School of Health and Social Care

Assessment of Practice in Pre-Registration Undergraduate Nursing Programmes.

Phase 2 Evaluation:
Survey of students' and mentors' experiences of grading student competence in practice.

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Contents

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The evaluation team would like to thank the students and mentors who gave their time to complete and return the questionnaire, as well as the practice and university education staff who assisted in its distribution.

Executive Summary

Context

Local and national concerns regarding competency in newly qualified practitioners provided the impetus for the undergraduate nursing programme team at Bournemouth University to radically change the practice assessment tool as part of a curriculum rewrite in 2005. Alongside the introduction of the new practice profile, an evaluation strategy was implemented with two stages; Phase One focused on year one of implementation and reported at the end of that year (2005-6). These findings were used to inform mentor education and to amend the tool for new students and those moving into year two. This phase used a qualitative approach to collect data from focus groups with students and mentors (Adult Branch only), and practice/HEI educators concerning their experiences of using the grading practice assessment scheme. Phase Two utilised the qualitative findings to develop a questionnaire survey. Questionnaires were selected as the research tool in order to access greater numbers of students and mentors from across all branch programmes. Education staff was not surveyed in this phase.

Purpose and project aim

The purpose of the project was to evaluate the impact of the new practice assessment scheme from the perspective of the users and to make suggestions to key stakeholders for quality improvement where necessary. Phase One of the evaluation involved small numbers and only Adult branch students; whilst the findings were informative, it seemed important to test these out on a wider sample.

The aim of Phase Two of the grading practice evaluation was to explore:
- mentor and student experiences of using the assessment tool across all nursing branches
- the impact of quality assurance processes

Pertinent literature

An overview of the historical and current context of practice assessment for nurses in the UK was provided, including the policy literature from the statutory body. Research on practice assessment in nursing was found to be relatively limited particularly concerning the grading of practice. Key studies include Bondy (1983; 1984) and Hillegas & Valentine (1986) from the USA, Glover et al. (1997) from

Australia; from the UK, Burns (1992) and Scammell et al. (2007). All studies had limitations but generally the notion of grading practice was well received by users; however there were concerns about quality assurance processes particularly around reliability as well as issues concerning mentor/practice assessor preparation. In light of an increased national emphasis on nurses' competency in practice, empirical work that evaluates a new practice assessment initiative is timely. Whilst of value locally in terms of reviewing and improving processes, the findings may also interest colleagues elsewhere.

Project design

A questionnaire survey of mentors and year two and three nursing students was undertaken to investigate their experiences of using the grading practice assessment tool. All branches of nursing were successfully targeted for inclusion using convenience sampling, but no learning disability students opted to participate. Mentors were accessed via an annual mentor conference; students were accessed via tutor groups.

112 (86%) of the 130 mentors available, completed and returned the questionnaire. The branch representation was adult nursing (62.5%; n=70), Mental Health (21.4%; n=24), Child Health (17%; n=19) and Learning Disability (1.8%; n=2). Questionnaires were distributed to 210 students; 107 were completed (51% response). The sample comprised Adult branch (72%; n=77), Mental Health (19.6%; n=21) and Child Health students (8.4%; n=9). The response rate broadly reflected the proportion of students enrolled within each branch of the targeted cohorts. Most student respondents were undertaking year 3 of their programme (70.1%; n=73); the exception was Child Health where all students were undertaking year 2.

As an evaluation study, formal ethical approval was not sought; however permission was granted to conduct the evaluation by the Associate Dean for Nursing, and the educational leads within placement areas. There was a project steering group with representatives of all parties including students and mentors; their role was to oversee the project process and to liase with colleagues within their organisations. Quantitative data was coded and inputted into the Statistical Package for the Social Sciences (SPSS for Windows version 15.0); where possible chi-square analysis was undertaken to explore whether the results were significant. Qualitative aspects of the questionnaire were transcribed and a content analysis was undertaken.

Given the sample size, it is not possible to generalise from this evaluation. Others may judge transferability to other settings. In reviewing the findings, a number of limitations must be acknowledged. The most significant limitations are that no Learning Disability students opted to participate and the response rate generally from students was not as high as anticipated (51%). This is however a reasonable response rate for a questionnaire survey but if time had permitted, an extension to the convenience sampling may have been beneficial. Other limitations include the fact that findings were generated from reported practice and, as such, may be subject to distortions of memory.

Findings

Five key areas emerged from the findings: questions around mentor education indicated that participation in updates was high although the sampling process may have introduced some bias. Indeed poor uptake was identified in Phase One, reflecting other studies and anecdotal evidence for the programme team. The findings around support for practice education were mixed; mentors appeared to want more support than was available. Student experience varied according to branch – Mental health students feeling most supported and Child Health the least. However the use of neutral grades was high in both mentor and student groups indicating some cause for concern. Perception on use of the profile in terms of whether it was fit for purpose indicated positive responses overall but some confusion from both students and mentors as to the status of the written sections in comparison with skills performance; the latter was perceived as the top priority.

The fourth area focused on how grading 'worked' and yielded some valuable perceptions. Generally respondents liked and wanted to grade or be graded in practice. Whilst the majority of mentors claimed to use the descriptors and found them useful, the number who did not use them was of concern. There were mixed perceptions of the appropriate use of second marking, some students perceiving that they were given middle grades due to logistical problems in accessing second markers, although this was not supported by the mentor data. The vast majority of mentors expressed confidence in grading students. However a significant minority responded neutrally or negatively or did not answer the question when asked whether they felt confident to fail a student. This finding is important when considered alongside the neutral response to feeling supported.

Finally accountability within the assessment process appeared strong, although at times profiles were signed by staff who had not worked with the student. It is unclear however whether these mentors were primary mentors or those functioning as second markers.

Overview of discussion

The Phase Two evaluation was broadly supportive of the Phase One findings but extended these to other nursing branches and has provided more useful detail on some of the issues underpinning the grading practice scheme. Quality assurance is a prime issue: the evaluation has shown that reliability of the tool could be improved if the descriptors are clear and robust processes are in place to ensure these are consistently applied. Second marking is another feature of reliability and perceptions varied as to whether this was utilised as much as required and is an issue for programme and placement staff to consider, particularly in the light of inter-branch discrepancies. Students and mentors should be encouraged to constructively make any concerns known. Education around grading and support for mentors was another key area; there perhaps can never be enough support but if any staff have concerns around failing students, this needs to be addressed. The reasons for differing perceptions of support across branches, needs to be explored further. Overall the grading of competency in nursing practice yields far more benefits than problems. It is an innovative scheme, not without challenges; both evaluation phases provide valuable data to focus quality improvement effectively.

Conclusion

The evaluation captured the views of mentors and students representing all nursing branches, with the exception of Learning Disability students. The issues raised across the branches were broadly similar, notably that the notion of grading practice was welcomed as a means of valuing the practice element of the programme, although implementation was not without challenges. These are reflected in the focus on the quality assurance processes and in fact this is where the branch experience differs most. Mental Health students felt the most supported in placement, were the most likely to receive grades that required to be second marked (indicating full use of the grading range) and were most satisfied that mentor comments matched the grades awarded. In contrast Child Health students were the least satisfied in all these parameters. Adult branch students gave mainly neutral responses which indicate some underlying issues worthy of further investigation.

