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Clinical Grading Rubric and Interrater Reliability

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by

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Abstract

Clinical documentation is an integral part of the nursing curriculum. Nursing students utilize clinical documentation to reflect on weekly clinical experiences and clinical instructors grade this clinical documentation to view the students understanding of the experience and the nursing process. As the student progresses, the documentation changes to a more critical thinking piece of the student's advancement toward their future work experience. Grading of clinical documentation can be challenging and often leads to poor self-efficacy of the instructor as well as the student. It has been known that students are often given the benefit of the doubt and passed when they should not have been, or an instructor has failed to fail a deserving student due to various conflicts of interest. This inconsistency in grading causes decreased interrater reliability and a potential hazard to future patients of these students once in the work environment. Grading rubric have been shown to increase interrater reliability (IRR), consistency, and self-efficacy. A clinical grading rubric is a method that can be utilized to increase these disparities that occur in the realm of nursing education.

Keywords: adjunct clinical instructor, clinical documentation, faculty, 'failure to fail', interrater reliability (IRR), nurse educator, nursing student, OSCE, pass/fail, rubric, self-efficacy.

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CHAPTER I

Introduction

Nurse educators are professionally, legally, and ethically expected to anticipate safety risks for patients and prevent students from causing harm to patients in the clinical setting. When a student's behavior or behaviors pose a threat to patient safety, that student may be subject to a failing grade in the clinical nursing course (Tanicala et al., 2011). In evaluating nursing students' performance, clinical educators serve as gatekeepers to the profession of nursing (Skúladottir & Svavarsdottir, 2016). Clinical skills are a major focus in nursing education. Academic writing has been embedded in most aspects of nursing including clinical because graduate nurses need to ensure the safety of their patients by providing clear and concise documentation of all treatment and care given to their patients so that errors in the clinical setting are minimized (Jefferies et al., 2018). Clinical documentation is a form of academic writing that is a crucial part of nursing student's performance in the clinical setting. Clinical documentation, required by colleges and universities, is dependent on the nursing student's clinical performance as well as their competency status in the realm of nursing education. This clinical documentation provides the instructor the information he or she needs to understand the student's knowledge of the nursing process for the clinical setting.

Nursing students will have different clinical leaders for the same practicum course. Due to individualized teaching styles and clinical expertise, the clinical expectations of a student may vary from instructor to instructor. The lack of consistent grading methods of clinical documentation by raters is a frustration for nursing students. It is essential for consistency in grading of nursing student's clinical documentation

between raters. Some instructors grade in a thorough manner requiring students to use critical thinking skills and knowledge. Other instructors just check that the paperwork was done without requiring the critical thinking aspect. There are instructors that stick directly to the rules of clinical paperwork grading where others may let things be omitted without repercussions for the student. This inconsistency causes issues for many students and could possibly show the failure to fail aspect of nursing. This lack of consistency and responsibility of the instructor is also confusing and frustrating for nursing students, especially in the first semesters of nursing school. As part of the faculty role, it is imperative for nurse educators to be concerned with objectivity, fairness, and equity with respect to student assessment, which will be evidenced in consistent grading practices carried out by educators (Dunbar, 2018).

Some colleges and universities utilize anecdotal type grading whereas others utilize a grading rubric. Still yet, there is only a pass/fail or a sat/unsat grading for clinical documentation. These grading techniques lead to the 'Failure to Fail' phenomenon, which is a term used in the literature to describe allocation of pass grades to nursing students who do not display satisfactory clinical practice (Hughes et al., 2016). Failing to fail may be evident simultaneously in both clinical and academic (theoretical) environments and may permeate across all aspects of the nursing education sector and across both university and community college settings (Docherty& Dieckmann, 2015). Fear of poor student evaluations, tenure systems, and the institutional response to economic challenges are all suggested as contributing to grade inflation and may also contribute to failure to fail (Docherty & Dieckmann, 2015). There may also be "personal, professional, and structural reasons" for failing to fail a student, including the fear of

diminishing the professional reputation of the program (Docherty & Dieckmann, 2015). By giving a negative grade to a student, the educator admits to having failed to effectively teach, motivate, or create a learning environment for a particular student; by unjustly giving a positive grade to a student the teacher does not ensure the quality of future patient care (Mak-van der Vossen, 2018). More recently described reasons for reluctance to fail are a lack of conceptual clarity about expectations, concern over the subjectivity of one's judgement, fear of harming a student's reputation, lack of appropriate faculty development, and uncertainty about the remediation process and its outcomes (Mak-van der Vossen, 2018). Regardless of the cause, educators' reluctance to fail is unfortunate, because underperforming students who are not identified cannot be offered assistance that would help them improve their performance (Mak-van der Vossen, 2018). In turn, this issue can have significant implications for individual students and assessors involved, as well as for nursing professionalism and patient safety (Hughes et al., 2016). The evaluation of student performance is complex and inherently subjective. Consequences of graduating marginally competent, novice nurses include increased patient safety risks, poor standards of nursing care, and a loss of the public's confidence in the nursing profession (Couper, 2018).

A detailed, numeric grading rubric, which provides specific details about grading criterion, could decrease inconsistent, subjective grading methods and in turn increase consistency and interrater reliability across the clinical grading spectrum. A numeric grading rubric would provide a more strategic structured method of grading clinical documentation as well as increase feedback to help underperforming students.

Problem Statement

The nurse educator competency III, Use Assessment and Evaluation Strategies (National League for Nursing, 2018) encourages use of evidence-based evaluative practices (Kopp, 2018). Clinical documentation of the nursing student's clinical experiences is required by colleges and universities. This clinical documentation is graded by clinical leaders including academic instructors, adjunct instructors, and preceptors. Most institutions utilize a pass/fail grading method for this clinical documentation leaving discrepancies in grading, potentially unfair results, grade inflation, decreased interrater reliability, and is ultimately based on subjectivity. The aim of this thesis project was to create a rubric tool for clinical documentation that is valid, reliable, improves interrater reliability, fairness, and increases the self-efficacy of students and clinical leaders alike.

Significance

An emphasis on quality and safety in health care has led to the need for accurate evaluation of performance in order to promote safe professional practice (Dunbar, 2018). The need for valid, reliable, and objective tools has always been emphasized in studies related to the clinical assessment of nursing students (Navabi et al., 2016). Clinical instructors each have their own ways of grading clinical documentation, but it is important to have consistency and interrater reliability. Students are often not familiar with the expectations of others and the evaluation processes (Navabi et al., 2016). Clinical evaluation requires the use of different measures such as diaries, checklists, questionnaires, observations, field notes, peer evaluation, self-assessments, and interviewing students and clinical teachers (Skúladottir & Svavarsdottir, 2016).

Consistency among nurse educators grading student performance of clinical skills is a crucial aspect that can enhance objectivity and fairness in the evaluation process (Dunbar, 2018). This is a vital component of student evaluation, and can lead to student satisfaction (Dunbar, 2018).

Purpose

The purpose of this thesis project was exploring an intervention that will improve consistency and interrater reliability in grading clinical nursing documentation assignments among all clinical faculty members. When consistency in grading is improved, interrater reliability is also expected to improve. This project will determine if a grading rubric can improve consistency and interrater reliability in grading among faculty members who grade clinical documentation.

Theoretical or Conceptual Framework

The nature of this thesis project required a framework that was capable of addressing multiple factors to include knowledge and skill acquisition as well as self-efficacy or self-confidence in skill utilization. The theoretical framework for this thesis project is based on multiple theories which include Patricia Benner's From Novice to Expert model and Albert Bandura's Self-Efficacy Theory.

Patricia Benner

The Novice to Expert Model introduced by Dr. Patricia Benner in 1982 is generated from the Dreyfus Model of Skill Acquisition and essentially discusses how an individual gains new skills and knowledge from novice stage to expert stage (Ozdemir, 2019). This nursing theory directly correlates with this thesis project in that it proposes that expert nurses develop skills and understanding of patient care over time through a

proper educational background as well as a multitude of experiences (Petiprin, 2020). Through this educational background of clinical experience and documentation as well as feedback, the nursing student can reflect and grow developing and perfecting skills as and the understanding of patient care. Dr. Benner found similar parallels in nursing, where improved practice depended on experience and science, and developing those skills was a long and progressive process (Petiprin, 2020). This model has been applied to several disciplines beyond clinical nursing, and understanding the five stages of clinical competence helps nurses support one another and appreciate that expertise in any field is a process learned over time (Petiprin, 2020). Benner's model stands on how a nurse develops nursing knowledge, skill, clinical competence, and comprehension of patient care through complete theoretical training and experiential learning from novice stage to expert stage (Ozdemir, 2019).

Benner's Novice to Expert model (Figure 1), begins with the nursing student's first year of nursing education and is described as one who has very limited ability to predict what might happen in a particular patient situation (Petiprin, 2020). The student in the novice stage has not had experience in the clinical setting therefore the recognition of change in the patient such as mental status is not an acquired skill. The nursing student has no information on how to transfer new knowledge and skills to their applications when they face with unique situations (Ozdemir, 2019).

The second stage in Benner's model is the Advanced Beginner stage. These are new grads in their first nursing jobs. The nurse has now had some experience and can recognize recurrent meaningful components of a situation, but not enough in-depth experience (Petiprin, 2020). These nurses still require assistance for patient care from

experienced nurses. The nurse in this stage focuses on completing all ordered treatments and procedures more than individualized nursing care (Ozdemir, 2019).

The Competent stage is the third stage in Benner's model. In this stage the nurse lacks the speed and flexibility of proficient nurses, but they have some mastery and can rely on advance planning and organizational skills (Petiprin, 2020). In the competent stage, nurses devise new procedures and develop new clinical knowledge along with learned procedures for managing the patient care while they are learning ethical behaviors (Ozdemir, 2019).

