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Assessment of practice in pre-registration undergraduate nursing programmes: An evaluation of a tool to grade student performance in practice

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Glossary of Terms

The following terms are used throughout the report:

- **Students:** nursing students who are undertaking pre-registration undergraduate nurse education programmes.
- **Mentors and associate mentors:** registered nurses who supervise and assess student learning and performance in practice.
- **Educators:** practice educators (now known as learning facilitators in some areas) generally based in practice areas, or personal tutors based mainly within the university. A few educators held both of these roles.
- **Outcomes:** graded assessments of student achievement taken in practice areas (found within the practice profiles, students must complete 20 outcomes during the first year of education programmes; in the second year and again in the third year, students complete 20 graded assessments taken in practice, now called standards of proficiency. All are referred to as outcomes), developed from the detail given in *Standards of Proficiency for Pre-registration Nursing Education* (NMC 2004).

Executive Summary

Nursing is essentially a practice discipline, informed by a growing theoretical base. It is crucial that students have a rigorous preparation in both the theoretical and practical elements of nursing throughout their pre-registration undergraduate programme. Similarly, the assessment strategy ought to place equal value on both elements. However, this has frequently not reflected common practice across the higher education sector in the United Kingdom and elsewhere. Generally, theoretical assessment has been the subject of considerable quality assurance measures, including graded marks, second marking and moderation. In contrast, practice assessment is frequently considered on a pass/fail basis only, with the resultant danger that theoretical work is perceived as more important than practice achievement and therefore excellence in practice can be 'hidden' as it is unrewarded in terms of grades. The challenge for those involved in nurse education is to not only accurately assess practice but to have mechanisms that assign equal value to both aspects of the curriculum.

With these issues in mind, the pre-registration undergraduate nursing curriculum rewrite of 2005 provided an opportunity for the School of Health and Social Care (SHSC) at Bournemouth University to address this anomaly. Using the standards described in the NMC (2004) document, a practice profile (a tool for grading nursing practice) was developed and introduced in September 2005. Given that this was 'new territory' for both the university and its practice partners, an evaluation project was developed to run alongside the implementation of Year 1 of the new programme.

The aims of the 'assessment of practice' project were to explore student, mentor and education staff experiences of their use of the new practice profile, to consider their views on the grading of practice using this tool, and to learn lessons to enhance on-going implementation. In addition, the issue of reliability when using the practice profile was acknowledged as challenging because it is used by many different mentors (markers); it was hoped that the evaluation would also yield some insights into this area. This report describes Phase 1 of the evaluation project, undertaken between November 2005 and October 2006.

Summary of the Literature Review: The Nature of Practice Assessment

A literature search of the major nursing and allied health databases was conducted using key words around the subject of assessment in practice and graded assessment in particular. This yielded surprisingly little literature; however, some significant studies from North America, Australia and England were found to be highly pertinent.

Definition of graded practice

As part of the literature review, it was important to define what was meant by the term 'graded practice'. For the purpose of this evaluation project, Reilly & Oermann's (1992, p421) definition of grading is used: 'quantitative symbols of qualitative dimensions of behaviour'. Grading generally uses 'a letter or number' to 'convey a complex and diverse array of competencies and attributes' that can be 'instantly understood by the viewer'. For these reasons, grading can be a useful tool for students and educators; but it is important to acknowledge that, as in any grading process, judgements are made and therefore grades are not value free.

Key studies of grading practice in nursing

Bondy's work conducted in North America is significant. Bondy (1983) developed a five-point rating scale for the evaluation of professional practice based upon findings from psychometric studies. Different components of the resulting tool were used to assess both single examples of performance and to record students' development over time. Bondy (1983) found that both assessors and students benefited from using the grading tool.

In a further work, Bondy (1984) found that accuracy and reliability were dependent upon two main factors. First, the use of criteria by students and assessors increased accuracy and reliability. In addition, student performance improved when they had the criteria with which to measure their own performance. Second, some situations were found to be easier to assess (e.g. task situations) than others (e.g. affective situations). Bondy (1984) concluded that assessor training rather than experience could improve rater reliability and consistency.

Focusing on reliability, Hillegas & Valentine (1986) reported the development of a five-point clinical grading tool to overcome difficulties with the summative grading process. Aware of the problems associated with subjectivity, this tool used detailed descriptions of expectations for each point on the scale.

An English study (Burns 1992) involved the development of a three-dimensional five-point grading framework that included clinical competencies, learning contracts and grading profiles. Findings from this study highlighted the need for mentors to learn what was required of them as well as the importance of mentors and educators to guide and support students. It was locally successful.

Finally, Glover et al. (1997) describe an Australian study with final year students. Assessment was made by direct observation and observation over time (the duration of the placement). However, direct observation was deemed to be unreliable on at least two levels:

- Different mentors could view performance differently;
- Students' performance could vary in different clinical situations.

For these reasons, observation over time was the favoured method of evaluation.

Key findings from this study indicated first that students' performance was rated higher than expected, a finding that appeared to reflect a difference in perception of the value of practice assessment as perceived by practitioners versus academics. Second, clinicians rated student performance higher than students rated their own performance. The reasons for this were unclear but it was suggested that for grades to be close both students and clinicians had to be able to agree precisely what was being assessed. The third finding was that clinician comments did not match the marks given for the performance and this was linked to a lack of preparation in using the assessment tool. Finally, students received higher grades for their clinical work than they received for the theory.

Role of the mentor

There is a wealth of literature on the pivotal role of mentors in the assessment process (Wilson-Barnett et al. 1995, Spouse 1998, Brown & Edelman 2000, Kilminster & Jolly 2000). Mentors remain central to the development of undergraduate nursing students in practice. Their importance in the education process cannot be stressed enough. Mentors are responsible for both helping students to learn and develop their knowledge and skills as well as for assessing student progress.

Failure to fail

The importance of the role of the mentor is placed in perspective by Duffy's (2004) study. The first part of the study was commissioned by the Nursing and Midwifery Council (NMC) focusing on the issue of mentors failing to fail students. When students were judged to be 'very bad' or 'unsafe' then the situation was clear but weak students, especially if they were good at some things while weak at others, were found to be

particularly difficult to assess. Sometimes weak areas involved practice but other times they involved professional issues that were thought to be inadequately covered within existing assessment tools. Mentors therefore tended to give weak students 'the benefit of the doubt' and a positive assessment result (Duffy 2004, p66).

Local Context for the Project

SHSC had been moving towards the grading of practice for some time. The 2001 pre-registration nursing curriculum rewrite (Bournemouth University 2001) included a practice assessment tool that was jointly developed with practice partners and focused the student on collecting evidence to support achievement of competencies; this evidence was then validated by mentors. Whilst this tool was in many ways very effective, it was also very time consuming in terms of writing for both the student and mentor. However, this set the scene for the redevelopment of the tool in 2005, focusing far more on observation and discussion of performance in practice and then the award of a grade for each key element.

Project Design

A steering group comprising SHSC academic and practice partner representatives monitored the project design and implementation. Given the limited literature in this area and the lack of suitable survey tools, it was decided that a broadly qualitative approach to data collection was appropriate. It was felt that an exploration of perceptions of the grading practice process from three perspectives – students, mentors and educators – would help to reveal the issues involved, with a view to using these to construct a survey tool for wider distribution at a later date.

The project started in November 2005 and data were collected between March and July 2006. Nine audio-recorded focus groups were held in different locations across Dorset, Somerset and Wiltshire. Three focus groups were held for students, four for mentors and two for educators. Approximate numbers of participants were: students – 70, mentors – 10, educators – 20. Focus groups were held within university time for students and educators and, as such, they were relatively simple to organise. Despite efforts to involve students from each nursing branch and programme, all student participants were from adult branch and were taking Advanced Diploma or BSc nursing programmes (ratio 2:1). Mentors were difficult to access as they had to be either released from their places of work or they came in their own time. Again, despite attempts to increase diversity, only mentors from adult nursing areas

participated. The educator groups represented a wide range of practice areas including each of the branches of nursing. All focus groups were audio-recorded and the transcripts were thematically analysed.

Findings

A considerable amount of data was collected from the focus groups. The issues raised by each group – students, mentors, educators – were similar in some respects and differed in others. An overview of these issues and where they overlapped between groups is illustrated in Diagram 1. Having reviewed the issues and the raw data from which they were derived, four central themes emerged from the findings:

- Valuing practice;
- Tripartite nature of practice learning;
- Learning environment;
- Using the tool.

'Valuing practice' emerged as the central theme; this reflects the fact that the data indicate that all groups perceived that the move to the grading of practice within the pre-registration nursing programme was to be welcomed. However, as might be expected, there were some issues to be addressed around implementation. These issues are reflected within the other themes: the 'tripartite nature of practice learning' considers the role of the student, mentor and educator in ensuring successful practice learning; the 'learning environment' theme considers some influences within placements affecting practice learning; and finally 'using the tool' unpacks some of the logistical considerations that emerged as the tool was used for the first time. The themes are illustrated in Diagram 2.

Valuing practice

All groups of participants were pleased with the introduction of the new grading practice profile assessment tool. Nursing is a practice discipline and the new practice profiles bring the emphasis of nursing education programmes back on to practice. To summarise the findings:

- Grading practice has helped to redress the balance between education and practice;
- Practice is now weighted equally with the written academic elements of education programmes;
- The tool was perceived as important for rewarding good practice and for identifying weak practice so appropriate help could be given;
- Mentors reported that students were more focused on practice and on gaining practical knowledge and skills than previously. Students also appeared to be more confident and more able to manage their own learning experiences with the new grading tool;

- Block practice placements were also thought to enhance student learning because block placements provided more realistic practice experiences and more continuity. Students were able to get to know their patients, work with mentors, and feel part of professional healthcare teams.

Tripartite nature of practice learning

Effective practice learning depends upon positive student attitudes, good quality mentorship and clear communication channels between the university and placement educators. Each has a role to play and the data describe how this worked in relation to the introduction of the new grading practice tool. To summarise the findings:

- Good quality mentorship is important for successful student development in practice;
- Students' perceptions of practice were sometimes different to reality. Some students might expect fast-paced, acute scenarios rather than older people with complex needs. When they begin education programmes, some students may have little experience of life, illness or death;
- Mentors help students understand the importance and significance of traditional care giving;
- Some students struggle with the competing demands of work and study. Physical and emotional demands may be underestimated;
- Educators support mentors and students in practice;
- Educators provide pastoral care for students. Role changes have led to uncertainty. There were concerns that students may suffer if educators are no longer able to provide this support when students are in practice;
- Educators provide valuable links between higher education and practice;
- Mentors are aware that students are more likely to take control of their own learning with new practice profiles;
- New practice profiles redress the balance between higher education and practice;
- Mentors' authority for assessing practice is confirmed, as is recognition for their roles as co-educators;
- Mentor preparation and regular updating are important;
- Mentors must be confident to fail failing students;
- Mentors must refuse to complete assessments for students they do not know;
- Failure to fail puts students, colleagues and patients at risk.
- Local strategies should be developed to improve mentor access to updating programmes;
- Assessment tools must be fit for purpose, with a broad focus – mentors must be able to assess all areas of students' practice.