It can be concluded from the mentor data that experience across branches did not differ markedly. The sample accessed updates and most felt confident in grading practice. However almost 18% did not feel confident about failing students and almost another 20% gave a neutral response to this question, indicating a need for further staff development in this area as well as a review of processes designed to support mentors in making these judgements.

Recommendations

- Explore ways of engaging learning disability students in sharing their perspective on the practice assessment tool and processes.
- Increase transparency of communication channels between placement providers and the university regarding practice assessment.
    - Flowcharts or algorithms for mentors and students might be useful
    - Include these on the back of each practice profile
- Review support mechanisms for students within placements. Identify best practice and include minimal standards on the clinical audit documentation to increase parity between placements and branches.
- Investigate peer support schemes for students in practice which include preparation and support for those undertaking this role.
- Child Health programme team should review support for students with practice partners to identify specific issues for improvement.
- Review level descriptors with students, mentors as well as programme teams to ensure clarity of language and processes.
- Re-emphasise the use of descriptors in mentor education as well as student preparation for placement
- Review criteria and processes for second marking and emphasise within mentor education.
- Disseminate HSC audit of practice profiles on a placement provider organisation basis and include a focus on quality of feedback in relation to grade awarded.
- Review current practice around preparing and supporting mentors in failing students and develop an action plan for implementation over the next academic year.

1   Introduction

Local and national concerns regarding competency in newly qualified practitioners provided an impetus for the undergraduate nursing programme team at Bournemouth University to radically change the practice assessment tool as part of a curriculum rewrite in 2005. Whilst practice accounted for 50% of the programme, until this time it was assessed on a pass/fail basis. Feedback from stakeholders indicated that excellence in practice was not being fairly recognised under this system; the final diploma result or degree classification in effect reflected the theory element of the programme. Further it was proposed that the introduction of grading criteria may more effectively support mentor decision making regarding the extent of student competence through the use of grading descriptors.

Alongside the introduction of the new practice assessment tool, an evaluation strategy was implemented with two stages; Phase One focused on year one of implementation and reported at the end of that year (2005-6). These findings were used to inform mentor education and to amend the tool for new students and those moving into year two. Phase One used a qualitative approach that involved separate student, mentor and practice/HEI education staff focus groups. Unfortunately although not the intent, only students from the adult branch participated. Four themes emerged: 'Valuing practice' was the central theme; all groups perceived the move to the grading of practice as positive, particularly in terms of valuing the mentors' role and reflecting excellence in practice. There were some logistical concerns around implementation and these were reflected in the other three themes: the 'tripartite nature of practice learning', the 'learning environment' and 'using the tool'. The report (Scammell et al. 2007) made a number of recommendations including a wider evaluation based on the themes, capturing participants from all nursing branches.

This report concerns the Phase Two project; building upon the qualitative findings a questionnaire survey was developed. Questionnaires were selected as the research tool in the hope of reaching greater numbers of students as well as mentors from across the branch programmes. In the interest of being concise, presentation of tables in support of the quantitative findings has been selective; keys points are highlighted in the text. The report concludes with a short discussion of implications of the findings and some suggested recommendations for future practice.

2   Literature Review

To purpose of this chapter is to provide some context for the report; pertinent policy and research literature concerned with the assessment of pre-registration nurses in practice will be briefly considered, focusing in particular on the concept of grading competency in practice.

Whilst curricula content in pre-qualifying nursing programmes has integrated knowledge and skills for practice for some time in the United Kingdom (UK), historically knowledge learned in the classroom and practice skills learned mainly on placement have been assessed separately. Further the value given to each component has differed, the latter being commonly graded on a pass/fail basis. The effect is that the students' overall degree or diploma classification is determined by their performance in the theory assessments (Girot, 2000). Designing reliable and valid practice assessments represents a considerable challenge given the diversity of nursing practice and this may account for a reluctance to move to a system where theoretical and practice components receive equal value as this would inevitably involve the introduction of tools to grade practice with associated complexities around quality assurance (Fordham, 2005; Scammell et al., 2007).

Assessing nursing practice in the UK: historical overview

A range of strategies have been used to assess student nurses in practice over the past four decades. According to Price (2007) practice assessments in the 1970s focussed on tasks (e.g. aseptic technique) or observation of the student on a single shift (e.g. total patient care). This approach afforded the student opportunity to excel on a given day and included set parameters to be followed by both assessor and student whilst working in what could be argued as a contrived situation. Similarities between this method of assessment and the more recently favoured Objective Structured Clinical Examination (OSCE) exist in relation to the assessor observing a snapshot view of practice which tends to centre on a task or series of tasks (Mitchell et al., 2009). However McKenna et al. (2006) argue that over time nursing has become more complex requiring advanced decision and critical analysis skills; the assessment of nursing practice cannot therefore focus on the student's ability to perform a task in isolation. Price (2007) adds that performance is not merely knowing and showing, but involves combining a range of knowledge in context-cognitive, affective and psychomotor skills. The craft of nursing occurs when the

student combines all of these with clinical observations and experience and applies them to a client centred situation.

Recognising the limitations of one-off task assessment, continuous assessment of practice was introduced in the 1980s with the responsibility of passing or failing the student primarily resting with the assessor in practice (Chambers, 1998). The danger of this approach is that students may not hone particular skills as the focus moved away from specific tasks; many universities therefore also include OSCEs as part of the practice assessment process. However academic credit is often not awarded within the practice assessment scheme as it is not graded (Fordham 2005); an exception to this is the programme offered at Bournemouth University which has graded practice since 2005; however the team did not underestimate the challenges this may involve, hence a two-stage evaluation was designed to run concurrently with the programme implementation..

Fitness for practice at the point of registration

Significant concerns have been raised nationally around the fitness for practice and purpose of pre-registration nursing students on qualification (Duffy, 2003). The challenges facing nursing in the twenty first century are considerable. It is recognised that nurses must meet the complex, technical and ever changing needs that the current health care environment presents (Maben & Griffiths, 2008). Public protection is essential and so ensuring that students are deemed fit for practice and purpose is central to all pre-registration nursing programmes in the UK (NMC, 2008). Competence is vital to ensure the safe and effective delivery of client care by nurses as they are expected to work professionally and autonomously (Fordham, 2005). Measuring competence however, can present a challenge to nurse educators writing programmes and mentors working with students on a day to day basis.

The Nursing and Midwifery Council (NMC) is the UK statutory body responsible for the professional regulation of nursing. Its key tasks include setting standards and guidelines for nursing and midwifery conduct and assuring quality in nursing and midwifery education. Two sets of Standards are particularly pertinent to pre-registration education as they seek to address issues concerning competence at the point of registration. All students must meet the *Standards of Proficiency for Pre-registration Nurse Education* (NMC, 2004) prior to entry to the Register. Central to all nursing curricula lays the challenge of how best to enable students to meet these standards in both theory and practice and how they can be effectively assessed.

The practice assessment tool is designed around these standards. However the process of assessing students in the workplace in order to ensure that they are competent, analytical individuals, able to respond to change, is recognised as worthy of scrutiny (Girot, 2000).

Assessment strategies to measure competence in practice are a subject of considerable debate. Much of the literature focuses on the skills required by the practice assessor; difficulties such as subjectivity (Dolan, 2003) and observer bias have been noted (Clemow, 2007; Calman et al., 2002). This view is supported by Rutkowski (2007), who cites direct observation of a student's performance in practice as a measure of competence but believes it is not uncommon for one mentor to pass a student when another would fail them, raising issues of reliability. Whatever assessment strategy is used mentor preparation and support is therefore a key factor in its implementation.