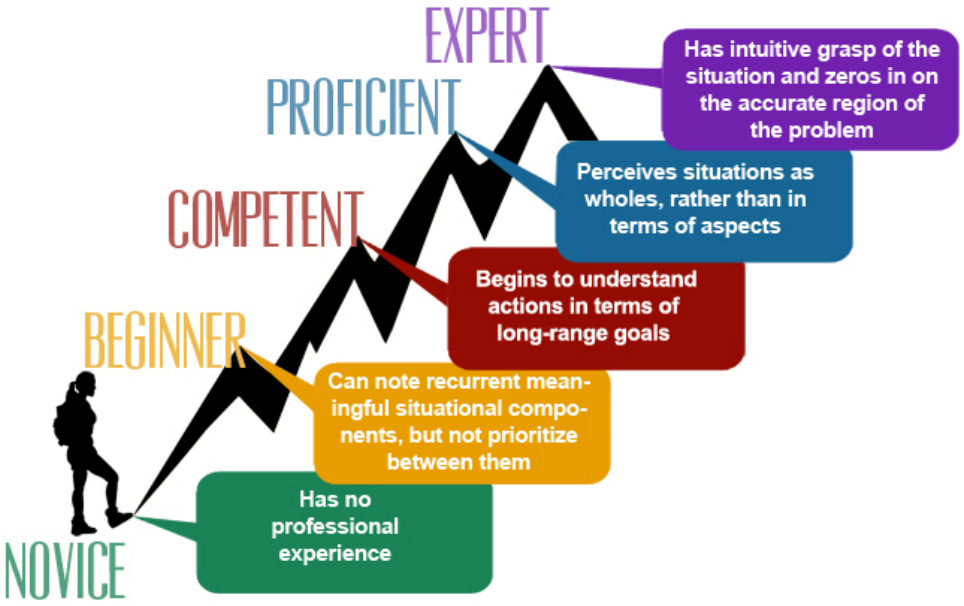
The fourth stage in Benner's model is the Proficient stage. At this stage, nurses are capable to see situations as "wholes" rather than parts (Petiprin, 2020). Proficient nurses learn from experience what events typically occur and are able to modify plans in response to different events (Petiprin, 2020).

The final stage in Benner's model is the Expert stage. These nurses are able to recognize demands and resources in situations and attain their goals with an intuitive grasp of the situation based on their deep knowledge and experience (Petiprin, 2020). Expert nurses have critical thinking skills to plan the patient care again in line with the patient's actual conditions, concerns and needs (Ozdemir, 2019).

Benner's Novice to Expert model can be narrowed down and relate specifically to the nursing student in that through each semester the student gains knowledge and skills to prepare him/her for their nursing career. Once the student has reached their last semester they are now experts in the student realm of nursing and are prepared to step into the new role as a novice nurse.

Figure 1

Patricia Benner's Novice to Expert Stages



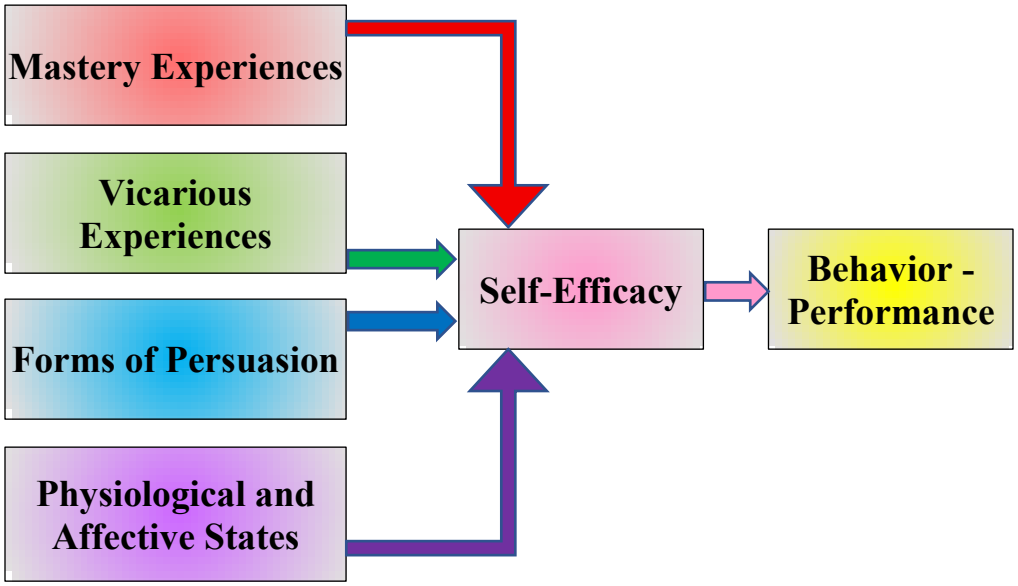
Albert Bandura

The self-efficacy component of Albert Bandura's social-cognitive theory is believed by many scholars to be a critically important theoretical contribution to the study of academic achievement, motivation, and learning (Artino Jr, 2012). Self-efficacy theory was originated from Social Cognitive theory by Alberta Bandura (Current Nursing, 2012). It is not enough for individuals to possess the requisite knowledge and skills to perform a task; they also must have the conviction that they can successfully perform the required behavior(s) under typical and, importantly, under challenging circumstances (Artino Jr, 2012). This self-efficacy can be built upon the fact that the nursing student has accomplished a particular skill set in the clinical setting. Once this skill set is achieved and practiced, the confidence of the nursing student will grow as will

their self-efficacy, especially with positive or constructive feedback. Self-efficacy theory postulates that people acquire information to evaluate efficacy beliefs from four primary sources: (1) enactive mastery experiences (actual performances); (2) observation of others (vicarious experiences); (3) forms of persuasion, both verbal and otherwise; and (4) 'physiological and affective states from which people partly judge their capableness, strength, and vulnerability to dysfunction' (Artino Jr, 2012). These four sources can be evaluated in Figure 2.

Figure 2

Bandura's Sources of Self-Efficacy



While experienced mastery has been shown to produce the most powerful influence on efficacy beliefs, individuals can also learn by observing the successes and failures of others (Artino Jr, 2012). This can be identified not only in the students realm, but from the instructors own self-efficacy.

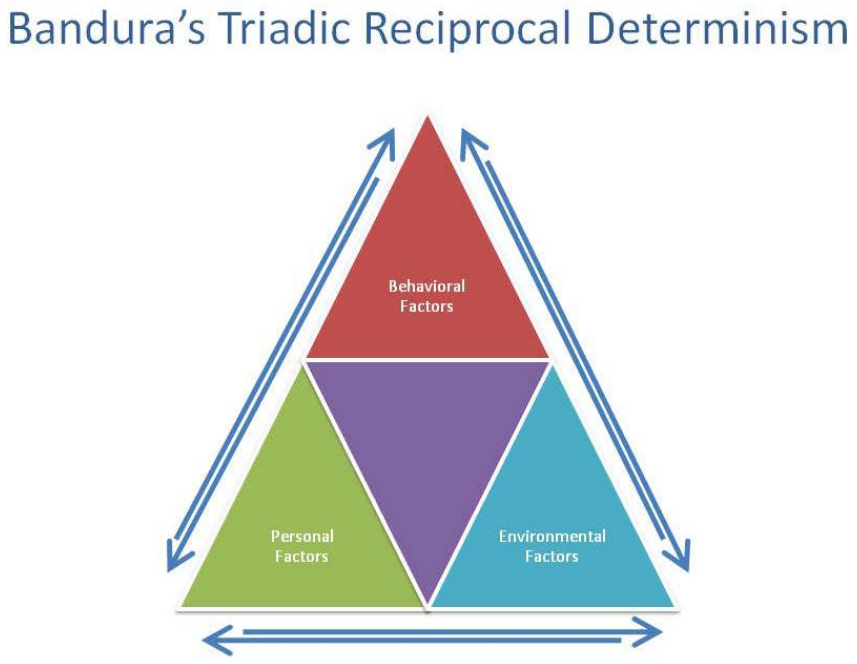
There has been an accumulation of research evidence supporting the positive links between students' academic efficacy and their achievement (Artino Jr, 2012).

Specifically, students with high self-efficacy in various academic domains choose to engage in tasks that foster the development of their knowledge, skills, and abilities in those areas; exert effort in the face of difficulty; and persist longer at challenging tasks (Artino Jr, 2012). Instructional strategies focused on providing students with opportunities for performance success aligns well with Bandura's emphasis on enactive attainment as the most influential source of self-efficacy information (Artino Jr., 2012).

Bandura's Social Cognitive Model says that there are three factors that influence self-efficacy which include behaviors, environment, and personal/cognitive factors (Current Nursing, 2012). This is the Bandura's Triadic Reciprocal Determinism model which can be seen in Figure 3.

Figure 3

Bandura's Triadic Reciprocal Determinism



These three factors all affect each other with the cognitive factors one of the most important (Current Nursing, 2012). When nursing students persevere or instructors

persevere and overcome obstacles, especially while observing others succeed, this increases ones self-efficacy which is their perception of their ability to reach a goal (Current Nursing, 2012).

Thesis Question

Does the use of a rubric in grading, for rating clinical paperwork, compared to a pass/fail grading method without a rubric, affect the consistency or interrater reliability in grading the clinical documentation of first year undergraduate nursing students?

Definition of Terms

The nursing student is matriculated in a nursing program; may be diploma, associate degree, baccalaureate, or master's program (student nurse, n.d.). Nursing students have a vast amount of responsibility during their education. One of the most complained about responsibility is the required clinical documentation. Clinical documentation is an evaluation tool, which colleges and universities require nursing students to complete with their clinical experience, to track a patient's condition and communicate the author's actions and thoughts to other members of the care team (Kuhn et al., 2015). Nursing clinical documentation includes databases, pathology sheets, laboratory sheets, medication sheets, concept maps and care plans. Critical thinking is vital for professional nursing practice, as is high level communication, and the experience of writing assignments during undergraduate nursing studies develops both of these skills (Jefferies et al., 2018). Clinical documentation is graded by adjunct clinical instructors as well as full time nurse educators. Nurse educators are registered nurses (RNs) who have obtained advanced nursing degrees that allow them to teach nursing curriculum at colleges and universities, teaching and helping to train the future nurses of the world

(Nurse Educator, 2020). Adjunct faculty are defined as faculty members who have a minimum of a BSN and are hired on a course-by-course basis to supplement the regular full- and part-time faculty (Elder et al., 2016). There are multiple ways of grading clinical documentation. One way is pass/fail or as termed as sat/unsat in which nursing students can have multiple sat/unsat situations each clinical rotation as deemed per college or university policy. Another way of grading clinical documentation is with a rubric which is "a coherent set of criteria for students' work that includes descriptions of levels of performance quality on the criteria" (Brookhart, 2015). Objective structured clinical examinations (OSCE) are innovative evaluation methods that are often used for assessing health sciences and nursing students' clinical skills including clinical documentation (Bdair et al., 2019).

With multiple clinical instructors there can be inconsistency in grading techniques which can cause a threat to the validity in grading of clinical documentation. This threat can be a variation in clinical instructor's perceptions or judgements and reliability of grading. When one clinical instructor (rater) grades or judges students clinical documentation differently than another clinical instructor (rater) this is interrater reliability (MacLean et al., 2018). Another issue with grading of clinical documentation is the term 'failure to fail'. 'Failure to fail' is the allocation of pass grades to nursing students who do not display satisfactory clinical performance (Hughes et al., 2016).