Learning environment

The literature indicates that the practice learning environment is central to effective student learning (Mogensen 1994). This evaluation supports this view; whilst students enjoyed the learning environment, several issues emerged that could prove barriers to learning from the perspectives of all groups. To summarise the findings:

- Most students really enjoyed their practice experiences;
- A few examples of unprofessional behaviour were given but more usually students were supported by all members of the professional teams;
- Previous practice experience was not necessarily an advantage. Students could benefit from familiarity but would sometimes have to 'unlearn' practices before new learning could occur. It could also be harder and take longer for them to adapt and identify with their new roles as nurses;
- Mentors in this study were flexible and adaptable to the different learning needs of students. However, students reported a few negative experiences with mentors who were not so enthusiastic about their roles;
- Hospital (acute) placements were sometimes valued over care home placements by some students and some mentors; there were perceptions of greater learning opportunities in acute settings. However, it emerged that the quality of the mentorship rather than the setting was likely to have a much stronger effect on the success of the placement learning experience;
- Student learning was enhanced by good mentorship;
- Concerns were raised that increased student numbers could be problematic for mentors. However, mentors in this study said they only rarely experienced problems with student numbers.

Using the tool

Any new assessment tool is bound to bring some degree of anxiety. Despite efforts by nursing programme education staff and placement-based educators, preparation of placement staff for use of the tool was less than comprehensive. This meant that mentors and students were essentially learning together. Whilst this worked for some, it was less satisfactory for others, particularly during students' first placements. However, some issues were addressed quickly, resulting in a better experience in the latter part of the year. To summarise the findings:

- Educators' attempts to prepare mentors for the introduction of the grading practice tool proved relatively unsuccessful in some areas;
- Mentor updating was not seen as a priority; inadequate knowledge about the tool impacted on its use;
- There were assumptions by practice partners and SHSC that the introduction of the tool would be straightforward; difficulties were underestimated;

- There were initial delays in response to queries. Subsequently, education staff successfully developed a range of strategies to access mentors and the situation improved;
- Some students were inadequately prepared to use the new grading practice profile tool before they entered practice. This put students in a difficult position, with some mentors looking to them to explain how the tool should be used.

Discussion

This evaluation provides a snapshot of the experience of mentors and students using a new practice assessment tool. The methodology provided some rich, in-depth data, albeit from a small sample of potential participants. The data from the educators provided a very useful insight into the logistics of implementing, supporting and managing a significant change in the way practice education in nursing is assessed. Whilst reflecting only one year of the programme, it is pleasing to note that, overall, the move to grade practice was viewed by all groups very positively. Predictably, some issues need to be addressed.

The findings clearly indicate that the new tool did place a more equal value on the practice education element of the nurse education programme through the grading of practice, thereby meeting a key aim. This had the effect of making the mentors feel more valued as a key part of the assessment process and enabled them to reward excellence in practice. For the mentors in this evaluation, the issue of failing students represented no concerns as they viewed this as an essential part of their role. Caution is required in interpreting this because the mentors were self-selecting and, given the numbers, the finding is not generalisable.

Some key concerns for all those involved in the practice education process – SHSC programme team members and placement providers – need careful and in some cases urgent consideration. Mentor preparation is provided and all mentors involved accessed this, but mentor updating mechanisms were found to be weak and seemed to be of low priority. The impact of this was that some students were disadvantaged in terms of grades because some mentors were unsure how to use the grading tool. Whilst this had no cumulative effect at this stage of the programme, it will in the latter stages and needs to be addressed. Equally, the issue of second marking in practice was reported to be inconsistent and sometimes avoided. Both issues in the long term will compromise the reliability of the tool if not addressed.

Finally, the issue of support from the university for students in placement and for mentors in practice was a strong theme. Communication mechanisms were viewed as unclear and some mentors were unsure of the support available given the withdrawal of many of the practice educator networks. Both these issues have received some consideration from the programme team and the placement providers since the evaluation took place but perhaps requires some on-going monitoring.

In reviewing the findings, a number of limitations must be acknowledged. The most significant limitation is that the student and mentor participants were all from the adult branch sector. All branches and placement areas had the opportunity to participate although access for some may have proved difficult. Mentors in particular proved to be difficult to access because it appeared that staff shortages and limited numbers of qualified staff in practice areas created difficulty in attending focus groups.

Other limitations include the fact that findings were generated from reported practice and, as such, may be subject to distortions of memory. Furthermore, not all individuals at all focus groups contributed equally and so the findings reflect those contributions that were made.

Conclusions

The evaluation of a new assessment tool for practice can only be viewed as positive. No previous evaluation has been undertaken by the nursing team and the learning from the experience has been significant, enabling the programme to institute solutions to problems in a timely manner.

A number of themes were shared by all participant groups, the most significant being that the new graded practice tools were well received. They have succeeded in putting the focus and value back on practice, and reinstated balance between theory and practice. Whilst a range of general difficulties and misunderstandings were experienced initially, these are being addressed and have resulted in some reorganisation of placement learning responsibilities within the programme team.

Recommendations

Retain the practice tool with grading:

- Build upon strengths within programme organisation;
- Use findings to inform staff development for personal tutors;
- Improve student preparation for first placement as well as for using the tool.

Reliability issues:

- Programme team to institute moderation mechanisms to check that comments reflect grades awarded;
- Students need to be aware of appeal mechanisms;
- Placement providers need to review mechanisms to enable second marking.

Communication and support mechanisms:

- The programme team needs to review systems for pastoral support for students;
- The programme team needs to review communication mechanisms with clinical settings and advertise these;
- Mentor support from placement providers should be reviewed in the light of the withdrawal of practice educators.

Mentor preparation and updating – policy:

- Develop a joint strategy between SHSC and practice partners to facilitate mentor updating education;
- Mentor updating for all 'live' mentors should become part of mandatory annual training;
- Personal responsibility for accessing updating should be monitored via annual appraisal mechanisms.

Mentor preparation and updating – content:

- Emphasise the grade descriptors and their use in justifying the allocated grade to improve reliability;
- Emphasise that the tool is designed for Common Foundation Programme (CFP) students and therefore the full range of grades can be used within each year of the programme.

Extended evaluation proposed using quantitative methods:

- Survey a wide range of mentors on use of the tool, including assessment of borderline students;
- Ensure that the mentor and student samples come from all nursing branches.

The Nature of Practice Assessment Within Pre-registration Undergraduate Nursing Education

Introduction

In 2004, the Nursing and Midwifery Council (NMC) published *Standards of Proficiency for Pre-registration Nursing Education*. This document provided clear guidelines for all aspects of nursing education. Nurses must achieve the standards defined in these guidelines to be admitted to the register. Nursing is a practice discipline and it remains the case that nurses must pass both the theoretical and practical aspects of their education programmes as a 'condition for graduation' (Bondy 1983, p376). The challenge for nurse educators is not only to accurately assess practice but to give equal value to both aspects of the curriculum.

In recent years, nursing curricula have favoured those who were academically able. Pass/fail systems for assessing practice meant that nursing students' abilities in the workplace were not valued equally. As a result, students who were strong academically but weak practically were able to do well while those who were good in practice but less able academically were unfairly penalised. The curriculum rewrite of 2005 provided an opportunity for Bournemouth University to correct this anomaly. Using the standards described in the NMC (2004) document, a practice profile (a tool for grading nursing practice) was developed and introduced in September 2005.

Overview of the Literature

Extent of the literature

A literature search was conducted using major nursing and allied health databases. Key words around the subjects of learning, competence, assessment, evaluation, practice and grading were employed. The search produced a limited amount of relevant literature that highlighted perceived difficulties with grading practice around the issue of subjectivity in particular (Hillegas & Valentine 1986). This concern led to a long-term acceptance of pass/fail systems for the assessment of nursing practice (Andre 2000).

Learning in practice

Clinical practice – that's where you learn.

(Mogensen 1994, p180).

This statement made by a student nurse inspired Mogensen (1994) to explore the learning that occurs in practice as a vital component part of

nurse education programmes. In England, practice makes up 50% of the education programme and students must pass as a condition for entry to the nursing register. Mogensen argues that 'exposure to the professional environment on the wards' (1994, p180) has a strong influence on student learning. She called this influence 'the construction of social representations' (ibid.) where students develop understanding from their theoretical education which is then activated through exposure to clinical situations. Mogensen suggested that this way of learning was opposite to how children learn, in that nurse education programmes provide theory first and that understanding comes later after exposure to clinical or practice situations. This study highlighted the importance of practice for the development of nursing knowledge that extended beyond clinical into social and organisational understanding. This was sometimes challenging and complex but nonetheless comprised the real world of nursing practice.

Definition of grading

Reilly & Oermann (1992, p421) refer to grading as 'quantitative symbols of qualitative dimensions of behaviour'. Grading generally uses 'a letter or number' to 'convey a complex and diverse array of competencies and attributes' that can be 'instantly understood by the viewer' (ibid.). For these reasons, grading can be a useful tool for students and educators but grades are not value free. The values, experiences and beliefs of the assessor will influence the grades given and this difficulty must be taken into account when making judgements based on grades.

It is pertinent to note, however, that prior to the local introduction of numerical grades, mentors 'graded' student performance as a pass or fail. This judgement was just as value-laden but arguably less constructive in terms of feedback for the student.

Studies of grading practice in nursing

Tools for quantitatively grading nursing practice have been used before. North American examples include Bondy who, in 1983, developed a five-point rating scale for the evaluation of professional practice based upon findings from psychometric studies. These studies recommended that rating scales should have between two and seven points. The aim was to reduce subjectivity and achieve high levels of objectivity and fairness. Reliability would be gained through clearly defined conditions for each point of the scale and reliability could be enhanced if assessors were able to use the tool repeatedly with many different students rather than on just one occasion. However, if the conditions for points given were vague or if assessors did not use the descriptions of conditions for points given, then reliability would be compromised (Bondy 1983). Different components of the tool were used to assess both single examples of performance and to record students' development over time. Bondy

(1983) identified that 'students tend to demonstrate patterns of development' when faced with new or more complex situations. These ongoing behaviours could also be graded as long as the descriptions were clear and unambiguous and the assessor 'compared the student's performance to the criteria' (p381).

