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Improving Adjunct Nursing Instructors' Knowledge of Student Assessment in Clinical Courses

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ABSTRACT

Utilization of adjunct nursing instructors to teach clinical courses is a common occurrence in nursing programs. Adjunct clinical instructors are often expert clinicians, but they have limited experience in teaching and lack the expertise needed to be successful in the educator role, such as knowledge of student assessment. Faculty development programs that focus on student assessment can provide adjunct clinical faculty members with the necessary knowledge to become effective educators and ensure student, faculty, and program success.

The purpose of this study was to examine to what extent a faculty development workshop on evaluating students in clinical courses affected adjunct clinical nursing instructors' cognitive and affective behaviors towards clinical evaluation of students. A convenience sample of 38 instructors at a single institution completed the faculty development workshop. A quasi-experimental research design using a single group pretest/posttest was utilized. Benner's Novice to Expert Model guided the development and planning of the faculty development workshop that focused on student assessment in clinical courses. A student oriented learning outline (SOLO) was provided prior to the workshop and evaluated after the workshop. Descriptive statistics, paired *t*-Test, Shapiro-Wilk test for normality, and a Wilcoxon signed rank sum test were used to analyze the data. The results indicated that adjunct clinical nursing instructors valued the use of the SOLO, gained knowledge about assessment of students in clinical courses, and indicated they would engage in activities that could increase their knowledge of assessment of students in clinical courses. Determining what skills and knowledge are needed for adjunct nursing instructors to be successful and creating formal processes to meet those needs are essential to the future of nursing education.

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This is my village, thank you all for your support!

DEDICATION

I dedicate this dissertation to my husband- Mitchell Johnson, children-Dallas and Morgan Johnson, and parents- Harold and Betty Vowell, who has always been right by my side cheering me on.

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I. INTRODUCTION

Context of the Problem

The national need for registered nurses is projected to increase 22.2% by the year 2018 (United States Department of Labor, 2009). One solution to the nursing shortage has been to increase enrollment in undergraduate nursing programs in schools of nursing (Forbes, Hickey, & White, 2010). With the increased enrollment and the lack of full-time nursing faculty required to meet program needs the make up of programs' teaching faculty has evolved to include large numbers of adjunct clinical instructors (Anderson, 2009; Forbes et al., 2010; Kowalski, Carroll, & Jarrett, 2007; Peters & Boylston, 2006). Adjunct clinical instructors are hired because they are experts in clinical practice, yet most lack a basic understanding of the role of an educator (Bell-Scriber & Morton, 2009; Cangelosi, Crocker, & Sorrell, 2009; Kelly, 2007). Nursing programs must ensure adjunct clinical faculty members have reliable educational practices to support student success. This can be accomplished in part by providing adjunct clinical instructors with faculty development programs to address the education gap that exist between expert clinician and clinical instructor (Davidson & Rourke, 2012; Hewitt & Lewallen, 2010). Utilizing adjunct clinical faculty is beneficial to nursing programs; however, attention must be given to the educator role development, specifically assessment of students in clinical courses to ensure the optimal program benefits (Davidson & Rourke, 2012).

Adjunct Clinical Instructors

Using adjunct clinical faculty to provide nursing education is a trend that is here to stay. Factors contributing to the growing use of adjunct faculty are the aging nursing professoriate and a multitude of recruitment and retention issues for nursing faculty (Sawatzky & Enns, 2009).

The past decade has seen large numbers of expert practitioners migrate into the role of clinical nursing instructor due to the nursing faculty shortage (Janzen, 2010; Kelly, 2007). Nursing schools continue to hire novice educators, yet have no systematic plan for orienting, training, or mentoring these clinical experts (Davidson & Rourke, 2012).

Supporting adjunct clinical instructors by including them in academic programs and decisions enhances their sense of belonging. Additionally, interacting with full-time faculty creates opportunity for mentoring and support that is needed for their role development (Forbes et al., 2010). A lack of role identity is one factor that creates job dissatisfaction for adjunct clinical instructors. Finn, King, and Thornburn (2000) stated that clinical faculty members frequently feel insufficient in the new educator role due to a lack of information, which creates feelings of inadequacy. Faculty development provides needed support and knowledge for part-time instructors and is a key factor in job satisfaction and retention (Davidson & Rourke, 2012; Forbes et al., 2010).

Adjunct instructors most often are full or part-time professional nurses who continue to work in a variety of clinical settings while teaching on a part-time basis. Currently practicing registered nurses provide unprecedented benefits in clinical course teaching because of rapid changes in medical technology and knowledge of clinical setting policies and procedures utilized in clinical courses. These skilled practitioners provide the needed link to clinical practice; however, they often lack foundational knowledge of a program's curriculum and conceptual framework (Desevo, 1995). The orientation and development of adjunct clinical instructors are topics that are often discussed at national, state, and local nursing education meetings.

Unfortunately, there is no clear protocol for the orientation and development of adjunct clinical instructors.

Faculty Development

Developing adjunct clinical instructors for the role of educator is challenging for nursing programs (Wolf, Beitz, Peters, & Wieland, 2009). Adjunct clinical instructors often struggle with effective teaching and evaluation practices (Scanlan, Care, & Gessler, 2001). Clinical evaluation is a complex task during which instructors not only assess students' theoretical knowledge, but also their critical thinking, communication, professionalism, and their ability to apply information before assigning a grade (Walsh & Seldomridge, 2005). The National League for Nursing identified instructional strategies to increase the effectiveness of clinical instruction and evaluation as a priority for future research in 2007 (Halstead, 2007). Specifically, it is critical to examine the role and the benefits of faculty development for adjunct clinical instructors in order to increase their knowledge level and affective behaviors as related to clinical evaluation.

Both positive and negative effects of adjunct faculty on the quality of higher education are well documented in the literature (Bettinger & Long, 2010). Providing support and education for part-time faculty is key to program, faculty, and student success. At all levels of nursing education, evaluations in the clinical setting are required to aid students to gain clinical and critical thinking skills, which are valuable to the development of the entry level registered nurse (Ard, Rogers, & Vinten, 2008). Information on how to evaluate students in the clinical setting is vital for programs to create reliable grading practices. As "gatekeepers" into the profession all levels of nursing faculty must be competent in evaluating students. Adjunct faculty members in

higher education are rarely provided with development opportunities and have less interaction with their full-time peers in education; therefore, they have fewer opportunities to have discussions about student learning and evaluation (Nunley, Bers, & Manning, 2011).

Clinical Course Grading

In nursing the clinical courses allow students to participate in selected aspects of client care. Competent clinical instructors are the most important factor influencing student success and satisfaction in clinical courses (Allison-Jones & Hirt, 2004). Adjunct clinical instructors must acquire the knowledge and skills needed to facilitate student learning and assessment competently in the clinical setting (Davidson & Rourke, 2012).

While clinical courses provide a rich learning experience for students, these courses are challenging to manage and support. There are many factors the instructor cannot control in the clinical setting, creating a strain for even the most experienced educator (Mogan & Knox, 1987). Changing client acuity and census challenges the adjunct clinical instructor to continuously adapt and support students in meeting course objectives. The clinical environment is a dynamic learning environment that requires educators to simultaneously manage clients, students, clinical partners, and academics (O'Connor, 2006; Windsor, 1987). The complex nature of the clinical environment is one factor that supports the need for faculty development for adjunct clinical instructors. In addition to the need for clinical instruction, there is a need to assess and evaluate students to ensure safe and successful entry-level registered nurses.

Furthermore, the clinical course for the undergraduate nursing student can be a source of stress (Elliott, 2002). This stress can create a dysfunctional learning environment for the student. Understanding how to evaluate students in the clinical setting helps adjunct clinical instructors in

providing appropriate and adequate feedback to students. Evaluation of students in the clinical setting is necessary; however, it should be provided in a supportive, non-threatening manner (Elliott, 2002). The need for fair and unbiased evaluations emphasizes the importance of the adjunct clinical instructors' development as related to evaluation in clinical courses. One strategy to decrease student stress in clinical courses is to provide expert clinical instructors.

Clinical grading is a topic that continues to be debated within the nursing profession. There is a long-standing debate over the best practices for evaluating students and types of grades that should be assigned in clinical courses: pass/fail or a letter grade (Alfaro-LeFevre, 2004; Amicucci, 2012; Dolan, 2003; Isaacson & Stacy, 2009; Walsh & Seldomridge, 2005). Regardless of the grading system, adjunct clinical faculty members require information about evaluation of students in clinical courses, in order to provide more reliable grading practices for nursing programs. Student evaluation practices by adjunct clinical instructors are more likely to be lenient, resulting in significant grade inflation (Salamonson, Halcomb, Andrew, Peters, & Jackson, 2010). More specifically they are less likely to assign failing grades when warranted in clinical courses (Duffy, Stuart, & Smith, 2008). Supporting faculty development will increase adjunct clinical faculty knowledge, which will encourage best practice for instruction and evaluation.

Statement of the Problem

Increased demand for nurses has created the need to increase student enrollment in nursing programs. This in turn has created an additional demand for full and part-time faculty in nursing programs. Programs across the country are hiring expert nurse practitioners, into both full and part-time positions, in response to the increase in demand. While these clinical experts are

skilled practitioners, the vast majority does not have formal education that supports their role as an educator (American Association of Colleges of Nursing, 2003, 2012; Kelly, 2007; Wolf et al., 2009). Due to the part-time status of the adjunct clinical instructors, they are often disconnected from the program activities and unaware of changes to curriculum and/or policies. They have limited to no involvement in school, college, or university level committees or development activities. The lack of connection to the program as a whole intensifies the need for faculty communication and faculty development for this at risk group.

Providing faculty development programs to improve teaching skills of clinical instructors is supported by the literature (Davidson & Rourke, 2012; Notzer & Abramovitz, 2008; O'Callaghan, 2007). Clinical faculty are well prepared to care for clients but they lack preparation to supervise and evaluate students: "While advanced knowledge and skills are essential for the educator role, clinical expertise alone is insufficient preparation for teaching in schools of nursing" (Oermann, 2004, p.1). Faculty knowledge of education techniques and strategies is paramount in providing the nursing student with the best educational experience possible. Evaluating students in the changing clinical setting creates stress for both students and adjunct clinical instructors (Elliott, 2002). Faculty development programs can provide the needed knowledge to the adjunct clinical instructor to begin the journey to expert clinical instructor. Expert instructors are better able to work within the complex role to create optimal clinical experiences for students.

Adjunct clinical instructors require knowledge in teaching and evaluation methods to make judgments about students' clinical performance and provide them with fair and reliable clinical grading (Scanlan et al., 2001; O'Conner, 2006). Faculty development is one way to provide the

tools and increase the skill level of adjunct clinical instructors so that they can adequately perform their job (Forbes et al., 2010; Gadberry & Burnstad, 2005).

Maximizing the effectiveness of student evaluation in the clinical setting increases reliable grading practices and client safety (DeYoung, 2003). Consistent and reliable feedback based on course objectives increases student satisfaction, enhances the clinical learning for all students, and ultimately, and has a positive effect on program pass rates for the National Licensure Examination-Registered Nurse (NCLEX-RN) (Morrison, 2005). Additionally, clinical evaluation is critical to ensure safe practices in the client care arena.

Opportunities for adjunct clinical instructors to engage with the nursing program through faculty development programs are paramount to long-term retention of adjunct faculty (Notzer & Abramovitz, 2008). Participation in faculty development sessions creates a sense of investment for both the institution and the adjunct clinical instructor. Faculty development increases faculty job satisfaction and improves clinical instructors' performance (Notzer & Abramovitz, 2008). Knowing what to evaluate in clinical courses and how to do it also increases adjunct clinical instructors' job satisfaction (Davidson & Rourke, 2012). Increased job satisfaction decreases attrition and expands the pool of available expert adjunct clinical instructors. The problem of untrained adjunct clinical faculty in nursing creates increased risk to the nursing profession and the health care system.

The educational processes in nursing are unique and should be evaluated and viewed differently than other professions. Like other practice professions, real world experience is vital to the educational process. There is a risk that undertrained clinical instructors teaching clinical courses will pass under-prepared students. Entry-level nurses, who are incompetent in the

clinical setting, could present unacceptable safety risks for clients. Furthermore, students who should have failed due to unmet objectives will struggle or fail at the next level of clinical courses and ultimately fail the NCLEX-RN. Nursing programs are evaluated on the first attempt passage of the NCLEX-RN as a marker of program quality (Pennington & Spurlock, 2010). The NCLEX-RN passage rate affects recruitment, funding, and vitality of the program. Not maintaining a passing rate above the national average has negative consequences for students, nursing programs and ultimately, for healthcare providers. Faculty development is one way of ensuring adjunct clinical faculty have the knowledge and support needed to adequately assess students in clinical courses and support program success.

Purpose of the Study

The purpose of this study was to examine to what extent a faculty development workshop on evaluating students in clinical courses affected adjunct clinical nursing instructors' cognitive and affective behaviors towards clinical evaluation of students.

Research Questions

To accomplish the purpose of this study it was necessary to answer the following research questions:

1. Did adjunct clinical nursing instructors' self-ratings of knowledge about evaluating students improve upon completion of a workshop on evaluating students in clinical courses?
2. Did adjunct clinical nursing instructors' knowledge about student evaluation improve after completion of a workshop on evaluating students in clinical courses?

3. Did adjunct clinical nursing instructors' affective indicators towards student evaluation change upon completion of a workshop on evaluating students in clinical courses?

4. What were the clinical nursing faculty views about the use of a student oriented learning outline (SOLO) for a faculty development workshop?

Definition of Terms

This section provides the definitions of key terms used in the study:

Adjunct clinical instructor: Adjunct clinical instructors are part-time instructors who teach clinical courses. An adjunct clinical instructor is an experienced registered nurse who holds a minimum of a bachelor of science in nursing degree. These instructors work with students in on-campus laboratories and/or off-campus clinical settings.

Clinical course: A clinical course is taught as a co-requisite to a lecture course. Clinical courses provide opportunities for students to practice and apply skills and knowledge through lab, client care, and simulation experiences (Oermann & Gaberson, 2009).

Clinical instruction: Clinical instruction, also called clinical teaching, refers to instruction that takes place in a variety of clinical settings where the instructor evaluates the students and facilitates the learning guided by the clinical course objectives.

NCLEX-RN: This is an acronym for the registered nurse licensure exam. The National Council Licensure Examination for Registered Nurses and the National Council of the State Boards of Nursing requires a candidate who has met the educational requirements to pass the NCLEX-RN examination before application can be made, for a registered nurse license, in all states. This exam measures competencies needed to perform safe and effective care for an entry-level registered nurse (National Council of State Boards of Nursing, 2014).

Cognitive: Cognitive learning is the extent to which the learner has increased their knowledge of a specific subject (Bastable, 2008). Cognitive learning is an active process that requires the learner to participate by taking in new information, interpreting the information, and understanding the information.

Affective behavior: A voluntary behavior that is often collected discreetly and anonymously by a faculty member or in this case the researcher. Affective behaviors are often self-directed actions that are not influenced by a reward such as a grade or compensation (Mager, 1968).

SOLO: A Student Oriented Learning Outline is a written communication that serves as a planner for the student prior to an education session (Hammons & Jaggard, 1984). A SOLO tells students what they will learn, in what way they will learn, and what the expected outcomes will be. For the purposes of this study the student is the adjunct clinical instructor.

Professional development: An activity that provides an opportunity for participants to gain knowledge and skill in order in increase their expertise and ability related to a specific topic or goal.

Delimitations and Limitations

A quasi-experimental design was used to evaluate the effect of a faculty development workshop on the cognitive and affective behaviors of adjunct clinical instructors in a Bachelor of Science nursing program. The sample in this study was delimited to adjunct clinical instructors at the University of Arkansas, Eleanor Mann School of Nursing (EMSON) who taught during the Spring 2014 semester. There are adjunct clinical instructors in both graduate and undergraduate programs at EMSON, but the focus for this study was delimited to undergraduate nursing adjunct

clinical instructors. Additionally, only those adjunct clinical instructors who attended the faculty development workshop were included in the study.