Nursing students are required to understand the importance of clinical documentation. In school, the nursing student is expected to complete documentation of the clinical experience. Nursing instructors are expected to grade this clinical documentation, but there is a lack of consistency in grading methods. There are also

inconsistencies and ‘failure to fail’ in grading, therefore causing problems with interrater reliability. Often the grading methods used for clinical documentation is a simple pass or fall, sat or unsat. After reviewing the literature and completing this project it will be determined if a grading rubric would improve the consistency in grading among all faculty members that are grading clinical documentation and increase interrater reliability.

An important factor in achieving writing competence of clinical documentation can be explained by having confidence that one can be a successful writer, as shown in studies using Bandura's concept of self-efficacy (1997) to predict writing success (Miller et al., 2015). Bandura defined self-efficacy as the “belief in one's capabilities to organize and execute the courses of action required to produce given attainments” (Miller et al., 2015). When this is applied to the clinical learning, nursing students demonstrate behaviors that are consistent with their level of self-efficacy such as expenditure of effort, task/assignment completion, nursing process knowledge, and progression toward accomplishing learning goals and competencies. Achievement and success in learning, evidenced by good grades, positive feedback from the instructor and peers, and importantly, a positive self-evaluation reinforce student confidence and enhance self-efficacy (Miller et al., 2015).

CHAPTER II

Literature Review

Literature has shown that there is inconsistency with grading of clinical documentation. Failure to fail has also been a problem with the grading of clinical documentation. The current trends of pass or fail and sat or unsat leads nursing students questioning the reliability of the grading methods by nursing instructors. Will the use of a grading rubric for clinical documentation change the failure to fail phenomenon and consistency in grading?

Literature Related to Statement of Purpose

Rubrics in Nursing Education

Renjith et al. (2015) provided information regarding rubrics in nursing education, which the article was not so much a research article, but a historical article regarding rubrics. The information and explanation of rubrics suggest that rubrics are the blueprint for effective clinical evaluation, provide consistency in evaluation, reduces subjectivity and reduces objectivity. Rubrics can facilitate communication. They can be used as a means to assess student performance while focusing on patient safety and quality of care. When rubrics are used simultaneously by different instructors for the same student they should arrive at the same score or grade. Rubrics can be a reliable source for consistency in grading methods.

Holistic Rubric vs. Analytic Rubric

Holistic rubrics comprise a comprehensive assessment of the complex multi-faceted characteristics of the tasks undertaken and are based on the overall impression of the experts who implement them. Analytic rubrics provide specific feedback according to

several sections or dimensions, allow students to identify which factors are missing from the holistic rubric, and enable continuous monitoring. Analytic rubrics are more reliable than holistic rubrics in that they check the key content, rather than providing a holistic evaluation. Yune et al. (2018) compared the usefulness of a holistic rubric versus an analytic rubric in effectively measuring the clinical skill performances of 126 third-year medical students who participated in a clinical performance assessment. A total of 292 clinical performance examination (CPX) evaluation cases (38.9%) and 488 objective structured clinical examination (OSCE) (65.1%) evaluation cases were used as data in the final analysis. In addition, 37 evaluators (77.1%) responded to a questionnaire. Evaluators assessed whether the holistic rubric for CPA, assigned a score from 0 to 4 and developed according to a score- based criterion, could measure students' clinical ability to perform. The analytic rubrics were developed based on the results of a questionnaire administered to the faculty focus group. In the OSCE, the task-specific checklist scores showed a strong positive correlation with holistic score and analytic rubric scores ($r = 0.751$, $P < 0.001$ and $r = 0.697$, $P < 0.001$, respectively). Holistic score also had a strong positive correlation with analytic rubric scores ($r = 0.791$, $P < 0.001$). In the case of CPX, the task-specific checklist scores showed a strong positive correlation with holistic score and analytic rubric scores ($r = 0.689$, $P < 0.001$ and $r = 0.613$, $P < 0.001$, respectively). Holistic score also had a strong positive correlation with analytic rubric scores ($r = 0.655$, $P < 0.001$). In the OSCE, the task-specific checklist scores showed a moderate agreement with holistic score and analytic rubric scores (Kappa = 0.441, $P < 0.001$ and Kappa = 0.429, $P< 0.001$, respectively). Holistic score also had a moderate agreement with analytic rubric scores ($r = 0.512$, $P <0.001$). Of the students who passed the task-specific

checklist, 96.6% passed the holistic rubric and 87.3% passed the analytics rubrics, while of the students who failed the task-specific checklist, 40.0% failed the holistic rubric, and 60% failed the analytic rubrics. In CPX, the task-specific checklist scores showed a fair agreement with holistic score and analytic rubric scores (Kappa = 0.351, P < 0.001 and Kappa = 0.420, P < 0.001, respectively). Holistic score also had a moderate agreement with analytic rubric scores (Kappa = 0.255, P <0.001). Of the students who passed the task-specific checklist, 98.4% passed the holistic rubric and 92.6% passed the analytic rubrics, while of the students who failed the task-specific checklist, 27.7% failed the holistic rubric, and 46.8% failed the analytic rubrics. In the OSCE, multiple regression analyses showed that both holistic score and analytic rubric scores were statistically significant in predicting task-specific checklist scores, with an explanatory power of 59.1% (F = 352.37, P <0.001), while although holistic score was the most influential variable (ß =0.534, P < 0.001). All variables had variance inflation factors of less than 10 or tolerances of greater than 0.1, which shows that multicollinearity does not exist. In the CPX, multiple regression analyses showed that both holistic score and analytic rubric scores were statistically significant in predicting task-specific checklist scores, with an explanatory power of 51.6% (F = 155.896, P < 0.001), and holistic score (ß =0.503, P < 0.001) showed greater explanatory power than analytic rubric scores (ß=0.283, P <0.001). These evaluator determinations cannot be conducted properly by relying on task-specific checklists, and although objective checklists are often used, they are not the best way to assess clinical performance. Yune et al. (2018) advised that specific information on student performance can be difficult to obtain using holistic rubric alone. Therefore, the concurrent use of analytic rubrics evaluation should also be considered for

applying evaluation results to real practical situations. This study demonstrates that holistic rubric and analytic rubrics are efficient tools for explaining task-specific checklist scores.

Standardized Clinical Performance Grading Rubric

Between 2011 and 2015, Mary Louisa Kopp, PhD, RN, CNE, CHPN collaborated with 23 clinical instructors to create an evaluation tool for more consistent measurement of clinical performance and reliability. Kopp (2018) acknowledged that academic grading rubric can offer a consistent means to bridge criterion-based clinical behaviors with evidence-based teaching. The grading rubric produced an overall Cronbach's alpha score of .917 when measured against all nine performance outcomes and a normalized bell curve. Internal consistency was found to be excellent within the grading rubric. A grading rubric has the potential to produce these fair, consistent and reliable scores. This can also help with identification of safe versus unsafe practices while supporting pass/fail and letter-grade policies in undergraduate nursing student's clinical performance.

Effect of Type of Grading

Reising et al. (2018) completed a study to determine if a student's performance varied depending on grading method. The methods that were in question was pass/fail versus numerical grading with calculation into a course grade. It was noted in their study that the issues related to numerical grading of clinical education involves availability of standardized, reliable and valid approaches to the evaluation. Reising et al. (2018) used the Indiana University Simulation Integration Rubric (IUSIR), a tool for measuring interprofessional communication in simulations. The findings suggested that there was no

significant difference in the grading method. Anecdotal notes from faculty did suggest that students who knew they were going to receive a letter grade, seemed more prepared for the clinical simulation, but these observations were not statistically validated in this study.

Clinical Nurse Leaders' and Academics'

When using a rubric scale for clinical assessment, the proficiency level of the student can be better assessed. This will allow the student to monitor their own progression throughout the clinical experience. This is evident in a literature review conducted by Wu et al. (2017). Through a qualitative research design, a thematic analysis was conducted to understand clinical assessment experiences from the perspectives of clinical nurse leaders and academics. Two of the researchers conducted the data analysis independently to ensure dependability. The research team then deliberated the themes, subthemes, and codes to confirm the validity of the findings. During the deliberation the team discussed any cases of disagreement to reach a consensus on the themes and subthemes. Researchers were mindful about credibility, thus, they avoided using overly broad and overly narrow meaning units. In addition, researchers used quotes from the participants to justify the interpretation. This analysis resulted in four common themes of concern for clinical assessment. The four thems included: (1) the need for a valid and reliable clinical assessment tool, (2) preceptors' competency in clinical assessment, (3) challenges encountered by the students in clinical assessment, and (4) the need for close academic and clinical collaboration to support preceptors and students. The authors found that clinical nurse leaders understood there was variations in clinical assessment even when two clinical nurse leaders or preceptors assessed a student using the same tool.

Understanding the bias[ness] between graders there needs to be a more objective way to assess nursing students during clinical rotations.

Interrater Reliability of a Clinical Documentation Rubric

One challenge to clinical documentation evaluation was the subjective nature of grading and the variability in grading between multiple evaluators. Rubrics provide a standardized method for assessment and are often used as evaluation tools for student performance. Villa et al. (2020) completed a study to evaluate a clinical documentation rubric used by multiple evaluators in pharmacotherapy problem-based learning (PBL) courses. Prior to using the rubric, student clinical documentation was evaluated by one faculty member or resident using a pass/fail scale and without clearly defined performance criteria, resulting in grading variability. The overall intra-class correlation (ICC) five assignments was 0.7 ($p<.01$; 95% CI, 0.6-0.8), indicating good IRR. The ICC for evaluations completed by second and third year student pharmacists using the rubric were 0.7 ($p<.01$; 95% CI, 0.7-0.8) and 0.5 ($p<.01$; 95% CI, 0.4-0.7), indicating good and fair IRR, respectively. Studies have found that students believe using a rubric to grade assignments limits subjectivity and variability when multiple evaluators are involved in a course. As a standardized method, in any type of healthcare profession, to evaluate clinical skills and documentation, rubrics should meet educational standards for reliability. Villa et al. (2020) results show that implementation of rubric use by multiple evaluators resulted in good IRR for grading clinical documentation.