The *Standards to support learning and assessment in practice* (NMC, 2006; 2008) are also significant in ensuring fitness for practice on registration; these embody a framework of the knowledge and skills required by educators to support students undertaking NMC approved programmes that lead to registration or a recordable qualification. The Standards define both the responsibilities of Higher Education Institutions (HEI) and Placement Providers. In response to concerns regarding fitness for practice of newly qualified nurses, a new role of 'sign-off mentor' was introduced to make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice for entry to the NMC register. In order to facilitate communication from mentor to mentor an ongoing record of achievement for students was also devised. These Standards also strengthened the expectation that mentors must maintain and develop their knowledge and skills as practice assessors. Mandatory annual updating was introduced and a responsibility was placed upon mentors to demonstrate to their employers how they have developed their knowledge, skills and competence; this is considered as part of a triennial review of their mentorship role.

Strategies for assessing practice

The strengthened NMC Standards are to be welcomed but the structure and process of practice assessment of nurses is largely left to the discretion of individual HEIs. Recent literature in this area is limited, making the sharing of best practice difficult with the consequent danger of different institutions 'reinventing the wheel'.

The literature available focuses on what to assess as well as issues of rigour within the assessment strategy. Watson et al. (2002) note that the measurement of clinical competence is widely debated amongst nurses and other health care professions; this can vary from observing a series of tasks over a period of time to a one-off assessment focusing on a complex nursing activity.

There is limited literature concerning the grading of practice in nursing. Bondy (1983) from the USA conducted a 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. 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 leniently. 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 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'.

Glover et al. (1997) describe an Australian study that involved the grading of final year students in practice. Findings from this study indicated that across all domains students' performance was rated higher than expected. 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 findings also indicated that clinician comments did not match the marks given for the performance suggesting a lack of preparation in using the assessment tool and a lack of understanding about the assessment criteria. The study also found that students received higher grades for their clinical work than they received for the theory.   In conclusion, this study highlighted the importance of mentor preparation and quality assurance processes.

Burns (1992) from the UK 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 (1992) emphasised 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.

Finally Scammell et al. (2007) describe Phase One of a two-part evaluation of a tool to grade student performance in practice. This phase focused on first year students and utilised a broadly qualitative approach to data collection to explore perceptions of the grading practice process from three perspectives- mentors (n=10), adult nursing students (n=70) and educators (n=20). The methodology provided some rich data, albeit from a small sample of potential participants. Overall the move to grade practice was viewed by very positively, notably by mentors and students. The data from the educators provided a useful insight into the logistics of implementing, supporting and managing a significant change to the way practice education in

nursing is assessed. Following a process of thematic analysis, four key themes emerged: Valuing practice (core theme), tripartite nature of practice learning, learning environment and using the tool. 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. Students and mentors welcomed the opportunity to recognise and reward good practice through grading. Concerns were raised about the adequacy of preparation of mentors for their role and issues of reliability, in particular second marking. Whilst useful especially for the programme team who used the findings to inform on-going development of the quality assurance processes, the study had limitations: the sample size was small as befitted the methodology although transferability to other settings may be judged. Secondly all student and mentor participants were from the adult branch.

Calman et al. (2002) argue that whatever system is selected, practice assessment is open to risks such as observer bias, poor reliability and validity and ineffective documentation. The limited research in this area indicates that clear criterion against which a student's performance can be measured (Gopee, 2008) are essential. Inter-rater reliability between mentors remains an issue with implications for preparation and support (Gopee, 2008; Scammell et al., 2007).

Issues for mentors

Effective mentoring fosters professional growth in knowledge, skills, attributes and practices (Bray & Nettleton, 2008) and is essential in developing the future generation of nurses (Royal College of Nursing, 2007). However the role is complex as it involves supporting and assessing students whilst managing increased and complex workloads and considering personal and professional development (Hall, 2006). Pollard et al. (2007) emphasize these difficulties and highlight barriers such as staff shortages, skill mix and lack of training for the role. This is of concern as the mentor holds full responsibility for facilitating learning, supervising and assessing the student's fitness to practice (Wilkes, 2006). Cleary the assessment tool has to be fit for purpose to assist the mentor in their role. However following a review of the literature, Watson et al. (2002) concluded that there remains confusion around how clinical competence is defined and measured. The lack of a systematic approach to assessing student nurses' competence in practice may contribute to some students passing clinical assessments without demonstrating sufficient competence. Duffy (2003) found a number of reasons why mentors were reluctant to fail incompetent

students, including misconceptions about whose role it is to fail a student (clinical or university staff). Gopee (2008) considers that 'failing to fail' remains a current concern, giving rise to fears for public safety.

Students' perspective

The student-mentor relationship in practice is key to the fostering a good learning environment. According to Wilkes (2006) a positive relationship will help the student to develop knowledge and skills whilst feeling supported in the assessment process. Students are known to favour working with a friendly, approachable mentor who is a good role model (Cope et al. 2000). Different supervision models exist internationally, with effective mentorship favouring a pedagogical approach where students are actively encouraged to take responsibility as they engage in the learning process (Saarikoski et al. 2007). Problems with how mentors are organised however have been noted, which raises the question of parity in any assessment process which requires mentors to observe students in practice.

Summary

This chapter has provided an overview of the historical and current context of practice assessment for nurses in the UK. Limited research to date indicates that assessment strategies that involve the grading of practice are generally well received by students and mentors, although there are concerns about processes to increase reliability as well as mentor preparation. Findings from the Phase One evaluation project were limited to adult branch students and mentors; it is important to test out the findings with a larger group and to include participants from other nursing branches. In light of an increased national emphasis on nurses' competency in practice, empirical work that evaluates a new practice assessment initiative is timely. Whilst of value locally in terms of reviewing and improving processes, it may also interest colleagues elsewhere.

3   Project design

Aims

The aims of the two-phase evaluation were to explore student, mentor and education staff experiences of the practice assessment profile, to consider their views on the grading of practice using this tool, and to learn lessons to enhance on-going implementation.

Building on the findings from the first phase, Phase Two was designed to explore:

- mentor and student experiences of using the assessment tool across all nursing branches
- quality assurance processes

Data collection

A questionnaire survey based on key issues to emerge from the qualitative data was designed and distributed to a range of students and mentors. Whilst Phase One accessed first year students, Phase Two accessed that same student group but now in their final year, plus some year two students. Mentor and student groups were given separate but complimentary questionnaires (appendices A and B). Question style varied including yes/no responses and 5-point Likert scale responses. In addition there were free-response open questions. Lastly there were questions in which mentors/students could identify multiple responses by ticking all that apply. Multiple response questions identify important information regarding patterns of behaviour but caution is required in interpreting these statistics in that the percentage values do not equate to 100%. The questionnaires were piloted by ten students representing all branches (Adult n=3; Child Health n=2; Learning Disability n=2; Mental Health n=3). Eight mentors were asked to pilot the questionnaire; five responded (Adult n=2; Child health n=1; Learning Disability n=2). Feedback from the pilot identified that the instructions were clear and that participants did not perceive that any major topic was omitted. Two questions were identified as ambiguous by one respondent and were amended.