The study had several limitations, which should be considered. First, the use of a convenience sample creates selection bias, since adjunct clinical instructors were not randomly selected to participate. With a convenience sample the researcher is unable to report with confidence that the participants are representative of the population (Creswell, 2012, p. 145). Second, the self-report nature of the pretest and posttest is another limitation. Self-reported data are often biased by participants' attitudes and feelings. Adjunct clinical instructors have been hired because they have a desire to teach or gain additional income. These faculty members are highly motivated to keep their position with the school of nursing. This might influence the answers in some areas of the pretest and posttest. Third, I developed the pretest and posttest tools. Although expert review of the instruments was completed for face validity there needs to be additional testing to assure validity of the instruments. Finally, I was also the developer of the workshop and delivered the majority of the content, which may have introduced some bias related to content and execution of the program.

Significance of the Study

This study made several important contributions to research and practice for adjunct clinical instructor faculty development. The study contributed to the existing research concerning adjunct clinical faculty in nursing and the gap that exist regarding evaluation of students in clinical courses. Implications for practice included the support of the need for faculty development workshops for adjunct clinical instructors. Furthermore, the necessity of having

prepared expert nurse educators to support reliable evaluation practices in clinical courses was emphasized.

A challenge for many nursing programs is the retention of qualified adjunct clinical instructors (Forbes et al., 2010). Turnover of adjunct clinical instructors is costly to the institution in both dollars and quality of programs. Providing adjunct clinical instructors with the tools necessary to be successful in the educator role is important for program success. Through the development of adjunct clinical instructors, nursing programs can fill the gap created by the nursing faculty shortage and maintain a quality nursing education. Additionally, employing adjunct clinical instructors is beneficial to nursing programs because it is cost effective, meets the changing clinical needs, and provides expert clinicians in clinical courses (Richardson, Gilmartin, & Fulmer, 2012). The challenges created by working with this distinctive group of educators are unique and requires additional investigation and review.

Full-time nursing faculty development needs are well represented in the literature (Camblin & Steger, 2000; Cash & Tate, 2008; Howland, Sullivan-Bolyai, Bova, Klar, Harper, & Schilling, 2008; Sorcinelli, 1994). However, there is little in the literature concerning specific faculty development programs beyond mentoring and orientation needs for adjunct clinical faculty (Forbes et al., 2010). The requirements for the role of adjunct clinical instructor differ from that of expert clinician and require supplementary education and support. Teaching effectiveness has been a concern related to teaching of adjunct clinical faculty in the clinical setting (Allison-Jones & Hirt, 2004). Hired as clinical experts these clinicians need additional education to support students in the clinical courses. Evaluating students in clinical courses is a dominant role for the adjunct clinical instructor and is something that generates great concern and anxiety (Emerson,

2007). Lack of faculty development and support could lead to substandard clinical evaluation practices and ultimately allow students to progress who do not meet the course standards.

Theoretical Framework

The framework for this study included Benner's Novice to Expert model for nursing (1984) and Gagne's (1970) description of learning. A faculty development workshop was offered based on the concept of the sequential development from novice to expert for the adjunct clinical instructor. Beneficial in the planning and development of the workshop was Benner's levels of expertise development. Additionally, a learning theory is relevant to this study based on the assessment of cognitive outcomes. Learning is a complex process; learning theories are an attempt to understand the process of learning. According to Gagne (1970), learning occurs when there is a change in behavior. For this study a pretest and posttest was used to assess a change in knowledge based on information gained from the faculty development workshop for adjunct clinical instructors.

Novice to Expert

Benner's model for the development of clinical expertise was used to guide this study. Benner's framework is based on Dreyfus' Model of Skill Acquisition (1986), which stated that a person develops skills and knowledge in a sequential progressive manner by acquiring five levels of proficiency (Benner, 2004). Benner (1984) stated that learners begin as *novices* and through acquisition of knowledge and practice; they continue to become more proficient until culminating in the *expert* state. Competence is viewed as having consistent, planned, and predictable outcomes. Benner focused on the combination of practice and theory to create

clinical competence (Alligood & Marriner-Tomey, 2006). Benner's model stressed that a lack of advanced ability was situational and not dependent on a trait or talent deficit (Benner, 2001).

Stage one of development is described as the *novice* stage. The major indicator in this stage is lack of experience in a given situation. A novice operates using abstract principles and needs formal models and theories to be successful (Dreyfus & Dreyfus, 1986). Novice behavior is governed by rules and creates an inflexible mind-set in a changing and unpredictable clinical environment (Benner, 2001, p. 21). This stage for the adjunct clinical instructor is filled with limited contextual meaning due to the lack of experience as an educator.

The nurse who has marginal experience in the clinical environment or with the needed skill is described in stage two as the *advanced beginner*. Nurses functioning at this level continue to be guided by rules and are oriented by task completion (Alligood & Marriner-Tomey, 2006, p. 145). The nurse continues to require support and reassurance in this stage of development. Advanced beginners need assistance in setting priorities and are only starting to see meaningful patterns in the clinical situation. This level requires additional assessment by competent level nurses to ensure that the advanced beginner does not miss important client needs. Benner (2001) stated, "the advanced beginner cannot yet sort out what is most important" (p. 25).

Stage three is described as the level of *competence* and is demonstrated by a nurse who is beginning to see the long-range outcomes of their actions. In this stage the nurse has the ability to plan and complete tasks needed to be successful. At this level the nurse is more efficient and organized but "lacks the feeling of mastery" (Benner, 2001, p. 27).

In stage four the nurse is described as *proficient*. The nurse is able to view the entire situation and make decisions based not solely on principles and guidelines. Perception of a situation is

based on experience and creates a pathway for action. Proficient nurses understand the situation in context of the long-term outcomes (Benner, 2004). Past experience allows the nurse to view the situation differently and recognize the priority of needs for the student or client.

The final stage in Benner's model is that of *expert*. The expert nurse has an extensive background of experience and knowledge (Benner, 2001). An expert often has an intuitive awareness of the situation and is able to quickly and clearly provide feedback. It is difficult to provide a description of the expert nurse, "because the expert operates from a deep understanding of the total situation: the chess master" (Benner, 2001, p. 32).

Benner's major concepts can be applied to clinical instructors as they enter into faculty practice at a variety of levels. While some clinical experts have knowledge and background in education many adjunct clinical instructors enter the faculty role as novice educators. Benner (2001) described knowledge areas as domains. A domain is a grouping of knowledge, skills, or competencies that have resembling content or meaning (Benner, 2001, p. 293). Benner's theory proposed that nurses could be experts in some domains of nursing while being beginners in other domains.

Benner's model suggests that in regards to nursing education nurse educators are limited in clinical course instruction by the background and knowledge brought to the clinical situation. This is described as secondary ignorance: "they do not know what they do not know, and have a limited understanding of how to go about learning it" (Benner, 2001, p. 185). Faculty development is provided to adjunct clinical instructors to provide the basic knowledge needed to begin the progression through Benner's model.

Benner's model has been studied and tested extensively in nursing (Anderson, 2009; Cusson & Strange, 2008; Gershenson, Moravick, Sellman, & Somerville, 2004; Haag-Heitman, 2008; Larew, Lessans, Spunt, Foster, & Covington, 2006; McArthur-Rouse, 2008). This model provided a conceptual base for the development of the adjunct clinical instructor workshop and the design of this study.

Learning Theory

Robert Gagne is best known for his contributions to the practice of instructional design and theory (Richey, 2000). Gagne's instructional theory (1970) described learning as a sequential process whereby a message is sent, stored, and later recalled. The learner gains the new information, which is described as a stimulus. This stimulus is called *input,* and the learner uses the *input* to change performance or a behavior.

Gagne (1985) identified the mental conditions of learning, which evolved into five categories of learning: intellectual skill, verbal information, cognitive strategy, motor skill, and attitude. Intellectual skill and verbal information categories of learning require the learner to retrieve previously learned knowledge. Cognitive strategies require the capability to learn, think, and recall. Clinical skill acquisition could be positioned in the motor skills learning category. Nurses learn basic clinical skill procedures and knowledge and translate them into skilled acts or functions. The learning category of attitude is important to the adjunct clinical instructors' role and must be recognized to create unbiased practices in the clinical setting toward both students and clients. Each category requires different teaching methods for participants to acquire new knowledge.

Gagne (1985) fundamentally viewed learning as dependent on past learning and experiences. Learning is stimulated and controlled by external events such as instruction. Additionally, learning is precipitated by the use of logical instructional strategies that provide motivation, direction, guided practice, feedback, and reinforcement (Richey, 2000). Gagne (1985) also asserts that working backwards from goals to the requirements of instructional events is an effective means of instructional design. This model supports the use of the SOLO, which was utilized as part of this project.

Gagne's influence on the more current learning theories is evident; they all represent a "line of thinking" (p. 284) that can be connected to Gagne's generic learning theory (Richey, 2000). Although Gagne's learning theory was developed over 40 years ago his learning principles continue to be relevant today (Richey, 2000).

Chapter Summary

This chapter provided an overview of the purpose of this study. The research questions, definitions, limitations, and significance of the study were also discussed. Faculty development concerning evaluation of students in clinical courses is important for both adjunct faculty role development and nursing program success. To ensure program success nursing programs must provide fair and reliable evaluation of students in the clinical courses. This study evaluated a faculty development workshop for adjunct clinical instructors and assessed the cognitive and affective behaviors of those instructors after the session. The findings from this study added to the current body of literature on adjunct clinical instructors' response to a faculty development workshop. Additionally, the study provided information that reinforced the continued support of

faculty development for adjunct clinical instructors for the nursing program at which the study was completed.

II. LITERATURE REVIEW

Introduction

This chapter provides an overview of the literature on adjunct clinical faculty, faculty development, and student assessment in nursing. The review is divided into five sections: the role of adjunct clinical instructors in nursing education, orientation of adjunct clinical instructors, clinical education in nursing, faculty development for adjunct clinical instructors, and clinical grading.

A thorough search of the literature was completed using CINAHL, Medline, ProQuest, GoogleScholar, and Worldcat with a focus on research studies from the nursing literature. In searching these databases the following key words were used: clinical instruction, clinical teaching, clinical education, adjunct, part-time instructor, and clinical grading. A limiting parameter between the years of 2000-2014 was set, with exception made for landmark studies. A search of the publications available using the same key words on the National League of Nursing and the American Association of Colleges of Nursing websites was also completed.

The Role of Adjunct Clinical Instructors in Nursing Education

The nursing shortage creates challenges in both the practice and education areas of nursing (Cangelosi et al., 2009). Expert adjunct clinical faculty members who have clinical expertise and are skilled educators are difficult to find in nursing education. Nursing programs will continue to rely greatly on part-time clinical instructors to provide instruction in clinical courses (Lee, Cholowski, & Williams, 2002; Peters & Bolyston, 2006; Pierangeli, 2006; Salamonson et al., 2010; Watson, Simpson, Topping, & Porock, 2002). In a national study on entry-level nurse educators, Poindexter (2013) reported that administrators expect novice educators to gain the

needed teaching competencies prior to obtaining a teaching position. If key issues are addressed before adjunct clinical instructors begin teaching the transition into the faculty role will be easier (Hewitt & Lewallen, 2010; McDonald, 2010).

The significance of competent clinical instructors in preparing nursing students for nursing practice is well documented (Cangelosi, 2007; Hewitt & Lewallen, 2010). In a study by Cangelosi (2007) students seeking a second-degree in nursing identified clinical instructors as critical in their development for becoming a nurse. Cangelosi used a phenomenological design and interviewed 19 accelerated second-degree graduates to gain information about the experiences that best prepared students for nursing practice. Clinical teaching that blended the pedagogy with practice was identified as a significant theme in this study. Clinical instructors are important in providing the link between the classroom pedagogy and clinical practice. Cangelosi (2007) concluded that "competent clinical instructors are highly valued" (p. 400) among accelerated second-degree students and are essential to their success.

Strategies for assuring the success of part-time faculty are important for retention of this essential group of faculty (Duffy et al., 2008). The literature points to orientation and mentoring as a way to support this unique and important group of nursing professionals (Davidson & Rourke, 2012; Hutchinson, Tate, Torbeck, & Smith, 2011; Peters & Boylston, 2006; Sawatzky & Enns, 2009). Providing education to support the novice clinical instructors and including them in nursing program activities have also been reported as important (Duffy et al., 2008). Understanding the specific needs of adjunct clinical instructors will aid in the development of orientation and education programs for this group.

Orientation of Adjunct Clinical Instructor

Adjunct clinical instructor orientation is not widely provided and often based on administration's assumptions of the orientation and learning needs of part-time clinical instructors (Hewitt & Lewallen, 2010; Higgs & McAllister, 2005; Jarrett, Horner, Center, & Kane, 2008; Gould, Kelly, White, & Chidgey, 2004). An assessment of the learning needs could provide valuable information to key stakeholders in planning and development of programs for adjunct clinical instructors.

The National League of Nursing (NLN) (2005), Task Force for Nurse Educators developed a list of core competencies needed for all nurse educators. These competencies lack specific details required for clinical educators to be successful and do not provide enough detail for translation into an evaluation for clinical educators (Davidson & Rourke, 2012). The NLN has identified the need to analyze instructional strategies for effective clinical instruction as a priority for future research (Halstead, 2007). Core competencies for clinical instruction are an important factor when assessing the requirements for clinical instructor development.

Davidson and Rourke (2012) found that the learning needs of part-time clinical faculty (N = 44) could be categorized into five specific areas. A 5-point Likert scale was used to rate the importance of 53 learning need items on a questionnaire. Results from this study revealed that knowledge of the pay system, the university calendar, and faculty resources were essential for 84% of the respondents. Additional knowledge areas that were rated "high need" include: curriculum (82%), simulation technology (90%), evaluation practices (80%), and faculty development (66%). The least important aspect noted by the participants was introduction to faculty members, administration, and program admission policies (Davidson & Rourke, 2012).

The identified content areas were utilized to create an on-line orientation for part-time clinical instructors at the study institution.

Adapting to the role of educator, with a lack of knowledge or resources, can create stress for the student, instructor, and program. Forbes et al. (2010) developed a three section needs survey to assess the teaching needs of 65 adjunct faculty members at a mid-size university. The nursing program offered an optional, one-hour orientation to adjunct faculty members prior to administering the survey. Even with the orientation, the adjunct faculty reported being minimally oriented to clinical evaluations, use of audiovisual equipment, and the use of blackboard. General groups of phrases that demonstrated major needs of adjunct faculty included: lack of resources, help with technology, inconsistent messages, and lack of contact with full-time faculty (Forbes et al., 2010). Adjunct faculty also expressed an interest in formal courses, workshops, and the need for a "go-to person" (Forbes et al., 2010, p. 122). Offering an orientation for adjunct clinical instructors is a good start to meeting the needs of these part-time faculty members. Including the information gained from a needs assessment of the adjunct clinical instructors will provide support for clinical instructor success. This success could aid in retaining adjunct clinical instructors who are well prepared and have experience supervising students (Forbes et al., 2010, p. 118).

Wolf et al. (2009) attempted to profile clinical instructors' knowledge using a 40 item multiple-choice test. The researchers developed and tested the Clinical Teaching Knowledge Test (CTKT). The CTKT evaluated clinical faculty members' understanding of clinical preparation, teaching, and evaluation. A convenience sample of 160 faculty members who taught clinical courses in undergraduate programs revealed six thematic knowledge deficit

categories. Thematic analyses were based on proportion correct indexes of less than 0.75. The results yielded clinical instructor knowledge deficit in the following areas: faculty legal responsibilities, student-faculty relationships, counseling approaches, educational theories in clinical teaching, students' legal rights, and nursing administrators responsibilities (Wolf et al., 2009). All participants answered one question on the CTKT, related to evaluation of student errors, accurately. Number of years of teaching experience were analyzed in an effort to ascertain contrasted group validity using a *t*-Test ($t = -1.417$, $df = 97.91$, $p = .160$). No statistical difference was found between the groups. The results from this study provided useful information for planning adjunct clinical faculty orientation and development.

Clinical Education in Nursing

Clinical education has evolved over time from an apprenticeship-learning model to structured courses, which are objective driven and provide supervised practice experience for nursing students (Blum, 2009). Clinical education is important in the development from student nurse to novice practitioner (Giddens et al., 2008). To function as a nurse upon graduation, students must be able to apply the concepts gained in laboratory and didactic courses to provide safe client care. Clinical experiences provide supervised practice in an unpredictable clinical environment, which allows students to gain the skill and confidence required to care for clients as a registered nurse (Gaberson & Oermann, 2007).