Measuring Grade Inflation

According to Paskausky and Simonelli (2014), the use of rubrics has been suggested to counter grade inflation and improve the quality of assessment. Rubrics have

become more widely utilized in U.S. nursing programs in recent years as methods to increase the accuracy of student evaluations. Clinical experience is the time nurse educators can identify and correct weaknesses in nursing students' skills and knowledge, but this must be an accurate assessment of measurement of competency which allows for early intervention in the academic progression of the nursing student. Inappropriate assessment of competency has been reported by clinical leaders because of factors such as lack of confidence in experience as a preceptor, recognition of high financial and personal costs of failing, guilt, aversion to making more work, poor student assessment tools and the need to pass students to address the perception of a nursing shortage. Regardless of the reasoning for grade inflation, if assessments fail to accurately reflect actual competency, students may be overconfident in comparison to their actual competency and retain unsafe practices into their professional careers. To determine whether clinical grade inflation correlated between licensure-style written final exams and faculty assigned clinical grades, Paskausky and Simonelli (2014) completed a study utilizing a descriptive correlational design in a secondary data analysis. Analysis of student scores (N ¼ 281) showed the correlation between these two measurements was moderate to low at 0.357. The faculty assigned clinical grades were negatively skewed with a reduced range from 76 to 95. The licensure-style written final exam scores were normally distributed with a wide range of scores from 56 to 93. The standard deviation of clinical performance was 3.7 points, whereas for the written exam it was 7 points. Calculated clinical grade discrepancy scores revealed that 98% of students had positive values, meaning that their faculty assigned clinical grades that were higher than licensure-style written final exam grades. Only two students had higher grades on the

licensure-style written final clinical exam than the faculty assigned clinical grades and only one student had the same grades for both. The remaining 278 students all had higher faculty assigned clinical grades than licensure-style written final exam grades. Over 90% of the students (N ¼ 255) had clinical grade discrepancy scores of 5 or greater, meaning the two assessments varied by at least one half-letter grade. Nearly 70% of students (N ¼ 194) had clinical grade discrepancy scores of 10 or greater, meaning the two assessments as to the performance of the student disagreed by a whole letter grade. Finally, 18% of students (N ¼ 51) had clinical grade discrepancy scores of 20 or greater, meaning the two assessments disagreed by two letter grades about the student's performance. Students must know, at the very least, what to do, and should know why, before they are able to execute nursing functions satisfactorily. Paskausky and Simonelli (2014) evidence of different grade distributions between licensure-style written final exam grades and faculty assigned clinical grades as shown through the clinical grade discrepancy score suggests that the validity of educational evaluation methods is likely the cause of the reduced range and skewed distribution of clinical grades, or grade inflation observed. Clinical grading rubrics can assist in this discrepancy.

OSCE Related to Nursing

A literature review to identify the advantages and disadvantages of using the objective structured clinical examination (OSCE) in nursing education was conducted by Bdair et al. (2019). This review iterated the purpose of the OSCE is to assess students' competencies and clinical performance. The literature review suggested advantages of the use of an OSCE in evaluation of undergraduate students to be a variety of benefits for students, instructors, nursing education processes and quality of patients' care as a

consequence. The implementation of OSCEs in nursing education was noted to have some disadvantages in that the implementation of OSCE requires organization, checklists, number of examiners, time and financial support. Overall, the advantages of the OSCE is a tool that improves the training process of undergraduate nursing students with versatile advantages in terms of structure, objectivity, transparency, uniformity and ability to assess a wide range of clinical skills that cannot be assessed via traditional strategies of clinical assessment (Bdair et al., 2019).

Development and Implementation of an Interprofessional Team-Based Care Rubric

Objective structured clinical examinations (OSCE) are intended to be a more objective and reliable form of assessment that reduce examiner subjectivity. In the absence of a well-established objective assessment tool, Hayes et al. (2018) developed an Interprofessional Team-based Care Rubric (ITCR) in an attempt to address this need. A reliable and valid tool to measure student team performance during interprofessional education (IPE) experiences could also be used to measure team performance over time and help guide future learning activities and materials related to developing interprofessional competencies throughout courses and curricula. The Interprofessional Team Care Rubric (ITCR) was found to have good reliability in testing (0.842) by three raters who used the rubric to evaluate student performance on a sample of 30 team documentation assignments during the development process, and (0.825) for all rubrics by three additional raters during the pilot study. The tool was determined to be reliable and valid. The process of rubric development highlighted differences in terminology, priorities, and interpretation of professional boundaries between the three professions involved in creating the rubric.

Failing to Fail Phenomenon Phase 1 and 2

Failure to fail was evident across baccalaureate and associate degree programs and across clinical and didactic settings in a study done by Docherty & Dieckmann (2015). Reasons for failing to fail include reluctance to fail students in the later part of the program and in the early part of the program on the assumption that they would have time to attain the required standard of clinical performance. Some of the other findings included team grading norms, lack of rubric clarity, personal bias, and fear of potential litigation. Given the potential implications for patient care and professional standards, Docherty (2018) continued with phase 2 of the study with a more nuanced exploration of grading practices and again aiming to explore the phenomenon of 'Failing to Fail'. Through a multisite, qualitative case study between November 2015 and June 2016, Docherty (2018) continued phase 2. The data that Docherty (2018) found suggested that faculty are aware of the responsibilities of the accuracy of their grading, both in terms of student success and public safety, and they strive to honor this responsibility. The data also found that there were two other points to 'Failing to Fail' which were: (1) there are a number of factors, positive and negative, that impact grading practices, and (2) when the negative factors are prominent, the risk of failing to fail can become the reality. Factors such as emotional ability and lack of confidence, team factors such as peer pressure, and institutional factors such as administrative and legal requirements were all noted by Docherty (2018) in phase 1 and phase 2 of the study.

Consistency in Grading

To examine interrater agreement among nurse educators, Dunbar (2018) conducted a study to examine interrater agreement among nurse educators grading

summative physical examinations performed by nursing students. Six nurse educators observed and graded independently a simulated student and patient actors during a physical assessment. The simulation session was audio-visually recorded for reassessment one month later to determine interrater agreement upon grading of live versus recorded grading methods. There was acceptable interrater agreement found in both methods, but discrepancy was noted amongst the evaluators regarding pass/fail determinations of both methods of grading. An interrater percent was used to determine the pass/fail guidelines. Seventy-six percent (76%) was the determining percent for a passing grade. The live grading percent was 75% to 89.6% and the recorded grading percent was 74.06% to 83.9%. The discrepancy was determined when one faculty gave a failing grade, and the other five faculty gave a passing grade. This discrepency calls attention to the need of consistency in evaluator grading. Improvement in interrater agreement will ensure consistent grading practices among nurse educators and improve consistency in grading. This will build clinical competency of nursing students as well as potentially improve the quality of care, patient safety, and patient outcomes in the clinical setting.

Establishing Interrater Reliability

According to Margaret Burns (2014), interrater reliability is the agreement of the same data obtained by different raters, using the same scale, classification, instrument, or procedure, when assessing the same subjects or objects. It is important that clinical instructors utilize the same scale, classifications, instruments or procedures when grading clinical documents. There are two tests to determine interrater reliability. These include percentage of agreement and the Kappa statistic. To calculate the percentage of

agreement you would add the number of times the instructors agree on the same data item, then divide that sum by the total number of data items. Kappa is a more complex statistical test. The Kappa statistical test, or better known as the Cohen's kappa, is completed using a formula to test categorical data, or information that can be sorted into groups, such as race, sex, and age. This formula would not be as helpful for interrater reliability due to the detail of the clinical documentation such as the care plan where the information is not the same specific data on each student's paperwork. As Burns suggested, it is necessary for clinical instructors to identify inconsistencies among raters. As part of reproducibility in interrater reliability, it involves consistent recording among raters. To identify the inconsistencies raters must use at least the percentage of agreement when testing the inconsistencies. Raters must meet and resolve discrepancies, with principal investigator intervening as needed. Data needs to be reliable and valid so it can be used both as a basis for using at reimbursement and as a guide for quality improvement initiatives.

Faculty Calibration and Students' Self-Assessments

Faculty calibration is defined as a process to prove faculty members agree to apply the same standardization in protocols, techniques and philosophies. One of the most important skills required by healthcare providers is the ability to self-assess their competence and to identify individual deficiencies and the need for further learning. The ability to assess one's competence and achievements is a skill that can be taught and enhanced. A grading rubric has been recommended as a useful self-assessment tool. To address the lack of consistency amongst faculty members during evaluation and to promote self-assessments amongst students, Oh et al. (2017) developed a new

instructional rubric. The ICC from the first calibration was 0.75. The percentage disagreement in critical failure (19 of 100) and overall failure (4 of 20) was 19% and 20%, respectively. The ICC from the second calibration was 0.97. The percentage disagreement in critical failure (3 of 60) and overall failure (2 of 12) was 3% and 17%, respectively. The high ICCs for both calibrations (ICC = 0.75 at the first calibration and ICC = 0.97 at the second calibration) confirmed a strong correlation amongst the faculty members. This strong correlation of the faculty members also indicates that the new rubric is an acceptable tool to evaluate instrumentation and clinical skills. When the new instructional rubric was used, interrater reliability of the faculty members in the evaluation of the periodontal instrumentation was strong. The strong correlation amongst the faculty members indicated that the new rubric was acceptable to assess quality of students' periodontal instrumentation. Using an instructional rubric and conducting faculty calibration improved the process of the periodontal practical examination. Improving the examination process and practicing self-assessments with feedback from faculty may have a positive impact on students' performances in the examination. This too could be utilized in nursing during clinical assessment of clinical leaders.

'Failure to Fail' – A Catch Phrase or a Real Issue?

When nursing students complete a nursing curriculum they are deemed to be 'competent' to practice and perform at a professional level. 'Failure to fail' is described in literature as a nursing student receiving a pass grade, but who has not shown satisfactory clinical practice. Hughes et al. (2016) completed a literature review utilizing five databases to determine what was known about 'failure to fail' within undergraduate nursing programs. Five main themes were discovered to be recurrent issues related to the

'failure to fail' phenomenon. These themes included failing a student is difficult, an emotional experience, confidence is required, unsafe student characteristics, and university support is required to fail students.