Bondy (1983) found that both assessors and students benefited from using the grading tool. Assessors found that the criteria within the tool enabled them to give more constructive and positive feedback. Students found they were more able to understand and make sense of the scores they received but only when the feedback they received equated with the grade given. When successful, this process enabled students to develop more self-awareness and awareness of their performance.

In 1984, Bondy conducted another study to investigate the effect of criteria on accuracy and reliability when assessing students' clinical performance. The study employed three different scenes/situations and two groups of students and assessors. One group of students and assessors used criteria for assessment and the other group did not. The study was video-taped to record the activities under investigation for examination later. Bondy (1984) found that accuracy and reliability were dependent upon two main factors. First, the use of criteria by students and assessors increased accuracy and reliability. In addition, student performance improved when they had the criteria with which to measure their own performance. Second, some situations were found to be easier to assess than others. The task situation, for example changing a wound dressing (psychomotor behaviour), was perceived as more tangible and measurable and was apparently easier to critique and to grade. As a result, the lowest marks were awarded for this behaviour. The highest marks were awarded to the interview situation (affective type behaviour) which was perceived as more abstract and open to interpretation. As a consequence, the interview situation was assessed with more leniency. The third situation, a medication scene (cognitive behaviour), fell in between. However, Bondy (1984) was keen to avoid drawing too many conclusions from these results. Even though the use of the marking criteria seemed to improve accuracy and reliability when evaluating student competency, she suggested that assessors might benefit from extra training rather than relying solely on their experience, and that this might achieve improved rater reliability and consistency.

Another North American example of grading is given by Hillegas & Valentine (1986) who also reported the development of a five-point clinical grading tool to overcome difficulties with the summative grading process. Aware of the problems associated with subjectivity, this tool also

used detailed descriptions of expectations for each point on the scale. When evaluated, faculty staff (87% response rate) and students (36% response rate) reported that the tool was helpful when discriminating between grades (80% and 62% respectively). In conclusion, Hillegas & Valentine (1986, p220) reported that the tool had been successful in removing 'some of the subjectivity and ambiguity of assigning clinical grades'.

An English example of grading the practice of undergraduate nurses is given by Burns (1992). With professional colleagues she developed a three-dimensional five-point grading framework that included clinical competencies, learning contracts and grading profiles. This approach relied heavily upon student reflection, written elements and discussion/negotiation with mentors and educators (lecturer practitioners). Clinical competencies were devised from the current professional regulations and the learning contracts used reflection and written elements that provided insight into student attitudes as well as ability. Burns' study raised the need for mentors to learn what was required of them and highlighted again the importance of mentors and educators in guiding and supporting students. It was locally successful.

An Australian example of the development of a clinical grading tool is given by Glover et al. (1997, pp110-111), who wrote:

In making the decision to grade the clinical component, the researchers made two assumptions based on their own teaching experience. Firstly, students demonstrated varying levels of clinical performance and secondly, not awarding a grade to clinical performance was somehow to devalue it.

Grading was restricted to final year students who were assigned a preceptor (mentor) with two years' experience or more as a registered nurse. This nurse would be responsible for evaluating the students' clinical performance. As in England, Australian student nurses have to achieve clinical competence to be admitted to the nursing register. Assessment was made by direct observation and observation over time (the duration of the placement, in this instance seven weeks). Students were also assessed using theoretical papers and oral vivas but it was unclear whether aspects of these methods of assessment were used by mentors in clinical areas or whether they were confined to other parts of the education programme. However, direct observation was deemed to be unreliable on at least two levels: different mentors could view performance differently, and students' performance could vary in different clinical situations. For these reasons, observation over time was the favoured method of evaluation.

Findings from this study indicated that across all domains students' performance was rated higher than expected (Glover et al. 1997). Possible reasons for this were explored and include:

- Academics (who are largely responsible for defining the parameters of assessment), clinicians and students may hold differing views about practice areas (an academic view of holistic individualised care verses the student and clinician view of getting through the workload);
- Speculation that competence may be regarded by academics as a standard/basic requirement of practice as a registered nurse, whereas clinicians may view the same competence as an achievement with status.

The second finding was that clinicians rated student performance higher than students rated their own performance. The reasons for this were unclear but it was suggested that for grades to be close both students and clinicians had to be able to agree precisely what was being assessed. At the same time it was also acknowledged that some procedures were easier to assess than others (for example, practical tasks were perceived to be easier to assess than situations that required the exercise of judgement). The third finding was that clinician comments did not match the marks given for the performance. Such comments tended to reflect traditional assessment frameworks which suggested a lack of preparation in using the assessment tool and a lack of understanding about the assessment criteria. The fourth finding was that students received higher grades for their clinical work than they received for the theory and this caused concern for Glover et al. (1997) because it suggested that students were well prepared for their roles as registered nurses, a view not supported by the evidence or students themselves (Longson Glover & De Bellis 1997, cited Glover et al. 1997). In conclusion, this study highlighted the importance of the clinician role as tutor, preceptor (mentor) and assessor.

The role of mentors

There is a wealth of literature on the pivotal role of mentors in the assessment process (Wilson-Barnett et al. 1995, Spouse 1998, Brown & Edelmann 2000, Kilminster & Jolly 2000). Mentors remain central to the development of undergraduate nursing students in practice. Their importance in the education process cannot be stressed enough. Mentors are responsible for both helping students to learn and develop their knowledge and skills and for assessing student progress. Northcott (2000, p31) suggested a number of areas that are central to the role of the mentor. These include:

- Listening – to everything and particularly to signs of unease;
- Providing structure – to help colleagues use their time wisely and work to their contract and aims;

- Encouraging – when the going gets tough;
- Sharing – their own experiences;
- Celebrating – successes and achievements;
- Setting tasks and signposting directions – to help learners meet course, programme and personal goals;
- Agreeing standards – aiming for high but achievable standards;
- Role modelling those standards.

Students must be supported and assessed by mentors.

(NMC 2006, p2)

Sound mentorship is key to student success. Mentors help students succeed. They must also fail students who fail to meet required standards. To support them in their vital roles mentors need appropriate preparation and regular updating (NMC 2006).

Failing students and failure to fail

Welsh (2003) highlighted the issue of mentors passing nursing students when their practice or behaviour was not up to professional standards. He discussed the worrying possibility that this practice might be commonplace, perpetuated by beliefs that failing students was a higher education institute responsibility and not that of clinicians, when in reality the responsibility was shared. Welsh (2003, p17) warned that if this practice continued the outcome would be 'the erosion of professional standards'.

In 2004, Duffy published the first part of a study commissioned by the Nursing and Midwifery Council (NMC) focusing on the issue of mentors failing to fail students. This study was done in response to an earlier investigation (Watson & Harris 1999, cited Duffy 2004) in which 46% of mentors agreed with a statement that suggested 'students were sometimes allowed to pass practice placement assessments when in fact their performance was unsatisfactory' (Duffy 2004, p2). This discovery raised grave concerns over 'patient care and safety and public confidence' (ibid.). When students were judged to be 'very bad' or 'unsafe' then the situation was clear, but weak students, especially if they were good at some things while weak at others, were found to be particularly difficult to assess. Sometimes weak areas involved practice but other times they involved professional issues that were thought to be inadequately covered within existing assessment tools. Mentors therefore tended to give weak students 'the benefit of the doubt' and a positive assessment result (Duffy 2004, p66).

This analysis oversimplifies what Duffy (2004) identified as a very complex area involving educators as well as mentors. Duffy recommended further research to explore what she called the 'borderline

status' in assessment (Duffy 2004, p77), a central issue of concern regardless of whether traditional pass/fail systems of assessment or grading are used.

Local Context for the Project

Grading practice in nursing programmes at Bournemouth University

Several issues led to the decision to revisit grading for the practice elements of the nursing curriculum at Bournemouth University. Nursing is a practice discipline and student nurses spend half of the programme in practice placements. They need to pass both practice and theory in order to graduate. In spite of this, in the pre-2005 programme, a first class honours degree would only be first class by virtue of academic achievement. Students' abilities in practice or lack of abilities were not recognised by a pass/fail system of evaluation. As a result, the curriculum team felt that practice had become a devalued part of the assessment process.

Looking more widely, it was felt that perceiving practice abilities as less valued than academic achievements could have a negative impact on students and mentors. The BBC News coverage of the Royal College of Nursing (RCN) Conference debated the notion that, since entering higher education, nurses believed they were 'too posh to wash' (BBC News 2004). Whilst not a widely held view, it could be reinforced by the fact that practice assessment was rarely graded in nursing.

The School of Health and Social Care (SHSC) at Bournemouth University had been moving towards the grading of practice for some time. The 2001 pre-registration nursing curriculum rewrite (Bournemouth University 2001) included a practice assessment tool that was jointly developed with practice partners and focused the student on collecting evidence to support achievement of competencies; this evidence was then validated by mentors. Whilst this tool was in many ways very effective, it was also very time consuming in terms of writing for both the student and mentor. However, this set the scene for the redevelopment of the tool in 2005, focusing far more on observation and discussion of performance in practice and then the award of a grade for each key element.

The 2005 curriculum rewrite therefore provided an opportunity to revisit practice assessment and develop a system of grading for the assessment of practice in undergraduate nursing programmes. In 2004, the NMC published standards of proficiency that outlined what student nurses were expected to achieve in order to qualify as registered nurses. This document was used as a guide for the development of graded practice profiles. The practice profiles were used to assess student

development in practice during Year 1, the Common Foundation Programme (CFP). In Years 2 and 3, students use branch-specific graded practice profiles.

In September 2005, two practice profiles were introduced: one for the BSc (Hons)/Advanced Diploma in Nursing students and the other for Diploma HE in Nursing. The practice profiles are similar but the descriptions of what is expected from students differs according to the programme of study and the various grades that can be awarded. Both practice profiles use six-point scales representing the grades/levels of passing. The numerals 0 and 1 represent failure, with 2 (acceptable pass) 3, 4 and 5 (excellent pass) representing the grades/levels of passing.