Excellence in clinical teaching requires knowledge of key factors to excel in the educator role (Stokes & Kost, 2005). Ard et al. (2008) examined the key components of clinical education. The authors used a survey to poll National League of Nursing members and state board representatives to provide information on key factors for clinical nursing education. The

majority of the 2,218 respondents agreed that the most essential component of clinical nursing education was a well-rounded experience with active involvement by students. The most controversial area of the survey involved the need for active involvement of staff and clients, in the clinical setting (Ard et al., 2008). This study gave insight as to how clinical education was interpreted by a large number of registered nurses.

An important factor for clinical education is the environment and quality of instruction (Elliott, 2002). In a review of the nursing literature Elliott (2002) reported that sources of stress for undergraduate nursing students in the clinical area could be categorized in three areas: clinical supervision, assessment, and preceptor nurses. By understanding these stressors concerted efforts can be made to improve the students' clinical experiences. Being required to act as the staff nurse, fear of harming a client, and not knowing the hierarchies of a specific setting are common student fears (Elliott, 2002, p. 35). A competent, caring, well-trained, and effective clinical instructor is important in decreasing student stress in the clinical setting (Cook 2005; Elliott, 2002; Moscaritolo, 2009; Timmins & Kaliszer, 2002).

Moscaritolo (2009) provided a review of the literature and reported that strategies for reducing student anxiety in the clinical learning environment are important to support student learning. Faculty must be concerned about how anxiety affects student performance in a clinical course and how student stress and anxiety affect program outcomes. The review of the literature supports that clinical experiences are the most anxiety producing activity for nursing students in the program of study (Moscaritolo, 2009).

The amount of support provided to students in the clinical setting has a significant influence on student satisfaction and success (Bergman & Gaitskill, 1990; Bettinger & Long, 2010;

Calman, Watson, Norman, Redfern, & Merrells, 2002; Espland & Indrehus, 2003). A study of Norwegian nursing students at three schools of nursing found that students reported the supportiveness of faculty to be the most important factor related to their success or failure (Espland & Indrehus, 2003). Students who reported a strong, supportive student-teacher relationship indicated they had an increased ability to focus on learning. The researchers concluded that the increased ability to focus created a good environment for student learning (Espland & Indrehus, 2003).

The nature of clinical learning is unique because it requires active learning by the student as well as application of previously learned concepts. There is little written about clinical learning. Clinical learning is an internal, experiential, dynamic, and difficult process (Gaberson & Oermann, 2007). Nursing students in clinical courses are required to take action based on changing client needs in the clinical setting. Engagement in the clinical environment is necessary to develop the ability to critically think and take appropriate actions based on multiple pieces of information (Benner, 2004).

Kan and Stabler-Haas (2009) in a facts handbook for clinical instructors described the importance of the clinical instructor's ability to create a good learning environment. The atmosphere in the clinical setting can be uninviting for nursing students. For clinical learning to occur the environment must support and accept the student as a care provider. The clinical faculty should create the bridge between the practicing nurse and the student (Kan & Stabler-Haas, 2009). Moreover, the relationship between the clinical setting staff and the clinical instructor is an important factor for student success. Clinical teaching requires the adjunct

clinical instructor to work with clinical staff on a variety of issues to create positive learning environments.

Clinical Teaching

Experienced clinical instructors are in high demand and short supply (Wolf et al., 2009). The majority of the literature concerning clinical instructors is clustered around effective clinical teaching. Effective clinical teaching is directly linked to student satisfaction and program success (Mogan & Knox, 1987). This portion of the literature review addresses effective instructor attributes for clinical course instruction.

A significant percentage of the literature regarding clinical instructors revolves around the theme of effective and ineffective teaching behaviors. Attitude and interpersonal relationships were found to be the most important factors for effective clinical instruction in a study completed with two nursing programs in Taiwan (Tang, Chou, & Chiang, 2005). A questionnaire was distributed to 214 nursing students at two schools of nursing with a return rate of 91%. Students were asked to think about two instructors, one liked and one disliked, and then asked to complete the questionnaire for each of these two instructors. There were no names of instructors associated with the questionnaires or faculty present during the questionnaire completion. Tang et al. (2005) used Pearson correlation for evaluation of the differences between the two schools. There was no significant difference between the two schools of nursing ($r = .48$, $p < .01$) for what constituted an effective instructor. What made an ineffective instructor demonstrated even more agreement among participants ($r = .87$, $p < .000$). Effective clinical instruction was described as having an awareness of student needs and the ability to meet those needs. Tang et al. (2005) summarized their findings about student perceptions of effective and ineffective

clinical instructors by stating, “we highly recommend that teachers strive to improve their attitudes toward students as the best way to achieve the goals of clinical teaching” (p. 187). The study also noted nursing competence, teaching ability, and evaluation ability as characteristics required for effective clinical teaching (Tang et al., 2005).

Expert clinicians who are novice clinical instructors often experience stress and anxiety in this new role due to a lack of preparation (Poindexter, 2013; Wolf et al., 2009). Students also report anxiety in clinical courses, which may be directly related to the instructor’s level of certainty in the educator role. Cook (2005) reported that baccalaureate nursing students’ perceptions of professionally inviting teaching behaviors exhibited by clinical instructors correlated with students’ self-reported anxiety levels. A descriptive, correlational, and comparative design was used to explore the relationship between junior and senior generic baccalaureate nursing students’ perception of inviting teaching behaviors and students’ anxiety level (Cook, 2005). Inviting teaching behaviors were divided into two categories: personal and professional. Personal inviting behaviors included an instructor who shared their own experiences and involved students in making decisions. Clinical instructors who scored high for having professional inviting behaviors provided clear instructions, used a variety of teaching methods, expected students to be prepared, and demonstrated up-to-date clinical expertise. Clinical instructors with higher scores of inviting behaviors positively correlated with lower student anxiety levels. These anxiety levels were specifically related to interacting with faculty during clinical experiences. Furthermore, there were similar anxiety levels reported by junior and senior level nursing students. This study indicated that both junior and senior level students

desired clinical faculty who demonstrated inviting teaching behaviors to provide a less anxiety producing clinical experience (Cook, 2005).

Effective clinical instructors provide positive student experiences, meet course outcomes, and ultimately positively impact program success (Ard et al., 2009; Allison-Jones & Hirt, 2004; Beitz & Wieland, 2005; Clark, Owen, & Tholcken, 2004; Duffy et al., 2008; Tang et al., 2005; Jones & Hirt, 2004; Kelly, 2007; Tanicala, Scheffer, & Roberts, 2011). Students spend large amounts of time in clinical courses with small student to faculty ratios, which allows for a more individualized experience. Knox and Mogan (1985) developed a tool called the Nursing Clinical Effectiveness Inventory (NCTEI), which has been utilized in many studies on effective clinical instruction (Allison-Jones & Hirt, 2004, Beitz & Wieland, 2005; Gignac-Caille & Oermann, 2001; Viverais-Dresler & Kutschke, 2001). The questionnaire contains a 47-item list of instructor characteristics, which are ranked using a 7-point Likert scale. Higher scores, on the inventory, were positively correlated with effective teaching characteristics. The tool described clinical instructor characteristics in five categories: teaching ability, evaluation of students, interpersonal relationships, instructor personality, and nursing competence (Knox & Mogan, 1985). The information provided from this tool when used in faculty development could provide a list of the best and the worst clinical instructor behaviors. Results of this test can be used for instructor self-reflection and evaluation.

Knox and Mogan (1985) conducted a descriptive study in which the NCTEI was developed and administered to traditional Bachelor of Science in nursing (BSN) students (n = 487), BSN graduates (n = 45) and faculty (n = 49). The scores for the evaluation category were the highest (93%) for all participants. Evaluation was assessed by the instructor's ability to provide

straightforward and constructive feedback. Knox and Mogan (1985) reported that there was no statistical difference between the perceptions of the three groups concerning effective clinical teacher behaviors.

There is concern over the effectiveness of part-time faculty in nursing programs. Effective clinical instruction aids students in developing critical thinking skills, which are essential for a successful registered nurse (Allison-Jones & Hirt, 2004). In a 2004 study by Allison-Jones and Hirt, students reported that part-time faculty members were less effective in each of the five categories measured by the NCTEI. The five categories on the NCTEI were teaching ability, evaluation of students, interpersonal relationships, instructor personality, and nursing competence (Mogan & Knox, 1987). There were significant differences between how full-time and part-time faculty ranked in the five categories. In contrast, Holmes (2006) surveyed 132 BSN students and 79 BSN faculty members, including 55 full-time and 24 part-time faculty members. The results differed from previous studies; the authors found that there were no differences between the teaching effectiveness of the full-time and part-time faculty. This difference in results between the two studies could be related to the type of institution used for the studies; the Holmes study was conducted at a four-year institution and the Allison-Hirt study was conducted at a two-year associate degree nursing program. Allison-Jones and Hirt (2004) found that students rated part-time clinical faculty significantly lower on clinical teaching effectiveness scales than their full-time counterparts. However, in the same study full and part-time clinical instructors rated themselves equally on effective instruction.

A study with similar results using the NCTEI, surveyed 292 associate degree nursing students and 59 faculty members from five programs (Gignac-Caille & Oermann, 2001). The results

indicated that faculty rated evaluation as the most important characteristic for teaching effectiveness. Students differed from the faculty and rated interpersonal relationships as the most important. The least important component for effective clinical teaching, rated by both students and instructors was instructor personality (Gignac-Caille & Oermann, 2001).

Lee et al. (2002) utilized the NCTEI to identify effective teaching characteristics of clinical instructors in Australia. The participants for the study included 104 nursing students and 17 clinical instructors. There was no significant statistical difference between students' and clinical instructors' perceptions of characteristics of effective clinical instructors. Both student and faculty participants ranked the top five characteristics as interpersonal relationships, evaluation, competence, teaching ability, and personality traits (Lee et al., 2002). However, the faculty participants ranked competence as second in the scoring of effective educator characteristics, while the students ranked competence as third.

When analyzing the teaching effectiveness of clinical nursing faculty, Beitz and Wieland (2005) described effective clinical behaviors using data from three groups of participants. A comparative descriptive design was used to assess the following three groups of students; generic Bachelor of Science students, students with practical nurse license, and associate degree registered nurses. All were seeking a Bachelor of Science in nursing degree. The NCTEI and the Observations of Nursing Teaching in Clinical Setting (ONTICS) scale were given to a stratified convenience sample of the three categories of participants. There was no significant difference in how the participants rated clinical instructor effectiveness. The associate degree registered nurse participants rated personal traits as important for clinical instructors higher than

the other two groups (p = .06). Effective clinical instruction was viewed equally important regardless of prior experience or licensure (Beitz & Wieland, 2005).

Identification of specific clinical teaching behaviors of faculty that facilitate or interfere with the clinical experience provides information that is important to clinical instruction (Kelly, 2007; Lofmark & Wikblad, 2001). Clearly there is an urgent need to gain a better understanding of what represents effective clinical teaching and how this affects student learning (Kelly, 2007). Even with this knowledge teaching effectiveness can be difficult to evaluate in the clinical environment. Using a convenience sample of 30 diploma and baccalaureate-nursing students, Kelly (2007) conducted an investigation of teaching effectiveness in the clinical setting. An exploratory descriptive method was employed during 1989 and again in 2003 to complete the investigation. Students in both groups (1989 and 2003) had comparable responses to what they perceived as important factors in a good clinical instructor, with an "emphasis on teacher knowledge" (Kelly, 2007, p. 889). Both groups of students also placed equivalent importance on communication skills and instructor feedback. Findings from this study supported the idea that student perceptions of an effective clinical instructor were based on a competent clinical instructor with good communication skills. Students perceived a positive relationship between the student and the instructor, as most important to clinical course success. Additionally, students reported being given individualized and positive feedback as important to learning in the clinical environment.

Clinical educators who cultivate teaching abilities that support student development improve the clinical experience for students (Hanson & Stenvig, 2008). In a descriptive study using grounded theory techniques, six BSN program graduates were interviewed concerning their

views about which clinical instructor attributes enhanced their preparation for safe practice as a registered nurse (Hanson & Stenvig, 2008). Open-ended questions encouraged expansion of the data concerning the clinical experience. Positive clinical instructor traits revealed during the analysis were: knowledge, interpersonal presentation, and teaching strategies. Participants reported a desire for realistic clinical assignments, which were defined as "experiences that are going to happen in real life" (Hanson & Stenvig, 2008, p. 40). The findings from this study were similar to prior studies that had explored effective clinical instructor behaviors.

Adjunct Clinical Instructor Development in Nursing

Participation in faculty development by clinical instructors provides a means by which to improve instruction in a variety of disciplines (Bell-Scriber & Morton, 2009; Higgs & McAllister, 2005; Notzer & Abramovitz, 2008; O'Callaghan, 2007). A study of 149 medical faculty members who provided clinical instruction to medical students found that a brief workshop created marked improvement in instructor availability and feedback (Notzer & Abramovitz, 2008). The nursing literature revealed limited research regarding specific faculty development models for adjunct clinical instructors. However, some nursing programs have implemented structured programs for clinical instructors in an effort to increase the number of qualified, competent clinical instructors (Bell-Scriber & Morton, 2009; Jarrett et al., 2008).

Further nursing studies have provided information about the evaluation of faculty development (workshops, courses, orientations) for adjunct clinical instructors (Forbes et al., 2010; Jarett, et al., 2008; Kowalski et al., 2007; Krautscheid, Kaakinen, & Warner, 2008). There are also a limited number of clinical instructor handbooks and reference manuals that support clinical instructor development (Pierangeli, 2006). Some nursing programs have created a

program specific guide as a reference for adjunct clinical instructors. Pierangeli (2006) provided detailed directions for the development of a clinical instructor handbook with suggested topics to support adjunct clinical instructors' development and orientation. The development of a program specific, clinical instructor handbook is one way to support adjunct clinical instructors. Clinical instructors need preparation in evidence-based learning and teaching methods; this is not typically what is often offered in an orientation or program specific guide or handbook.

A few studies have focused on specific clinical faculty development courses to support growth of the adjunct clinical instructor. Kowalski et al. (2007) with support from the Colorado Department of Labor created and implemented a 40-hour preparation course to develop staff nurses as clinical instructors/scholars. The project goals were to prepare 45 new clinical instructors, staff 362 clinical rotations, decrease student attrition rates, increase the knowledge base of the clinical instructor, and maintain or improve NCLEX-RN pass rates. For this project there was collaboration between eight clinical facilities and three baccalaureate programs of nursing. Kowalski et al. (2007) reported that due to intense interest in the course, the results exceeded expectations with 91 clinical instructors completing the course. Many of the nurses who completed the program reported a renewed interest and optimism in the nursing profession. These results from this study supported the expansion of the nurse clinical expert role to include the nurse educator role for increasing job satisfaction and renewed interested in nursing.

Hutchinson et al. (2011) described a clinical instructor orientation and training model used by a large acute care medical site. The course consisted of a two-day program for new instructors and a one-day program for returning instructors. The facility described the program as meeting the educational needs of the clinical instructors and as relieving the responsibility of staff nurses

orientating the clinical faculty. Topics included in the orientation were operational, philosophical, educational, legal, and ethical considerations that affected the instruction of students. Over a three-year period, 100% of the participants reported that the program was worthwhile. Additionally, 77% of attendees requested to return to the institution as clinical instructors. This program was recommended as a requirement for all clinical faculty members to "enhance faculty preparation for clinical teaching" (Hutchison et al., 2011, p. 61).

Other factors that support the need for formal education programs for clinical instructors are a lack of courses, orientations, or mentorships offered for their development. A four-day clinical nurse academy was designed and offered to baccalaureate and masters prepared nurses who were interested in "developing new skills as clinical nurse educators" (Cangelosi et al., 2009, p. 368). Benner's (1984) model of the process of moving from "novice to expert" was used to explore the progression of the expert clinician entering a new unknown professional role. All participants provided three reflective writings on the process of acquiring new knowledge and skills needed for clinical instruction. Using an interpretive phenomenological design the researchers identified one overarching pattern: learning to teach. Also recognized were three major themes: " buckle your seatbelt," "embrace the novice," and "mentoring in the dark" (Cangelosi et al., 2009, p.369). The themes were related to feelings and thoughts about being a novice in their new role.