Pass/Fail and Discretionary Grading

There are two approaches to grading in nursing education. These include pass/fail or satisfactory/unsatisfactory and letter or numerical grades. Pass/fail or satisfactory/unsatisfactory evaluates competency and overall understanding. Letter or numerical grades are values such as F− to A+ or values between 0% and 100%. There are advantages, according to Melrose (2017), which include the belief that pass/fail grading exerts positive influences on learning by supporting students' psychological health and wellbeing; reduces feelings of emotional exhaustion, depersonalization, burnout, and the desire to drop out; influential in supporting students towards providing safer care to their patients, including a reduction in medication errors; it is considered to have a less detrimental effect on learning than discriminatory approaches; purported to increase students' intrinsic or internal motivation to learn; and it lays a foundation for the self-direction and self-regulation required in nursing and all health care disciplines. Melrose (2017) also advises that there are disadvantages to the pass/fail grading. These disadvantages include the fact that it exerts negative influences on learning such as students who have excelled and demonstrated remarkable achievements may not be recognized or differentiated from those who simply met the requirements to pass. Other disadvantages include: it may not depict an accurate picture of the specific learning objectives that were mastered and those that need improvement; can create situations where students do not perform effectively on critically important objectives, but achieve

a passing grade because they have performed well on those of lesser importance; the subtle suggestion that only the bare minimum is needed to pass; a possible decline in student classroom attendance; weakening of academic performance; and a potential decrease in pass rates for regulatory licensing examinations. Melrose (2017) concluded that pass/fail grading can promote the self-directed, intrinsically motivated learning expected in professional nursing practice and it can support students' psychological health and well-being. However, it limits opportunities for recognizing excelling students.

Just How Bad Does It Have to Be?

Some nursing students pass assessments in clinical courses despite not clearly demonstrating competency needed for practice. This is a significant concern as when a student achieves an accredited nursing qualification, they are deemed safe to practice independently at an acceptable professional, community and university standard (Hughes et al., 2019). Failure to fail ultimately effects the integrity of the nursing profession and ultimately patient safety. Hughes et al. (2019) designed a survey to explore assessors' experiences of grading student performances in clinical courses when that performance was not a clear pass or fail. The sample consisted of academic and industry-based assessors of preregistration nursing students in clinical assessments in Australian undergraduate nursing programs. Academic respondents included clinical facilitators, course convenors and lecturers who assessed student nurses as part of their role. Industry based assessors included direct-care registered nurses and preceptors from hospital or community who had a direct role in assessing student nurses. A total of 149 participants completed the online survey. The majority of assessors found providing feedback

rewarding (85.9%) with associated improved student performances following feedback (87.3%), most participants did not find providing feedback confronting (91.9%), 29.5% of participants reported feeling intimidated sometimes or often, the participants were split as to whether they found it harder to give feedback if the student was ‘likeable’ (40.2% agreeing it is harder and 41% disagreeing). Generally, participants (73.8%) did not believe that students should be given the benefit of the doubt. In the first year of the program 12.0% had passed poorly performing students, 4.7% had passed a student in second year that was poorly performing and 1.3% of assessors have passed a completing student who was poorly performing. The vast majority (97%) of participants used criteria to grade a student's performance rather than intuition (21.6%) and found marking rubrics helpful discriminators (74.7%).

Literature Related to Theoretical Framework

Who is Failing Who?

“Who is failing who?” is a question that Nugent et al. (2020) raised in their descriptive quantitative questionnaire study. Through research, it has been shown that not failing students who are not performing in a competent manner are results of multiple reasons. These reasons according to Nugent et al. (2020) included: lack of time and increased workloads often compounded by staffing shortages; inconsistencies and language used in assessment tools; perception (and often the reality) that failing a student's clinical assessment, more is demanded of the instructor in terms of time due to the extra documentation and time required for meetings and student support; lack of sufficient information, fear of litigation or the stage of progress of the student and their personal behaviors; influenced by the consequences of failing the student; inhibited by

the prospect of personal and professional consequences for the student; perceived lack of experience and confidence; belief that they are failing in their role as an educator and experience feelings of self-doubt during the process; leniency when a student is junior and/or when they display a willingness and cooperation to improve; perceived or anticipated lack of support for decision making; and the experience of having a decision overturned by colleagues or by university committees. This questionnaire study was a cross-hospital project exploring the issue of failure-to-fail in two large teaching hospitals. The questionnaire findings suggest that there were several undecided answers and uncertainties. The uncertainties and potential lack of confidence could create a reluctance to fail students who are not performing a level of competence for a passing student. Clinical preceptors and or instructors may have concerns and of possible failure for the student, even discussing this with the student verbally then fail to follow through with a fail grade. A common finding such as this tends to be seen in the earlier areas of the program and is thought to be an instructor / preceptor's way of giving the student the benefit of the doubt. As a student progresses into higher levels of the nursing program the competency worsens. This failure on the instructor / preceptor's part to fail the student when competence was first shown as lacking leads to difficult situations when the student enters the profession and potentially compromises the patient safety.

Failing Underperforming Students

Evidence has shown that some clinical nursing leaders, adjunct clinical instrutors and preceptors have had difficulty failing the incompetent student. All too often healthcare programs judge clinical on a pass/fail rather than a grading system. This is a method that has been looked at, but not changed in programs and is concerning for lack

of feedback to the student as well as allowing a student to pass when they really should have failed. Heaslip and Scammell (2011), explored these issues through focusing on selected findings from a service evaluation of a practice assessment tool incorporating grading of practice of pre-registration nursing students from one university in the United Kingdom (UK). Through the use of convenience sampling, a questionnaire survey was given to 107 nursing students, and 112 practice-based assessors such as clinical nurse leaders, preceptors and adjunct instructors. There was a 51% response by students and an 86% responses by assessors. Several issues were noted from the study which included the assessors perceived that there was a lack in confidence in failing students. As reported in the study, only 59.8% (n = 67) of mentors indicated confidence to fail students. In addition 17.9% (n = 20) acknowledged a lack of confidence and 19.6% (n = 22) responded with a neutral grade. Furthermore, 59.8% (n = 67) of the respondents indicated a wish for more education on managing failing students. The study appears to show that assessment tools that use more discriminatory grading systems (as opposed to pass/fail) and clear descriptors are helpful and welcomed by practice assessors (Heaslip & Scammell, 2011).

Re-Imaging Clinical Education

Clinical practice in nursing education is a crucial part of nursing school. Nursing students need guidance from clinical leaders who are continuously assessing their competence and abilities. An important part of this assessing is also the feedback to improve the student in their competencies and abilities as they are prepared for their chosen career path. According to Filice et al. (2020), most literature is lacking in the description of how to help clinical teachers become experts at providing formative

feedback to facilitate student learning and improvement. The authors explored how self-regulated learning (SRL) could be used to develop a deeper understanding of the interdependence of students' learning and clinical teaching. Though this thesis project was not for the argument of SRL, but through the authors preparation of the model proposed to increase SRL information was gained regarding clinical assessment. Self-regulated learners are aware of their strengths and limitations, are guided by goals, and learn from feedback. Student learning is dependent on valid and accurate assessment and feedback on their performance from clinical leaders. Clinical leaders have a duty to uphold the standards of practice and are required to fail a student who does not meet the required competencies in the practice environment. Through literature, clinical leaders have acknowledged that they are not always prepared for the role nor have the necessary emotional and when poorly prepared, clinical leaders fail to hold students accountable for learning in their clinical practice. Other factors that contribute to clinical leaders failing to hold students accountable for their progress is unclear course objectives, constantly changing learning environments, discrepancies between the teaching of different teachers, and student anxiety associated with feedback and assessment. Past efforts to improve clinical teacher effectiveness have primarily focused on attitudes and motivation, self-efficacy, and self-reflection on teaching ability confidence. There are a number of further challenges to assessing students in clinical practice, including the inability to control the learning environment, grading disparity from one teacher to another, and the sense that clinical experience is subjective. Rubrics are one way to address the challenges of grading clinical practice. Rubrics are a way of addressing the challenges of grading clinical practice and are a means to communicate context-specific

standards for quality performance as well as used to provide student-centered formative feedback. Rubric development has been recognized to unite faculty so they have a common understanding of the curriculum, can articulate the expectations of success, and can enhance feedback to support student learning and success. Rubrics can be used to assess the quality of clinical practice and map a student's progress toward achievement of the expected learning clinical practice and to map a student's progress toward achievement of the expected learning outcomes in clinical practice. The learning outcomes delineated in the rubric form the basis for dialogue between the clinical teacher and student about their performance and progress in meeting the course objectives and for identifying opportunities for improvement for both student learning and teacher pedagogical practices. According to the authors, rubrics facilitate mutual understanding of the curriculum, goals, learning outcomes, teachers and students cannot simply be handed a rubric. The difficulty clinical teachers have in using rubrics are that they are cumbersome and filled with educational jargon that prevents their effective use. But with explanation and demonstration, rubrics can be an effective tool utilized by clinical leaders. Unfortunately, initiatives to improve clinical teacher effectiveness have not been rigorously evaluated, including the use of rubrics in the clinical context. Filice et al. (2020) proposed efforts to improve clinical teacher effectiveness that was important to focus on students' SRL but also on the clinical teacher's role as a self-regulated teacher. The Clinical Education Double Loop SRL and Teaching Model was developed after a careful analysis of SRL models for both students and teachers, and an examination of the literature on effective clinical teachers and the challenges of assessing student learning in clinical practicum placements. The model was not tested by the author and they advise

that further research is required to test the model's application to teaching and learning in clinical practice.

Strengths and Limitations of Literature

The strongest literature supports the use of rubrics to improve interrater reliability, grading practices, and improves the failure to fail phenomenon. A reliable and valid clinical assessment tool could facilitate the accurate and consistent evaluation of nursing students' clinical competence (Wu et al., 2017). Rubrics can be an important component in the delivery and assessment of clinical evaluation (Villa et al., 2020). Rubrics are vital tools that can be utilized to solve the problem of subjectivity in evaluation (Renjith et al., 2015). Holistic rubric and analytic rubrics are efficient tools for explaining task-specific checklist scores (Yune et al., 2018). Students deserve fair and clear direction for their learning needs to ultimately provide safe, effective, professional, patient-centered nursing care. Fair grading can equate to consistency and reliability and the performance rubric has the potential to produce fair scores (Kopp, 2018). Establishing the utility of the rubric is reliable assessment tool to evaluate interprofessional team-based skills and guide educational efforts to develop these skills (Hayes et al., 2018). The use of reliable and valid rubrics for evaluation is strongly encouraged regardless of the grading methodology (Reising et al., 2018). As stated by Burns (2014), "reproducibility is not only the cornerstone of good science; it is the cornerstone of good regulation and health care as well" and part of reproducibility involves consistent recording among graders. A validated instructional rubric can affect students' ability to evaluate their own performance and the extrinsic motivation factor, such as the student's grade, plays a role in self-assessments and improved clinical competence (Oh et al., 2017).

