction
- Do portions of treatments
- If the CI cannot trust that the student can be safe, the CI may need to “call it” and say the student cannot be in their facility.
  - To be discussed in greater detail later.

Professionalism Problem

- Accountability
  - Poor responsibility for learning
  - Lack of accurate self-reflection

- Accepting feedback

- Lack of preparation
### Slide 37

**Defense Mechanism in Response to Environmental Demands**

- **Externalization of responsibility**
  - Displacement of accountability onto others because unable to assume own obligations and duties (blame CI, patient or school for actions)
  - Used to justify one’s behaviors and preserve one’s sense of self

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### Slide 38

**Professionalism Activities**

- CI models the behavior they are expecting of the student.
- Practice
  - Provide clear expectations/outline of how to prepare.
  - Verification/confirmation – at the end of the day can the student accurately identify the top 1-2 things that went well and that need to improve.

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### Slide 39

**Communication**

- **Verbal**
  - Has difficulty with interactions
    - Between self and patient
    - Between self and CI
  - Doesn’t articulate what they are thinking
  - Difficulty accepting feedback (resistive/dismissive)
- **Non-verbal**
  - Lacking eye contact
  - Blank stares
Communication Activities

• Model
• Practice
• Scenarios
• Further provide questioning to assist with developing communication skills
• Develop cue to inform the student when non-verbals are presenting

Continued Patient Treatment through Failure

• There may be benefit to beginning to develop some skill sets even though there is too much of a gap to meet passing criteria for the experience.
• Communicate clearly with the student.
• Limiters: Safety and patient confidence

ONGOING FEEDBACK – JUST THE FACTS
Slide 43
Focus on the Facts

- "Student is lazy and irresponsible"
  - "The student did not review the new patient’s chart nor did they review their tests and measures associated with the condition. They could not articulate the precautions or contraindications associated with the condition nor could they prioritize the top tests and measures to be performed or the differential diagnosis to be ruled out."
- Another role here for senior CI’s or faculty to assist in translation eliminating emotions.

Slide 44
It’s All In The Wording

- Monitor performance with objective facts
  - "You completely fell apart today" vs "when collecting your subjective, you did not follow up on the MOI which did not prompt you to consider fully screening the neck as the source of the elbow and forearm pain."
  - "It seemed that you were having difficulty figuring out the next step, for example _______."
- Provide details and solutions
  - "That took awhile to gather the eval subjective" vs "It took you 30 minutes to get that subjective completed. You could try to ask more directed questions instead of open ended ones."
- Curb your own frustration to provide appropriate feedback
  - "You are not thinking today." vs. "What do you think is the main issue here?"

Slide 45
Formative Feedback

- Feedback sheets
- Self-assessment confirmation
  - Wrap-up sessions
  - Set boundaries with respect to time/availability
- Phrasing of comments
- Critical Incident Reports
**Slide 46**

**Feedback Sheets**
- Summary of performance to date
  - Can be completed at set intervals for all students throughout clinical experience
- Snapshot of student’s overall self-assessment
- Proactive vs reactive
- Provides direction through goals set to focus on progression toward midterm and final

**Slide 47**

**Student Self-Assessments**
- Provides CI confirmation that the student is hearing feedback provided
- Wrap-up session
  - End of treatment day summary
  - Identify something that went well and something that could be improved
  - Be mindful of the time you are giving the student
  - Need enough feedback to progress and need to develop skills to respect their judgment

**Slide 48**

**Phrasing Comments**
- Focus on the facts – objective
- Identify strength areas
- Identify growth areas to outline for the student what behavior/performance item(s) need to change
- Avoid setting false hopes
  - “This behavior should improve with more experience.”
  - “The student is currently on track for this experience.”
Summative Feedback – Examples

Support Summary Statements

- CI Mid Term
  - SPT consistently demonstrates safe practices with patients. She seeks guidance from the CI as needed during chart reviews to determine if initiating treatment will be safe and requests physical assistance for transfers and gait training for patients of all complexities. She has shown great improvements with her patient handling skills for the acute care setting and continues to incorporate feedback to advance her techniques. She continues to practice line management and monitoring in the ICU setting to ensure the safety of the patient during treatment. She is able to recognize contraindications to treatment for simple patients and requires minimal assistance to recognize contraindications related to complex critical illness.