Mentoring as a strategy for faculty development is well documented in the nursing literature (Peters & Boylston, 2006; Records & Emerson, 2003; Roberts, Chrisman, & Flower, 2013; Thorpe & Kalischuk, 2003). In a position statement, the National League for Nursing (2006) advocated for the use of mentoring to facilitate career development for nursing faculty.

Mentoring is needed for the intentional guiding and support of new faculty members (Roberts et al., 2013).

Expert clinicians desire support and guidance as they move into the new role of clinical instructor (Roberts et al., 2013). In a recent study of 21 adjunct clinical faculty Roberts et al. (2013) used a naturalistic inquiry method to gain information about the perceived needs of clinicians transitioning into the educator role. A major theme identified by Roberts (2013) was the clinical faculty members' desire to have a mentor guide the transition. Additionally the participants reported needs in these areas: responsibilities, roles, and support systems. New adjunct clinical instructors desired a key contact to assist them in developing the needed skills for student instruction (Neese, 2003; Peters & Bolyston, 2006; Roberts et al., 2013). Other studies also supported that mentoring programs for new instructors are important components for effective role transition (Gies, 2003; Hutchinson et al., 2011)

The most significant stressor of a new faculty member is fitting into the academic world (Sawatzky & Enns, 2009). Some adjunct clinical instructors feel marginalized and isolated (Finn et al., 2000). Nursing programs often do little to incorporate adjunct clinical instructors into the faculty culture. Providing a faculty mentor is one means to support adjunct clinical instructors. In a study of 29 full-time faculty members at a single institution, Sawatzky and Enns (2009) used a cross-sectional survey design to collect information on the perceived requirements of a faculty mentor. Based on a review of the current mentoring literature, the researchers developed a survey to assess what faculty members believed was required of a good mentor. The needs assessment questionnaire was distributed to the participants; the results specified career function and caring as the most important roles and responsibilities for mentors. Participants were also

asked to provide comments concerning additional roles and responsibilities that were not represented in the questionnaire. The identified themes of the additional roles and responsibilities included: teaching support strategies, insight into role expectations, policies, and celebrating achievements (Sawatky & Enns, 2009). The results from this study are consistent with other findings that support mentoring programs in nursing education.

Simulated clinical experiences have been used extensively in nursing education with students for clinical skill development (Feingold, Calaluce, & Kallen, 2004). The features of simulation are equally applicable for the development of adjunct clinical faculty for the teacher role (Krautscheid et al., 2008). Clinical courses require instructors to possess both clinical expertise and education pedagogy in order to be effective clinical instructors (Kelly, 2007; Krautscheid et al., 2008). Clinical environments have changed over the past decade with all units in acute care facilities having critically ill clients. Clinical faculty can no longer teach the same way they were taught due to these complex clinical environments. Krautscheid et al. (2008) used simulated clinical experiences for faculty development of the teaching role for adjunct clinical faculty. Identified developmental needs of clinical faculty guided the structure of the three-hour development program. The identified essentials for the clinical faculty were the need for clinical faculty to capitalize on teachable moments, application of evidence-based practice, provide constructive feedback, and meet student-learning needs. Faculty members participated in a variety of simulated clinical teaching experiences and were provided with immediate feedback from an expert educator. A group debriefing, which included students who participated, provided additional feedback. Faculty reflected on how the simulations contributed to their clinical teaching ability. Three themes emerged from the participants: teaching strategies,

communication (verbal and nonverbal), and self-assessment. Participants reported that the simulated experience was a "powerful and safe strategy to enhance their ability to effectively facilitate learning in a clinical setting" (Krautschied et al., 2008, p. 433).

Clinical Grading

Grading practices in clinical courses are important to assure safe nursing practices both during the pre-licensure program and upon entering the workforce. Faculty members identify client safety as a major concern but are often hesitant to give negative feedback to students (Dolan, 2003). Student evaluation in the clinical setting requires clinical faculty to make assessments concerning students' knowledge, preparation, judgment, skill, and adaptability to a changing clinical environment (Amicucci, 2012; Walsh & Seldomridge, 2005). Clinical faculty members have the responsibility of recognizing substandard clinical practice and giving a failing grade if it is warranted (Boley & Whitney, 2003).

A national survey of assessment and grading practices in nursing schools was conducted by the Evaluation of Learning Advisory Council of the NLN and reported in a two-part series to inform nurse educators of the current practices used by pre-licensure programs (Oermann, Saewert, Charasika, & Yarbrough, 2009; Oermann, Yarbrough, Saewert, Ard, & Charasika, 2009). The first part of the survey consisted of 29 items and assessed evaluation practices in the cognitive and affective domains and factors that influenced the grading of students in nursing courses (Oermann, Saewert et al., 2009). Using the NLN database, the invitation to participate was emailed to 21,719 members, asking only pre-licensure faculty members to respond. A total of 1,573 educators completed the survey, with the majority reporting they were full-time faculty members (N = 1,461, 93%). The results from this study showed that examinations carried the

most weight in course grades in didactic courses. However, papers, group projects, and case studies were the most frequently used assessment method. Faculty members reported that affective domain assessment of student learning was most frequently done by faculty observation. Additionally, faculty shared that the most important factor for student assessment and grading practices in both didactic and clinical courses was the need for students to pass the NCLEX-RN (Oermann, Saewert et al., 2009).

In an extension of the national survey of assessment and grading practices, the Evaluation of Learning Advisory Council of the NLN presented data related to clinical courses from the original study (Oermann, Saewert et al., 2009). The Council stated that nursing continues to lack a clear definition of what constitutes clinical competence. Clinical competence is clearly safe practice, but it is much more complex that simply providing safe client care. Clinical courses typically evaluate students on their cognitive skills, interpersonal skills, psychomotor skills, and professional behaviors (Gaberson & Oermann, 2007; Hand, 2006; O'Conner, 2006; Oermann & Gaberson, 2009; Reising & Devich, 2004). The NLN national survey indicated that all faculty members reported using a clinical evaluation tool or checklist. Two common strategies for evaluation were student participation in clinical conferences and self-assessments (Oermann, Yarbrough et al., 2009). The majority of nursing programs used a pass/fail grading system (N = 1116, 83%). The remaining schools used a letter or numerical grading system. The highest percent of numerical grading systems were reported from the baccalaureate programs.

Clinical grading is important to ensure that the beginning level nurse has the knowledge and skills required for safe practice. Amicucci (2012) used a qualitative phenomenological method to describe faculty experiences of grading nursing students' clinical performance with

experienced full-time nursing faculty. Interviews of 11 participants revealed five essential themes: subjectivity, safety, change, wishful thinking, and discontent. All participants identified subjectivity and safety concerns as part of the clinical grading experience. Opportunity for change and a desire for students to do better were related to the instructor's need to provide the student with multiple opportunities to improve in the clinical setting. All participants described some undesirable feelings or discontent about clinical grading. Lack of administrative and colleague support with clinical grades was a basis for discontent for many participants (Amicucci, 2012). Better preparation and assistance with student assessment and clinical grading is an important factor for supporting reliable grading practices in nursing.

There is little debate among faculty members that there is grade inflation in higher education (Sonner, 2000). Grade inflation in clinical courses is a problem that has been identified in the nursing literature (Seldomridge & Walsh, 2006; Walsh & Seldomridge, 2005). Walsh and Seldomridge (2005) reported that there was a significant difference, over a five-year period, between didactic and clinical grades at one university between ten paired courses. Using a Wilcoxon signed rank test a significance difference between the didactic and the paired clinical course was demonstrated. The grades in clinical courses were negatively skewed, with students in clinical courses scoring much higher. The researchers found that the criteria for clinical course grading were not clear, provided fewer objective measures, and created inflated student grades. Clinical courses were also graded differently than didactic courses. Clinical courses required students to provide client care and perform skills while being evaluated by the clinical instructor. Didactic courses used more objective measures in a classroom setting. Suggestions for grading clinical performance included using agreed upon elements for grading, employing a

more detailed grading scale, evaluating performance from the beginning of the course, and utilizing both the laboratory and clinical setting for evaluating students. Assessments of students in clinical courses, for grading, are more subjective in nature than didactic assessments requiring the student to put theory and practice together to be successful (Walsh & Seldomridge, 2005).

Nursing faculty recognize that clinical grading is challenging, complex, and prone to subjectivity (Boley, 2003; Woolley, 1977). Because didactic courses use more objective evaluation methods they are less likely to be contested by students (Beezer, 1985). The most complex and subjective of all grading takes place in the clinical environment (Beezer, 1985; Boley, 2003). Boley (2003) reviewed several landmark cases that have set precedence for grade disputes. When graduates are conferred a degree of nursing from an accredited nursing program this is confirmation of a safe, effective graduate prepared to provide care to clients in the clinical setting. Although a graduate is still required to pass the NCLEX-RN before licensure the nursing program has declared this student prepared to pass this nursing licensure examination. Boley (2003) concluded that faculty must be clear in how a grade is assessed because passing the student also infers preparation to progress in the nursing program.

Faculty members frequently fear lack of support, loss of job, and litigation when assigning a failing grade (Boley, 2003). The courts overwhelmingly have supported faculty members' decisions; the courts have recognized their lack of expertise in the discipline of nursing. Faculty must be confident in assigning clinical grades on the basis of meeting program goals and maintaining professional standards. Chasens, DePew, Goudreau, and Pierce (2000) provided an overview of legal aspects of grading and student progression for nursing faculty. The authors described the intensity over grading in nursing as a trend, which could be related to consumerism

in higher education. Nurse educators are responsible for providing competent entry-level nurses for complex clinical environments. Faculty members should be aware that legal protection is provided when determining clinical competence based on professional judgments (Chasens et al., 2003). In addition to professional judgment expectations of the nurse educator, the nursing program must provide all policies and procedures in writing to students. While litigation is always a possibility, nurse educators are required to protect the public by failing students who do not meet the program outcomes (Boley & Whitney, 2003).

In an exploratory study on the differences in the grading rigor of full-time versus part-time faculty members, Schutz, Drake, and Lessner (2013) found that adjuncts have less rigorous standards than full-time faculty members when assigning grades. Analysis of Variance (ANOVA) showed a significant difference in the use of rigorous standards during the courses, taught by part-time versus full-time faculty members ($F = 22.28$, $p < 0.0001$). Additionally, there was also a significant difference in the final grades given by the two groups, with the part-time faculty giving students higher grades ($F = 14.91$, $p = 0.0001$) (Schutz et al., 2013). A limitation of this study was that a faculty survey was the data collection method and the actual grades assigned were not evaluated. This study supports administrative backing of faculty development to improve educational practices of adjunct faculty.

In an important study which attempted to improve summative grading practices in clinical courses, Woolley, Bryan, and Davis (1998) developed a comprehensive approach to clinical evaluations at a single institution. The researchers created a Clinical Performance Manual (CPM) that provided information on the evaluation process. The CPM was provided to faculty and students. The manual stipulated what abilities and skills students needed to meet the

objectives of the clinical component of each course. Faculty and staff reported satisfaction with the CPM as it provided clear expectations for both faculty and students (Woolley et al., 1998).

Refusing to fail students who do not meet clinical competencies could be due to unclear information about expectations of students in the clinical courses. Tanicala et al. (2011) in the first phase of a multi-phased project, reported faculty perspectives regarding what constituted a failure in a clinical course. Full-time and part-time expert clinical faculty members were part of four focus groups ($N = 26$). An inductive, qualitative approach was used for the project; the focus group participants were asked six questions all related to student behaviors, which would result in failure in a clinical course. Context of clinical event and patterns of behavior were identified as factors for consideration when failing a student. Context of event and patterns of behavior were also supported as creating risk of failure by Walsh and Seldomridge (2005). Tanicala et al. (2011) also reported that safety was identified as a prominent subtheme for clinical failures. Safety is a key component in health care reform (Institute of Medicine, 2004) and is acknowledged as the most important aspect of clinical course evaluation when supervising students in clinical courses (Killam, Montgomery, Luhanga, Adamic, & Carter, 2010; Penn, 2008; Walsh & Seldomridge, 2005). Tanicala et al. (2011) reported these additional subthemes for behavioral areas that could create clinical failure: critical thinking, ethics, communication, and professional standards. The researchers concluded that a change in the culture of student assessment is needed to promote client safety and optimal student outcomes in clinical courses.

The debate concerning how to assess clinical competence remains strong in nursing education (Clark et al., 2004; Watson et al., 2002). In a systematic review of the literature Watson et al. (2002) supported the position that there is a great deal of confusion in nursing about the

definition of clinical competence. There continues to be issues with the reliability and validity of assessing students for clinical competence in complex clinical environments. Clapper and Kardong-Edgren (2012) described the use of "deliberate practice" (p. 110), through simulated clinical experience to assess clinical competence. This practice offers a path to competency through improved skill and performance (Clapper & Kardong-Edgren, 2012). Providing clearly defined objectives based on nursing competencies creates a path for improved grading practices in nursing.

Dolan (2003) reported that a lack of consistency and uncertainty of the evaluation process continues to pose problems with assessing student nurse clinical competency. A revised clinical competency based system with increased requirement for documentation by faculty members and students was the impetus for this study (Dolan, 2003). Using a mixed method design with focus groups comprised of students, preceptors, and instructors, the researcher assessed the participants' views of the revised evaluation system. Both faculty members and students felt the amount of written evidence to support clinical competency required too much time and effort. The amount and type of evidence required of the students was dependent on the students' abilities and the individual preceptor's interpretation of the requirement. This study supported the need for adjunct clinical instructor development in assessment of clinical competency.

Objective measures for clinical evaluation are important for reliability and validity in grading practices. Rentschler, Eaton, Cappiello, and McNally (2007) developed an objective structured clinical evaluation (OSCE) for senior undergraduate nursing students. The development of the OSCE was prompted by the nursing faculty in an effort to provide more reliable grading practices. A faculty team developed case studies, identified or developed assessment tools,

trained clinical instructors, and planned a pilot study (Rentschler et al., 2007). The pilot study was conducted to assess the effectiveness and efficiency of the OSCE. Students (N = 49) participated in a series of simulated clinical experiences, written assignments, and evaluation sessions. Descriptive analyses were used to report the program results. Overall, the students reported that the structure and immediate feedback was valuable and recommended the evaluation process be used in other nursing courses. The researchers identified cost of the program as a major consideration for discussion prior to implementing this program at other schools of nursing.

Wiles and Bishop (2001) provided a report on a college of nursing where the faculty members were dissatisfied with the pass/fail grading system in clinical courses. The faculty reported that a pass/fail system created motivational issues for students and faculty. The proverbial bar in the pass/fail system was for the student to meet the standard; there was little motivation to exceed the standard. In an attempt to address faculty and student dissatisfaction, faculty explored the options available to improve the "correlation of clinical behaviors specific to course objectives" (Wiles & Bishop, 2001, p. 37). A review of the literature did not provide the needed tools; therefore, the faculty developed a clinical performance appraisal (CPA) to be used for clinical performance scoring. The faculty chose to change the grading system to a criterion based grading system, providing the students with a letter grade. A CPA committee was formed with representatives from all levels of the nursing program. After a faculty orientation to the new grading system, the tool was evaluated for inter-rater reliability. Simulated clinical vignettes were used for the faculty members to score the clinical student. The tool was revised based on

student and faculty feedback after one semester. The use of simulated clinical situations for the training of faculty in clinical grading was an innovative means of faculty development.

Assessing and evaluating students in the clinical setting challenges both novice and expert clinical instructors. Nurse educators often struggle due to issues of inconsistency with assessment and grading when assessing clinical performance (Calman et al., 2002; Dolan, 2003; Hrobsky & Kersbergen, 2002; Killam et al., 2010; Pfeil, 2003). Clinical instructors reported that they often struggle due to unclear rubrics or objectives (Isaacson & Stacy, 2009). There is a lack of knowledge and experience, specifically related to defining competency which influences clinical faculty members ability to assign a failing grade (Duffy et al., 2008; Teeter, 2005; Scanlan et al., 2001).