Introducing the new practice assessment tool

The pre-registration nursing curriculum was approved in June 2005, with the proposal to grade practice receiving particular praise from the NMC and practice partners. However, given that the introduction of the new profiles was due to commence in October that year, limited time was available for placement preparation. The programme team set up road-shows, mentor preparation updates were instigated across placement areas and mentor programmes were updated to include profile use.

Despite these efforts, and perhaps predictably, there were difficulties initially with the introduction of the new practice profiles. These issues are apparent within the findings. In particular, for a variety of reasons, some practitioners were unable to access mentor update programmes. A significant restructuring of practice education support coincided with the implementation of the profiles and communication channels between practice and the HEI were perceived by some as unclear. While this was problematic at the time, the situation was tackled promptly and many of the difficulties have been addressed.

Notwithstanding these concerns, the overriding view from the findings was that the grading of practice was a worthwhile venture to equalise the balance between the practice and theory programme components in terms of their value. Much has been learned from this project and the next section will explore how this was achieved.

Project Design

Aims of the Study

The aims of the evaluation were to explore student, mentor and education staff experiences of using the new profile, to consider their views on the grading of practice using this tool, and to learn lessons to enhance on-going implementation. In addition, the issue of reliability when using the practice profile was acknowledged as challenging because it is used by a range of students and mentors; it was hoped that the evaluation would also yield some insights into this area.

Steering Group

The steering group members were stakeholder representatives from education and practice partners. Members included the Academic Head of Nursing from SHSC at Bournemouth University, the Head of Practice Education, a researcher attached to the Nursing Academic Group, representatives from programme management teams across the different branches of nursing, and representatives from NHS Trusts. The steering group was chaired by the project lead and Head of Learning and Teaching from SHSC at Bournemouth University. The steering group members' role was to monitor progress and make sure that the interests of the different groups were being represented.

Ethics

Ethical approval was not sought for this study because it was an evaluation following the introduction and subsequent use of the new graded practice profiles. All participants were volunteers who were able to take part or not as they wished, without penalty, and all data were anonymised to protect the identity of participants.

Methodology

Data collection

Given the limited literature in this area and, in particular, the lack of suitable survey tools, the steering group decided that a broadly qualitative approach to data collection was appropriate. It was felt that an exploration of perceptions of the grading practice process from three perspectives – students, mentors and educators – would help to reveal the issues involved with a view to using these to construct a survey tool for wider distribution at a later date.

The project started in November 2005 and data were collected between March and July 2006. Nine audio-recorded focus groups were held in different locations across Dorset, Somerset and Wiltshire. Three focus groups were held for students, four for mentors and two for educators. Approximate numbers of participants were: students – 70, mentors – 10, educators – 20. Focus groups were held within university time for students and educators and as such were relatively simple to organise. Mentors, however, were more difficult to reach. For logistical reasons, only public sector (NHS) mentors were approached to take part in this study. They had to be either released from their places of work or they came in their own time. As a result, mentors' contributions were particularly appreciated. Despite efforts to involve students from each nursing branch and programme, all student participants were from adult branch and were taking Advanced Diploma or BSc nursing programmes (ratio 2:1). The mentors were also from adult nursing areas. The educator groups comprised practice educators (practice based) and personal tutors (university based) with some members holding both roles. They represented a wide range of practice areas including community and acute, NHS and the private/independent sector, and each of the branches of nursing.

Focus group facilitation

Focus groups were selected as the principal tool of data collection because it enabled participants to share and review ideas, generating considerable data in a short space of time (Kitzinger 2000). The facilitator was a researcher from Bournemouth University, not involved in the development or implementation of the practice profiles. This 'independence' added an element of objectivity to the facilitation process as she learned about the profile use incrementally from the perspective of focus group participants. The facilitator used a number of stimulus questions derived from suggestions from the steering group.

Data analysis

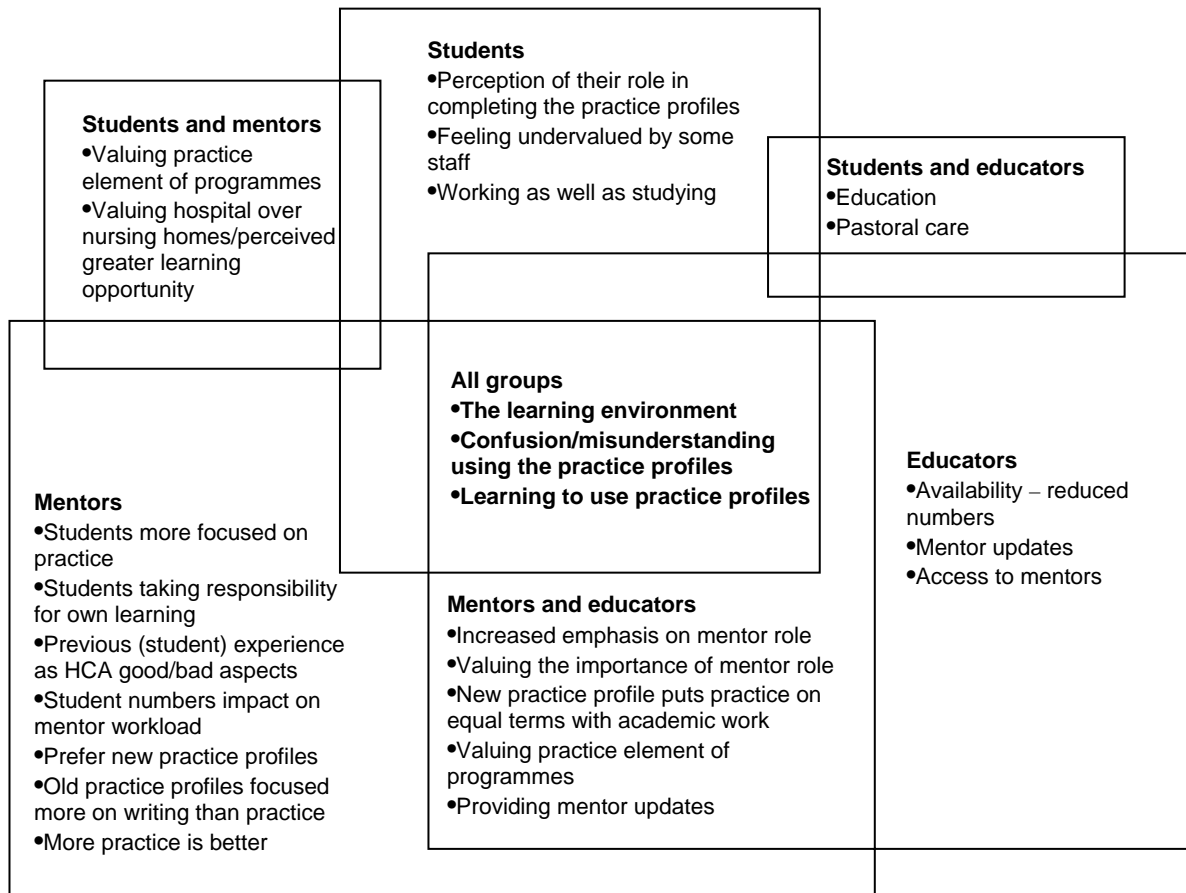
All focus groups were audio-recorded and the transcripts were thematically analysed. The data were analysed inductively from raw units of information and then subsumed into categories or themes and refined as the evaluation proceeded. Data collection was therefore continuous and simultaneous with data processing (Lincoln & Guba 1985).

Findings

Data Presentation

A large amount of data was collected from the focus groups. The issues raised by each of the groups (students, mentors, educators) were similar in some respects but differed in others. An overview of these issues and where they overlapped is illustrated in Diagram 1.

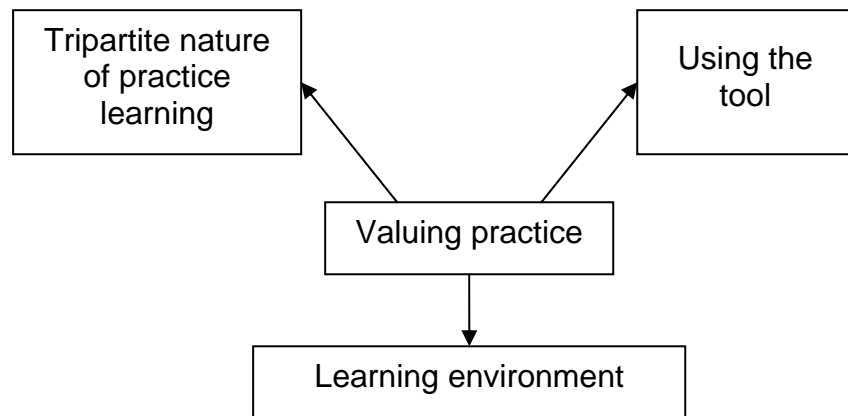
Diagram 1. Overview of the findings: issues raised by groups



Having reviewed the issues and the raw data from which they were derived, four key themes emerged from the findings (see Diagram 2):

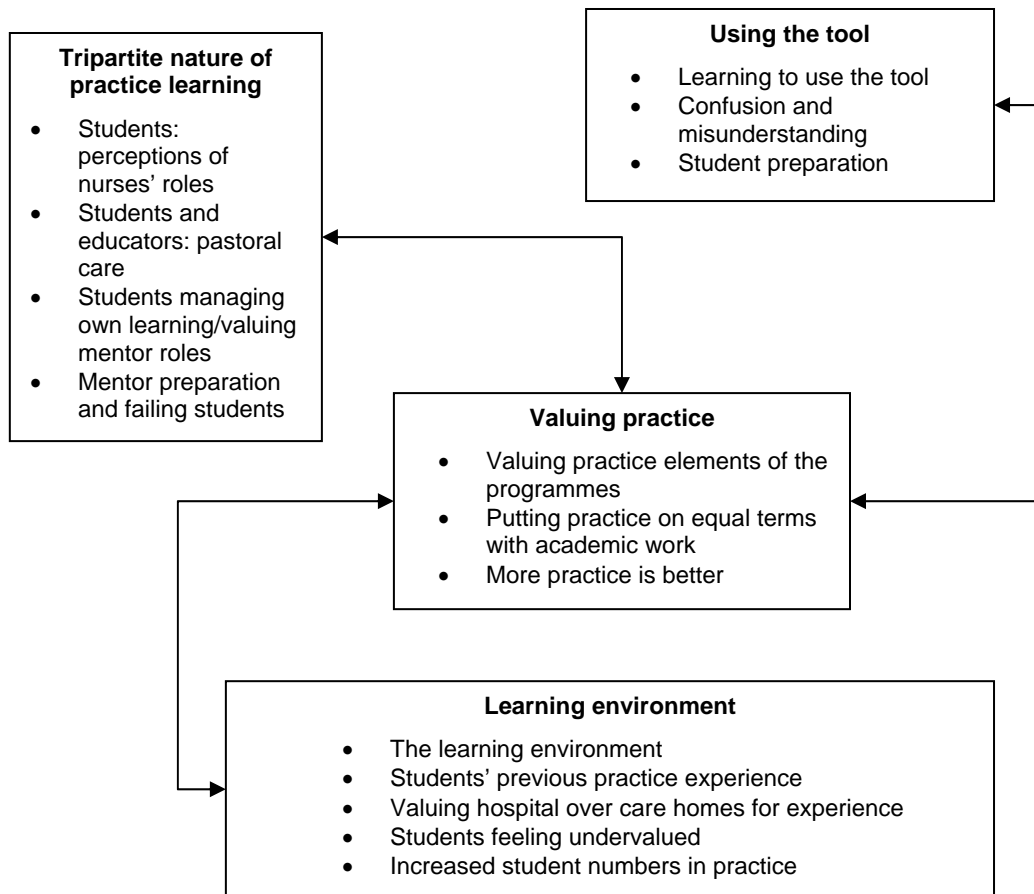
- Valuing practice;
- Tripartite nature of practice learning;
- Learning environment;
- Using the tool.

