

# THE BORDERLINE STUDENT NURSE

by

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and their faculties encounter a myriad of problems in teaching student nurses who will upon graduation make a contribution to the profession. These problems are constantly changing, and as soon as yesterday's are solved, new ones present themselves. Where in the past, for example, concern was directed toward involving nursing faculty in matters of curriculum, selection and policy decisions, now focus of attention has shifted toward problems of student participation.<sup>1</sup> Nevertheless there are other broad issues which are *not* a function of the times which nurse educators constantly encounter. One of these is the borderline student nurse.

The borderline student nurse is one who requires extra faculty and administration attention because of unsatisfactory or deteriorating performance in her program. She may, or may not, have been marginal at the time she was selected to enter the program. Recently completed case studies indicate that problems with the borderline student are relatively common and that administrative action is usually influenced by three factors: student selection, evaluation procedures, and educational policies. Design and operation of student personnel systems often do not specifically reflect concern for the borderline student. In such instances students may suffer or excessive amounts of time and effort may be necessary to identify and solve student problems.<sup>2</sup>

These conclusions come from in-depth case studies of students with problems in Ontario and Quebec schools of nursing.\* The project was undertaken to ascertain what problem themes are encountered at schools of nursing. The particular schools were asked to identify an important student problem that had arisen in recent

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times. All participating schools of nursing did so on a voluntary basis.

A case study describing each problem and the action taken was prepared. Major themes emerged and were identified in subsequent analysis. More problems than those discussed in this paper were apparent but the three discussed below were common to most of the schools involved.

### *THE SELECTION PROBLEM*

Careful selection of an incoming class is an important and difficult function in a school of nursing. Pressure to admit students who do not meet minimum standards often arises and sometimes has consequences which last throughout the class's entire experience. Educators do not need to be reminded of the problem inherent in selecting a new class. Picking the best from a batch of applications is difficult even when many more applications are received than places are available. In spite of efforts to obtain all the information needed, decisions must be made on inadequate and sometimes misleading data. Grades, for example, may reflect but do not measure motivation. In the end, decisions are made and errors committed. Students who will have problems are accepted; some who would have been satisfactory are not. The objective is to minimize both these errors as their costs are reflected in subsequent demands on the time and effort of teachers, administrators and counselors. The wear and tear on the student and consequent cost of wasted investment in education makes the exercise of caution in student selection mandatory.<sup>3</sup>

For example, Mussallem in her "Study of Nursing Education in Canada," estimated that the direct cost of educating one student for one year in a hospital school ranges from \$1,000 to \$1,400. She also stated that indirect costs are equal to the direct cost, so that the total ranges between \$2,000 and \$2,800 per student per year.<sup>4</sup> Subsequent estimates have put the cost per student even higher. These are 1964 figures and undoubtedly understate today's cost.

Withdrawal, or dropout rates for student nurses are costly and not only for economical reasons. Those students who were admitted and later withdrew may have displaced other qualified students who would have graduated satisfactorily. Willett states "the morale of some students or an entire class may be affected by the admission and later withdrawal of students who encounter difficulty within the program."<sup>5</sup> The attrition factor can influence the effectiveness of instruction within a program both in terms of the quality of classroom discussion and the excellence of instruction. Competent faculty

may leave programs which have a high attrition for others with more rewarding teaching environments. The following table shows that attrition rates have been high in Ontario.

*Percentage attrition for students  
admitted in 1965<sup>6</sup>  
Classified by type of program*

<i>Program</i>	<i>Percentage Attrition</i>
4 year	15.7
3 year	26.1
2 + 1	20.3
2 year	15.9

Student A's problems illustrate the costs of poor selection. She was admitted with a Grade XII average of 64.7% at the age of eighteen. The minimum admission standard of her school was an average incoming grade of 66%. Her clinical performance had unsatisfactory aspects from the beginning and she failed three of the first set of examinations. She was seldom accepted by her peers and her relationships with patients were never more than social. With counselling, she improved only temporarily and later was recommended by her teachers to withdraw. Instead she was placed on probation for three months. No noticeable improvement took place and at the end of this time, she was asked to leave. Her stay in the school, at that point, had been sixteen months.