Clinical competency is often a focus for evaluation of students in clinical courses. In one effort to gain additional information concerning clinical competency, a large school of nursing in the southwest United States developed a Self-efficacy for Clinical Evaluation Scale (Clark et al., 2004). The faculty-developed tool was created for a required, generic baccalaureate-nursing course and items were based on the clinical course objectives. The tool assessed the students' self-efficacy and the perceived importance of the specified competency. Two separate 5-point Likert type subscales were created for the 30-item questionnaire, which rated students' self-efficacy and importance of the nursing competency for a specific nursing course. A study of 80 third semester nursing students, enrolled in both the clinical and didactic courses for which the instrument was developed was completed. Clark et al. (2004) reported that student self-efficacy scores ranged from one to five with a mean of 4.07 and standard deviation of .68. A Cronbach's alpha of .98 demonstrated a strong internal consistency of the tool for the self-efficacy and .95

for the perceived importance scale. Although course evaluations provided information about the extent to which the course objectives were met, faculty members desired more information. Important to the faculty was how students valued the competency and students' belief that they could complete the competency. Based on the results from this study, faculty identified areas that the students believed to be important but had little confidence in their knowledge or ability to obtain the competency. This study provided information that could be used for clinical course improvement and student remediation in nursing.

Chapter Summary

The literature review has provided an overview of the research concerning the role of adjunct clinical instructors, orientation of adjunct clinical instructors, clinical education in nursing, adjunct clinical instructor development, and clinical grading. Researchers have explored what behaviors create an effective clinical instructor and strategies to develop adjunct clinical instructors. The use of mentoring programs and orientation is recommended but the literature provides scare outcome measures to support these recommendations

The literature reinforced the necessity for continued study and review of adjunct clinical instructors' need for faculty development concerning student assessment in clinical courses. A gap in the literature exists in describing specific development activities for adjunct clinical instructors and changes in behavior following a development activity. The next chapter examines the methods used in this study that has attempted to address the need for and the outcomes of a faculty development workshop for adjunct clinical instructors in nursing.

III. METHODOLOGY

Introduction

The purpose of this study was to examine to what extent a faculty development workshop on evaluating students in clinical courses affected adjunct clinical nursing instructors' cognitive and affective behaviors towards clinical evaluation of students. Adjunct clinical instructors in this study were part-time clinical faculty who taught in clinical courses at the Eleanor Mann School of Nursing, University of Arkansas. This chapter explains the rationale for selecting a quasi-experimental research design for this study. A description of how participants were selected and how data were collected and analyzed is also presented.

The study considered four research questions to evaluate the impact of a faculty development session on the cognitive and affective behaviors of adjunct clinical faculty. The questions considered were:

1) Did adjunct clinical nursing instructors' self-ratings of knowledge about evaluating students improve upon completion of a workshop on evaluating students in clinical courses?

2) Did adjunct clinical nursing instructors' knowledge about student evaluation improve after completion of a workshop on evaluating students in clinical courses?

3) Did adjunct clinical nursing instructors' affective indicators towards student evaluation change upon completion of a workshop on evaluating students in clinical courses?

4) What were the adjunct clinical nursing faculty views about the use of a student oriented learning outline (SOLO) for a faculty development workshop?

Research Design

This study utilized a quasi-experimental research design using a single group pretest/posttest to answer the research questions. Experimental research allows the researcher to assess a practice, procedure, or action to determine what influence the action has on specified outcomes (Ary, Jacobs, & Razaviech, 2002; Creswell, 2012). Quasi-experimental designs are utilized when an intervention is employed, but there is not random assignment of participants (Creswell, 2012, p. 326). The quasi-experimental within group design was utilized due to opportuneness availability of the participants. Because of time constraints and resources I did not select a control group for this study.

A four-hour faculty development workshop was offered for this study. The workshop was provided at a pre-planned orientation session for adjunct clinical instructors. The topic for the workshop was selected based on an assessment of adjunct faculty needs at a single institution. In preparation for the workshop, I took a poll of the supervising full-time clinical faculty and the results indicated that grading reliability was the biggest need for the nursing program at the time. Additionally, I completed a review of the literature on assessment of students in clinical courses and found this to be a priority for adjunct clinical instructor development (Amicucci, 2012; Clark et al. 2004; Culleiton & Shellenbarger, 2007; Knox & Mogan, 1985; Lee et al. 2002; Roberts et al. 2013). Therefore, assessment of students in clinical courses for the purposes of grading was selected for the workshop topic.

I was the primary presenter at the workshop and developed all materials for it. One adjunct clinical instructor from the study site was selected to present one thirty-minute session. The adjunct faculty member presenter was excluded from the participant group. To assist the

selected adjunct clinical instructor in developing the presentation on student problems, the outcome objectives were provided. The following topics were covered in the faculty development workshop on evaluation of students in clinical courses: trends and issues, evaluation basics, student problems/problem students, and evaluation strategies/techniques (Appendix A). The SOLO was the guide for participants' preparation and guided the content of the workshop (Appendix B). The SOLO provided the workshop objectives, activities, and special instructions for the content presented at the workshop. The workshop included active learning, lecture, and small group discussions to engage participants. The room was comfortable and conducive for the learning. The faculty development workshop was four hours in length and was completed on January 9, 2014.

Research Site and Participants

The research site was the Eleanor Mann School of Nursing at the University of Arkansas. The University of Arkansas is a public university with approximately 24,500 students. The University of Arkansas offers approximately 200 academic programs. The Eleanor Mann School of Nursing (EMSON) offers both undergraduate and graduate nursing degrees. Students choose pre-nursing as a major and apply to the nursing program after completion of the pre-requisite coursework. Admission into the nursing program is competitive, with 100 students admitted each semester (approximately 43% of applicants). EMSON has approximately 400 nursing students in the undergraduate nursing program. EMSON undergraduate programs are approved by the Arkansas State Board of Nursing and accredited by the Commission on Collegiate Nursing Education (2009).

Adjunct clinical instructors teach the undergraduate clinical courses at EMSON with a one to eight faculty to student ratio. The adjunct clinical instructors are under the direct supervision of a full-time faculty member who coordinates and supervises all sections within a single course. The undergraduate program was chosen for this study due to the large number of adjunct clinical instructors utilized for clinical teaching.

A convenience sample for this study consisted of 38 adjunct clinical instructors employed by the Eleanor Mann School of Nursing at the University of Arkansas. A convenience sample was used due to the need for willing and available participants (Ary et al., 2002; Creswell, 2012). All participants were registered nurses with an unencumbered license in the State of Arkansas, had a minimum of a Bachelor of Science degree in nursing, with two or more years of experience as a registered nurse. All participants were attending an orientation for adjunct clinical instructors at the Eleanor Mann School of Nursing, University of Arkansas. The workshop was approved by the nursing administration to replace the afternoon orientation session that had been previous planned.

All 38 adjunct clinical instructors who attended the orientation agreed to participate in the workshop. Demographic information was gathered from institutional records at the school of nursing. The large majority of the participants were female (93%). The amount of clinical course instruction experience ranged from no experience to ten years ($M = 4$, $SD = 2.06$). The participants had two levels of education preparation with 24 having a Bachelor of Science in Nursing (BSN) and the remaining 14 with a master's degree or higher. It should be noted that of the 24 adjunct clinical faculty with BSN's 10 were enrolled in master's programs during the time of the study.

Data Collection

This research was reviewed and approved by the University of Arkansas Institutional Review Board (Appendix C). Planning is key to a successful project; with busy part-time instructors prior notice is imperative to a successful event. Two months prior to a required orientation and workshop, the date was provided to returning adjunct clinical instructors at the EMSON. Contract letters were sent to returning instructors with course assignments, pay scale, and the orientation date. All new adjunct clinical instructors were informed of the orientation date when they were hired. It was decided that the faculty development workshop would replace the afternoon session of the orientation for all EMSON adjunct clinical instructors. An email explaining the research project and invitation to participate in the faculty development workshop was sent to all adjunct clinical faculty at the EMSON two weeks prior to the planned orientation (Appendix D). Included in the email was the consent form (Appendix E) for participants to review. All adjunct clinical instructors were informed that participation in the workshop was encouraged as part of the orientation for faculty development irrespective of participation in the research study. I developed a student oriented learning outline (SOLO) and sent it to all participants one week prior to the workshop by email (Appendix B).

The one-week email contact provided the SOLO and a reminder of the event. The SOLO provided the objectives for the session, activities that would be completed to meet the objectives, and suggested readings to be completed prior to the workshop. Student oriented learning outlines were developed to make learning more efficient, to decrease participant anxiety, and to motivate participants to learn (Hammons & Jaggard, 1984). SOLOs have been used in a variety of disciplines; however, the research is limited to a moderate number of dissertations and journal

articles (Hammons & Jaggard, 1984; VanArsdale & Hammons, 1998). The participants were directed to review the SOLO and complete the suggested readings. Suggested readings were based on a review of the nursing literature on topics relevant to assessment of students in clinical courses. The two articles provided by email to the participants for suggested reading prior to the workshop were: *Failure to assign failing grades: Issues with grading the unsafe student* by Luhanga, Yonge, and Myrick (2008) and *Should clinical courses get a letter grade* by Alfaro-LaFevre (2004).

Participants were asked to sign the consent form prior to the beginning of the workshop. An opportunity for the participants to ask questions was also provided. After the consent form was collected, the pretest (Appendix F) was given to all participants to assess their knowledge level about evaluation of students in clinical courses and affective behaviors prior to the workshop intervention. A non-biased faculty volunteer at the beginning of the faculty development workshop administered the pretest. The pretest consisted of three sections and took approximately fifteen minutes to complete. The post-test (Appendix G) was given immediately following the faculty development workshop and took approximately twenty minutes to complete. Completion of pretest and posttest were voluntary by the participants in the workshop. A total of 38 participants participated in the workshop and completed the instruments. Participation in the research project had no bearing on the clinical faculty relationship with EMSON, nor did it affect the benefits or participation in the workshop.

Instruments

The study used a pretest and posttest assessment to provide information before and after the workshop intervention. A pretest provided an initial measure for both cognitive and affective

domains of each participant. The posttest utilized parallel measures in both domains and also included an assessment of the SOLO. I development the pretest and posttest based on a review of the literature and selected nursing education textbooks (Gaberson & Oermann, 2010; Kan & Stabler-Haas, 2009).

The pretest consisted of three sections: section one included five self-assessment of knowledge topics, section two was six affective behavioral selections and section three provided nine knowledge assessment questions. On knowledge self-assessment questions participants were asked to rate their knowledge of five evaluation topics that were presented at the workshop, including, general knowledge of clinical grading; knowledge of student assessment strategies; ability to apply grading rubrics; understanding of grading terminology; and knowledge of grading systems used for clinical grading using a 5-point Likert scale (1 = no knowledge, 5 = expert knowledge). Six affective behavior items requested participants to choose the choices they would make in the future about evaluation of students in clinical courses. Finally there were nine knowledge true/false questions covering the objectives of the workshop on the pretest. The posttest was a parallel measure with an additional section for evaluation of the SOLO. The SOLO was provided to participants one-week prior to the workshop to provide the goals and activities for the workshop. Participants were asked to use a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree) to answer questions about the value of the SOLO.

Dr. James Hammons, professor of higher education at the University of Arkansas, who is considered a primary author in the development of SOLOs in higher education, reviewed the evaluation of the SOLO section for the posttest providing face validity. Face validity is described as the ability of the instrument to measure what it appears it is intended to measure

(Anastasi, 1988; Lynn, 1986; Melnyk & Fineout-Overholt, 2011). Affective indicators, assessed in both the pretest and posttest, were also reviewed by Dr. Hammons as an expert in the assessment of affective indicators in education. Two full-time nursing faculty members assessed content validity of the instrument in regard to evaluation of students in nursing clinical courses with experience in the areas of clinical instruction, student evaluation, and question development. One change was made to the posttest based on the feedback from the nursing faculty. Lynn (1986) noted that for content validity researchers often go to experts and have them identify the validity of questions. The experts utilized for this study deemed the pretest and posttest as valid measures for this study.

Variables

The dependent variables consisted of four different sets of assessments: self-assessment of knowledge, knowledge, affective behaviors, and value of the SOLO. A pretest (Appendix F) and posttest (Appendix G) were used to evaluate the variables of self-assessment of knowledge, knowledge, and affective behaviors in this study. The value of the SOLO was measured only in the posttest.

Self-assessment of knowledge of clinical grading. The following knowledge areas were self-assessed by the participants in this study: general knowledge of clinical grading; knowledge of student assessment strategies; ability to apply grading rubrics; understanding of grading terminology; and knowledge of grading systems used for clinical grading. This variable was measured using a 5-point Likert scale: 1 = having no knowledge; 5 = having expert knowledge. Respondents were asked to rate their knowledge on the five evaluation topics before and after the workshop.

Knowledge of clinical grading. A series of nine true/false questions was provided in a pretest/posttest format to assess the adjunct clinical instructors' knowledge of clinical grading before and after a faculty development workshop. The questions were based on the workshop objectives but were not the same questions for the pretest and posttest. An improvement in the participants' score was viewed as an increase in knowledge.

Affective behaviors. Affective behaviors are often self-directed actions that are not influenced by a reward such as a grade or compensation (Mager, 1968). Affective behaviors provide information beyond the cognitive realm, providing information about the participants' feelings or emotions (Atherton, 2004). The participants were asked to select behaviors that they would complete outside of the required activities of the faculty development workshop. Affective behaviors included attend additional sessions on clinical grading, read the articles provided for the workshop, discuss clinical grading with a peer, seek additional information on clinical grading, or volunteer to be mentor to new faculty to assist with development of clinical course grading. Respondents were asked to mark all that apply to the choices they would make.

Value of SOLO. The value of using the SOLO for the faculty development workshop was assessed by the posttest. Ten questions were presented to participants concerning the SOLO. A 5-point Likert scale, with a score of one indicating the participant strongly disagreed and five indicating the participant strongly agreed, was provided to assess the SOLO. The participants evaluated the value of the SOLO in preparing for the workshop and whether or not specific elements in the SOLO were helpful. Additionally the participants indicated if they would use SOLOs for planning future workshops. Participants were asked if the SOLO made it easy for them to understand what they were expected to learn.

Data Analysis

After all identifiers were removed from the pretest and posttest and an identifying number was added to each respondent in the data set (pretest/posttest), the data were then entered into an Excel spreadsheet. There were no missing data from the pretest or posttest. After the data were prepared and organized, descriptive statistical analyses were competed to describe the participants. Creswell (2012) specified that descriptive statistics indicate general tendencies and can be used to describe a population.

A paired *t*-Test, Shapiro-Wilk tests for normality, and Wilcoxon signed rank sum tests were used for the paired observations in the study to respond to questions 1 through 3. A paired *t*-Test is used when a single group of participants is studied (Kim & Mallory, 2014). According to Creswell (2012), a paired *t*-Test is an appropriate statistical analysis for a pretest/posttest design. The differences between the two measures (pretest and posttest) were the unit of measurement. For each section of the test a composite score was calculated which provided a continuous variable. Specifically for research question one, self-assessment of knowledge, a total score was calculated based on the Likert scale. Research question two assessed the knowledge of the participant; this section of the test was scored based on the number of items the participant answered correctly. Finally, for research question three the data was analyzed based on the total number of affective behaviors the participant selected. A paired *t*-Test, Shapiro-Wilk test for normality, and Wilcoxon signed rank sum test was used to determine whether or not there was a significant difference between the pretest and posttest measures for the participant group. Posttest measures allowed for the evaluation of the differences in the group scores between the pre- and posttest results.

Descriptive statistics were used to analyze the data collected for question four. The means, frequencies, and standard deviations were calculated for each of the ten questions concerning value of the SOLO in the posttest measure. Descriptive statistics help to explain data accurately and with great detail (Kim & Mallory, 2014).

Threats to Validity

In order to make valid inferences from the results of a study, the threats to internal and external validity must be addressed in experimental research (Shadish, Cook, & Campbell, 2002; Creswell, 2012). Threats are confounds that serve as possible explanations other than the treatment for research findings (Bordens & Abbott, 2005). Eliminating or controlling for the research threats allows for causal inferences in quasi-experimental studies (Shadish, Cook, & Campbell, 2002).