Diagram 2. Key themes and their relationship



'Valuing practice' emerged as the central theme. This reflected the data which indicated that all groups perceived that the move to the grading of practice within pre-registration nursing programmes was to be welcomed. However, as might be expected, there were some issues to be addressed around implementation. These issues are reflected within the other three themes: the 'tripartite nature of practice learning' considered the role of the student, mentor and educator in ensuring successful practice learning; the 'learning environment' theme considered influences within placement settings that could affect practice learning; and finally 'using the tool' unpacked some of the logistical considerations that emerged as the tool was used for the first time. The themes and sub-themes are illustrated in Diagram 3 and are explored below.

Diagram 3. Overview of the findings: themes and sub-themes



Valuing practice

It was pleasing to note that, although the introduction of the new tool was not unproblematic, all groups felt that, overall, the concept was a positive one. Much learning has been gained from the experience which has been incorporated within subsequent iterations of the programme. Key to the feedback has been the perception that the new tool valued practice more than the previous one. A number of sub-themes have been collated under this theme and these will now be described using quotes from focus group participants (N.B. M = mentor, S = student, E = educator [practice-based or university-based]).

Valuing the practice elements of the programmes

All groups of participants were pleased with the introduction of the new grading practice profile assessment tool. Nursing is a practice discipline and the new practice profiles bring the emphasis of nursing education programmes back on to practice.

The student nurses I have been in contact with recently are much more focused on their clinical skills. They want to get experience doing different things as well as developing skills talking to people. (M)

Mentors complained that earlier programmes had sometimes caused students to focus on their academic work at the expense of practice.

All they used to worry about was their assignments [written work] and passing them...they weren't really marked on practice. (M)

There was the perception that written elements of programmes were more important than practice and that somehow practice was not as valuable as written work. These beliefs were perpetuated when mentors heard that students who were strong in practice but weaker academically had to repeat the year because they had failed written assignments.

Some students were excellent practically but the next you heard was that they had been put back a set or something...you were not able to grade what they were doing and they were doing really well sometimes. (M)

Nursing students were always required to pass both written and practice elements of programmes but, before the introduction of grading, the two parts of the programme did not seem to be weighted equally. The imbalance led to perceptions that practice was not valuable because it was not adequately rewarded.

Previous practice profiles also favoured students who could write well without equal consideration being given to their performance in practice. This meant that students who were weaker in practice were able to advance without difficulties being addressed. The new practice profiles are different. They are practice focused and grading reflects the students' performance in practice not their writing skills. Therefore, students who are weaker in practice will be identified and helped, and students who are strong in practice will be recognised and rewarded.

I do think it's important to encourage them. Nurses are notoriously bad at praising so if it's warranted then the excellent mark is a good thing. (M)

I think this profile is good and the feedback is very good and very beneficial to students. (M)

Educators liked the new graded practice profile assessment tool as well.

In general the new practice profile is a vast improvement on the old one. It's a lot easier to use and a lot more succinct and a lot more practice based. (Ed)

And I think that's the way it's been received in practice as well. In my opinion it's a great leveller, a great equaliser for students who are not so academically strong but fantastic nurses. (Ed)

Putting practice on equal terms with academic work

Previous nurse education programmes weighted theory and practice equally but this was not how it was perceived by students and mentors. They believed that theory and academia were more important than practice, a view that was reinforced by the academic nature of previous practice profiles. Students who could write well had an advantage over those who found academic writing more difficult. The new practice profiles aimed to change perceptions by using grading for practice in the same way that grades were given for written work.

It's nice for students to be graded on practice rather than just all the academic work. (M)

I think there is a much more balanced experience now. (M)

More practice is better

The time nursing students spend working in practice remains unchanged but perceptions were that students now spent more time working in practice. What had changed was the pattern of student working. Students currently work in practice for block periods of time. These practice blocks alternate with blocks where students receive education. This pattern replaced earlier patterns of work where students would be in practice for only part of each week. Typically students would work in practice for one day each week, then two days, then three days, spread across the whole academic year. While this fragmented pattern of working made it easier for students to study, they had very disjointed practice experiences. The short times students were in practice made it difficult for them to get to know their patients or to feel part of professional teams. As a result, these patterns of working were abandoned and replaced with block placements. Since the introduction of block placements, mentors noticed positive changes in students' confidence and attitudes:

They take the initiative now...they're planning ahead more whereas before they would stand back and wait. They weren't there long enough to get into the routine. (M)

Block placements enabled students to manage their own learning more effectively. According to mentors, students were more self-reliant and able to find more opportunities for learning and for working with mentors. Mentors believed that the change to block placements was good for students' self-esteem as well as helping them to build knowledge and self-confidence.

The five day week, it's like real life, dealing properly with shift work, weekends...it's what nursing is about...the routines. (M)

However, both students and mentors found that the time students were in practice passed very quickly. They found the short time frame limited what could be achieved. Mentors in particular said that they would like students to have longer practice placements.

Blocks are much better but they still could do with being longer. (M)

Summary: valuing practice

The introduction of the graded practice profile assessment tool has raised the profile of practice. It was perceived by all groups as a positive development.

- Grading practice has helped to redress the balance between education and practice;
- Practice is now weighted equally with the written academic elements of education programmes;
- The tool was perceived as important for rewarding good practice and for identifying weak practice so appropriate help could be given;
- Mentors reported that students were more focused on practice and on gaining practical knowledge and skills than previously. Students also appeared to be more confident and more able to manage their own learning experiences with the new grading tool;
- Block practice placements were also thought to enhance student learning because they provided more realistic practice experiences and more continuity. Students were able to get to know their patients, work with mentors, and feel part of professional healthcare teams.

Tripartite nature of practice learning

Effective practice learning depends upon positive student attitudes, good quality mentorship and clear communication channels between university and placement educators. Each has a role to play and the data describe how this worked in relation to the introduction of the new grading practice tool. Again, a number of sub-themes have been collated under this theme and these are described below.

Students: perceptions of nurses' roles

Some student nurses had perceptions about their roles based upon popular television programmes. These programmes inspired them to become nurses but could also lead to unrealistic expectations. For example, media influences could mean that some students believe they would only be learning and using advanced technical skills, which would mean disappointment when they discovered that reality was different. Another distortion related to the ages of patients. Television programmes tend to show acute care scenarios with younger patients whereas in reality most practice settings have older patients with complex needs. These patients were arguably more interesting and challenging to care for than those popularly represented, but students could still feel disappointed when their expectations were not met.

In recent years, there has also been criticism of nurses who no longer view traditional care-giving as part of their roles. Mentors reported that this shift had impacted upon some nursing students:

We actually have had quite a few that said 'I do not wash or wipe bottoms'. (M)

Mentors thought this might be due to some students' lack of experience of the profession and they challenged this view. Mentors explained to students that personal care was very important and that it should be kept as an integral part of nursing care.

You get to know a patient a lot better when you are doing personal care...better than you ever will by sitting on their beds. So you try and impress that on students. (M)

And observation, the skin condition, mobility, nutrition. I don't know if that's an old fashioned view but you can learn so much from that. (M)

Another mentor thought that students' reluctance to give personal care might be due to their lack of confidence and ability to give this often intimate nursing care. There was evidence that some students began nurse education programmes with little experience of dealing with people, particularly if those people were sick or members of an older age group:

Before I started there I was scared of old people. (S)

So, although students wanted to care for patients, real situations could be daunting for them. Mentors also thought that some students might be

more interested in careers in management than traditional nursing roles, and their reluctance to give care might therefore be due to different expectations. Whatever their motivation, mentors still wanted all nursing students to learn how to give patient care.

Nursing is not just about doing doctors' rounds and giving out medicines. (M)

Practice environments could be very demanding for students and some had concerns about the competing pressures of work and study. Students were learning in practice while completing written assignments as part of their education programmes. Some students dealt with this issue by completing written work before going into practice, but this was hard to achieve within the reduced time frame. Others suggested that some study time could be built into the practice placement time to help with this problem. However, it was explained that a system similar to this suggestion had been tried in the recent past and was found to be more disruptive than beneficial. It was subsequently abandoned in favour of the current system. It was acknowledged that competing interests could be challenging but that students should try to develop strategies that most suited them and their lifestyle in order to deal with this. There was also recognition that the physical and emotional demands of working in practice could be underestimated. It was thought that perhaps student nurses were not taking sufficient breaks while working in practice, given the continuous nature of nursing work. Some students did seem to manage but others struggled and it was suggested that students should explore different strategies to help them overcome these difficulties.

Students and educators: perceptions of pastoral care

It was inevitable that some students would experience difficulties at different stages during the three year education programme. These difficulties could be personal or work-related. If problems occurred while students were based in practice, it might be more difficult for them to cope than at other times. In practice, students might be isolated, away from supporting friends and family, where they would be expected to deal with the physical and emotional demands of practice at times when they might be feeling vulnerable themselves. Students reported that, on placement, they were exposed to challenges unlike any they had faced earlier in their lives before they started nursing. These challenges included:

- Learning to deal with demanding patients, aggression from patients or patients' families;
- Learning to manage difficult colleagues;
- Dealing with death and dying.