Failing to fail does exist and appears to permeate clinical and didactic nursing education and across different institutional settings (Docherty & Dieckmann, 2015). Consistency can enhance objectivity and fairness in the evaluation process, which is a vital component of student evaluation, and can lead to student satisfaction Dunbar (2018). Clinical grade discrepancy scoring is an indicator of grade inflation in the clinical setting and could streamline faculty identification of problems in the clinical setting and provides a more objective measurement from which to engage this problem (Paskausky & Simonelli, 2014). Objective Structured Clinical Examinations and Assessments, as well as other simulation-based testing models, provide a means to instill a degree of standardization and rubrics into grading process to enhance validity and reliability (Docherty, 2018). The implementation of the OSCE in nursing education programs as a format of clinical assessment has versatile advantages in terms of structure, objectivity, transparency, uniformity and ability to assess a wide range of clinical skills that cannot be assessed via traditional strategies of clinical assessment (Bdair et al., 2019). "Reproducibility is not only the cornerstone of good science; it is the cornerstone of good regulation and health care as well" and part of reproducibility involves consistent recording among graders (Burns, 2014). A validated instructional rubric can affect students' ability to evaluate their own performance and the extrinsic motivation factor, such as the students' grade, plays a role in self-assessments and improved clinical competence (Oh et al., 2017).

There is strong evidence to support the use of rubrics to improve interrater reliability. Despite the 'failure to fail' phenomenon, which there is sufficient evidence in the literature, albeit of mixed quality, to establish that 'failure to fail' is indeed a real and

significant issue, interrater reliability can still be improved through utilization of rubrics (Hughes et al., 2016). Failing to fail does exist and appears to permeate clinical and didactic nursing education and across different institutional settings (Docherty & Dieckmann, 2015). Consistency in grading can increase interrater reliability with a grading rubric as well. Consistency can enhance objectivity and fairness in the evaluation process, which is a vital component of student evaluation, and can lead to student satisfaction (Dunbar, 2018). Clinical grade discrepancy scoring is an indicator of grade inflation in the clinical setting and could streamline faculty identification of problems in the clinical setting and provides a more objective measurement from which to engage this problem (Paskausky & Simonelli, 2014). Objective Structured Clinical Examinations and Assessments, as well as other simulation-based testing models, provide a means to instill a degree of standardization and rubrics into grading process to enhance validity and reliability (Docherty, 2018). The implementation of the OSCE in nursing education programs as a format of clinical assessment has versatile advantages in terms of structure, objectivity, transparency, uniformity and ability to assess a wide range of clinical skills that cannot be assessed via traditional strategies of clinical assessment (Bdair et al., 2019). Best practice, in relation to education and preparation of nursing students internationally, requires a robust system of clinical competence assessment, supported by quality teaching, supervision and assessment in the clinical area. Core factors that facilitate the success of this system are trained personnel to support students' learning and assessment, reliable competence assessment tools and strong academic partnerships (Nugent et al., 2020).

Despite the attention that the topic of grading students continues to receive among educators, the process is far from exacting. Elements of both pass/fail and discretionary grading have merit as nurse educators strive to fully and accurately represent student achievements (Melrose, 2017). Tools which enable the grading practice allows feedback to be more discriminating than pass/fail systems (Heaslip & Scammell, 2011). There are a number of challenges to assessing students in clinical practice, including the inability to control the learning environment, grading disparity from one teacher to another, and the sense that clinical experience is subjective. In clinical education, rubrics can be used to assess the quality of clinical practice and to map a student's progress toward achievement of the expected learning outcomes (Filice et al., 2020). Clinical grading rubrics, when used as criteria to grade a student's performance, are a helpful discriminator rather than intuition such as pass/fail (Hughes et al., 2019).

There is limited research on clinical documentation in itself especially in relation to utilizing the documentation for grading purposes. Clinical documentation is a part of the nursing student's assessment and competence throughout programs. This is an area that could further be researched in nursing education.

CHAPTER III

Needs Assessment

To determine if a grading rubric would improve the consistency in grading among all faculty members that are grading clinical documentation and increase interrater reliability the following needs assessment is addressed.

Target Population & Target Setting

The target population for this thesis project was the nursing staff who play a role in the clinical setting and grading. This was full time faculty as well as adjunct faculty. The clinical grading rubric was presented to the nursing students. The target setting was at the local community college where the rubric was implemented. The setting was a classroom style setting in which faculty were educated on the clinical grading rubric, the benefits, and the method of grading with the rubric.

Sponsors and Stakeholders

Sponsors and stakeholders for implementation of this thesis project included the community college, administrative staff involved with the nursing curriculum, the director of nursing at the community college, all full and part time nursing instructors who are involved with clinical education, all adjunct nursing clinical instructors, nursing mentors for the clinical grading rubric development, and the nursing students in the program.

SWOT Analysis

When implementing an evidence-based, quality improvement project, the strengths, weaknesses, opportunities, and threats or SWOT need to be identified (Inman, 2020). The SWOT analysis strength for this thesis project was that the experienced

clinical faculty could assist in the design process of the grading rubric and it could be altered at the beginning of curriculums to fit the specific semester clinical needs. Weaknesses for the clinical grading rubric included the fact that there was not a lot of research or information for nursing documentation or for standardization of clinical paperwork. For organizations looking to improve interrater reliability and consistency, the clinical grading rubric can be a positive aspect to the curriculum. This too can be tied to the curriculum student learning objectives to meet the goals of the program. The threat analysis for the clinical grading rubric could include staff that do not want to change current trends. Though the financial pieces for changing to the clinical grading rubric are small, this could also be a threat analysis as well as time in developing the clinical grading rubric.

Available Resources

Available resources included nursing faculty members, including peer support, who identified the need for increased interrater reliability and consistency in clinical grading. Administration allowed the nursing staff to utilize the clinical grading rubric and allow ample time and opportunity to utilize the clinical grading rubric in the nursing program.

Desired and Expected Outcomes

If implementation of a clinical documentation rubric is utilized, as was by Villa, et al. (2020) in the pharmacotherapy problem-based learning (PBL) courses, the desired and expected outcomes of increased interrater reliability (IRR) and consistency will occur. The clinical documentation rubric utilized in the pharmacotherapy courses demonstrated overall good IRR, especially when it was utilized between multiple

evaluators. By education and use of the clinical grading rubric IRR will improve in nursing programs alike.

Through utilization of the clinical grading rubric the self-efficacy of staff and students will increase. With implementation of the clinical grading rubric the outcome will consist of improved IRR, more confidence in grading by faculty, and self-efficacy for faculty and students.

Team Members

Team members were those who were involved in the development and utilization of the grading rubric. This included, but was not limited to, the director of nursing who was sending emails to staff and overseeing the project, faculty who was involved in clinical grading and utilization of the clinical documentation rubric, the administrative assistant who reserved rooms for education of the rubric and directing staff to those rooms, and administrative staff who approved the use of time for the education of the clinical documentation rubric to faculty.

Cost/Benefit Analysis

Utilization of the clinical grading rubric will have a return on investment in that student satisfaction could increase. More consistency in grading will occur, which will ensure nursing competencies are being met and potentially improve be higher certification exam scores achieved by nursing students from the program. The primary benefit is overall student and faculty satisfaction. Satisfaction leads to increase faculty and student retention rates.

Cost benefit analysis includes the ability to retain students due to satisfaction in grading, and the ability to retain faculty because they become less frustrated with grading

clinical paperwork. With the cost of recruitment of faculty then training of faculty for positions, the retention would be a large cost benefit for the community college. When student retention is increased the financial gain is greater than when a student drops out of the program and financial loss occurs. The retention of faculty and students is a positive cost benefit gain for the college (Higher certification exam results improve recruitment opportunities and prevent issues with credentialing agencies).

CHAPTER IV

Project Design

Goal (Overall Purpose)

The purpose of this thesis project was to explore an intervention that will improve consistency and interrater reliability in grading clinical nursing documentation assignments among all clinical faculty members. This project will determine if using a grading rubric can improve the consistency in grading and interrater reliability among faculty members that grade clinical documentation.

Objectives

By the end of this project, the goals and outcomes of IRR, consistency in clinical documentation grading, and increased self-efficacy will have been shown to occur when the clinical grading rubric is utilized. Retention of faculty and students will show to improve benefit and cost for the college. Satisfaction amongst faculty and students will improve as the IRR and consistency improves once the clinical grading rubric is implemented.

Plan and Material Development

The Clinical Grading Rubric for Care Plan (Appendix A) for clinical paperwork was based on the current Clinical Document Care Plan (Appendix B) which nursing students at the community college currently use. Faculty will be educated on the clinical grading via the Clinical Grading Rubric PowerPoint (Appendix C). Knowledge assessment for using the rubric is essential and a questionnaire capable of measuring the faculty's self-efficacy both before and after receiving the clinical grading rubric training course will compare the level of skills evaluated by perceived self-efficacy (Axboe et al.,

2016). The questionnaire will be given through the Qualtrics online survey tool. Interrater reliability will be tested using the Cohen's kappa tool, which is symbolized by the lower case Greek letter, κ (7), and is a robust statistic useful for either interrater or intrarater reliability testing (McHugh, 2012). Similar to correlation coefficients, it can range from -1 to +1, where 0 represents the amount of agreement that can be expected from random chance, and 1 represents perfect agreement between the raters (McHugh, 2012). Cohen suggested the Kappa result be interpreted as follows: values ≤ 0 as indicating no agreement and 0.01–0.20 as none to slight, 0.21–0.40 as fair, 0.41– 0.60 as moderate, 0.61–0.80 as substantial, and 0.81–1.00 as almost perfect agreement (McHugh, 2012). A clinical care plan document will be graded by faculty prior to the implementation of the rubric using the present pass/fail or sat/unsat method. After the educational session the faculty will grade a clinical care plan document utilizing the clinical grading rubric. The information gathered will determine the interrater reliability pre and post clinical example. It will be determined using the Cohen's kappa tool if there is change in interrater reliability. Faculty will then be incorporating the clinical grading rubric at the beginning of the semester. At the end of the semester, interrater reliability will then be reassessed by having staff grade another clinical care plan document. The self-efficacy questionnaire, via Qualtrics online survey, will then be repeated to assess faculty self-efficacy after implementation and use of the clinical grading rubric.

The items that will be utilized for this thesis project will be three examples of clinical care plan paperwork, Qualtrics online survey for questionnaires, Cohen's kappa tool, a classroom at the beginning of the semester for education of faculty on the clinical grading rubric as well as at the end of the semester for re-evaluation, a box for

deidentified graded examples, PowerPoint teaching slides, the clinical grading rubric, pencils, pens, paper, tables, chairs, snacks, and marketing tools (DON will making it mandatory to use the rubric for clinical paperwork and attend training).