Convenience sampling was selected to access mentors from all branches invited to university-based mentor conference as well as mentor update sessions hosted within practice placement organisations. 112 (86%) of the 130 mentors available, completed and returned the questionnaire. The branch representation was adult

nursing (62.5%; n=70), Mental Health (21.4%; n=24), Child Health (17%; n=19) and Learning Disability (1.8%; n=2). The mentors assessed students across the three years of the undergraduate programme (first year 55.4%; n=62, second year 77.7%; n=87 and third year 75%; n= 84). 44.6% (n=50) of the sample worked in hospital settings and 49.1% (n= 55) worked in community settings; the majority worked for the National Health Service (NHS) (89.3%; n=100).

Students were also accessed using convenience sampling of year two and three tutor groups, as they had some experience of using the tool. 210 questionnaires were distributed; 107 were completed (51% response). The sample comprised Adult branch (72%; n=77), Mental Health (19.6%; n=21) and Child Health students (8.4%; n=9). No Learning Disability nursing students opted to complete the questionnaire. The response rate reflected the proportion of students enrolled within each branch of the targeted cohorts. Most student respondents were undertaking year 3 of their programme (70.1%; n=73); the exception was Child Health where all students were undertaking year 2.

Ethical considerations

As an evaluation study, formal ethical approval was not sought; however permission was granted to conduct the evaluation by the Associate Dean for Nursing, and the educational leads within placement areas. There was a project steering group with representatives from Placement Providers and the University plus students and mentors; their role was to oversee the project process and to liase with colleagues within their organisations.

With respect to individual participation, mentors and students were briefed in groups by the project team or their colleagues about the nature and purpose of the evaluation. It was emphasised that participation was entirely voluntary; anyone not wishing to participate were simply asked to return the blank questionnaire when they were collected. Students were also reassured that non-participation would not have a detrimental affect upon their studies. Written consent was not obtained as completion was taken to indicate consent. The questionnaires did not request any personal identifiers such as name or workplace and so confidentiality was assured.

Analysis

Quantitative data was coded and inputted into the Statistical Package for the Social Sciences (SPSS for Windows version 15.0), where possible chi-square analysis was

undertaken to explore whether the results were significant. Analysis of the mentor questionnaires revealed that some respondents supported students in differing years of the programme and across the differing branches; it was therefore inappropriate to conduct chi-square analysis due to a violation in the independent assumption (Kepple, 1992) and therefore descriptive analysis only was undertaken. With respect to the analysis of the student questionnaire, due to the small numbers of child health and mental health respondents, it was inappropriate to utilise chi-square as a statistical test (where one degree of freedom is present). However exploring potential correlations between the students' experience and their branch programme were important; Fishers Exact Test (FET) was therefore utilised which Kepple (1992) argues to be an appropriate remedial step in restoring accuracy of the statistical test. Free response sections of the questionnaire were extracted and a content analysis undertaken.

Strengths and limitations

Given the sample size, it is not possible to generalise from this evaluation. Others may judge transferability to other settings. In reviewing the findings, a number of limitations must be acknowledged. The most significant limitations are that no Learning Disability students opted to participate and the response rate from all students was not as high as anticipated (51%). This is however a reasonable response rate for a questionnaire survey but if time had permitted, an extension to the convenience sampling may have been beneficial. Other limitations include the fact that findings were generated from reported practice and, as such, may be subject to distortions of memory.

Summary

Developed from the themes identified in the Phase One evaluation, a questionnaire survey of mentors and year two and three students was undertaken to investigate their experiences of using the grading practice assessment tool. All branches of nursing were successfully targeted for participation using convenience sampling, but no learning disability students opted to participate. The sample size precludes generalisation; the findings do however offer a valuable insight into the grading practice in nurse education.

4   Findings

The quantifiable findings and those derived from qualitative content analysis have been integrated for ease of presentation. Five key areas have been identified within the findings: mentor education, support for practice education, using the profile, perceptions of grading and accountability in assessment practice. Locally the assessment tool is known as the practice profile and so this term will be used throughout.

Mentor Education

The findings indicated that most mentor respondents had been qualified as mentors for sometime whilst others had only recently obtained mentor status (mean=1999). When asked "What year did you last attend mentor updating" of those which responded to the question 81.25% (n=91) attended during the last year (2007/8), whilst only 2.8% (n=3) had not attended an update in the last 4 years. These results are very positive but caution is required as the sample was derived from those attending an update, so we may have been 'speaking to the converted'. Most attended an update during work time but 12.5% (n=14) of the respondents attended in their own time. Attendance at mentor updates (Table 1) was at times problematic due to staff shortages (11.5%, n=12); location of mentor updates was less of an issue than expected. It is positive that mentors were willing to attend updates but concerning that they could not be released from clinical work; this may explain why some mentors attended mentor updates in their own time and has implications for adherence to the NMC standards for supporting learning in practice (NMC, 2008).

Table 1: Table Demonstrating Factors making Attendance at Mentor Updates Problematic

	Yes	
	Count	%
Attendance difficult due to length of journey	6	5.8%
Attendance difficult due to staff shortages	12	11.5%
Attendance difficult due to practice area emergency	1	1.0%
Attendance difficult due to child care problems	3	2.9%
Attendance difficult due to other reason	9	8.7%

Support for practice education

Both mentors and students were asked about their knowledge and use of support and communication mechanisms for practice education. Looking at the mentor data first, mentors demonstrated an awareness of who to access support from if they had a concern about a student (90.2%; n=101). Exploring frequency of contact 58% (n=65) did not contact that person within the last six months, largely due to a lack of need. The majority of the respondents preferred telephone contact (39.6%; n=42) as opposed to email (21.7%; n=23); this may be due to ease of access as many practice areas have limited access to the internet especially within community settings.

Moving on to questions about support for their role as mentors, the majority of the sample 33% (n=37) selected a neutral response, which indicates some concerns. None the less 49.10% (n=55) felt very or quite supported which whilst positive does indicate that over half the sample felt less supported than they wished (Figure 1).

Graph Demonstrating Levels of Support Perceived by Mentors When Working in Practice

Figure 1
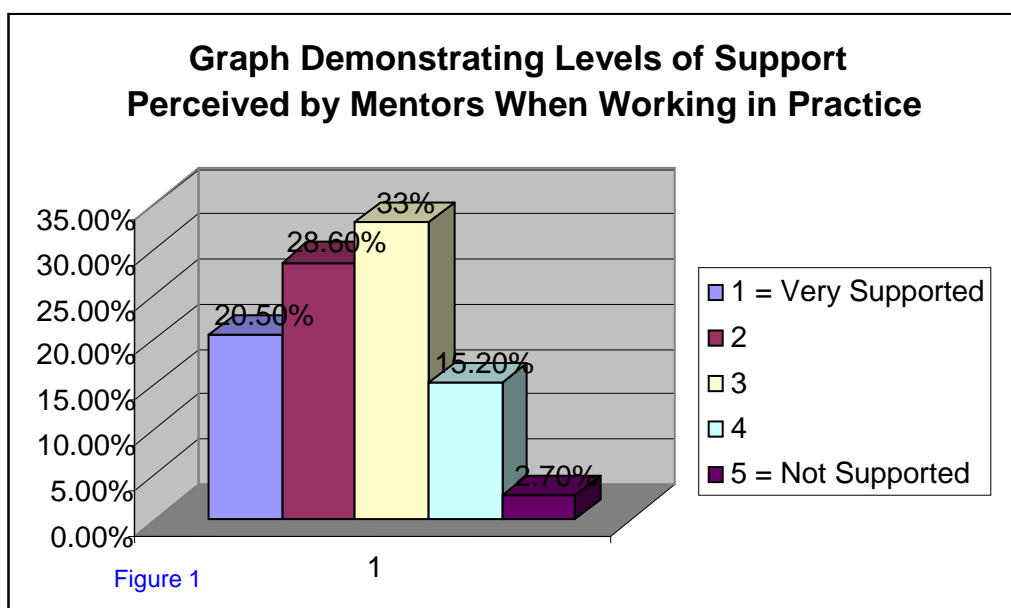
Mentors were also asked to indicate from whom they gained support from a range of options, indicating all that applied. Unsurprisingly most support was accessed from work colleagues (89.7%; n=96). Presumably when an issue could not be resolved, mentors accessed Learning Facilitators/Practice Educators (49.5%; n=53), many of whom are practice-based. Tutorial staff were also accessed less frequently (15.9%;