Experiences such as these were demanding and sometimes life-changing for students. Students had to learn to manage their emotions at times when some were also exposed to personal difficulties, including:

- Struggling financially – many nursing students are not typical undergraduate students; they are often older with families to support or other responsibilities. They could find it particularly difficult to juggle both home and working lives;
- Struggling with fatigue – some students were working full time for the first time in their lives. Fatigue was a serious problem for many students. Their physical fatigue was in addition to the emotional demands found in workplaces where the combined pressures could make life difficult for some students;
- Relationship problems – these could be a challenge at any time but the nature of student nurses' working lives could make these problems particularly difficult to manage.

The nature of nursing work appears to have the potential to make the challenges experienced by nursing students more complex than challenges faced by most other student groups. While not all nursing students struggled with difficult issues, many students did. Currently, practice educators provide practice-based help and support for nursing students and mentors. They also keep personal tutors informed about students' progress, particularly when there have been practice-based problems. However, a decrease in practice educator cover is being implemented. Educators were particularly concerned about the loss of their support roles, often built up over a number of years, and the impact this loss could have on staff in practice areas:

There is a danger with reorganisation...it may be breaking up what is good. Some clinical areas had nothing before we came into post and we've started from scratch and built up lots of really strong relationships and it's taken an awful long time to do that. (Ed)

The way practice educators work is being changed to try and provide better cover across some areas but, at the same time, the number of educators is being reduced. There were fears that, while cover might be improved in some areas, other areas may no longer have access to practice educators.

Practice educators also provide valuable links between practice and higher education. The changes could have an impact on these links and existing links might now be broken. The link between practice and higher education was actively developed over many years to the benefit of both

but they now appear to be threatened. Educators expressed concern that the two parts of this valuable education system, education and practice, could again become separated to the detriment of both.

Mentors and students: students taking responsibility for their own learning/increased emphasis and value of mentor role

Mentors noticed that students were much more likely to take responsibility for their own learning with the new practice profile tool than they had previously.

I noticed this morning; one of them said 'could you watch me do this because I want to complete it'. That's more positive...I felt she was very keen to show me what she had done. (M)

I found that too...students were asking 'do you think it's alright to cover this outcome? Do you think it will fit?' They all seem much more aware. (M)

Mentors also believed that their role had gained increased recognition through the introduction of the new practice profiles because of the increased emphasis on practice and grading. Some mentors discovered that the new practice profiles relied more on their assessments of students' performance through observation and discussion and less on what was written down to record events. This shift highlighted the importance of mentors and their valuable contribution to the educational process of students while in practice settings.

This profile relies more on discussion, verbal discussion and less on documentation. (M)

Change was also reflected within the pages of the new practice profiles. Previous practice profiles demanded that a lot of extra information be added to the tool, for example the inclusion of published evidence, but this was no longer required. Students were still expected to justify their actions and to support their actions with evidence, but this was to be established verbally through discussion with mentors rather than demonstrated as written evidence included in practice profiles. This process again puts greater emphasis on mentors to explore with students the rationale and justification for their actions. There is also only a small space to record the assessments in the new practice profiles. This was intentional to highlight the need for mentors to check students' knowledge and justification for their actions, so only a short record would be needed. The combination of short records with mentors' signatures emphasised that it was mentors who were making the assessment of competence and

that they had judged students to be competent when performing the activity or exercise. Working with students enabled mentors to assess many different aspects of the students' performance. This experience made mentors the people most qualified to judge whether or not students were competent and safe to practice.

Mentors have always been responsible for the assessment of students in practice but this was not necessarily their perception. Students reported that some mentors thought they were not allowed to give students the grades they wanted to give. Students were told:

I can't give you any higher marks because we're not supposed to. (S)

And:

I had a great placement but she would only give me a maximum of three because she said 'you are only in year one and that's what they want to see'. (S)

The mentors in these examples clearly believed that they did not have final authority for the grades they wanted to give students for their performance while working in practice. It was not clear where these beliefs originated but there were reports of university-based educators asking students to provide more evidence when work was already approved by mentors. Actions like these, even when well-intentioned, could undermine mentors' confidence and authority. It was anticipated that the format of the new practice profiles would help to reinforce the notion that mentors do have the authority to assess students' performance in practice.

It could be expected that mentors would have opportunities to share their experiences and to share their learning. This could be viewed as a healthy and informal way for mentors to learn and grow, but it became apparent that under normal working conditions mentors appeared to have very little contact with each other. Mentors did not take breaks together nor did they have other opportunities to talk.

We don't get time to discuss issues with colleagues. (M)

Mentors did say, however, that if there were concerns about a student's performance they would make time to discuss this with colleagues, 'just to make sure there was no favouritism' (M), and to obtain their colleagues' points of view, but it seemed that informal communication or other team-building opportunities rarely, if ever, occurred. The relative

isolation of mentors in practice could make their already often difficult jobs even harder. If mentors were expected to perform to high standards, as would seem to be increasingly demanded of them, it could become more important for them to meet regularly with colleagues. Mentors need opportunities to gather formally for education and informally for team-building and support. The findings seem to indicate that insufficient emphasis is placed upon mentor education and on-going support. This is of some concern given the central role of mentors in the preparation of future practitioners.

The importance of mentor preparation and failure to fail

Mentors need to be appropriately prepared and regularly updated so they have the knowledge and confidence they need to perform their mentorship roles. The findings indicated that fulfilment of this requirement varied across the sector.

Educators reported that mentors working in the independent or private sector (non-NHS organisations) were generally enthusiastic about mentorship programmes and regularly attended updating programmes as well. However, educators found that mentors working in the public sector (NHS) could be more difficult to reach. There were many valid reasons given for this (see below) but the end result remained that public sector mentors struggled to attend updating programmes.

With the introduction of the new grading practice profiles, educators had prepared NHS Trust-based 'road shows' so mentors could be updated on-site, but these were poorly attended. As a result, most of the mentors who took part in this study had not been prepared for using the new practice profiles, although some had looked through examples. When asked about updating, mentors were very honest:

I must admit since I did my course I haven't had an update and that was four or five years ago. Up until now you just look through the new paperwork and get on with it. (M)

With many demands being made upon mentors' time, it seemed as if mentor updating programmes were not necessarily given priority by some (NHS) staff or their employers. The introduction of the new practice profiles had begun to change this view because the new profiles were found to be significantly different from previous ones. Also, educators in some areas were considering ways in which they might be able to include mentor updating programmes into mandatory education study days. They believed a formal approach would help mentors to attend updating programmes.

As mentioned previously, mentors working in the public sector (NHS) could be difficult to reach. Legitimate reasons for their unavailability were given as follows:

- Few mentors on duty at any one time – sometimes only one qualified nurse would be on duty so they were obliged to stay in the practice area;
- Unexpected emergencies occurred that necessitated mentors staying in work areas to help.

These were worthy reasons but they failed to acknowledge that mentor update programmes were important as well. Mentors are responsible for the education and assessment of undergraduate nurses in practice. This is arguably one of the most important roles mentors have and they need to be updated in order to perform that role effectively. The value of good mentorship, to prepare students for their future nursing roles, cannot be overestimated, so it is important for mentors to be regularly updated.

There is also another important reason why mentors should attend regular updating programmes. Educators expressed concerns that a few mentors appeared to be willing to sign student practice profiles even when they did not know the student. This issue was of particular concern to educators because they knew of some students who had levels of sickness that prevented them from becoming proficient in practice, but who had been able to 'slip through the net' (Ed) and progress to the next year without their lack of proficiency being formally identified and addressed. Educators wanted these students to repeat the year so they could develop the skills they needed for practice. They were willing to work with the students to help them achieve the necessary standards but the actions of a few mentors had failed to stop these students who were then able to progress to the next education year without the necessary skills. Educators thought that these mentors were just trying to be kind without appreciating the risks associated with their actions. It was anticipated that by attending regular updating programmes mentors could gain the knowledge, insight and confidence they needed to deal appropriately with all students.

In the literature (Duffy 2004), some mentors are criticised for not failing students when they should. The mentors who took part in this study appeared to be confident and capable practitioners and were willing to discuss this difficult issue. These mentors stressed that they would involve colleagues to provide help and support but they were also willing to fail students if there was no alternative, if students were indeed failing to achieve the required standards.

If you're passing someone who isn't capable you are signing off that they are safe and they're not...for your own registration and accountability you have to be able to say 'they can't do it'. (M)

Yes you have to do it, for everybody's sake you can't pass them. (M)

But this study also showed that sometimes these decisions were not straightforward. Educators identified that sometimes mentors felt unable to fail students because earlier assessment tools related only to practice, which was deemed satisfactory, rather than professional standards, the area where students were failing.

I was talking to a mentor last week and she had a student who last year got through because although she was advised about attitude and conduct she could still get through...whereas this year I could have referred her. (Ed)

I had one mentor who went out in her lunch break and bought a toothbrush for a student and said, 'This placement has a no smoking policy. You may not smoke within the grounds and I know you were smoking in the back of the kitchen'. (Ed)

Unkempt, late, holes in tights, she says she can't afford... (Ed)

Clearly the tools have to be appropriate for the job. It would appear that previous assessment tools were too narrow in their focus. The new practice profile tool has a much wider scope and gives mentors the authority to assess on a wider range of professional as well as practical activities.

Mentors like it...they feel empowered now they are able to make decisions on professional judgement...now they are being listened to...they like that. (Ed)

Summary: the tripartite nature of practice learning

- Good quality mentorship is important for successful student development in practice:
- Students' perceptions of practice are sometimes different to reality. Some students might expect fast-paced, acute scenarios, not older people with complex needs. When they begin education programmes, some students may have little experience of life, illness or death;
- Mentors help students understand the importance and significance of traditional care giving;

- Some students struggle with the competing demands of work and study. Physical and emotional demands may be underestimated;
- Educators support mentors and students in practice;
- Educators provide pastoral care for students. Role changes have lead to uncertainty. There are concerns that students may suffer if educators are no longer able to provide this support when students are in practice;
- Educators provide valuable links between higher education and practice;
- Mentors are aware that students are more likely to take control of their own learning with new practice profiles;
- New practice profiles redress the balance between higher education and practice;
- The profiles confirm mentors' authority for assessing practice and recognise their roles as co-educators;
- Mentor preparation and regular updating are important;
- Mentors must be confident to fail failing students;
- Mentors must refuse to complete assessments for students they do not know;
- Failure to fail puts students, colleagues and patients at risk,
- Local strategies to improve mentor access to updating programmes should be developed;
- Assessment tools must be fit for purpose, with a broad focus – mentors must be able to assess all areas of students' professional practice.