Should student A have been admitted? Clearly, her grades were below the minimum requirement; yet schools must frequently give serious consideration to such students. Circumstances arise where a class will not be filled if such students are not accepted. For example, most selections are made some months before classes begin. In many instances, applicants who more than meet minimum standards are rejected at that time because the class is full.

As registration nears, however, some of those accepted withdraw for various reasons. The good applicants, previously rejected, are no longer available and, if a full class is to be achieved, less qualified applicants must be given serious consideration. The school, in effect, must choose between a smaller class than desired, with its unfavourable budget consequences, and students with less-than-desired qualifications. The risk of unsatisfactory consequences thus arises.<sup>7</sup>

If at the time of application, the school knew that a particular applicant would fail or would require much special attention in order to become a borderline graduate, it would obviously not accept her. This knowledge is, of course, unavailable then. In order to reduce these risks, schools utilize second and third selection stages.

Psychological and achievement tests are used often in combination with personal interviews to improve the quality of the selections. Even then, "mistakes" are made. Consider student B.

In student B's case, an exhaustive battery of tests was administered before the decision to admit her was made. The psychologist who administered and analyzed the test results concluded that this student was not a suitable candidate for the nursing program. In her report, the psychologist suggested that student B's limited knowledge of English was a barrier and this, combined with certain personality traits, warranted rejection of her application. She was accepted, however, and as early as three months after admission, faculty recommended that she receive extra help. Her early clinical experience was acceptable but after seven or eight months it deteriorated and became quite unsatisfactory; subsequently many hours were devoted to counselling. The student felt nothing was wrong. After ten months, her work, application, and comprehension were still unsatisfactory and in June she was asked to withdraw.

In this case the applicant was accepted against the advice of the psychologist. How should such advice be used? For the borderline applicant a good rule to consider is that extra information received from tests and interviews should reveal some special attributes to warrant acceptance. High intelligence scores, and evidence of extra strong motivation to nurse, high aptitude for nursing and so forth, are examples of information to be gained from tests and interviews which would encourage acceptance.<sup>8</sup> In the absence of such achievement, acceptance of those who do not meet minimum acceptance criteria should not take place. Student C's case illustrates the point.

Student C entered the school when she was twenty-four years old. She had been a student in another school of nursing previously for eight months but had been dismissed because of failure. In high school she had repeated Grades IX and X. This particular student ranked very low in the Scholastic Aptitude Tests of Ontario. During her first few months she progressed normally. Theoretical grades at that time were 67% and her clinical experience record indicated satisfactory results; however, student C failed paediatrics and was required to write a supplemental examination. In this particular school, students were permitted to write only one supplemental examination per year. Although this student was doing well clinically and was receiving good comments from the patients, she was having to face the fact that if she failed another examination that term, she must withdraw.

Here the additional information obtained by tests did not show any

special attributes to merit acceptance. Even in the part of the program where the student was repeating work taken at a previous school, her performance was marginal.

Admission procedures should ensure that all the information available on an applicant is given systematic and balanced consideration. In the absence of strong positive evidence from interviews or references a grade average marginally above the minimum acceptable should not offset previous failures and low test scores.<sup>9</sup>

No school can expect to be completely successful in their admission decisions. However, a systematic approach to selection will help to reduce problems and to direct the admission officer's attention and effort. One method to consider is a multi-stage admission procedure that could be used to structure the timing and collection of additional information when needed (Figure II). In this procedure tests and interviews would be utilized only for borderline applicants (using grades as criteria). Test results would facilitate further screening. The time consuming and expensive task of interviewing could thus be reserved for applicants still borderline after the previous stages.