n=17). Overall this data appears to indicate adequate communication channels between the HEI and practice partners, but scope for improvement.

Moving on the student response to similar issues, 80.4% (n=86) of the sample indicated they knew who to contact if they had concerns regarding a mentor whilst 19.6% (n=21) indicated that they did not. Given the seniority of these students, the latter finding is somewhat surprising. Of those responding 'yes', 66.4% (n= 71) had not contacted that person within the last six months, largely due to a lack of need. Regarding the question concerning how well students felt supported when working in practice, their response reflected that of the mentors; the majority of the sample 36.4% (n=39) selected a neutral response to this question. 40.1% (n=43) felt quite or very supported but 21.5% (n=23) perceived little or no support (Figure 2).

Figure 2
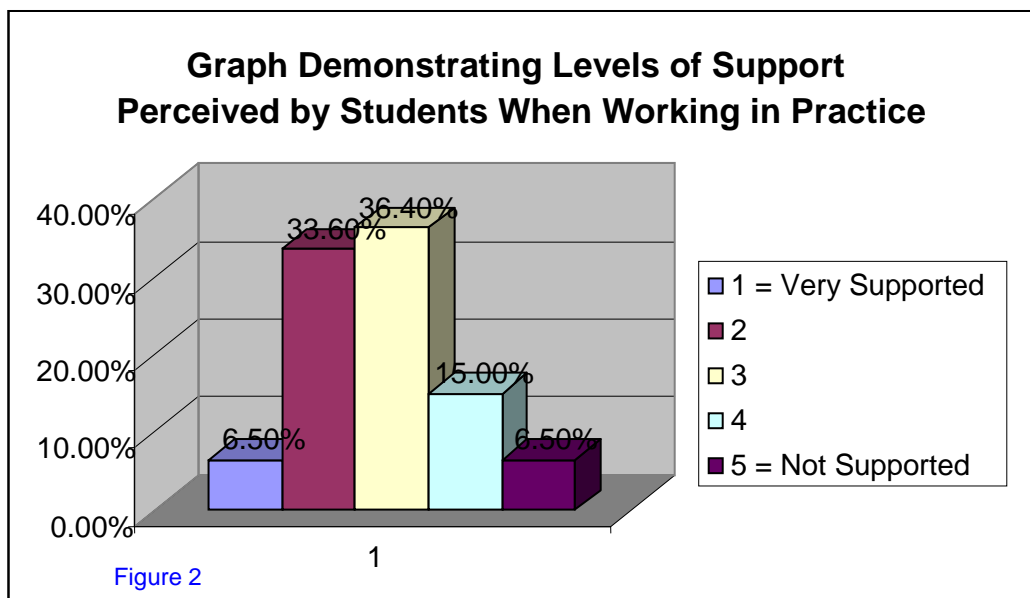
Interestingly Table 2 indicates that Mental Health students felt the most supported as 40% (n=8) of the sample selected a grade 2; Adult Branch students gave the highest neutral score (39.5%; n=30), whereas Child Health students felt the least supported with 55.6% (n=5) selecting grade 5; this branch split is statistically significant p=0.005 (FET). This is worthy of further investigation as this finding represents a disparity in branch student experience.

			How well they felt supported as a student in practice					Total
			1	2	3	4	5	
Student branch	Adult	Count	5	26	30	13	2	76
		Expected Count	5.1	26.1	28.2	11.6	5.1	76.0
		% of Total	4.8%	24.8%	28.6%	12.4%	1.9%	72.4%
	Mental Health	Count	2	8	7	3	0	20
		Expected Count	1.3	6.9	7.4	3.0	1.3	20.0
		% of Total	1.9%	7.6%	6.7%	2.9%	.0%	19.0%
	Child health	Count	0	2	2	0	5	9
		Expected Count	.6	3.1	3.3	1.4	.6	9.0
		% of Total	.0%	1.9%	1.9%	.0%	4.8%	8.6%
Total		Count	7	36	39	16	7	105
		Expected Count	7.0	36.0	39.0	16.0	7.0	105.0
		% of Total	6.7%	34.3%	37.1%	15.2%	6.7%	100.0%

Looking in more detail at who provides this support, like the mentors, the majority of the students perceived that their greatest support came from work colleagues (83.3%; n=85); this was followed by friends (76.5%; n=78), family (57.8%; n=59), Link tutors (18.6%; n= 19), Learning Facilitators (17.6%; n=18) and Practice Educators (16.7%; n=17). It is possible that in responding to the question concerning how well they felt supported, they may have interpreted this as 'official' organisational support. These results indicate that family and friends are significant sources of support as has always been the case. It could be that the introduction of a buddy system might capitalise more formally on support from experienced students. It is important to recognise that the majority of support was provided by placement staff, reinforcing the need to support mentors in this role.

Using the Practice Profile

This section considers some responses on whether the assessment tool was considered to be fit for purpose. 64.3% (n=72) of mentors identified that the practice profile covered all elements they would like to assess, whilst 26.8% (n=30) felt that it not (Table 3).

Table 3: Demonstrating Mentors Perspective on Whether the Practice Profile Tool covered all elements they would like to assess.

		Frequency	Percent
Valid	Yes	72	64.3
	No	30	26.8
	Total	102	91.1
Missing	9	10	8.9
Total		112	100.0

Some comments indicate possible reasons for these different views; some mentors viewed the profile as adaptable to different clinical environments whilst others found it too generic:

> *"I think there is enough flexibility in the tool for it to be relevant to different work areas / work places". (Mentor Questionnaire (MQ))*

> *"Within Mental Health some areas not specific enough to student / patient interactions – interpersonal skills, public issues and general attitude". (MQ)*

In particular some mentors appeared to want specific skills to be listed, perhaps like the skills schedules used before the introduction of continuous assessment of practice. The idea of the profile is to use the proficiencies as the benchmark but this requires that the mentor and student break this down into the skills that would demonstrate its achievement. The following comment indicates a lack of clarity or perhaps a preference for the specific rather than the generic:

> *"Would like included skills related to nursing i.e. aseptic technique". (MQ)*

It could be argued without specific lists much is left to the skill of the mentor and perhaps opportunity within the placement; it is therefore likely that students will not show competence in all practical skills. These findings support the work of Boxer & Kluge (2000) who identified that clinical skill performance is valued above all others in the practice setting, with an emphasis on skills rather than on the underlying attributes such as knowledge (Clarke & Holmes, 2007). Indeed concerns of skill deficits in qualified practitioners has resulted in the introduction of the Essential Skills Clusters (NMC 2007), which identifies key skills that pre registration students must successfully demonstrate at the end of the Common Foundation and branch elements of the programme.