Learning environment

The literature indicates that the practice learning environment is central to effective student learning (Mogensen 1994). While many students enjoyed the learning environment, several issues emerged that could prove barriers to learning, from the perspectives of all groups. These have been collated into sub-themes and are explored below.

The learning environment

Most students really enjoyed their practice placements:

That's the best bit...being with the patients. (S).

The learning environment was supported by mentors and other health care teams, including doctors, physiotherapists and occupational therapists.

On our wards students go and look at procedures and things.

The doctors explain the procedures to them. (M)

We have pretty good feedback from students. They like this area, there's so much to see and do. (M)

Student nurses' previous practice experience

It could be expected that previous practice experience would be beneficial, but some students who had been health care assistants had difficulty finding new roles and new identities as student nurses. They sometimes felt they were just 'another pair of hands' (S) when working on the wards. Feeling this way made them question their decision to undertake nurse education programmes, but good mentorship could help students to adjust to their new roles.

Mentors found that previous experience as health care assistants could be a mixed blessing. Students with experience were more likely to be comfortable in practice settings but mentors were cautious. They found that sometimes old habits had to be broken before new learning could occur. Mentors accepted that students came from a variety of different backgrounds and that their abilities varied enormously. Mentors would therefore assess students individually and give 'direction and guidance according to their need' (M).

Mentors also found that students' needs varied throughout their education programmes. They were reluctant to generalise but mentors did notice patterns of learning that were common to many students across the three years. They found that first year students could be easier to manage because they were 'so enthusiastic' (M) even though they needed a lot more of the mentors' time at this stage. Mentors also found that third year students were much more likely to suffer from stress and might lack confidence at this stage of their development. Mentors wanted to give 'lots of support' (M) and to help students get through this difficult time. The mentors in this study were very understanding and supportive of students and their different learning needs.

Valuing hospital over care home placement experiences

Students were generally apprehensive about moving between acute settings into care homes. This issue was discussed with educators who thought that, in general, students were likely to have a mixture of placements across the three year education programme and that acute settings and care home placements were of a comparable quality in terms of learning opportunities and support. Students' perceptions seemed based on the belief that there were fewer learning opportunities in care homes but their experiences did not necessarily support this view. What seemed more important to the success of any placement experience was the quality of the mentorship. When students were

placed with mentors and associate mentors who helped them and worked with them, they had enjoyable experiences regardless of whether the setting was acute or a care home.

One student described her experiences working in a care home:

My associate mentor was brilliant and the other staff nurses were lovely. They'd come and say I'm doing this injection, or doing this, come and do it with me. (S)

But another student was less fortunate:

I didn't learn anything. I never worked with my mentor at all; I was just left... whenever I asked if there was anything I could do I was told 'no, not really'. (S)

This student correctly sought help from the practice educator but, in this instance, the mentor remained distant and unhelpful. She felt particularly unlucky because her friends were working in different care homes and they were having good placement experiences. It would appear that the quality of the mentorship was the most important factor to achieving successful student learning rather than the nature of the placement.

Students feeling undervalued by some placement staff

There were a few unfortunate examples of staff behaving unprofessionally around students. One student was really upset by a colleague who criticised her lack of ability when really she was just new and feeling nervous. Another was dismayed to hear a doctor being rude to a senior nurse colleague. They were alarmed that senior colleagues would speak to each other in such an unprofessional way. A different student reported that, when a doctor was rude to her, she challenged him and he apologised. She said that although she was a student she refused to be spoken to that way. These comments caused students to question whether they were right to pursue a career in nursing. These were indeed regrettable examples of unacceptable behaviour by a few members of staff, but most were considerate towards students.

Increased student numbers in practice placements

The mentors who took part in this study were enthusiastic about working with students but they found there was always too little time for everything.

It's the same old thing – staff and time. (M)

These mentors seemed adaptable and were willing to give students as much or as little help as they needed, even when the mentors themselves had become tired. They had found that some students could 'tag along with you' (M) but that others 'needed more' (M) and so could be 'more time-consuming' (M).

It's hard work because you have to constantly explain and I find I'm worn out by the end of the shift from talking so much and from concentrating. (M)

But other students were not so fortunate:

My mentor didn't really have a lot of time to sit down and speak to me. She was the sister and trying to get her to sit down was...a nightmare. (S)

Although time was an issue, when these mentors were asked if they ever had more students than they could manage, they said, 'No, that's very rare...generally it's okay' (M).

These mentors also wanted students to have good learning experiences. They refused to let students work as just 'another pair of hands' (M) saying, '...it's not acceptable' (M). They were very aware how easily students could be drawn into work that did not necessarily reward them or help with their learning. These mentors made sure that students were able and encouraged to pursue appropriate learning activities.

The mentors who took part in this study seemed to be particularly sensitive to the needs of students and provided them with good quality learning experiences. However, students reported a mixture of good and bad experiences with the mentors they encountered. Quality mentorship seemed to be one of the most important factors contributing to good experiences in the learning environment. When mentorship was good, student learning was good. When mentorship was poor, students struggled. It appeared that, although many students aspired to work in acute settings more than care homes, their learning was shaped more by the quality of the mentorship than the location.

Summary: the learning environment

- Most students really enjoyed their practice experiences;
- A few examples of unprofessional behaviour were given but more usually students were supported by all members of professional teams;
- Previous practice experience was not necessarily an advantage. Students could benefit from familiarity but would sometimes have to

'unlearn' practices before new learning could occur. It could also be harder and take longer for them to adapt and identify with their new roles as nurses;

- Mentors in this study were flexible and adaptable to the different learning needs of students. However, students reported a few negative experiences with mentors who were not so enthusiastic about their roles;
- Hospital (acute) placements were sometimes valued over care home placements (by some students and some mentors). There were perceptions of greater learning opportunities in acute settings, but it emerged that the quality of the mentorship was likely to have a much stronger effect on the success of the placement learning experience;
- Student learning was enhanced by good mentorship;
- Concerns were raised that increased student numbers could be problematic for mentors. However, mentors in this study said they only rarely experienced problems with student numbers.

Using the tool

Any new assessment tool was bound to bring with it some degree of anxiety. Despite efforts by nursing programme education staff and placement-based educators, preparation of placement staff for use of the tool was less than comprehensive. This meant that mentors and students were essentially learning together. Whilst this worked for some, it was less satisfactory for others, particularly during students' first placements. However, some issues were addressed quickly, resulting in a better experience in the latter part of the year. These logistical issues associated with the introduction of the tool have been summarised under a number of sub-themes.

Learning to use the tool

The new practice assessment tools were not expected to cause mentors and students too much difficulty. Consideration had been given to whether or not the new tools should be completely revamped and the decision was made to retain a similar format to previous practice profiles in order to avoid unnecessary anxiety. When mentors first looked through the tools they thought they looked 'fairly straightforward' (M) and in many respects this was true, but there were logistical issues that had been underestimated by all parties and so a degree of confusion and misunderstanding did occur in the short term.

Confusion and misunderstanding

Confusion and misunderstanding, based on mentors' previous experience of practice tools, arose around issues like whether practice profile outcomes should be hand written or somehow typed and pasted into place, whether bullet points were appropriate or whether examples

should be written in essay form; these were small but significant difficulties for users. There was also concern about how some mentors were awarding grades. A few students reported that mentors were awarding them grades similar to those they had previously received, regardless of their current performance. This practice applied particularly where mid-range grades were awarded and only one assessor was required.

The two lowest grades (failure) and two highest grades awarded (for good and excellent practice) required second marking. There were mixed responses to the need for second marking. A few mentors felt threatened by this, perceiving the idea as undermining their authority and their ability to reliably assess. But others welcomed the opportunity to share the responsibility and for practice to be awarded the same scrutiny as written assignments.

Another difficulty related to mentors' previous experiences of practice assessment. For a number of years students were required to produce an 'academic' piece of written work to justify each outcome. However, the new practice profiles sought to move away from this method of assessment and instead encouraged verbal justification and verification between student and mentor, with just a simple record of the achievement being written down. This change posed quite a challenge for some mentors and it took a while for them to realise that, provided they were active participants in this process, it was an equally sound and possibly more rewarding engagement than previous assessment mechanisms.

Student preparation

Personal tutors gave students all the documentation they would need for their practice placements. At this time, students would ask questions and find out exactly what they had to record and how this should be done. However, some tutors were not familiar with the new practice profiles so they were unable to help the students. This put students in a difficult position when they entered practice because some mentors looked to them for guidance. The lack of preparation undoubtedly caused problems in some areas but educators responded quickly, improvements were made and the situation continues to be monitored.

Summary: using the tool

- Educators' attempts to prepare mentors for the introduction of the grading practice profile tool proved relatively unsuccessful in some areas;
- There were assumptions that the introduction of the tool would be straightforward, but difficulties were underestimated;

- Some logistical difficulties were experienced in the short-term;
- Mentors were challenged to reconsider and re-evaluate their roles in the practice assessment exercise;
- Some students were inadequately prepared to use the new tools before they entered practice. This led to difficulties with mentors who expected students to explain how the tool should be used.

Discussion

This evaluation provides a snapshot of the experience of mentors and students using a new practice assessment tool. The methodology provided some rich, in-depth data, albeit from a small sample of potential participants. The data from the educators provided a very useful insight into the logistics of implementing, supporting and managing a significant change to the way practice education in nursing is assessed. Whilst reflecting only one year of the programme, it is pleasing to note that, overall, the move to grade practice was viewed by all groups very positively. Predictably, some issues need to be addressed.

Strengths of the assessment process

The findings indicated that, from the perspective of mentors and educators, the new tool appeared to have made the students more focused on their responsibilities within the assessment process. Independent learning appears to be evident and represents a key focus of learning within higher education; if the tool promotes this way of working, this is to be applauded. Obviously, as new students, they had no comparison, but the findings from the mentors indicate that they could see a change in attitude compared with previous students using the old tool.

Another strength of the tool was that it was valued by all groups for rewarding good practice in the way that good academic practice is rewarded, which is a key message according to Glover et al. (1997). Whilst direct observation of skills and competencies is made, the judgement concerning the grade is given over the full time of the placement, because observation over time is a more reliable method of evaluation (Glover et al. 1997).