Controlling for internal threats allows the researcher to ensure that any treatment effect, if found, is more likely due to the treatment itself and is not an artifact generated by the drawbacks of the design itself (Campbell & Stanley, 1963). There are at least eight potential threats (Creswell, 2012) that were addressed concerning the internal validity of this study. The threats to participants that were controlled for were: history, maturation, selection, interaction, mortality, and regression. The design of the study eliminated or minimized all threats to participants. First the threats of history and maturation were eliminated by the four-hour time interval between the pretest and posttest. The limited time frame excluded the possibility of learning or developmental changes of the participants taking place outside of the environment after the workshop; therefore the threat of history and maturation were removed. Threats to selection are described as differences in characteristics between participant groups (Bordens & Abbott, 2005).

This study was designed to use a single intact group therefore there was no threat of selection (Bordens & Abbott, 2005). The threat of interaction was also eliminated from this study due to the convenience use of one participant group. Additionally, losing participants for any reason creates a mortality threat to internal validity (Creswell, 2012). Providing the time frame of the intervention in advance to all potential participants controlled for mortality. The workshop and data collection were completed within the provided timeframe. Furthermore, the threat of regression is minimized if not eliminated in this study. While not a definite but still possible threat, given the design of this study, Campbell and Stanley (1963) stated that regression is an inevitable threat for "imperfect test-retest correlation for groups *selected for their extremity*" (p. 11). They continue by asserting "If a group *selected for independent reasons* turns out to have an extreme mean, there is less a priori expectation that the group mean will regress on a second testing, for the random or extraneous sources of variance have been allowed to affect the initial scores in both directions" (pp. 11-12). With these two important points in mind, this study controlled for regression in two ways: (1) convenience selection of an intact group; and (2) selection of participants unrelated to extreme values (e.g. prior very low performance or very high performance) on any of the variables critical to this study.

The two remaining potential threats to the internal validity were related to procedures: testing and instruments. Participants could become familiar with the outcome measures and remember the responses for the posttest. Creswell (2012) stated that to remedy this threat the researcher should use different items on the posttest. The testing threat was addressed in the posttest by providing a different set of true/false questions. The other two sections in the instruments were a self-assessment of knowledge and affective behaviors. The knowledge questions asked the

participant to rate their knowledge of clinical grading using a 5-point Likert scale. The affective section of the pretest/posttest required participants to select all that apply from the list of affective indicators. Testing effect could have created an increase in self-reported interest in the affective behaviors or confidence in knowledge of the participant reported on the posttest (Melnyk & Fineout-Overholt, 2011).

External validity is important to the generalizability of the results (Melnyk & Fineout-Overholt, 2011). External threats to validity for experimental designs make it difficult to generalize the results beyond the study group or to other settings (Bordens & Abbott, 2005, Creswell, 2012). According to Cook and Campbell (1979) there are three threats of interaction with treatment that could affect generalizability: selection, setting, and history. First, selection threat in this study was related to the use a convenience sample, which creates a significant threat to the ability to generalize the results to other populations. Second the setting used in this study was a single public university BSN nursing program. This study cannot be generalized beyond the selected study site. Cook and Campbell (1979) describe external threat of history as the specific time the invention has taken place. The threat of history was significant because the workshop was completed as a one-time intervention. The treatment was part of an orientation that occurred prior to the beginning of Spring 2014 academic semester. Replication of this study at another time would be necessary to minimize this threat (Bordens & Abbott, 2005; Creswell, 2012). Due to the threats to selection, single study setting, and a one-time treatment, this study cannot be generalized beyond the parameters selected for this study.

Chapter Summary

This chapter described the research methodology for this study, including the research design, site/participants, data collection, instruments, variables, and data analysis techniques. The participants consisted of adjunct clinical faculty who taught clinical courses for the Eleanor Mann School of Nursing at the University of Arkansas during the spring of 2014. Descriptive statistics and *t*-Tests, Shapiro-Wilk test for normality, and Wilcoxon signed rank sum test were used to evaluate adjunct clinical instructors cognitive and affective behaviors before and after a faculty development workshop. The use of a SOLO as a pre-organizer for the faculty development workshop was also evaluated.

IV. RESULTS

Introduction

The use of adjunct clinical instructors to teach clinical courses is well established in nursing programs. Adjunct clinical instructors are most often expert clinicians who have a desire to contribute to the profession by preparing the next generation of nurses. They often lack or have limited education in teaching pedagogy, which is needed to be successful in the educator role. The literature on adjunct clinical instructors supported the need for foundational knowledge on how to evaluate students in clinical courses for successful educator role development.

The purpose of this study was to evaluate the use of a faculty development workshop to assess the changes in cognitive and affective outcomes for adjunct clinical instructors towards evaluation of students in clinical courses. The University of Arkansas, Eleanor Mann School of Nursing was the research site. The value of a SOLO provided to the participants prior to the workshop was also assessed.

This chapter provides the results for this study. First an overview of the project is presented followed by the review of demographic information of the participants. Next, the chapter provides the description of the findings from the data analysis that afforded answers to the research questions. The chapter concludes with a summary of the major findings.

Overview of the Study

The purpose of this study was to examine to what extent a faculty development workshop on evaluating students in clinical courses affected adjunct clinical nursing instructors' cognitive and affective behaviors towards clinical evaluation of students. Specifically I focused on how the workshop changed participants' scores from pretest to posttest in three areas: self-assessment of

participants' knowledge of clinical evaluation, clinical evaluation knowledge, and affective behaviors. Also included was an evaluation of the value of a SOLO used for the workshop.

I utilized a quasi-experimental research design using a convenience sample of a single homogeneous group to answer the research questions. A pretest posttest design was used to assess the change in affective and cognitive behaviors of clinical nursing instructors after the workshop. A faculty development workshop was provided to all adjunct clinical nursing faculty at the EMSON on January 9, 2014. I collected data for this study from a pretest and posttest administered to 38 participants. The sample included both BSN and MSN or higher educated registered nurses with at least two years of nursing experience. Descriptive statistics, paired *t*-Test, Shapiro-Wilk test for normality, and a Wilcoxon signed rank sum test were used to analyze the data in this study using SAS 9.3.

Participant Demographics

A total of 38 participants completed the pretest and posttest for this study. All participants turned in completed forms therefore the sample consisted of 38 adjunct clinical instructors at the EMSON, University of Arkansas. The participants were all registered nurses attending an orientation and faculty development session at the school of nursing. The session was provided on January 9, 2014. Participants were predominately female ($N = 36$) and ranged in nursing experience from two to 30 years. The majority of the participants had a Bachelor of Science degree (63%) and the remaining had a master's degree in nursing or higher (37%). The range of clinical course teaching experience was from zero to ten years ($M = 4$, $SD = 2.06$). All participants had an unencumbered registered nurse license in Arkansas. The EMSON required that all adjunct clinical nursing faculty members have current cardiopulmonary resuscitation

(CPR) for health providers' certification, tuberculosis screening, and a flu shot. Each adjunct clinical instructor at the EMSON is mandated to complete additional requirements set by the assigned clinical facility partner.

Findings

The findings are presented for each variable assessed in this study. To accomplish the purpose of this study it was necessary to answer the following research questions:

1. Did adjunct clinical nursing instructors' self-ratings of knowledge about evaluating students improve upon completion of a workshop on evaluating students in clinical courses?
2. Did adjunct clinical nursing instructors' knowledge about student evaluation improve after completion of a workshop on evaluating students in clinical courses?
3. Did adjunct clinical nursing instructors' affective indicators towards student evaluation change upon completion of a workshop on evaluating students in clinical courses?
4. What were the clinical nursing faculty views about the use of a student oriented learning outline (SOLO) for a faculty development workshop?

Self-rated Knowledge of Clinical Evaluation

The first research question addressed in the study concerned adjunct clinical nursing instructors self-assessment of their knowledge of clinical grading. I used a pretest posttest design utilizing a paired *t*-Test, Shapiro-Wilk test for normality, Wilcoxon signed rank test and descriptive statistics, which provided information about the change in self-rated knowledge of clinical grading of the participants. Table 1 presents the mean and standard deviation for the total score of the self assessed clinical grading topics. Prior to conducting the paired *t*-Test, a

test for normality of the differences among the pairs was conducted. Normality of the differences is one assumption that must be met to use the parametric version of the paired *t*-Test. According to the Shapiro-Wilk test for normality (*W*), the data were not normally distributed. Comparing the mean of the differences to the median of the differences, it was clear that the mean was considerably higher ($M = 5.79$, $Mdn = 5.00$). Thus, the data were positively skewed. Therefore, a non-parametric test, the Wilcoxon signed rank test (*Z*), was completed. This revealed that the posttest scores were significantly greater than the pretest scores, $Z = 17.5$, $p < 0.001$. Therefore, the self-rated knowledge of clinical evaluation was significantly improved after the workshop. Also noted in Table 1 is the significance testing value $p < 0.001$, quantifying the strength of the results against the null hypothesis. This is a probability confidence interval of .001 or 0.1%, thus rejecting the null hypothesis. The self-assessment topic of clinical grading systems demonstrated the most improvement with a mean score of 2.76 on the pretest and a mean of 4.18 on the posttest.

Table 1

Wilcoxon Signed Rank Test of Mean Differences of Self-Rated Clinical Evaluation Knowledge

Pretest – Posttest Difference					
M	*Mdn*	*n*	*SD*	*Z*	*p*
5.79	5.00	38	3.73	17.5	< 0.001

Knowledge of Clinical Evaluation

Research question two inquired whether or not adjunct clinical nursing instructors' knowledge about student evaluation improved after completion of a workshop on evaluating

students in clinical courses. To answer this question, an analysis of the knowledge assessment in the pretest and posttest was completed. Prior to conducting the paired *t*-Test, a Shapiro-Wilk test for normality of the differences among the pairs was conducted. According to the Shapiro-Wilk test for normality, the data were not normally distributed, $W = 0.91$, $p = 0.004$. As illustrated in Table 2, the mean was slightly lower ($M = 1.92$, $Mdn = 2.00$). Thus, the data were negatively skewed. Due to skewed results, a non-parametric test, the Wilcoxon signed rank test was used. This revealed that the posttest scores were significantly greater than the pretest scores, $Z = 15.5$, $p < 0.001$. The results indicated that the knowledge of clinical evaluation was significantly improved after the workshop.

Table 2

Wilcoxon Signed Rank Test of Mean Differences of Clinical Evaluation Knowledge

Pretest – Posttest Difference					
M	*Mdn*	*n*	*SD*	*Z*	*p*
1.92	2.00	38	1.28	15.5	< 0.001

Additional information is presented in Table 3 below. The largest gain in clinical knowledge can be seen for summative evaluation. On the pretest 42% of participants answered the summative evaluation question correctly. The posttest also evaluated participant knowledge on the topic of summative evaluation, with 95% of participants answering the question correctly. The topic areas that could be matched for content are listed in Table 3. There were two questions answered correctly by all participants on the posttest (i.e., questions related to clinical competencies and formative assessment).

Table 3

Repeated Content Pre and Posttest Percentage Correct

	Pretest		Posttest		
Content Area	Q#	%	Q#	%	% Difference
Summative Evaluation	3	42%	4	95%	53%
Educator Role	4	55%	1	92%	37%
Anecdotal Notes	5	76%	3	89%	13%
Clinical Competencies	8	63%	6	100%	37%
Professionalism	9	76%	7	95%	19%

Affective Behaviors

Research question three examined if there was a change in the adjunct clinical instructors' affective behaviors after the workshop. To measure this, participants were asked both on a pretest and a posttest to select activities they would engage to learn more about student assessment in clinical courses. The data from the pretest were compared to the data from the posttest. Prior to conducting the paired samples *t*-Test, a test for normality of the differences among the pairs was conducted. According to the Shapiro-Wilk test for normality, the data were not normally distributed, $W = 0.78$, $p = 0.001$. Table 4 presents the results from the analysis of the pretest and posttest. Comparing the mean of the differences to the median of the differences, it is clear that the mean was slightly lower than the median ($M = 0.81$, $Mdn = 1.00$). Thus, the data were slightly negatively skewed. Because of this, the Wilcoxon signed rank test was used.

The results revealed that the posttest behaviors were significantly greater than the pretest behaviors, $Z = 11.0$, $p < 0.001$. The results revealed that on average the number of affective behaviors increased significantly after the workshop.

Table 4

Wilcoxon Signed Ranks Test of Mean Differences of Affective Behaviors

Pretest – Posttest Difference					
M	*Mdn*	*n*	*SD*	*Z*	*p*
0.82	1.00	38	0.93	11.0	< 0.001

The affective behavior of mentoring was selected the least on the pretest and posttest (Table 5). The three behaviors with the highest frequency of selection after the workshop were, *look up additional information on clinical grading* (97%), *discuss clinical grading with a peer* (95%), and *participate in a group discussion about clinical grading* (92%). The only behavior that decreased in selection on the posttest was *read the article provided*.

Table 5

Number of Respondents that Selected Each Affective Indicator on Pre- and Posttest (N = 38)

Affective Indicator Question	Pre	Post
Attend additional sessions on clinical grading	28	32
Read the article provided	36	33
Discuss clinical grading with a peer	33	36
Look up additional information on clinical grading	25	**37**
Participate in a group discussion about clinical grading	30	35
Sign up to be a mentor to a new faculty to assist with assessment techniques for clinical grading systems	15	25

Note. Bold indicates the largest increase from pre- and posttest

SOLO

The final research question answered in this study was about the value of the use of a SOLO for the faculty development workshop. All participants completed the posttest measure using a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree) about the value of the SOLO for the faculty development workshop. Descriptive statistics were used to analyze the data. The means, frequencies, and standard deviations are provided in Table 6 for each of the ten questions concerning value of the SOLO in the posttest measure. The question concerning the value of the learning activities reinforcing the materials for the session received the highest overall combined rating with a Mean of 4.5. The lowest scored question was concerning the participants' interest in using a SOLO if they were leading a session (M = 4.08, Mdn = 4.0). Overall, above 4.00

mean scores for each question suggest that the participants believed that the SOLO was valuable for the faculty development workshop.

Table 6

Descriptive Statistics for Post-Session Evaluation of SOLO Questions (N = 38)

SOLO Evaluation Question	*M*	*Mdn*	*SD*	*Min*	*Max*
Made understanding of session objectives easy	4.29	4.00	0.61	3.00	5.00
Helpful in learning clinical assessment of students	4.21	4.00	0.62	3.00	5.00
Helpful in session preparation	4.26	4.00	0.64	3.00	5.00
Would be beneficial in other training sessions	4.39	4.00	0.55	3.00	5.00
Learning activities reinforced the session material	4.50	4.50	0.51	4.00	5.00
Self-quiz a good indication of my knowledge	4.24	4.00	0.63	3.00	5.00
If leading a session would use a SOLO	4.08	4.00	0.75	2.00	5.00
Handouts pertinent	4.34	4.00	0.67	2.00	5.00
Posttest helped assess my learning	4.45	4.00	0.55	3.00	5.00
I liked using the SOLO	4.34	4.00	0.63	3.00	5.00

Chapter Summary

Data were collected using a quasi-experimental design, to examine to what extent a faculty development workshop on evaluating students in clinical courses affected 38 adjunct clinical instructors' cognitive and affective behaviors towards clinical evaluation of students. This study utilized descriptive statistics, paired *t*-Test, Shapiro-Wilk test for normality, and Wilcoxon signed rank sum test to answer the research questions. The results from the statistical analysis

indicated that there was a significant change in the cognitive and affective behaviors of adjunct clinical nursing instructors. Additionally, the participants valued the use of a SOLO for a faculty development workshop. This study provides useful information in support of faculty development for adjunct clinical nursing instructors to improve their knowledge and skills of student assessment in clinical courses.

V. DISCUSSION

Introduction

The utilization of adjunct clinical nursing faculty to teach clinical courses is one strategy that is being employed to meet nursing education program needs (Anderson, 2009; West et al., 2009). The goal of faculty development programs for adjunct clinical instructors is to assist them in developing skills and knowledge needed to be successful. Faculty development is one way of assisting adjunct clinical instructors to increase reliable teaching practices, which support positive program outcomes (Roberts et al., 2013). Previous research suggests that adjunct clinical instructors require additional education in the area of student evaluation (Davidson & Rourke, 2012; Duffy et al., 2008; Salamonson et al., 2010). In order to provide reliable grading practices in clinical courses a faculty development workshop was offered to assess the changes in adjunct clinical instructors' cognitive and affective behaviors concerning assessment of students in clinical courses. Additionally, the use of a SOLO for the faculty development workshop was evaluated. This chapter provides a summary of the study followed by a discussion of results and conclusions. Also included are limitations, recommendations for future research, implications for practice and a chapter summary.