None the less a majority of mentors (75.9%; n=85) indicated that the tool enabled the assessment of student practice. Apart from the addition of grading, the profile had been simplified from previous versions; however students are still expected to justify their practice with written comments and to reflect in order to integrate theory and practice; this written element was a much less substantial requirement than previously.   Some comments indicated a degree of confusion regarding how much emphasis to attribute to each element when assessing students' practice and written accounts of practice. The focus is supposed to be primarily on assessing the students' clinical capabilities as written abilities are adequately assessed elsewhere; the idea is to encourage students to document evidence of what they have achieved. Clearly this needs to be highlighted to mentors more explicitly.

"Hard to grade practical element and written element as One". (MQ)

"Some students perform well practically and know what they do but struggle with writing". (MQ)

Moving on to the students' perceptions of using the Practice Profile, when asked 'What do you like most…', the responses identified that students liked practice being graded and valued alongside the academic elements of the programme:

"The opportunity to show my abilities in practice as I find the academic work hard but my practical work is much better". (SQ)

These comments identify that the process of grading practice enables the development of self efficacy and self esteem in some students who excel within the practice arena but may struggle with the academic components within the programme. Some students also commented favourably on the written component as a means to integrate the theoretical aspects of the programme with the practical:

"As a student it makes you think about the rationale regarding your practice". (SQ)

Views differed regarding the structure of the profile; it is important that the assessment process is transparent to the user.   Its simplicity was highlighted favourably by the students; conversely some students felt that the profile was too complex and required too many signatures in differing places:

"I know what is required of me". (SQ)

"There are too many things to sign and sometimes you forget and have to go back". (SQ)

Multiple signatures act as a deterrent to forgery and allow for mentorship to occur in teams. However the student essentially has to co-ordinate completion of the documentation prior to submission.

Students were also asked 'What do you like least about the practice profile?' Many of their concerns related to its use rather than to the profile itself. Some students reflected the confusion also perceived by the mentors regarding the status and extent of written work required within the profile. If viewed as an account of the evidence to support the achievement of proficiencies with some theoretical justification, it is a useful way for peers to verify grades, alongside assessors' verbal accounts:

"I feel that some mentors only mark on what I have put for outcomes and not on my overall performance as a student nurse". (SQ)

Perceptions of grading practice competency

The section will consider the findings around perceptions of how the grading system actually worked in practice. The findings from this phase of the evaluation supports those from Phase One; the idea of grading valued the practice element of the programme more explicitly. Focusing on the mentor view first, some felt that grading presumed a greater degree of autonomy in decision making. In practice the expectation of grading seemed to enhance their communication with students regarding the on-going development of students' competence; in this way students had a clearer idea what to aim for and could see progression:

"Satisfying to give graded feedback. Able to indicate whether they are a borderline pass or are really excelling". (MQ)

However some mentors felt that the space available for written feedback was overly restrictive; this design was deliberate so that mentors did not feel they had to provide copious detail. Predictably others felt the profile was overly long and

complicated. Ease of use is essential given time constraints; however the opportunity to justify a 'good grade' is just as important as justifying a 'poor' one. If able to be completed on-line then the boxes could be designed to expand, something to be considered for the future:
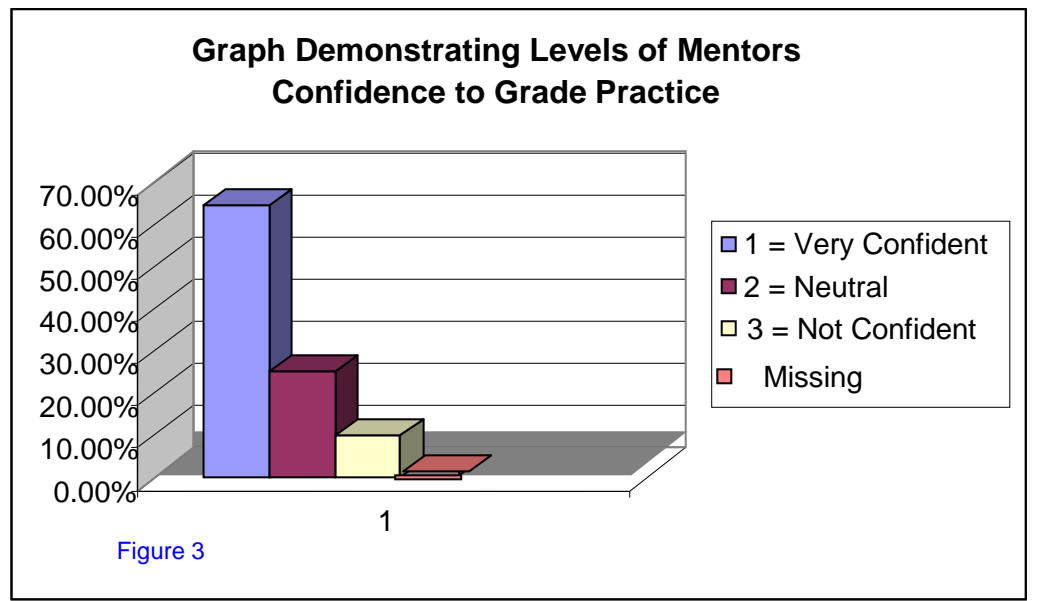
> *"I like to write about my grading decision to provide feedback to student".*
> *(MQ)*

> *"Long and complicated to navigate through, Time consuming". (MQ)*

Grade level descriptors

Descriptors are an essential part of the profile in order to increase user reliability. 71.4% (n=80) of the mentor sample identified that they used the level descriptors; 13.4% (n=15) apparently did not, with the remainder (15.2%; n=17) opting not to answer the question. It is not possible to know whether the non-responders did so because they did not know what the descriptors were, but this is possible. If so over one-quarter of the sample were not using the descriptors; given the newness of the tool, this is somewhat concerning. However 70.5% (n=79) of respondents found the descriptors useful, perhaps indicating that the remainder did not; this merits some further investigation.

The majority of the mentor respondents expressed confidence in their ability to grade practice (figure 3); 64.3% (n=72) of the sample indicated a very positive response whilst 9.8% (n=11) indicted a lack of confidence (figure 3). Interestingly 25% of the sample (n=28) responded to this question with a neutral grade; this could indicate indicating a lack of confidence or a caution to categorise themselves as confident, perhaps due to limited experience. Overall however mentors were confident to grade student performance in practice; the phase one evaluation highlighted academic staff concerns in this matter but these are clearly not substantiated.   None the less 67.9% (n=76) of the mentor sample requested further education on grading.