- CI Final
  - SPT consistently demonstrates safe practices with patients without guidance from the CI. She is able to determine if initiating treatment will be safe based on chart review and requests the appropriate level of physical assistance when needed for transfers and gait training for patients of all complexities. She continues to practice excellent patient handling skills for the acute care setting and incorporates feedback to advance her techniques. She is able to recognize contraindications to treatment related to complex critical illness, seeking clarification as needed in first exposure situations. When ambiguous situations arise with highly complex patients, she is able to problem-solve safety related issues by talking through solutions with the CI to arrive at the most appropriate clinical decision.

Critical Incident Report (CIR)

- Formative tool used to communicate in writing unacceptable behaviors +/or performance of the SPT
- Located on CPI or can use hard document
- “Performance” Incident Report
- Conveys consequences that can occur if behavior +/or performance is not changed
- CI must be prepared to carry out the proposed consequences if there is no change
### Slide 52

**Use of CIR**

<table>
<thead>
<tr>
<th>Performance Criterion</th>
<th>University of Delaware (n=104)</th>
<th>National (n=1864)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>12 (12%)</td>
<td>78 (42%)</td>
</tr>
<tr>
<td>Communication</td>
<td>12 (12%)</td>
<td>137 (7%)</td>
</tr>
<tr>
<td>Accountability</td>
<td>12 (12%)</td>
<td>80 (4%)</td>
</tr>
<tr>
<td>Professional Behaviors</td>
<td>12 (12%)</td>
<td>280 (8%)</td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>12 (12%)</td>
<td>201 (11%)</td>
</tr>
<tr>
<td>Documentation</td>
<td>4 (4%)</td>
<td>38 (2%)</td>
</tr>
<tr>
<td>Professional Development</td>
<td>3 (3%)</td>
<td>92 (6%)</td>
</tr>
<tr>
<td>Examination</td>
<td>1 (1%)</td>
<td>50 (3%)</td>
</tr>
</tbody>
</table>

- **Safety:** 12 (12%)
- **Communication:** 12 (12%)
- **Accountability:** 12 (12%)
- **Professional Behaviors:** 12 (12%)
- **Clinical Reasoning:** 12 (12%)
- **Documentation:** 4 (4%)
- **Professional Development:** 3 (3%)
- **Examination:** 1 (1%)
- **Pattern:** 45 (43%)
- **Not available:** Not available

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### Slide 53

**CIR**

- **Behavior**
  - What was observed?
  - Include what was the potential or witnessed negative impact of the SPT’s behavior/performance.
  - Include synopsis of any discussion with the student.

- **Antecedent**
  - Was the SPT able to do the skill/behavior successfully/appropriately or not in the past?
  - Was there any related information provided to the student prior to the incident?

- **Consequence**
  - What will the consequence to the student be if the behavior continues?

- **CI Comment**
  - Any additional information.

- **Definitions**
  - “Will”/“Shall”
    - Not optional
  - “May”/“Could”
    - Indicates that there are options

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**Behavior**

- SPT asked a patient to perform a progression of exercises (2x20 reps) when at last visit only 3x10 reps were performed. The plan for the day was to perform the treatment exactly the same as it had been performed the day prior (no progressions).

**Antecedent**

- SPT had been told in prep meeting twice that the plan for today’s visit should be exactly what was performed last visit with no progressions as his incision was still healing with significant wound drainage noted during previous visits.

**Consequence**

- My trust in SPT’s ability to follow through with previously discussed actions has been compromised. If future violations occur, my ability to simultaneously supervise 2 students will be limited. SPT will be removed from the floor and asked to f/u with DCE immediately.

**CI Comments**

- After discussion with SPT, she accurate identified that we had previously discussed not progressing the patient’s exercises twice during our prep meeting. She felt that the information was clear and no further strategies were needed. The expectation is that SPT will continue to follow the agreed upon plan. If she decides that changes to the pre-agreed plan are warranted based on patient presentation, SPT must update me and share her observations and the changes she would like to implement prior to completing with the patient.
Slide 55

Behavior
SPT was treating a patient s/p complex knee surgery (ACL revision with meniscal transplant). SPT has regularly treated this patient and has demonstrated an understanding of the pt's surgical precautions.

Antecedent
Prior to last night's evaluation, we discussed the importance of providing information to the CI regarding any decision-making or information that would impact patient care. Earlier in the semester, there were instances where information was not included in the CI and decisions were made by SPT without first discussing with the CI.