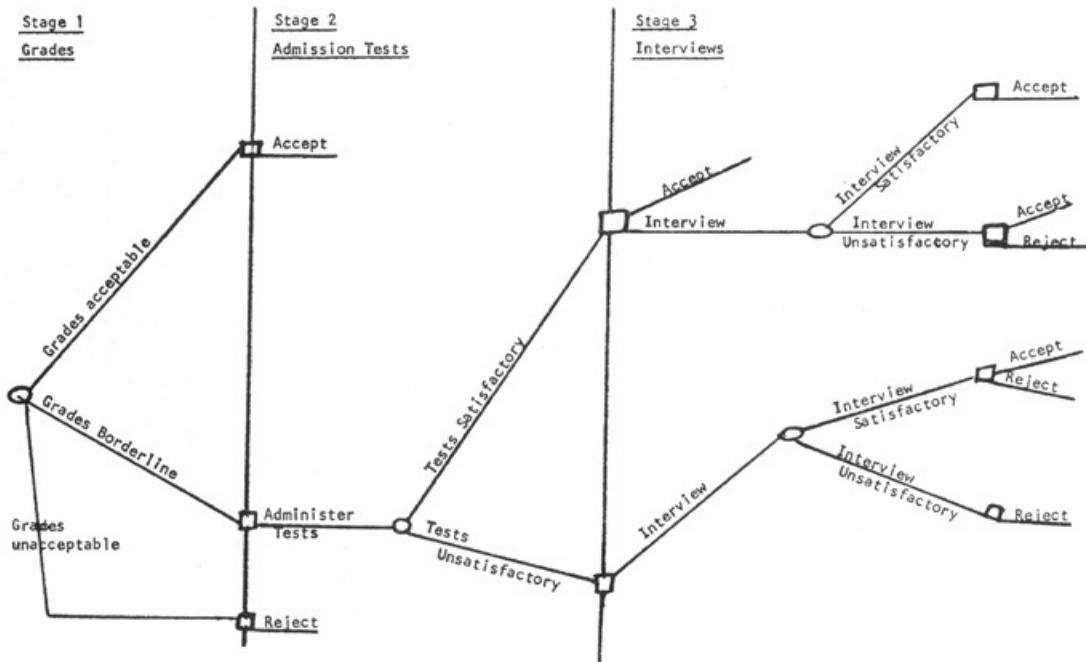
The staged admissions procedure will serve to reduce the time spent on admissions at the cost of extended elapsed time before some cases are resolved. This extended time, however, will be spent on those applications that warrant it. A higher proportion of successes should result.

### *ASSESSMENT OF STUDENT NURSES*

The most frequent concern of nursing schools, school faculty and administrators in this study was the assessment of student nurses. This concern had two major aspects. The first was the use and abuse of the assessment tools utilized in evaluating the clinical performance of student nurses. This one issue occupied large parts of faculty discussion and attention. Problems arose in which evaluations conflicted, were ignored or had not been documented. Often, the evaluation forms themselves made assessment awkward. Some were blank sheets of paper while others were standard rating scales used indiscriminately for every clinical experience. Faculty were unable in these instances to set up assessment tools as they should — with behavioral objectives stated in relation to the objectives to be derived from that particular learning experience.<sup>10</sup>

The second area of controversy was the final assessment of the student nurse. Opinions differed as to the means of determining the overall grades for decision purposes. There are many ways that the final grades can be handled. One is the weighting of the courses taught before grades are averaged together for a final percentage.

Fig. II. A Staged Selection Procedure



For example, a fifteen-hour course should not have the same weighting as a 150-hour course. The latter course should carry more weight in the final event.<sup>11</sup>

Another factor that presented problems was the occurrence of differences between the written evaluation and the verbal report of a particular student's progress. Consider the case of student F. Her performance was described as satisfactory in her evaluation reports. Yet, upon interview with the faculty, several teachers stated she was "slow and immature." No such information had been recorded. It would seem that if teachers found the behavior of students not meeting the behavioral objectives of the programs, then these conclusions should have been written into the record. These discrepancies underlay the difficulties encountered with student assessment.<sup>12</sup>

Student F had become ill with a knee injury, and although her performance had been rated excellent, she was considered a physical risk. Consequently she was permitted to attend classes and excused from her clinical practice while her knee healed. After returning to clinical practice her teachers said her performance was deteriorating but that she needed "watching." Her evaluation reports, however, indicated that she could give "good patient care." After a few months, progress in her clinical performance was noted, but interviews revealed that her teachers still felt the need to "watch" her. In student F's case, subjectivity in assessing her performance and contradictory statements about her performance complicated the task of evaluating her performance and deciding on an appropriate program for her. In personal interviews, her teachers said that this student's performance was "deteriorating" yet the written analysis of her evaluations in the clinical situation omitted such comments. Several reasons may account for these discrepancies. Perhaps the evaluation tools were too subjective or perhaps the teachers themselves were inadequately prepared in the task of writing assessments.