Summary of the Study

The purpose of this study was to examine to what extent a faculty development workshop on evaluating students in clinical courses affected adjunct clinical nursing instructors' cognitive and affective behaviors towards clinical evaluation of students. I used Benner's model of Novice to Expert to develop and implement a faculty workshop on evaluation of students in clinical courses for adjunct clinical instructors at the EMSON. Benner's (1984) model suggested that clinical

instructors while expert clinicians require education to develop from novice to expert in the educator role. The scope of this study was limited due to the use of a convenience sample. A convenience sample was employed because of limited time and number of available participants.

The data were collected using a pretest/posttest quasi-experimental design to evaluate the effect of a faculty development workshop on the cognitive and affective behaviors of adjunct clinical instructors at EMSON. The data were collected during a faculty orientation and development workshop on January 9, 2014. The sample consisted of 38 adjunct clinical nursing instructors and included both new and experienced adjunct instructors. Data analysis included descriptive statistics, paired *t*-Tests, Shapiro-Wilk test for normality, and Wilcoxon signed rank sum test. These tests provided the answers to the research questions for this study. Each research question was analyzed individually to evaluate whether or not there was a change in specific knowledge or affective behaviors. Additionally, the value of a SOLO was assessed. A summary of the findings for each research question is presented below.

Research Question One

1) Did adjunct clinical nursing instructors' self-ratings of knowledge about evaluating students improve upon completion of a workshop on evaluating students in clinical courses?

Adjunct clinical nursing instructors reported significantly higher self-ratings of knowledge about evaluation of students after the completion of the faculty development workshop. These variables were measured using a 5-point Likert scale: 1 = having no knowledge and 5 = having expert knowledge. Participants were asked to rate their knowledge on five evaluation topics before and after the workshop. The findings revealed that the largest increase in self-assessed knowledge was for types of clinical grading systems (pretest $M = 2.76$, posttest $M = 4.18$). The

second area that showed significant increase in participants' self-rated knowledge was in regard to assessment terminology. Knowledge of clinical grading systems and assessment terminology are needed for effective assessment of students in clinical courses. A lack of this basic information could create inconsistent grading practices in clinical courses. Also important to note was that the overall self-rated knowledge on all five items significantly increased from a pretest mean score of $M = 2.94$ to an overall mean score of $M = 4.11$ on the posttest. These findings exposed that the participants gained confidence in their clinical assessment knowledge as a result of the workshop.

Research Question Two

2) Did adjunct clinical nursing instructors' knowledge about student evaluation improve after completion of a workshop on evaluating students in clinical courses?

Adjunct clinical nursing instructors answered more questions correctly on the posttest after the workshop on the knowledge based true/false questions. There were five content areas that were repeated on the posttest, and these questions were matched for analysis. All questions could not be matched due to the necessity of providing different questions for the pretest and posttest. The data were analyzed using the total number of questions answered correctly on both the pretest and posttest. Participants provided more accurate responses on the nine questions on the posttest. Also, there were two questions on the posttest that all participants answered correctly. One question stated: *clinical evaluation is based on predetermined outcomes or competencies that are used to guide the assessment process*; all participants correctly marked this as true on the posttest. The other question that all participants answered correctly purported a false statement that offered: *in an eight week clinical course a mid-term is not valid.*

Research Question Three

3) Did adjunct clinical nursing instructors' affective indicators towards student evaluation change upon completion of a workshop on evaluating students in clinical courses?

Adjunct clinical instructors chose more affective behaviors on the posttest after a faculty development workshop. The average number of affective indicators selected of the six behaviors on the pretest was 4.3, which increased on the posttest to an average of 5.2. While the least selected affective behavior on both the pretest and posttest was signing up to be a mentor, the results indicated that there was still interest in this behavior by a majority of the participants. A total of 66% of adjunct clinical instructors indicated after the workshop that they would be willing to sign up to be a mentor to a new instructor to assist them with assessment techniques. Additionally, only one participant indicated that they would not choose to *look up additional information on clinical grading*. Also, *read the article provided* was selected less on the posttest (pretest 95%, posttest 87%). Reading the article may have seemed unnecessary to some participants after the workshop.

Research Question Four

4) What were the clinical nursing faculty views about the use of a student oriented learning outline (SOLO) for a faculty development workshop?

The use of a SOLO as a pre-planner for adjunct clinical nursing faculty was rated highly by the participants. A 5-point Likert scale, with a score of one indicating the participant strongly disagreed and five indicating the participant strongly agreed was provided to assess the SOLO. The overall mean rating of the SOLO was 4.3 on a 5-point Likert scale. The participants rated the learning activities to be the most valuable section of the SOLO. The lowest scored question

was concerning the participants' interest in using a SOLO if they were leading a session (*M* = 4.08). However, even with the lowest rating, the findings still suggest they are likely to use a SOLO when they plan a session. Overall, the SOLO was rated highly and should be used when planning future faculty development sessions.

Discussion and Conclusions

Several important conclusions can be drawn from the results of this study. The findings from this study revealed that a faculty development workshop for adjunct clinical instructors at the EMSON positively affected the knowledge level and affective behaviors towards assessment of students in clinical courses. Additionally, the use of a SOLO in the planning and delivery of a faculty development workshop was valued by the participants. While the current literature supported faculty development as a need for adjunct clinical instructors of nursing, there is little information concerning specific development or implementation of this type of program. Discussion and conclusions based on the research findings are provided in this section.

First, the study showed significant improvements in adjunct clinical nursing instructors' self-ratings of their clinical grading knowledge after the completion of the faculty development workshop at the EMSON. Simply taking a self-assessment can assist the adjunct faculty members in identifying new areas to study or the need for additional knowledge. Perception of the *need to know* is critical for the intrinsic motivation required to gain new knowledge or skills. Benner's model of Novice to Expert points out that adjunct clinical instructors bring limited background as educators and do not know what information is needed to be successful in this new role (Benner, 2001). Without experience to draw upon, the new educator may not have the confidence or ability to seek out information needed to be successful. Moreover, the expert

clinician may feel inadequate in the role of educator but have no way of knowing what is required to be effective. Adjunct clinical instructors often view themselves as clinical experts; however, this does not translate into having the expertise needed for supervising, teaching, or evaluating students in clinical courses. A lack of experience and knowledge often proves to be a problem because the novice instructor lacks the tools and support needed to provide reliable assessment of students (O'Conner, 2006; Scanlan et al., 2001). Providing adjuncts the needed support and education is one way to create reliable grading practices and a path to success for this group of nurse educators.

Another important conclusion that emerged from this study is that adjunct clinical nursing instructors gained knowledge after a faculty development workshop. Formal programs that support the education of adjunct clinical faculty development are essential for providing competent instructors who can support students and program outcomes (Forbes et al., 2010; Jarrett et al., 2008; Kowalski et al., 2007; Krautscheid et al., 2008). Previous research studies suggested that adjunct clinical instructors that feel more confident in their knowledge are more likely to persist in the clinical instructor role (Kowalski et al., 2007). Faculty turnover for both full-time and part-time nursing instructors creates stress to the current nursing faculty members and program (Sawatzky & Enns, 2009). A shortage of prepared adjunct clinical instructors creates stress on nursing programs and jeopardizes enrollment targets, which are important to meeting the health care system's need for caregivers. Furthermore, maintaining a consistent adjunct clinical instructor group is important to the process of developing expert clinical instructors.

Third, after the workshop adjunct clinical instructors were more likely to indicate that they would engage in activities that could potentially increase their knowledge of assessment of students in clinical courses. I considered affective behaviors to be an important factor due to the necessity of continued development and growth beyond the workshop for all adjunct clinical instructors. Assessment of affective behaviors in this study indicated that the adjunct clinical instructor would continue to gather information about assessment of students in clinical courses after the workshop. One factor that improved significantly was that after the faculty development workshop, more instructors indicated that they would be willing to sign up to be a mentor to assist new instructors with clinical grading.

Mentoring programs have been identified in the literature to be useful to support the transition from clinical expert to nurse educator (Neese, 2003; Peters & Boylston, 2006; Records & Emerson, 2003; Roberts et al., 2013; Thorpe & Kalischuk, 2003; Sawatzky & Enns, 2009). These results indicated that the participants were highly motivated prior to the workshop and were even more motivated to continue to gain information and assist by volunteering to mentor new adjunct clinical instructors after the workshop. Mentoring has been addressed in the literature but not in regards to experienced adjunct clinical instructors mentoring novice instructors. Providing faculty development opportunities for adjunct instructors creates opportunities for role development and increased educator expertise. These expert clinical educators can increase the number of available mentors for new clinical faculty members. The results could support implementing a mentoring program at the EMSON.

A forth conclusion that can be drawn from this study is that adjunct clinical nursing instructors value the use of a SOLO for a faculty development workshop. The SOLO was

provided one week prior to the workshop to the adjunct clinical instructors and included topics, rationale, learning objectives, and scheduled activities for the workshop. Adult learners typically prefer to be provided with a schedule, objectives, and rationale for educational sessions (Merriam, Caffarella, & Baumgartner, 2007). The results from this study also indicated that adjunct clinical nursing instructors would use a SOLO if they were planning a faculty development workshop. Other studies have similarly found that students value the use of a SOLO for educational sessions (Emery & Kalscheur, 2000; Hammons & Jaggard, 1984; VansArsdale & Hammons, 1998). The participants in this study valued all components of the SOLO; the overall assessment of the SOLO as a means of providing information to participants for faculty development workshops was positive.

Nursing programs should consider faculty development opportunities as an important factor when considering the needs of adjunct clinical nursing instructors. This conclusion is reinforced by the existing research that supports the use of faculty development programs (Davidson & Rourke, 2012; Hewitt & Lewallen, 2010; Notzer & Abramovitz, 2008; Nunley et al., 2011; O'Callaghan, 2007). A faculty development workshop had a positive effect on the cognitive and affective behaviors of adjunct clinical nursing instructors at the EMSON. Additionally, the SOLO was valued and considered as a useful tool for the faculty development workshop.

Limitations

In addition to the limitations provided in chapter one, limitations were exposed during the research project. Limitations that could have affected this study were adjunct clinical instructors' teaching or nursing experience, materials provided prior to the workshop, and my relationship to the participants in this study.

This study revealed that adjunct clinical instructors who teach clinical courses improved their knowledge and increased affective behaviors after a faculty development workshop. It was, however, not possible to determine if the number of years of experience as an adjunct clinical instructor or registered nurse affected the outcomes of this study. It should be noted that the participants had a wide range of years of experience; therefore, the participants did not have similar backgrounds. Even with this as a factor, the results indicated that the participants were motivated to learn and gained valuable information from the faculty development workshop.

One week before the faculty development workshop, adjunct clinical instructors were provided with a SOLO. Included in the SOLO were two suggested readings on clinical grading. The majority of the instructors indicated they had read the articles prior to the workshop (95%). Providing the participants with the information on the workshop topic prior to the workshop could have improved their scores on all sections of the pretest, which could have potentially affected results of this study.

I was the developer of the workshop and presented the majority of the program, which may have introduced some bias related to content and execution of the program. My position as the Undergraduate Coordinator for the school of nursing could have also created bias in the participants. Part of my job includes supervision of the clinical coordinators who oversee the adjunct clinical instructors. I was highly invested in the EMSON and the workshop; therefore, this study may be hard to replicate at other nursing programs. Conclusions from this study cannot be generalized beyond the sample or study site.

Recommendations for Future Research

Replication of this study using random sampling with larger numbers of adjunct clinical instructors from multiple nursing programs is needed to generalize the results. The use of a convenience sample of faculty from a single nursing program in this study limits my ability to report that these findings are representative of all adjunct clinical instructors of nursing. Furthermore, as previously indicated, the majority of the participants were BSN prepared registered nurses. A master's degree in nursing (MSN) is preferred as a minimum standard for faculty teaching in a BSN program; however, the majority of the adjunct clinical instructors at the EMSON are BSN graduates. This is due to a shortage of MSN prepared registered nurses in the geographic area. The over reliance on BSN prepared nurses at the study site also limits the generalizability of the findings to other nursing programs. Additionally, due to limitations in gathering the demographic information, subgroup analysis by years of experience, education level, or age of instructor could not be performed. For future studies, demographic information should be obtained from the participants to examine how these variables may affect the outcomes.

This study should be repeated using an experimental design. The use of random sampling and a control group would increase the rigor of the study. Experimental design decreases the threats to validity, with the threat to internal validity controlled or minimized. I would recommend the use of two randomly assigned groups, including one group who attended the orientation and the faculty development workshop and one group who attended only the orientation. Furthermore, a continuation of data collection is recommended to assess for positive

changes in the assessment of students in clinical courses. Finally, the instruments that were developed for this study need additional testing for increased validity and reliability.

Recommendations for Practice

The results of this study provided support for several implications for practice and policy for the EMSON in regards to adjunct clinical instructors. This section offers implications and recommendations in the following areas: needs assessment, faculty development programs, and use of the SOLO. These recommendations are based on the findings from this study and a review of the literature.

A formal needs assessment of adjunct clinical instructors at the EMSON could be useful in determining if evaluation practices in clinical courses were the most pressing need identified by the target audience. The literature supports assessment of students in clinical courses as an adjunct clinical instructor need. However, there could be other needs that should be identified and addressed. Creating systems that would encourage adjunct clinical instructors to be proactive in identifying and addressing knowledge and skills deficits would decrease future difficulties and support their success in the educator role. Knowing what information is needed to properly prepare and orient adjunct clinical faculty is also critical for the institution in order for adjunct clinical instructors' needs to be met. I would recommend a formal needs assessment of the current EMSON adjunct clinical instructors and their supervising faculty to assist with the development of future events.

Orientation programs for new adjunct clinical instructors are identified as important for clinical instructor success in the literature (Davidson & Rourke, 2012; Roberts et al., 2013). Beyond the basic orientation, I would recommend a formal adjunct clinical instructor

development program to facilitate successful educator role development (Wolf et al., 2008). A formal development program has the potential to increase job satisfaction and retention of adjunct clinical instructors. Faculty development programs like the workshop provided in this study, can be an effective means for providing novice educators with the knowledge and skills needed to supervise, teach, and evaluate students in clinical courses. Programs should be accessible and based on a school specific needs assessment to increase the value of the development program for adjunct clinical instructors. These programs should be offered at a variety of times with easy access to encourage participation. Faculty development programs should also include the supervising clinical coordinators to ensure continued support and buy-in from those who are directly managing adjunct clinical instructors. Faculty development programs are one way of providing the essential tools for adjunct clinical instructors to create optimal clinical experiences for students (Duphily, 2011).

Also important is the assessment of faculty development program outcomes. An assessment for a positive change in adjunct clinical instructor behaviors after a faculty development program, similar to this study, is recommended. By providing the administration with specific outcomes and data to support adjunct clinical instructor programs, nursing administrators are more likely to fund these programs. Furthermore, increased retention of adjunct clinical instructors could be an outcome of faculty development programs and should be tracked to support continued funding of development programs (Dunham-Taylor, Lynn, Moore, McDaniel, & Walker, 2008; Roberts et al., 2013).

Mentoring programs are another means of supporting adjunct clinical instructors' development. The number of participants in this study who would volunteer to be a mentor

increased after the faculty development workshop. A mentor provides contact with an experienced faculty member to help guide novice clinical instructor as they learn the educator role. A mentoring program should be in place regardless of other development activities provided for the adjunct clinical instructors.

Finally, adjunct clinical instructors in this study supported the use of a SOLO. The needs of the adult learner are important to consider when planning a faculty development program. The SOLO is one tool that could meet the needs of adult learners by providing concrete information prior to the delivery of a workshop. Using a SOLO is recommended for future workshops or programs for adjunct clinical nursing instructors at the EMSON.

Chapter Summary

The purpose of this study was to examine to what extent a faculty development workshop on evaluating students in clinical courses affected adjunct clinical nursing instructors' cognitive and affective behaviors towards clinical evaluation of students. The results indicated that adjunct clinical nursing instructors valued the use of the SOLO, gained knowledge, and increased affective behaviors about assessment of students in clinical courses after a faculty development workshop. This study contributed to the current nursing literature concerning the support of a faculty development program about assessment of students in clinical courses for adjunct clinical instructors at a single institution.