Consequence
If the student repeats this error, it may result in a safety violation or be recorded as demonstrating performance below expectation level.

CI Comments
The expectation is that the student will provide information to the CI prior to a decision being made regarding patient care. Appropriate notification/update was not provided to the CI prior to patient leaving facility and has been discussed in the past.

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Slide 56

Gallant A Remediation Process for Nursing Students at Risk for Clinical Failure Nurse Educator 2006

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Slide 57

Learning Contract

<table>
<thead>
<tr>
<th>Standard</th>
<th>Remediation</th>
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<tbody>
<tr>
<td>Learning objectives</td>
<td>Performance concerns</td>
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<tr>
<td>Learning resources and strategies</td>
<td>Corrective actions</td>
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<td>Target dates to meet the objectives</td>
<td>Timeliness</td>
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<td>Types and sources of evidence for learning</td>
<td>Consequences</td>
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<td>Criteria for evaluating evidence</td>
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</table>


### Slide 58

**Extension vs Failure vs Withdrawal**

**Extension**
- **Definable**
  - Very specific performance or behavior
  - Very specific time frame (usually < 3 weeks)
  - Residency/Fellowship can be months

**Failure**
- Can be multiple domains or extensive deficits in one domain that cannot be resolved in a relatively short (defined) time frame

**Withdrawal**
- Other reason – medical

### Slide 59

**Debarment Policy**

A student may be denied from class, laboratories, clinical practice, laboratories, and assignments for persistent nonattendance, unsatisfactory clinical practice, and failure to produce assignments to the satisfaction of the instructor. Students so disturbed will have failed the course.

### Slide 60

**Debarment**

- Sites can request to have a student “pulled”/debarred if safety is a concern or if the student is not competent to the bar of care for their facility.
  - Site may be hesitant to “call it” but they feel burdened because they don’t want to see the student “fail”.
  - Program deeming a student “ready” does not guarantee that the student will pass.
When to Debar a Student

- Egregious safety concerns
- When the CI can no longer competently supervise because of the demands of the student's deficits
  - Extent of the deficit(s) are too profound/pervasive
- Inability to demonstrate growth toward goal
  - Failure to meet outlined requirements in stated timeframes

Repeatedly not following supervision rules despite multiple discussions

- S/P motorcycle accident (pelvic fx, knee disloc, multiple road rash, skin graft near knee)
- CI discussed SPT no longer using theraband for patellar mobs
- CI out sick and covering CI notices the pt leaving with a bandage on knee that he didn't have coming in for treatment. Covering CI finds out from pt that SPT had used theraband for patellar mobs and opened the graft. Put bandages on it without alerting CI.

Behavior

This am, as we were going over pts with the student partner, I asked SPT where his planning forms were. He said he didn't print them out. I told him to go and print them out using the student computer and I later asked him if he had printed them out after. He said yes, but then I asked him why was he using the students computer and he said he just forgot. Upon review of the pts, I asked how many ex's and manual techniques were practiced for his pts and he said he didn't practice any. I then asked him what he expected to do today and he said he didn't know. When I asked him why on of his pts did not receive e-stim, he said he didn't know. I asked him where should he look up why and he was on the pdf format of the IE. When I opened up the pt chart, it was immediate on the pt name line that the pt had active CA treatments and to not do stim.

Antecedent

I requested to both my students at 5:16pm on 2/9 for their planning forms for treatment the following day. I received an email soon after, from SPT that asked: "Also, I've finished 3 of my 5 planning forms. Would you like me to send those 3 or finish the last 2 and send them all together? They have been taking me over an hour on average, so I'm guessing I'd be done with the last 2 by 7 tonight." I responded to both and the student at 5:16pm on 2/9 for their planning forms, for treatment the following day. I received an email soon after, from SPT that asked: "Hey, I've finished 3 of my planning forms. Should you like me to send those 3 or finish the last 2 and send them all together? They have been taking me over an hour on average, so I'm guessing I'd be done with the last 2 by 7 tonight." I remained in contact with SPT via email and the information on the planning forms remained the same, and I added a lot of comments and questions for him to do, which I returned to him within an hour.
Consequence

Due to SPT being unprepared to treat the case, he was pulled from the clinic.

I felt he had no consistent or retained patient care. I felt he was not prepared with the patient as a PT student. I felt him being actively involved with setting up equipment and ensuring interventions were added to the plan of care, and that he was having a successful day. I felt him implementing new interventions into the plan of care was not adequate.