The tool also helped to identify weak students at an early stage to enable additional support to be given. The challenge of 'borderline' practice, however, remains. The pass/fail border has always been a challenge for educators; grading does not affect this but it does offer advantages. Students and mentors welcomed the opportunity to recognise and reward good practice through grading.

Valuing practice education

One key impetus behind the design of the assessment tool was to value the expertise of the mentor to assess practice competence. The education team were aware that a pass/fail system did not do this and that students' overall grade for the programme thus suffered. The central theme of the findings, 'valuing practice', shared by all groups – students, mentors and educators – would appear to have addressed this issue. In

this respect, the introduction of the grading practice tool can be judged to have been a great success. However, a significant limitation is that only adult branch students and mentors volunteered or were able to participate in the evaluation. Any extension of the evaluation would need to address this.

Findings from Glover et al.'s (1997) study indicated that, following the introduction of grading, students' performance was rated higher than expected across all domains. Possible reasons for this were explored and included:

- Academics (who are largely responsible for defining the parameters of assessment), clinicians and students may hold differing views about practice areas (an academic view of holistic individualised care verses the student and clinician view of getting through the workload);
- Speculation that competence may be regarded by academics as a standard/basic requirement of practice as a registered nurse, whereas clinicians may view the same competence as an achievement with status.

In introducing this tool, it was accepted by the programme team that more students may achieve higher overall marks than previous cohorts and indeed initial analysis of exam board results from 2006 indicate some support for this trend.

Preparation of mentors for their role

Any assessment system has to have good quality assurance mechanisms. Welsh (2003) highlighted the issue of mentors passing nursing students when their practice or behaviour was not up to professional standards. He discussed the worrying possibility that this practice might be commonplace, perpetuated by beliefs that failing students was a higher education institute responsibility and not the clinicians', when in reality the responsibility was shared. The findings of this evaluation did not support this view in the sense that the participating mentors expressed no concerns about failing students. Indeed, they saw this as a challenging but important part of their role. Obviously, whilst reassuring, these findings must be treated with caution given the numbers involved. Further work with greater numbers would be useful.

As the literature demonstrated, quality mentorship and assessment depends on well prepared and fully informed mentors (Bondy 1984). Equally, the assessment tool has to contain clear and unambiguous descriptors that must be applied consistently by the assessor to compare students' performance against the descriptors (Bondy 1983). The new practice profile tool contained a number of descriptors to help the mentor

decide what grade applied to the student. However, the findings indicate that these were not used widely, raising concerns about reliability. Clearly this is an issue for mentor preparation. Burns (1992) highlighted the need for mentors to learn what was required of them to guide and support students. The mentor role is vital as a 'gatekeeper' for the profession in terms of promoting and assessing competent practice standards in learners. The findings indicate that some mentors, whilst clearly dedicated and committed, were in some instances not fully conversant with the new tool. Within the limitations of this evaluation, it would seem that personal and corporate responsibility for annual mentor updating seems unclear and subsumed by the more pressing priorities of clinical practice.

Some students reported instances where the grading structure was not used correctly, resulting in inappropriate awarding of lower grades. Glover et al. (1997) also found that clinician comments did not match the marks given for the performance. Clinician comments tended to reflect traditional assessment frameworks which suggested a lack of preparation in using the assessment tool and a lack of understanding about the assessment criteria. The evaluation found a similar trend, where excellence in particular was not reflected in the grade awarded, although it was verbalised and sometimes reflected in written comments. This seems to relate to a misunderstanding about the use of the grading range with first year students and reflects again the need for better mentor updating.

Unlike some other health care professions, the statutory body for nursing is very clear that all staff acting as mentors should receive preparation and annual updating (NMC 2006). Sound mentorship is key to student success. Mentors help students succeed. They must also fail students who fail to meet required standards. Whilst there is a clear mandate for mentor preparation, findings from this evaluation show that actual implementation of this policy in some areas supporting SHSC students is problematic and requires some joint working between SHSC and practice partners to rectify this.

Reliability

Mentor preparedness (or otherwise) for use of the tool clearly impacts on reliability of practice assessment. The findings indicate that mentor updating did not appear to be a priority for mentors personally, given the considerable competing demands on their time; nor was it facilitated readily by the placement providers. It was possible to use the new tool without any preparation and the fact that this is possible is of some concern. This impacted on some students as their marks were capped at grade three because their mentors did not realise they could use the

higher range of marks. In the event, this will make no difference for these students because their honours classification (if on this route) is calculated only from the marks in the last 18 months of the programme. However, clearly this must be addressed in time for Years 2 and 3 of the September 2005 intake.

Related to this is the issue of second marking. This is an essential quality assurance mechanism but the findings indicate that this may not have been used due to logistical difficulties in practice. Students need to be aware of appeal mechanisms if they believe that they have been awarded a lower grade because second marking was not possible. Equally, placement providers need to be made aware of this element of the assessment and the resource implications it involves to make this work in a fair manner for all concerned. Fail grades also require second marking; compromising the implementation of this is unacceptable.

Supporting student experience

In the findings associated with the 'tripartite nature of practice education', each party seemed aware of their contribution but the joining up between each element could have been improved. Communication mechanisms between the university and mentors and the university and students on placement were perceived to be vague. This matter has been subsequently addressed by the programme team with the appointment of a unit coordinator related to the practice units as a central point of contact. The findings revealed that some students found the demands of study, placement experience and personal life considerably challenging. The programme team may wish to use the findings to revisit the preparation of students for their first placements and to review systems of pastoral support, as the latter in particular were perceived to be weak by the participants involved.

The finding that prior experience is not always beneficial is interesting and reflects teacher perceptions when supporting some 'long-serving' health care assistants in the development and critique of their clinical skills as student nurses. In contrast to this, some students with limited life experience found considerable challenge in interacting with different age groups and in putting themselves forward to participate in care. SHSC positively encourages the possession of some care experience before starting the programme but, despite this, the evaluation indicates that media influences tend to be a powerful factor. This is well known and carefully considered within the recruitment process, and opportunities to reflect on this are provided within the programme.

Limitations

Given the sample size, it is not possible to generalise from this evaluation. This was not, of course, the aim; to recap, the aims of the evaluation were:

- To explore student, mentor and education staff experiences of their use of the new profile;
- To consider their views on the grading of practice using this tool;
- To learn lessons to enhance on-going implementation.

The methodology was appropriate for these aims and the data that emerged provided pertinent and timely information for programme managers to act upon and to inform initial mentor education and on-going mentor update sessions.

In reviewing the findings, however, a number of limitations must be acknowledged. The most significant limitation is that the student and mentor participants were all from the adult branch sector. All branches and placement areas had the opportunity to participate, although access for some may have proved difficult. Mentors in particular proved to be difficult to access because it appeared that staff shortages and limited numbers of qualified staff in practice areas created problems in attending focus groups.

Other limitations include the fact that findings were generated from reported practice and, as such, may be subject to distortions of memory. Furthermore, not all individuals at all focus groups contributed equally and so the findings reflect those contributions that were made.

Constraints

There was no external funding for this project and the design reflected this constraint. In addition, it was important that the project was completed within one academic year in order to influence the first year experience in an on-going manner, as well as to inform future use of the profile by subsequent students and mentors. Therefore, whilst it would have been interesting to ensure mentors and students from all branches contributed to the findings of the evaluation, neither time nor resources were available to ensure that this was the case. However, even with these limitations, much pertinent information was collected and has been used to enhance current practice and plans for the future.

Dissemination of Findings

Initial findings were shared with the SHSC Nursing Academic Group in July 2006 and these were then fed into subsequent programme planning

meetings. These were also shared with NHS partners at the annual NHS contract management review in November 2006. Staff involved in mentor education have also been made aware of key themes from the evaluation and are using these to inform on-going curricular development. In addition, an article for *The Mentor* magazine was distributed in December 2006. This article also appeared on the SHSC website.

Looking more widely, copies of the project report will be sent to all Trust nurse executives, SHA representatives, education facilitators for Somerset, Dorset and South Wiltshire, and key players within the independent sector. Conference presentations were planned; one conference paper was delivered at a UK-wide education conference in September 2006 and another at an international education conference in July 2007. Publications in academic journals are also planned for 2007.

Conclusions

The evaluation of a new assessment tool for practice can only be viewed as positive. No previous evaluation has been undertaken by the nursing team and the learning from the experience has been significant, enabling the programme to institute solutions to problems in a timely manner.

The number of themes were shared by all participant groups, the most significant being that the new graded practice tools were well received. This has succeeded in putting the focus and value back on practice, and has reinstated balance between theory and practice. The tool may have led to an increased emphasis on the role of mentors as co-educators and may have contributed to students being more enthusiastic and in control of their learning. It may also have contributed to the reaffirming of practice areas as important learning environments. Whilst a range of general difficulties and misunderstandings were experienced initially, these are being addressed which has resulted in some reorganisation of placement learning responsibilities within the programme team.

Whilst this evaluation has provided an in-depth picture of placement learning and assessment, the limitations in terms of numbers and range of participants make generalisation of the findings problematic. Hence, it is proposed that a second phase of the evaluation takes place using a survey tool based on the findings from Phase 1, administered to a wider group of mentors and students. It is hoped that this will be completed by summer 2008.

Recommendations

Retain the practice tool with grading

- Build upon strengths within programme organisation;
- Use findings to inform staff development for personal tutors;
- Improve student preparation for their first placement as well as for using the tool.

Reliability issues

- Programme team need to institute moderation mechanisms to check that comments reflect grades awarded;
- Students need to be aware of appeal mechanisms;
- Placement providers need to review mechanisms to enable second marking.

Communication and support mechanisms

- Programme team need to review systems for pastoral support for students;
- Programme team need to review communication mechanisms with clinical settings and advertise these;
- Mentor support from placement providers should be reviewed in the light of the withdrawal of practice educators.

Mentor preparation and updating – policy

- Develop a joint strategy between SHSC and practice partners to facilitate mentor updating education;
- Mentor updating for all 'live' mentors should become part of mandatory annual training;
- Personal responsibility for accessing updating should be monitored via annual appraisal mechanisms.

Mentor preparation and updating – content

- Emphasise the grade descriptors and their use in justifying allocated grades to improve reliability;
- Emphasise that the tool is designed for common foundation programme (CFP) students and therefore the full range of grades can be used.

Extended evaluation proposed using quantitative methods

- Survey a wide range of mentors on use of the tool, including assessment of borderline students;
- Ensure there is a mentor and student sample from all nursing branches.

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