The importance of educating the next generation of nurses to support the health care system is a driving force for creating change in the nursing education system. Reform of the health care system has generated an increased awareness of the need for all levels of healthcare providers. Nurse educators are charged with the responsibility of providing competent beginning level

nurses who can fulfill the need for registered nurses in the health care system. Adjunct clinical nursing instructors are a valuable piece of the puzzle for educating future nurses. Determining what skills and knowledge are needed for adjunct nursing instructors to be successful and creating formal processes to meet these needs are essential to the future of nursing education. Faculty development programs are one way to support the development, retention, and success of adjunct clinical nursing faculty.

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Appendix A

Eleanor Mann School of Nursing
Clinical Instructor Orientation & Workshop
Spring 2014

Thursday, January 9 ECHP 122		
8:00-9:00a	Introduction to Curriculum/Clinical Instructor Ro New Adjunct Faculty ONLY Room 122	Clinical Coordinator
8:00-9:00a	Team Meeting- Immersion Room 217 (Simlab area)	
9:00-9:15a	Welcome (New/Returning Adjunct Faculty) Room 122	Dr. Pegge Bell, EMSON Director & Kelly Vowell Johnson MNSc, RN Undergraduate Coordinator
9:15-9:30a 9:30-10:00a	Administrative Issues: Time Sheets, Lockers Policy Changes Introduction and Pre-test- Evaluating Students in the Clinical Setting Development Session	Kelly Vowell Johnson MNSc, RN
10:00- 11:45a	Team Meetings (BREAK during meeting)- Orientation to Curriculum & Course Health Assessment: Room 118 (Computer classroom) Foundations: Room 225 (Skills lab) Med/Surg: Room 122 (Classroom) Mental Health: Room 207 (Simlab area) Maternal/Child: Room 206 (Simlab area) Management: Room 208 (Simlab area) Community: Room 117 (Conf room 1st floor) Critical Care: Room 218 (Simlab area)	Course Coordinators: – Syllabus/Blackboard – Student/Instructor Orientation – Student lists – Typhon – Typhon EASI Eval – Post Conferencing – Clinical Partner Information
11:45 - 12:30p	LUNCH	Room 123 (Laptops set up in back for Typhon/ATI questions)
12:30-1:30p	Clinical Grading and Assessment Techniques- Development Session I. Trends II. Evaluation Basics	Kelly Vowell Johnson MNSc, RN
1:45-2:15p	III. Student Problems	Adjunct Clinical Instructor
2:15-2:45p	BREAK	
2:45-3:30p	IV. Evaluation Strategies & Techniques	Kelly Vowell Johnson
3:30-4:00p	Evaluation of Development Session	BSN Faculty Representative

Appendix B

Eleanor Mann School of Nursing

Evaluating Students for Clinical Grading
Student Oriented Learning Outline (SOLO)

January 9, 2014
Estimated Time: 4 hours

Evaluating Students for Clinical Grading
SOLO

Topics**:**
1. Basic Concepts used in Evaluation of Students
2. Trends in Clinical Evaluation and Grading
3. Reasons for Student Problems and Strategies to Assist in Solving These Issues.
4. Evaluation Techniques and Strategies in the Clinical Setting

Rationale:
Evaluation of students in the clinical setting creates challenges for students and faculty that are unique from those that they encounter in the classroom. Gaining knowledge about current evaluation practices in the clinical setting for grading purposes is key to student, faculty, and program success. An in-depth knowledge of trends, problems, and techniques for student evaluation is important to your career as an adjunct faculty member. After this presentation you will have a clear understanding of trends and issues related to student evaluation for grading purposes, and will be able to discuss and describe strategies and techniques for evaluation of students in the clinical setting.
This SOLO was designed to first provide you with information about evaluation of students in clinical courses, but second, and most importantly, it was designed to make you think, question, and gain the information necessary to make informed decisions/assessments concerning student evaluation.

Learning Goals:
1. Become familiar with basic educational evaluation terminology.
2. Be aware of trends in clinical evaluation and grading and the implications for assessing students.
3. Become acquainted with reasons why clinical faculty experience problems in grading and suggest strategies for success.
4. Learn how to do reliable students evaluation in the clinical setting.

Clinical Grading SOLO

Instructional Objective	Learning Resources	Special Instructions
1.a. Given any basic evaluation term or concept define it in your own words	1.a. PowerPoint Presentation	1.a. Evaluation Bingo
2.a. Describe current trends in clinical evaluation and grading. 2.b. Given a future trend or change in the clinical environment describe how it will effect student evaluations	2.a. Read prior to the session Alfaro-LeFevre, R. (2004). Should clinical courses get a letter grade? *The Critical Thinking Indicator, 1*(1), 26-27. Retrieved from http://alfaroteachsmart.com/clinicalgradenewsletter.pdf 2.b.1. Powerpoint Presentation 2.b.2. Class Discussion	2.a. Trends group activity: Truths in the clinical setting
3.a. Knowing the characteristics of students entering the EMSON program predict potential issues/problems that could be encountered. 3.b. Describe difficulties faculty encounter in student assessment in the clinical setting and suggest workable solutions. 3.c. List common student problems and strategies for remediation that are encountered in the clinical setting.	3. a. Powerpoint 3.b. Pair/Share 3.c.1. Read: Luhanga, F., Younge, O., & Myrick, F. (2008). Failure to assign failing grades: Issues with grading the unsafe student. *International Journal of Nursing Education Scholarship, 5*(1), 1-14 3.c.2. PowerPoint Presentation	

3.d. Given any clinical scenario propose strategies to resolve the identified issue.	3.d. Clinical Scenarios	3.d. Discussion: Student Scenarios, What Would You Do?
4.a. Name successful strategies and techniques for properly evaluating students in the clinical setting. 4.b. Given scenarios of clinical student issues, describe what you would do and defend your choice.	4.a.1 Powerpoint 4.a.2. Polling activity 4.b. Panel Discussion and Questions	4.b. Small group activity- What technique or strategy would you choose?

SOLO References

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Appendix C

December 18, 2013

MEMORANDUM

TO:	Kelly Vowell Johnson James Hammons
FROM:	Ro Windwalker IRB Coordinator
RE:	New Protocol Approval
IRB Protocol #:	13-12-237
Protocol Title:	*Using Solos to Influence Adjunct Clinical Instructors' Cognitive and Affective Behaviors towards Assessing Clinical Performance*
Review Type:	☐ EXEMPT ☒ EXPEDITED ☐ FULL IRB
Approved Project Period:	Start Date:12/18/2013 Expiration Date: 12/16/2014

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (http://vpred.uark.edu/210.php). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 45 participants. If you wish to make *any* modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 210 Administration Building, 5-2208, or irb@uark.edu.

Appendix D

COLLEGE OF EDUCATION AND HEALTH PROFESSIONS
ELEANOR MANN SCHOOL OF NURSING
606 N. RAZORBACK RD. #111
FAYETTEVILLE, AR 72701

You are invited to participate in a research study conducted by Kelly Vowell Johnson, MNSc, RN, doctoral candidate of the Higher Education Leadership Program in the College of Education and Health Professions at the University of Arkansas. As a doctoral candidate in the Higher Education Faculty Leadership Program, I am conducting a study about assessment of clinical performance for student grading.

Your participation in this study is entirely voluntary. Please read the information provided on the consent form and ask questions about anything you do not understand, before deciding whether or not to participate. You have been identified as a possible participant because you are a clinical instructor and will be participating in the orientation/faculty development day at the Eleanor Mann School of Nursing. Participation in this study is voluntary, and choosing not to participate will not change your involvement in the development day activities. You are free to refuse to participate in the study and to withdraw from this study at any time with no negative consequences or penalty to you.

There are no anticipated risks to you as a result of participation in this study. No personal identifiers will be linked to the data.

THE CONSENT FORM IS INCLUDED FOR YOUR REVIEW BUT WILL BE PROVIDED 1/9/2014 FOR YOUR SIGNATURE. If you have questions about the study or your rights as a participate, please contact:

Kelly Vowell Johnson
Primary Researcher

You may also contact the University of Arkansas Research Compliance office listed below if

you have questions about your rights as a participant, or to discuss any concerns about, or problems with the research.

Ro Windwalker, CIP
Research Compliance
University of Arkansas

Appendix E

Using Solos to Influence Adjunct Clinical Instructors Cognitive and Affective Behaviors Towards Assessing Clinical Performance

Principal Researcher: Kelly Vowell-Johnson, MNSc, RN

You are invited to participate in a research study about assessment of student clinical performance for grading in nursing. You are being asked to participate in this study because you serve as a clinical instructor with baccalaureate nursing students.

WHAT YOU SHOULD KNOW ABOUT THE RESEARCH STUDY

Who is the Principal Researcher?
Kelly Vowell Johnson, MNSc, RN
Undergraduate Coordinator
University of Arkansas
Eleanor Mann School of Nursing

What is the purpose of this research study?
The purpose of this study is to determine if an education intervention using Student Oriented Learning Outline (SOLO) can influence the cognitive outcomes and affective behaviors of clinical faculty towards assessing clinical performance.

Who will participate in this study?
All clinical instructors employed for the Spring 2014 semester will be asked to participate.

What are EMSON clinical instructors being asked to do?
Your participation will require the following:

Attendance at the scheduled EMSON orientation for clinical faculty.
Completion of a pre-test and post-test instrument.

What are the possible risks or discomforts?
There are no anticipated risks or discomforts from participation.

What are the possible benefits of this study?
It is hoped that the educational session will increase your knowledge about assessment of students in the clinical setting.

How long will the study last?
A SOLO will be sent to you one week prior to the orientation/development session via email. At the beginning of the EMSON orientation/development session you will be asked to complete a pre-test instrument. The estimated time for completion is 15 minutes. At the end of the modules you will be asked to complete a post-test and satisfaction survey. The estimated time for completion is 20 minutes.
Will I receive compensation for my time if I choose to participate in this study?

No additional compensation will be provided beyond your contracted pay for the orientation and development day.

What are the options if I do not want to be in the study?
If you do not want to be in this study, you may choose not to participate. Also, you may refuse to participate at any time during the study. Your position with the University will not be affected in any way if you refuse to participate. You will still participate in the clinical grading education session regardless of your decision to participate in this study.

How will my confidentiality be protected?
All information will be kept confidential to the extent allowed by and applicable to University policy, State and Federal law.
Participants will be assigned a code number for all tests and surveys. A faculty member not involved in the project will keep the coded data information sheet. Data from the study will be stored on a password protected faculty computer in a locked office. No personal identifying data will be recorded. Data will be analyzed and reported as aggregate results.

Will I know the results of the study?
At the conclusion of the study you will have the right to request feedback about the results. You may contact the Principal Researcher, Kelly Vowell Johnson. You will receive a copy of this form for your files.

Kelly Vowell Johnson, MNSc, RN
University of Arkansas
Eleanor Mann School of Nursing

You may also contact the University of Arkansas Research Compliance office listed below if you have questions about your rights as a participant, or to discuss any concerns about, or problems with the research.

Ro Windwalker, CIP
Institutional Review Board Coordinator
Research Compliance
University of Arkansas

I have read the provided statements and have been able to ask questions and express concerns, which have been satisfactorily responded to by the investigator. I understand the purpose of the study as well as the potential benefits and risks that are involved. I understand that participation is voluntary. I understand that significant new findings as a result of this research will be shared with participants upon request. I understand that no rights have been waived by signing the consent form. I have been given a copy of the consent form.

Name Date

Appendix F
Pre-test
INSTRUMENT I: CODE # _____

Name: _____

I. Rate your knowledge of clinical grading: *1 indicates you have no knowledge, 5 indicates you are an expert. Circle the rating that best describes you.*

General knowledge of clinical grading	1	2	3	4	5
Knowledge of student assessment strategies	1	2	3	4	5
Ability to apply the grading rubric provided	1	2	3	4	5
Understanding of student assessment terminology	1	2	3	4	5
Types of assessment systems for clinical grading	1	2	3	4	5

II. Please choose the items below that best describe choices you will make. *Mark all that apply:*

_____Attend additional sessions on clinical grading

_____Read the article provided

_____Discuss this with a peer clinical grading

_____Look up additional information on clinical grading

_____Participate in a group discussion about clinical grading

_____Sign up to be a mentor to a new faculty to assist with assessment of students for grading

III. Self-Assessment

Kan, E. Z., & Stabler-Haas, S. (2009). *Fast facts for the clinical nursing instructor: Clinical teaching in a nutshell*. New York: Springer Publishing Co.

1. T F Grading policies are not usually found in the student handbook.
2. T F Clinical evaluation involves advanced preparation.
3. T F It is a good idea to do a summative evaluation at mid-term.
4. T F Clinical grading requires you to think more like a teacher and less like a nurse.
5. T F Anecdotal notes are paramount to all instructors.

6. T F Early warning signs of students at risk for failure are present and should be identified and documented.
7. T F Clinical grading systems can be pass/fail, satisfactory/unsatisfactory, a letter/number grade, or a combination of these systems.
8. T F The clinical grade should be based upon how well a student performs each skill.
9. T F Adopt a casual approach to documentation of students' clinical performance.
10. Using the clinical evaluation tool provided for your assigned course, describe how you would respond to this student in the following scenario. Provide a brief anecdotal note and the objectives in your course that this would affect (list all that apply).

Appendix G
Post-Test
INSTRUMENT II: CODE # _____

Name: _____

I. Rate your knowledge of clinical grading: *1 indicates you have no knowledge, 5 indicates you are an expert; circle the rating that best describes you.*

General knowledge of clinical grading	1 2 3 4 5
Knowledge of student assessment strategies	1 2 3 4 5
Ability to apply the grading rubric provided	1 2 3 4 5
Understanding of student assessment terminology	1 2 3 4 5
Types of assessment systems for clinical grading	1 2 3 4 5

II. A Student Oriented Learning Outline (SOLO) was sent to you last week. Please answer the following questions concerning this tool.

*This SOLO was developed in an effort to succinctly let you know the goals for the training session.

Please check the boxes next to the statement below on a scale of 1 – 5 where:

1 = Strongly Disagree
2 = Disagree
3 = Neutral
4 = Agree
5 = Strongly Agree

Question	1	2	3	4	5
1. The SOLO made it easy for me to understand exactly what I was expected to learn.					
2. I found the SOLO helpful in learning clinical assessment of students.					
3. I found the SOLO helpful when preparing for the session.					
4. I think that using a SOLO would be beneficial in other training session.					
5. The learning activities reinforced the material in this session.					
6. I found the self-quiz to be a good indication of my knowledge on the subject of assessment of students in clinical for grading.					
7. I would use a SOLO if I were leading a training session.					
8. The handouts associated with this SOLO were pertinent.					

9. The post-test helped me assess my learning.					
10. I liked using the SOLO for this training.					

**Evaluation of SOLO developed by Kathi Jogan, University of Arkansas*

III. Please choose the items below that best describe choices you will make. *Mark all that apply:*

_____Attend additional sessions on assessment of students for clinical grading

_____Read the article provided

_____Discuss with a peer assessment for clinical grading

_____Look up additional information on assessment for clinical grading

_____Participate in a group discussion about types of clinical grading

_____ Sign up to be a mentor to a new faculty to assist with assessment of students for grading

IV. Post- Assessment

Kan, E. Z., & Stabler-Haas, S. (2009). *Fast facts for the clinical nursing instructor: Clinical teaching in a nutshell*. New York: Springer Publishing Co.

1. T F Clinical expertise are the most important aspect in providing fair and accurate student assessments.

2. T F In a 8 week clinical course a mid-term evaluation is not valid, as the instructor has not had adequate time to provide feedback.

3. T F The use of anecdotal notes should be shared with students as frequently as possible.

4. T F Rating scales are most useful for summative evaluation of performance; after observing the student over a period of time.

5. T F Clinical grading systems are defined individually by each clinical course coordinator.

6. T F Clinical evaluation is based on predetermined outcomes or competencies that are used to guide the assessment process.

7. T F It is up to the clinical instructor to develop a supportive learning environment regardless of the assigned clinical setting or level of student.

8. T F The clinical instructor should adopt a casual approach to documentation of students' clinical performance.

9. T F Clinical course outcomes should be specific enough to guide the evaluation of students in clinical practice.