Due to SPT being unprepared to treat this am,

he was pulled from the clinic.

He had not practiced or reviewed patient charts thoroughly therefore I felt he was unfit to work with the patients as a PT student. I felt him being actively involved with setting up equipment and ensuring interventions were added to the plan of care, and that he was having a successful day. I felt him implementing new interventions into the plan of care was not adequate.

He had not practiced or reviewed patient charts thoroughly therefore I felt he was unfit to work with the patients as a PT student. I still had him actively participate in putting subjective history and measures into additional findings of Optimis. I asked him to do an acute taking next to review and set up stimulation, but not turning it on. We also went to follow up next with him and the clinic director.

Prior to his first day, he and his student partner were on an hour and a half early for orientations and being prepared.

DCE Comments

DCE alerted about student removal discussion with Clinic Director at 8am. DCE met with student after clinic and discussed major concerns for patient care/safety, accountability, and communication. SPT voiced understanding that he didn't prepare adequately and he didn't seek help in doing so. DCE discussed strategies for effective communication in all clinical settings. SPT agreed to meet with the clinic director about what steps he is taking to be ready for clinic. In the future, SPT will ensure that he is ready.

Final Outcome

Student cleared to continue to treat in clinic after meeting. Strategies in place to help SPT focus his preparation for clinic. SPT will be making up 3 days and will be completing an additional assignment RE ethics.

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Behavior

On 2/26, SPT kept raising the bed as his older adult pt sat w/ one side of his bottom supported on the edge of the bed and the other hanging off the side w/ no foot support. I had him stop raising the bed and asked him what he had planned on doing as he didn't seem to care much to move the bed.

I returned the bed lower and was by the side of the pt as I had him transfer to supine position.

Antecedent

Prior to this incident (last wk), SPT had been working w/ another pt. As he was trying to take knee ROM, he kept raising the bed but kept his eyes on the pt's knee only. I had to call out to him to stop raising the bed as he didn't notice the pt was about to hit his head on one of the hanging baskets on the ½ wall in the clinic.

Consequence

I consulted w SCCE, DCE and they will f/u w/ SPT for further discussions.

O Comments

During the wrap up after the treatment day, I asked SPT how he thought he was doing in this ICE. He reported that he felt that he was putting in a lot of effort and not getting a whole lot of product back. I asked him about his learning style and he told me that w/ academic and sports he's learned he has to fail in order to succeed. I discussed w/ him that this is not an optimal learning style here in the clinic and that he should discuss his learning styles with DCE.

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Slide 66

REMEDICATION AFTER FAILURE OR REMOVAL– WHAT RESOURCES ARE AVAILABLE WITH HOW TO CASE EXAMPLES
Slide 67

To Remediate or Not?

- Variety of ways programs deal with student failure
  - Dismissal
  - Remediation
- To what extent?
- How many?

Slide 68

Preparing a Student for Remediation

- Getting the student “on board”
  - Want to create an environment that the student trusts the faculty to have their best interest in mind
  - May need to “spin” the student to be ready to begin remediation
- Student may be dealing with a number of emotions/concerns
  - Disappointment, denial, anger, etc
  - Financial impacts
  - Self-esteem/pride impacts
  - Life impacts

Slide 69

Formal Remediation

- Identify area(s) in need of remediation
  - Professionalism
  - Communication
  - Aid in a clinic and practice
  - Knowledge/Problem solving
  - Retake or sit in on courses
- Many times there are multiple influences
- Provide encouragement without implying automatic success
Slide 70

Options

• Retake classes
• Audit classes / TA class
• Review if taped / video taped
• Paper cases
• Journaling
  • Recommend aiding – multi-tasking, increase confidence, interpersonal
  • Observe PT – flow of evaluation, collecting subjective, focus on deficit area

Slide 71

WHEN FAILURE LEADS TO GRIEVANCE, THE DOCUMENTATION AND PREPARATION

Slide 72

Grievance

• Hearing Panels
  • 3 major considerations
    – Natural justice component (fairness and reasonableness of the decision)
    – Administrative component (policies and procedure followed)
    – Academic component (professional judgement)

• Only half of review panels consider all 3
• Professional judgment is considered even when clinical faculty are not represented at those levels
• Maintain paperwork for 2 years after course
  — Students have 2 yrs to file lawsuit