Timeline

The timeline for this thesis project began 6 months prior with the development of the clinical grading rubric. Two months prior to implementation was with the director of nursing to schedule the space for the education of the clinical grading rubric. At this time, the clinical care plan document examples will be selected and prepared. The PowerPoint presentation was designed 2 months prior to the implementation of education. One week prior to implementation of the education on the clinical grading rubric all copies were made. The administrative assistant assisted in printing the copies needed. The project researcher implemented the training as the project manager to collect the pre and post graded care plans, complete the statistical analysis of change in IRR, compare the three IRR calculations, and prepare results and training material for future development and education of the clinical documentation rubric.

Budget

The estimated cost to implement use of a grading rubric for clinical documentation for all nursing faculty who grade clinical documentation was approximately $4,500.00. The greatest expenses for the project included rubric development and faculty training. Faculty included full time, part time, and adjunct faculty. An itemized budget for the project design and implementation of a clinical documentation grading rubric consisted of rubric development by an education expert, director of nursing time, faculty training, and supplies (Table 1).

Table 1

Budget

Budget	
Rubric development	$2,600.00
Faculty training	$2,000.00
Supplies for training	$45.00
Total cost	$4,645.00

Evaluation Plan

An Inter-Rater Reliability Method using Percent Agreement for Two Raters (Appendix D), and Self-Efficacy to Regulate Clinical Documentation (Appendix E) was compared and statistically analyzed using a paired t-test. Evaluation of the results and dissemination of the information were presented to the faculty, director of nursing, administration, and stakeholders.

CHAPTER V

Dissemination

Dissemination Activity

After implementation and evaluation of the clinical grading rubric, if IRR and consistency are increased among faculty, as well as increased self-efficacy amongst faculty and students, the project design can and may be presented to nursing program directors at other colleges and or universities. If there is a significant amount of IRR, consistency, self-efficacy, satisfaction, compliance, utilization and interest in the clinical grading rubric, the project manager may address the need to incorporate a policy for use with the North Carolina Board of Nursing. Implications for utilization will be determined upon completion of the project and evaluation of the results.

Limitations

Limitations for this thesis project design of a clinical grading rubric included the fact that the researcher did not find specific information for nursing documentation but did find correlating information noted in the article regarding pharmacotherapy by Villa et al. (2020). Other limitations to the thesis project is the current situation with the COVID-19 virus requiring mask and social distancing.

Implications for Nursing

Implementing the clinical documentation grading rubric will provide faculty with a tool that will provide a more objective means for grading clinical paperwork. It is designed to decrease failure to fail, increase faculty self-efficacy in grading, improve student and faculty satisfaction, and increased interrater reliability and consistency in grading. These implications for nursing education -to reduce the subjectivity in grading

clinical paperwork and provide a means to ensure that all students are attaining the goals necessary and required to become competent nurses.

Recommendations

Consistent grading practices are essential for all aspects of nursing education. The subjective grading practices, related to clinical documentation, has caused various challenges for providing consistent grading practices. Inconsistencies in grading cause an inability to adequately determine if nursing students are truly meeting the competencies necessary for nursing. Recommendations for further research on consistent grading methods for clinical documentation and the use of clinical grading rubrics are suggested for nursing and other programs. It is recommended that if a clinical grading rubric is created and implemented, adequate staff education about use of the rubric should also be implemented with introduction of the rubric and continued upon hire for new faculty. Continued education about use of rubrics should be sustained and throughout the program as rubrics are adjusted.

Conclusion

The nurse educator competency III use Assessment and Evaluation Strategies from the National League for Nursing encourages use of evidence-based evaluative practices (Kopp, 2018). Research has shown that nonspecific criteria encourages clinical grade inflation with an example being that of the use of broad course objectives, which can result in subjective, inconsistent, and disputable evaluations (Kopp, 2018). The complexity of nursing environments fosters variance in clinical experiences, making standardized clinical evaluation even more perplexing for academic pedagogy (Kopp, 2018).

Failure to fail is evident across baccalaureate and associate degree programs and across clinical and didactic settings (Docherty, 2018). Failure to fail allows student nurses to progress into the profession without meeting professional standards of practice (Hughes et al., 2019). This may have significant impacts on students, assessors, organizations, the profession and most importantly, to vulnerable patients (Hughes et al., 2019).

Challenges with inconsistent grading and a lack of reliability has been noted in research regarding clinical skills (Dunbar, 2018). Consistency among nurse educators grading student performance of clinical skills is crucial. Consistency can enhance objectivity and fairness in the evaluation process, which is a vital component of student evaluation, and can lead to student satisfaction (Dunbar, 2018).

Rubrics are one way to address the challenges of grading clinical practice (Filice et al., 2020). Specifically, rubric development can unite the faculty, so they have a common understanding of the curriculum, can articulate the expectations of success, and can enhance feedback to support student learning and success (Filice et al., 2020).

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Appendix A

Clinical Grading Rubric for Care Plan

Criteria	Guidelines		Total Points	Student Points
Organization	Clear understanding of the care plan.	2	13	
	Appropriate content for the patient.	2		
	Care plan correlates with the patient's clinical condition.	2		
	Care plan sections all flow with the nursing diagnosis.	2		
	There are no blank areas on the clinical document.	2		
	All areas of the care plan are completed as instructed.	3		
NANDA Nursing Dx	The student has chosen the appropriate NANDA approved nursing diagnosis.	3	6	
	Correlating etiology that is appropriate for the patient's condition.	3		
Patient Centered Goal	The student has developed an appropriate goal that are:		6	
	Realistic,	2		
	Broad,	2		
	Patient-Centered.	2		
Expected Outcomes	The student has developed three expected outcomes for the patient that are:		9	
	Realistic (1 point per expected outcome),	3		
	Measurable (1 point per expected outcome),	3		
	With an appropriate timeframe (1 point per expected outcome).	3		
Nursing Interventions	The student has six (6) interventions related to the chosen NANDA nursing diagnosis.	3	12	
	Intervention is appropriate for the specific patient (1 point per intervention).	6		
	The student has not included no more than 2 assessment and/or monitor items as interventions.	3		
Rationales	The student has a rationale for each intervention.	3	15	
	Rationale explains reason for the chosen intervention (1 point per rationale).	6		
	Rationale correlates with the specific intervention (1 point per rationale).	6		
Patient Response to Interventions	The student has a patient response for each intervention.	3	15	
	Each patient response correlates with each intervention (1 point per patient response).	6		
	The patient response is a verbal or physical response to the intervention is not an observation (i.e. 'pt. appears', 'pt. seems', or 'patient resting quietly after medication', etc.), unless approved by the instructor (1 point per patient response).	6		
Evaluation of Expected Outcomes	The student has an evaluation for each expected outcome (1 point per evaluation).	3	6	
	Evaluation should not only state Met, Partially Met or Not Met, but also explain the evaluation of each expected outcome with factual data that correlates with the expected outcome. If the outcome is Partially Met or Not Met, the student should also state why these were chosen as the outcome with factual data. All three evaluations must meet these requirements (1 pt each).	3		
Resources	The student has a resource for each rationale (1 point each).	6	18	
	Resources must be cited on the reference sheet with correlating resource number (1 point each).	6		
	Resource must be listed beside each rationale in parenthesis with the resource number followed by coma and page number. *EXAMPLE*: (2, 451-452)	6		
*Grades of an **80** or above is considered a **SAT**. *Any grade **< 80** is an **UNSAT** for this care plan.		**TOTAL**	**100**	
Comments:				

SLRN 2020

Appendix B

Clinical Document Care Plan

CARE PLAN SHEET

LEARNER: _____ **INSTRUCTOR: _____**

DATE: _____ **PATIENT' S INITIALS: _____**

PHYSICAL AND PSYCHOSOCIAL RESPONSES

Nursing Diagnosis R/T etiology

Patient Centered Goal: *(general/broad)*

Expected Outcome(s): *(as manifested by: realistic, measurable and projected time for goal accomplishment, as many as needed.)*

1.
2.
3.

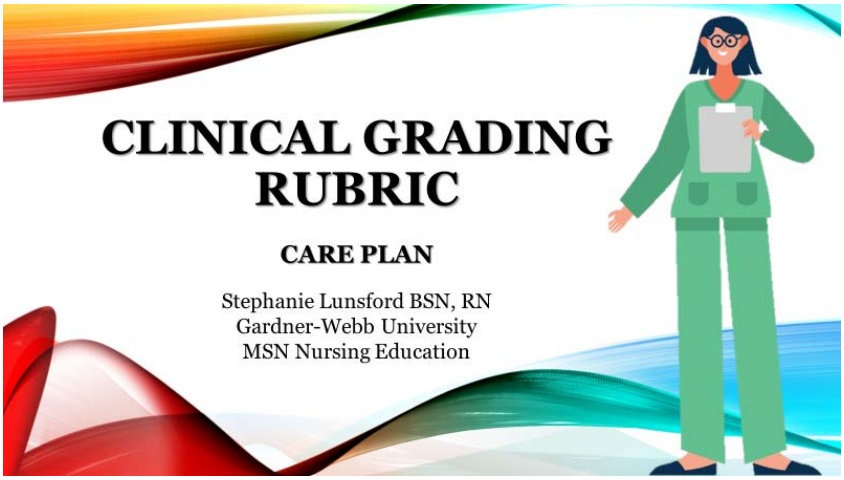
Nursing Interventions: *Number, include written rationale with footnote for each; (source #; page #), minimum of 6 interventions.*	**Patient Responses (evaluate each intervention)**:Number to match each intervention, include factual data)

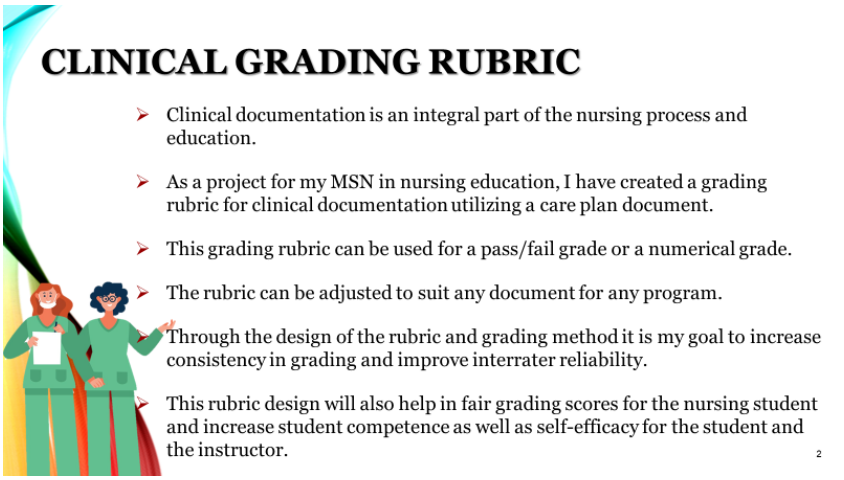
Evaluate each expected outcome listed above: ***(Met, Partially Met, or Not Met with support data)***