Also in the case of student A contradictory evaluations impeded analyses and resolutions of performance inadequacies. Her clinical performance had unsatisfactory aspects from the beginning. The verbal statements made by the teachers however, were not always corroborated by their written evaluation. Consequently fifteen months elapsed before consensus was reached and the student was asked to leave the school. There were other examples of contradictions between written and verbal evaluations of clinical performance by faculty. These two elements of assessment — the final grade, and evaluation of clinical experience — were frequently problems to nursing school faculties.

How can one arrive at a realistic and fair final assessment of a

student nurse? Data from the cases indicate that student nurses are sometimes, in fact, short-changed on their final assessment. It would appear that appropriate grades are simply averaged without giving cognizance to the appropriate weighting of the courses.

Consider the case of student F again. She was told she had two supplementals to write as below 65 was considered a failure. Figure III is the chart of this student's final marks.

FIGURE III. Student F.

<i>NURSING PHASE #1 FINAL MARKS</i>		<i>Class Hours</i>
Anatomy and Physiology	74	150
Bacteriology	67	30
Chemistry	78	40
History of Nursing	69	20
General Medicine	62	95
Pharmacology	64	51
Nursing Principles and Methods	69	217
General Surgery	65	103
Psychology	69	84
Sociology	85	53
Practical Work — 1st year average —		77 %
Theory		70.2%
First year average —		73.6%

*School's Rating Scale*

A	88 - 100
B	71 - 87
C	65 - 70
F	Below 65 (Failure)-

Upon close examination, many questions can be raised about the final assessment. How can one justify simple averaging a twenty-hour course with a forty-hour course and a 150-hour course? Weighting of courses would seem to be required here. For example, for every twenty hours of classroom teaching a weighting of one would be given. The twenty-hour course would have a weighting of one; the forty-hour course a weighting of two; and the 150-hour course a weighting of 7.5.

Besides the simple averaging of final marks, consider the marks and courses in which student F failed. In Pharmacology this student received a grade of 64. The passing grade was 65. The pharmacologist, in retrospect, stated that had he known that 65 was the passing

grade, he would have raised student F's mark. Several questions come to mind. Why were the faculty from related disciplines so ill-informed? Second, with a mark as close as 64, surely one could not consider this student as a failure. She could be considered marginal or borderline. Third, what was the class average in Pharmacology? For instance, if student F had received 64 and the class average was 60, then she really did not fail. It would appear that the arbitrary failure mark of 65 was not taken in relation to the class average. The same can be said of the General Medicine grade of 62. What was the class average? All of these things are related and are not to be considered in the abstract.

### *DECISION-MAKING WITHIN SCHOOLS OF NURSING*

Already we have seen the problems of admitting the borderline student. In spite of improved admission procedures, problems of student performance will still arise, however. The decision-making process by which this problem is handled again will affect the effectiveness of teaching within the program. How long do you keep a borderline student in the program, particularly now that we have two-year programs, and at what point do we ask the student to withdraw? Are we really protecting the patient when we keep unsafe students around? Again, studies show that there is room for improvement.

V. V. Murray, in his "Nursing in Ontario," stated:<sup>18</sup>

In general, among the schools we visited in 1967, the predominant decision-making process within the schools was broadly decentralized with regard to curriculum, while decisions on budget and staffing were more strongly controlled by the director. Like any other organization with overall goals which are occasionally conflicting, impossible to define in operational terms, and whose attainment is difficult to measure unambiguously, our impression was that most schools were characterized by possessing a few cliques and factions representing opposing viewpoints on significant issues. At best, their skirmishes tend to slow down the decision time; and at worst, they substantially harmed the quality of education in the school.

Such slowness tends to aggravate problems. Consider student A, whose clinical performance had unsatisfactory aspects from the beginning. She failed three of her first set of examinations. She had "superficial relationships with her patients" and she was seldom accepted by her peers. Even with counselling, there was no marked improvement, yet she was allowed to continue in the program. Then student A was given three months probation. She was not asked to withdraw until she had been in the school about fifteen months.