Source:
Clinical Probation: Supporting the At Risk Student Nurse Education
CI in Grievance

- Support needed
- Clarify information that needs to be collected and steps to be taken
- Counsel supervisor
  - How to speak to the student
  - Anticipate information a student may need to know
  - Support with the student’s individuality
- How to handle the appeal process
- Support through appeal process (BC, CUNY, and others for help)

* At the university, when a student fails and then writes a letter defending their actions, the letter is sent back to the supervisor. Then, it’s up to the supervisor to support their decision in response to this letter. And it’s like being accused of not being truthful... We need support for when that happens. That may seem really silly, like, oh I failed a student, boo hoo, I need moral support. But you know? You do.*

Slide 76

Antecedent: SPT was not adequately prepared to treat a postoperative rotator cuff patient the evening before. He was unaware of the time frame from surgery, obtained the blood pressure machine, and did not have the blood pressure protocol readily available.

Consequence: This is the second SPT has been evaluated on for not planning forms to be used, and in order to give an assessment of how to complete planning forms, the planning forms are reviewed.

O Comments: After the session, we discussed the planning forms and how to use them more efficiently. This was also the third evaluation that the student has had since beginning the ICE rotation, and has been given an example of how to complete planning forms. Her planning forms for the day lacked details for adequate preparation for treatment.

Slide 77

Antecedent: After the session, we discussed the planning forms and how to use them more efficiently. This was also the third evaluation that the student has had since beginning the ICE rotation, and has been given an example of how to complete planning forms. Her planning forms for the day lacked details for adequate preparation for treatment.

Consequence: If the student repeats not utilizing the BP algorithm during initial evaluation, she will be pulled from the floor or be recorded as demonstrating performance below expectation level.

O Comments: This student repeats not utilizing the BP algorithm during initial evaluations, it could result in a safety violation and the student may be pulled from the floor or be recorded as demonstrating performance below expectation level.

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Antecedent: SPT performed an initial evaluation (shift of the intevent) for a patient with left back pain during the second week of her clinical rotation when she was assigned to her current patient. It was noted that the patient had multiple concerning instances of SPT's self-care, including keeping the patient's MAJOR posterior lean/falling backwards while sitting EOB).

Consequence: Aside from this there have been multiple concerning instances of SPT's self-care. There have also been two instances of attempting to place the patient in the incorrect position (ex: being behind the wheelchair of an unfamiliar/new patient going from bed to WC instead of in front of the patient; ex: not removing a footplate therefore making it more difficult to plant a patient's feet on the ground); or being unable to complete tasks while treating the patient in question (leaving what was not complete after the session, as well as being reprimanded in the next session).

O Comments: Met with student on performance and discussed future consequences, student accepted responsibility of actions.
**Behavior:** PF was not appropriately guarding patient while ambulating (am)

**Antecedent:** Pt had a dx of Devic's/NMO (J/364) and had sig LE involvement and BUE tremors and tone, oftentimes preventing her from grasping the handles of a rollator or maintaining grip on arm rests of WC while standing. Overall, the pt is very ataxic w/ poor trunk control, overall unsteadiness and unpredictable gait. The previous day, the pt was on 2 PT sessions. All were sched for 2 sessions w/ [redacted] pt. SPT reported that PT completed the 1st am session fine. However, the pt was new to SPT and his 1st day working w/ us, so he wanted to "watch" my session first. PT was in agreement. Due to the pt's UL involvement and unpredictable gait, pt was placed at a CGA level w/ pt. When needing more mod CGA due to UL/arms were mod CGA. SPT observed all of this and stated, "I'm really glad I was able to see you treat her first, she needed more assist than I was anticipating." All other PT notes prior to our treatments reflected this amount of assistance needed. Yesterday afternoon the pt was off the floor, so SPT was unable to complete scheduled treatment. The am of the incident, SPT and PT reviewed treatment plan for the day, which was appropriate for pt's functional level and rehab goals. While amb to the gym from the pt's room, SPT was guarding the pt at a sup level while amb w/ the rollator. PT was following w/ the WC. PT had to verbally cue SPT to maintain physical contact w/ the pt. After walking a few more steps, both of the pt's hands slipped off the rollator, requiring at least mod A from SPT and min A from PT on the other side of the pt to prevent LOB/fall. SPT then appropriately terminated amb and had the pt sit.