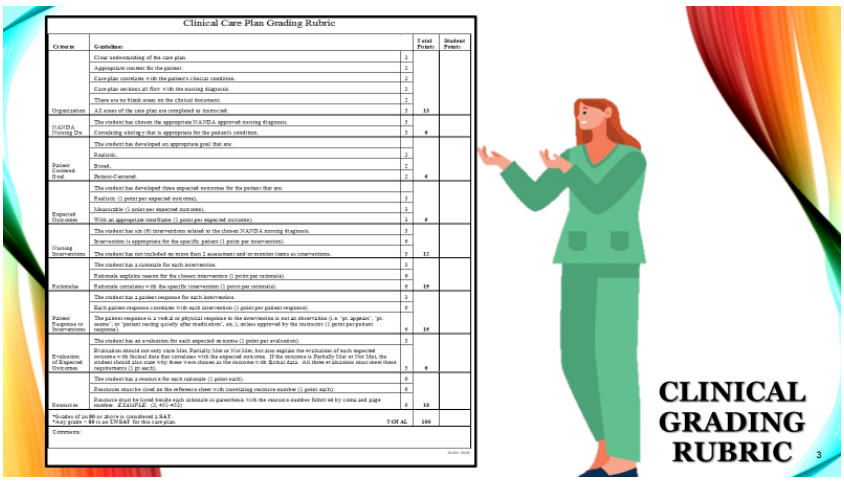
1.
2.
3.

Appendix C

Clinical Grading Rubric PowerPoint

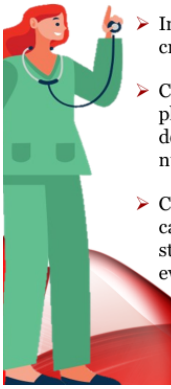






CLINICAL GRADING RUBRIC

COLUMN 1



- In this column you will find the criteria categories for the care pan.
- Criteria is based off the current care plan used for clinical documentation in a local ADN nursing program.
- Care plan criteria must be met for care plans to be complete and the student receive an appropriate evaluation.

Criteria
Organization
NANDA Nursing Dx
Patient Centered Goal
Expected Outcomes
Nursing Interventions
Rationales
Patient Response to Interventions
Evaluation of Expected Outcomes
Resources

4

CLINICAL GRADING RUBRIC

COLUMN 2

- Column 2 is the guidelines for each of the categories.
- These are the guidelines already in place for the ADN program in which instructors and students alike are utilizing for current clinical documentation practices.
- The guidelines have point basis in each section that is for met criteria.
- Guidelines must be met by the student to get appropriate points.

Guidelines
Clear understanding of the care plan.
Appropriate content for the patient.
Care plan correlates with the patient's clinical condition.
Care plan sections all flow with the nursing diagnosis.
There are no blank areas on the clinical document.
All areas of the care plan are completed as instructed.
The student has chosen the appropriate NANDA approved nursing diagnosis.
Correlating etiology that is appropriate for the patient's condition.
The student has developed an appropriate goal that are:
Realistic,
Broad,
Patient-Centered.
The student has developed three expected outcomes for the patient that are:
Realistic (1 point per expected outcome),
Measurable (1 point per expected outcome),
With an appropriate timeframe (1 point per expected outcome).
The student has six (6) interventions related to the chosen NANDA nursing diagnosis.
Intervention is appropriate for the specific patient (1 point per intervention).
The student has not included no more than 2 assessment and or monitor items as interventions.
The student has a rationale for each intervention.
Rationale explains reason for the chosen intervention (1 point per rationale).
Rationale correlates with the specific intervention (1 point per rationale).
The student has a patient response for each intervention.
Each patient response correlates with each intervention (1 point per patient response).
The patient response is a verbal or physical response to the intervention is not an observation (I.e. "pt. appears", "pt. seems", or "patient resting quietly after medication", etc.), unless approved by the instructor (1 point per patient response).
The student has an evaluation for each expected outcome (1 point per evaluation).
Evaluations should not only state Met, Partially Met or Not Met, but also explain the evaluation of each expected outcome with factual data that correlates with the expected outcome. If the outcome is Partially Met or Not Met, the student should also state why these were chosen as the outcome with factual data. All three evaluations must meet these requirements (1 pt each).
The student has a resource for each rationale (1 point each).
Resources must be cited on the reference sheet with correlating resource number (1 point each).
Resource must be listed beside each rationale in parenthesis with the resource number followed by coma and page number. EXAMPLE: (2, 451-452).

5

CLINICAL GRADING RUBRIC

COLUMN 3-5

- Column 3 is the individual points the student can receive for each guideline of the specific category.
- Column 4 is the total points for the guidelines that the student could receive for the specific category.
- Column 5 is the total points for the guidelines, in the specific category, for which the student has obtained for the clinical document.
- Criteria must be met by the student to get appropriate points.

	Total Points	Student Points
1		
2		
1		
2		
2		
2	13	
3		
3	6	
2		
2		
2	6	
3		
3		
3	9	
3		
6		
3	12	
3		
6		
6	18	
3		
6		
6	18	
3		
3	6	
6		
6		
6	18	

6

CLINICAL GRADING RUBRIC

- It is imperative that the student has a good understanding of the nursing process in order to be able to organize a care plan.
- The organization category is a generalized grading part for the entire document and not directed to a specific part of the document.

There are six (6) guidelines in this category that the student must meet.

- Each guideline is followed by a number which the student will receive if that guideline was met.

Organization	Clear understanding of the care plan.	2
	Appropriate content for the patient.	2
	Care plan correlates with the patient's clinical condition.	2
	Care plan sections all flow with the nursing diagnosis.	2
	There are no blank areas on the clinical document.	2
	All areas of the care plan are completed as instructed.	3

7

CLINICAL GRADING RUBRIC

- Nursing diagnosis should be appropriate to the patient and their condition.
- The care plan starts with the nursing diagnosis, so this would be the next category for the rubric.
- The following column is the guidelines for the category.
  - The guidelines are only for the specific category.
- The last column is the points for each of the guidelines. These points in any category can be adjusted for any curriculum.

NANDA Nursing Dx	The student has chosen the appropriate NANDA approved nursing diagnosis.	3
	Correlating etiology that is appropriate for the patient's condition.	3

8

CLINICAL GRADING RUBRIC

- The patient centered goal is the next section of the care plan and grading rubric.
- The same principle applies here with the category, guidelines and total points the student can receive for each guideline.
- The rows will continue until all categories and guidelines have been addressed.

Patient Centered Goal	The student has developed an appropriate goal that are:	
	Realistic.	2
	Broad.	2
	Patient-Centered.	2

9

CLINICAL GRADING RUBRIC

- There may be times when a guideline has multiple points to grade.
- The expected outcomes of the care plan is a good example in that the student must have three (3) expected outcomes for each care plan.
- Each of the expected outcomes have guidelines that must be met there for the points the student can receive is noted in the guideline.
- The third column is the same in that it is the total points the student can receive for the specific guideline in that category.

Expected Outcomes	The student has developed three expected outcomes for the patient that are:	
	Realistic (1 point per expected outcome),	3
	Measurable (1 point per expected outcome),	3
	With an appropriate timeframe (1 point per expected outcome).	3

CLINICAL GRADING RUBRIC

- Other columns and rows continue until all grading points of the clinical documentation have been evaluated and graded according to the guidelines.

Nursing Interventions	The student has six (6) interventions related to the chosen NANDA nursing diagnosis.	3
	Intervention is appropriate for the specific patient (1 point per intervention).	6
	The student has not included no more than 2 assessment and/or monitor items as interventions.	3
Rationales	The student has a rationale for each intervention.	3
	Rationale explains reason for the chosen intervention (1 point per rationale).	6
	Rationale correlates with the specific intervention (1 point per rationale).	6

Patient Response to Interventions	The student has a patient response for each intervention.	3
	Each patient response correlates with each intervention (1 point per patient response).	6
	The patient response is a verbal or physical response to the intervention is not an observation (i.e. 'pt. appears', 'pt. seems', or 'patient resting quietly after medication', etc.), unless approved by the instructor (1 point per patient response).	6
Evaluation of Expected Outcomes	The student has an evaluation for each expected outcome (1 point per evaluation).	3
	Evaluation should not only state Met, Partially Met or Not Met, but also explain the evaluation of each expected outcome with factual data that correlates with the expected outcome. If the outcome is Partially Met or Not Met, the student should also state why these were chosen as the outcome with factual data. All three evaluations must meet these requirements (1 pt each).	3
Resources	The student has a resource for each rationale (1 point each).	6
	Resources must be cited on the reference sheet with correlating resource number (1 point each).	6
	Resource must be listed beside each rationale in parenthesis with the resource number followed by coma and page number. *EXAMPLE*: (2, 451-452)	6

CLINICAL GRADING RUBRIC

- The row following the categories and guidelines is an informational area in which the parameters of the sat/unsat or pass/fail grading can be placed.
- The third column in this section shows the total points the student can receive.
- The last column is where the student's points are totaled.
  - This can be the numerical score the student receives for the clinical document or it can be the numerical guide for the sat/unsat or pass/fail grading method.
- The last row is for comments the instructor may have for the student.

*Grades of an **80** or above is considered a **SAT**. *Any grade **< 80** is an **UNSAT** for this care plan.		**TOTAL**	**100**
Comments:			


Thank You
Stephanie Lunsford BSN, RN
2020
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Appendix D

Inter-Rater Reliability Method Using Percent Agreement for Two Raters

Student	Faculty 1	Faculty 2	Agreement
A	Grade	Grade	Number of grades in Agreement
B	Grade	Grade	Number of grades in Agreement
C	Grade	Grade	Number of grades in Agreement
% Agreement			*Number of grades in agreement/ Total number of student's graded

*A precent agreement of 75% is acceptable for inter-rater reliability of this project.

Appendix E

Self-Efficacy to Regulate Clinical Documentation

Inter-rater reliability is difficult when grading student nurse clinical documentation. The use of a grading rubric often provides more structure for consistent grading among faculty.

Please rate how certain you are that you can do the things discussed below by writing the appropriate number.

Rate your degree of confidence by recording a number from 0 to 100 using the scale given below:

0 10 20 30 40 50 60 70 80 90 100

Cannot do at all — Moderately can do — Highly certain can do

	Confidence (0-100)
Use a rubric to grade student nurse clinical documentation.	_____
Provide a grade for clinical documentation that is consistent with other faculty.	_____