Student problems sometimes show where current policy is inappropriate or where no policies exist. Current changes in student attitudes and characteristics are leading to decision problems which previously did not occur. For a given school, past practice (policies) are often not appropriate for these new problems.

A policy that was perhaps too rigid for current problems was evident in the case of student D. She was well recommended, functioned very well in her time within the program (76.6% academic, 83% clinical) and was maintaining her good performance when she became pregnant and was married. At that time she was forced to leave the school because school policy maintains that a student who marries must withdraw. Many schools have revised this policy because of changing social values and the expense of losing an otherwise competent nurse.

In this case, an old rule had, over time, become inappropriate. In such circumstances the school's procedures should permit quick consideration of (a) making an exception or (b) revising the policy to suit changed conditions. There is a tendency for policies to become enshrined as absolute truths when, in fact, the opposite should hold. The pace of change in values, objectives, student sophistication and maturity and so forth promises that the permanence of any student policy is a myth. Clinging unknowingly to obsolete policies extends the tenure of individual problems and frustrates the learning process.

An example of, on one hand, lack of foresight in policy change and, on the other, an offsetting flexible approach occurred in the case of student E.

This student consumed a large amount of medicine for "kicks." The school had not developed a policy governing such behaviour. At first, the reaction of the director was to dismiss the student; however, after further consideration, the student was permitted to remain and a decision about her future delayed until a psychiatrist had examined her. Developing an ad hoc policy to cope with this situation, although successful, cost faculty and administration much time and emotional energy.

In another situation the absence of a quick reaction led to what probably was an unnecessary withdrawal. Student F entered a school of nursing after Grade XII and had been well recommended. During Phase I in the first year, she was rated as satisfactory although some teachers had called her "slow and immature." At that time the policy at this school for promotion from Phase I to Phase II was to review the student's clinical and academic progress, considering a course grade below 65% a failure. Students were permitted two supplemental examinations. This student failed two subjects, and had

achieved 65% in another. She then left for vacation before writing supplementals, and while away, wrote to the school suggesting she might withdraw and requested an interview. Student F felt she would not be able to successfully complete second year. No interview took place and this student withdrew. In this case, inability to identify and counsel borderline performers resulted in the student taking action which was probably not in her, or the school's, best interest.

Good operating policies and procedures serve to protect the student, promote uniform and fair treatment, and reduce the resulting friction and time involved when inappropriate or no policies exist. The school which waits until a problem exists before reviewing policy must analyze and act under time pressures that cannot help the decision process. The risk of poor decisions and generation of poor policies rises substantially.

While accurate forecasting of all problems and prior development of all needed policies are unreasonable expectations, considerable improvement is possible.<sup>14</sup> Systematic and periodic policy appraisal and revision should be built into the school's operating procedures. In this way, faculty and staff have more time to devote to their priority — improving the teaching-learning environment and their teaching techniques. Such a review, combined with a flexible approach to applying policy, could reduce administrative problems and their attendant frustrations.

### *SUMMARY*

Part of the assessment problems encountered in the studies can be related to the schools' operation of their own student personnel systems. Their inherent inadequacies allowed situations to develop that more sensitive arrangements would have anticipated.

It is these situations — assessment and problem identification of the borderline student — that test student personnel systems. What is needed are 1) admission procedures that minimize the probability of accepting students who will not meet requirements, (2) assessment tools which quickly highlight student problems, and (3) policies and procedures which ensure positive action to resolve those problems. We have seen that in situations where inadequacies exist in these systems problems develop which occupy excessive amounts of faculty time and attention. More importantly the teaching-learning environment deteriorates and students suffer when these systems are deficient.

We have indicated some approaches which can be taken to avoid the problems described above. Generally, admissions procedures should spotlight potential borderline students and ensure in-depth consideration of their applications and programs prior to decision.

Assessment techniques should be designed to obtain consistent, unbiased evaluation of student performance. Clinical performance is one area where special care is needed. Because of its nature, objective measurement tools of clinical experience are difficult to develop. The risks of subjective measurement cannot offset the necessity to obtain information on student performance and problems. Thus every effort should be made to get good information. The teacher's sometimes reluctance to put in writing her whole evaluation of the student's performance and potential can be offset by striving to ensure their balanced and objective use.

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