Graph Demonstrating Levels of Mentors Confidence to Grade Practice

- 1 = Very Confident
- 2 = Neutral
- 3 = Not Confident
- Missing

Figure 3

The need for further support and training of mentors may reflect some problems identified by students; some perceived that some mentors did not understand the tool sufficiently and as such were confused as to the elements that they were grading students upon. Students highlighted their perception that level descriptors were used inconsistently:

> *"This is not enough for the mentors to understand which mark to give you". (SQ)*

> *"I found that different mentors mark you differently". (SQ)*

> *"Mentors rarely, if ever, look at them (level descriptors)". (SQ)*

This variation in perceptions raises possible quality assurance concerns regarding parity of students' experience. A judgement is being made and two issues are important: first the grade awarded must reflect the student's practice competency (mentor judgement) and second the perceived level of practice competency must reflect the description of the grade (mentor competency in using the tool).

Second marking

Second marking is required when a student attains referral grades (0 and 1) and distinction grades (4 and 5). Findings from the Phase One indicated that mentors appeared to avoid grades that required second marking and so it was important to investigate this further. The results demonstrate that 41.1% (n=46) of the sample did not frequently allocate marks that require second marking, whilst 31.3% (n=35) did.

20.5% opted for the neutral grade, quite a high number. The reasons given for not second marking are shown in Table 4.

Table 4: Reasons why mentors do not allocate a grade that requires a second marker.

	Count	%
Didn't give a grade that required second marking because student performance did not meet criteria	59	86.8%
Didn't give a grade that required second marking because no appropriately qualified staff on duty	3	4.4%
Didn't give a grade that required second marking because it was too difficult to get work second marked	1	1.5%
Didn't give a grade that required second marking because it takes too long	1	1.5%
Didn't give a grade that required second marking due to other factor	4	5.7%

Of particular interest is the use of the referral grades.   When asked 'How confident do you feel to fail students?', 59.8% (n=67) of mentors within the sample expressed confidence to fail students whose competence was in question, whilst 17.9% (n=20) were not confident. A further 19.6% (n=22) of the sample responded with a neutral grade to this question:

Figure 4
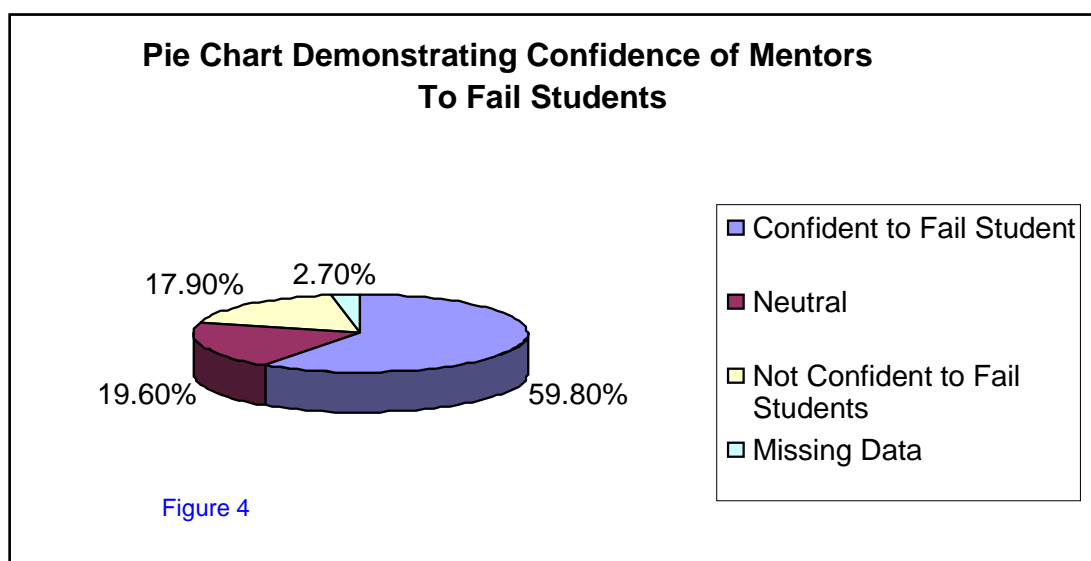
Despite a focus on 'failure to fail' in mentor preparation since the publication of Duffy's report (Duffy, 2003), the data from this evaluation indicates on-going problems for mentors around feeling able to fail students whose competence was in question. Indeed 59.8% (n=67) of the respondents indicated a wish for further education in this area.

Feedback

When using a system of continuous assessment and grading, it is clear that students require on-going feedback in order to appreciate areas of strength and to work on areas requiring development. Mentors were asked 'When do you grade the students practice?'; the results indicate that some mentors appear to use continuous assessment whilst others reserve feedback until the end of the placement. Mentors were asked to indicate all responses that applied; 81.6% (n=80) assessed students at the end of the placement, 44.9% (n=44) in the middle of the placement, and 20.4% (n=20) assessed students during the first week of placement. 10.2% (n=10) assessed at other times. The development of competence depends upon students receiving feedback regarding their development as part of a continuous assessment cycle; the results identify most 92.2% (n=95) mentors believed that they provided feedback during the placement.   Lastly when asked whether they felt that their feedback matched the grade awarded perhaps unsurprisingly the majority responded 'yes' (89.3%; n=100); however 2.7% (n=3) gave a negative response.

Students' perceptions of grading of practice

Moving on the student perceptions of the grading system, similar issues emerged. 74.8% (n=80) of the sample responded that they had used the level descriptors within the profile, whilst 24.3% (n=26) had not. Of the participants who provided a 'no' response to this question 73.1% were in year three of the programme compared to 26.9% who were in year 2, although this is not statistically significant (pvalue: x^2 (1:105) = 0.46(b); p=0.83). Interestingly only 58.9% (n=63) of student participants identified that they found the descriptors useful and 23.4% (n=25) indicated that they were not. A further 14% felt that this question was not applicable; this response indicates that some students may be inadequately aware of the importance of the descriptors in grading their practice.

Perceptions of the need for second marking differed markedly from the mentor sample responses: the majority of student participants perceived that they frequently received marks that required second marking:

Graph Demonstrating Frequency in which Students Received Marks that Required a Second Marker

Figure 5
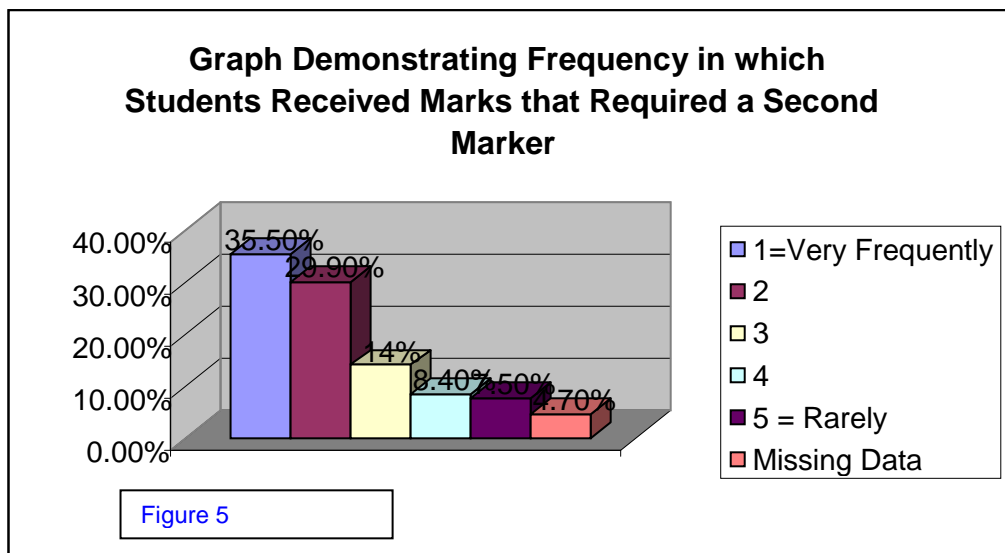
Analysis of the qualitative comments indicated that some students perceived that mentors did not understand the grading categories and imposed their own 'ceiling' of grades that could be achieved, irrespective of the students' performance:

> *"I feel that mentors don't know about the new practice profiles, lots of mentors had not seen them, and many are reluctant to grade high even if you have done really well. Not so much in the 3rd year but definitely in year 1 and 2". (SQ)*

> *"Mentors generally don't want to give you 4s or 5s as they say it gives you something to aim for even if they think you are worth 4s or 5s". (SQ)*

The incidence of second marking appeared to vary across different branch programmes (Table 5): Mental Health students are most likely to receive grades that require second marking whilst Child Health students were least likely to receive a grade that required second marking although this result is not statistically significant (P= 0.627; FET).

Table 5: Cross tabulation Student Branch versus Frequency of Receiving Grades That Require Second Marking.

			How often you received grades that required second marking					Total
			1	2	3	4	5	
Student branch	Adult	Count	27	23	10	8	6	74
		Expected Count	27.6	23.2	10.9	6.5	5.8	74.0
		% of Total	26.5%	22.5%	9.8%	7.8%	5.9%	72.5%
	Mental Health	Count	9	6	3	1	0	19
		Expected Count	7.1	6.0	2.8	1.7	1.5	19.0
		% of Total	8.8%	5.9%	2.9%	1.0%	.0%	18.6%
	Child health	Count	2	3	2	0	2	9
		Expected Count	3.4	2.8	1.3	.8	.7	9.0
		% of Total	2.0%	2.9%	2.0%	.0%	2.0%	8.8%
Total		Count	38	32	15	9	8	102
		Expected Count	38.0	32.0	15.0	9.0	8.0	102.0
		% of Total	37.3%	31.4%	14.7%	8.8%	7.8%	100.0%

Students were asked 'When you have not received a grade that required second marking, why do you think this was?' Students were able to select all statements that applied; it is relevant to note that these statements were derived from student data provided in phase one of the evaluation. The results are shown in Table 6:

Table 6: Reasons why Students Perceive they do not get allocated a grade that requires second marking.

	Yes	
	Count	%
Did not receive a grade that required second marking because my performance did not meet criteria	32	34.4%
Did not receive a grade that required second marking because no appropriately qualified staff on duty	29	31.2%
Did not receive a grade that required second marking because it was too difficult for staff to get work second marked	46	49.5%
Did not receive a grade that required second marking because it takes too long	18	19.4%
Did not receive a grade that required second marking due to other factor	21	22.6%

Whilst most mentors perceived that individuals were not second marked due to students not meeting the criteria, many students felt that there were essentially more logistical reasons 'getting in the way' of second marking. Caution is required in interpreting this data as they reflect perceptions; however they do indicate if nothing else that mentors and students need to have a dialogue about the mark awarded.

Mentors must ensure their mark is based on the criteria and justify this and students should be encouraged to appeal if they feel unfairly marked due to staff shortage.

Moving on to the timing of grading the majority of students indicated this occurred the end of placement (82.9%; n=87), followed by the middle of the placement (24.8%; n=26), and lastly at other times (15.2%; n=16). This pattern is largely consistent with the mentors' responses demonstrating that continuous assessment occurs for some students in terms of awarding a grade. Informal feedback is an important precursor to this; the majority of student respondents identified that they received feedback <u>during</u> the placement (72.1%; n=75), a lesser number (56.7%; n=59) claimed they only received feedback at the <u>end</u> of placement. Of concern in terms of identifying struggling students is the finding that 12.5% of students (n=13) claimed that they rarely received any feedback (Table 7):

Table 7: Highlighting When Students Receive Feedback Regarding Their Practice

	Yes	
	Count	%
Usually receives feedback close to beginning of placement	17	16.3%
Usually receives feedback during the placement	75	72.1%
Usually receives feedback at the end of placement	59	56.7%
I rarely get feedback	13	12.5%
Usually receive feedback at other times	3	2.9%

Mentors and students are expected to meet formally on three occasions (beginning, mid point and end of placement). Students appeared to value these interviews providing opportunities for feedback on how students could develop their practice further:

> *"The interviews – gives an opportunity to look at areas that need developing or areas that have improved." (SQ)*

> *"I feel the interviews are good as they follow your progress." (SQ)*

These comments highlight the importance of review interviews, but the quantitative data indicate that they do not always occur. Students were also asked if they perceived that feedback received matched the grade awarded; 60.7% (n=65) felt that it did and 29% (n=31) felt that it did not. This was supported by comments; the following is typical:

"Grades seldom reflect comments made!" (SQ)

Comparisons between branch programmes indicates an inconsistency in experience; 90% (n=18) of Mental Health students felt that feedback matched the grade awarded compared to 64.3% (n=45) of Adult branch students and 33.3% (n=2) of Child Health students. In addition the Child Health students indicated the greatest dissatisfaction: 66.7% (n=4) identified that feedback did not match the grade awarded compared with 35.7% (n=25) Adult branch and 10% (n=2) of Mental Health students. This branch split is statistically significant p= 0.012 (FET) (Table 8).

Table 8: Cross tabulation of Student Branch versus Whether Feedback Matches Grade Awarded.

			Does feedback match grade awarded		Total
			Yes	No	
Student branch	Adult	Count	45	25	70
		Expected Count	47.4	22.6	70.0
		% of Total	46.9%	26.0%	72.9%
	Mental Health	Count	18	2	20
		Expected Count	13.5	6.5	20.0
		% of Total	18.8%	2.1%	20.8%
	Child health	Count	2	4	6
		Expected Count	4.1	1.9	6.0
		% of Total	2.1%	4.2%	6.3%
Total		Count	65	31	96
		Expected Count	65.0	31.0	96.0
		% of Total	67.7%	32.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	8.163(a)	2	.017	.015		
Likelihood Ratio	8.890	2	.012	.013		
Fisher's Exact Test	8.249			.012		
Linear-by-Linear Association	.015(b)	1	.902	1.000	.533	.145
N of Valid Cases	96					

a 2 cells (33.3%) have expected count less than 5. The minimum expected count is 1.94.
b The standardized statistic is -.123.

Accountability

The final area to emerge from the findings concerned issues of accountability within the assessment process. A critical factor within any practice assessment scheme is whether it enables the reflection of competence; to judge this the mentor signing the assessment needs to have worked with the student. An exception to this may be the role of the second marker who on occasion may act as a sounding board to the assessing mentor, seeking clarification from the mentor of the grade awarded; this may not require working with the student. All mentors and students are accountable for their actions in the assessment process; the student should not request a signature to corroborate practice that was not seen, nor should a mentor sign in such circumstances. In interpreting the responses below it is possible that some mentors who claimed to sign a profile for a student they had not worked with may have been a second marker; the question did not ask for this to be specified.

When mentors were asked whether they had signed a practice profile of a student they had not worked with 84.8% (n=95) of the sample indicated that they had not; however 7.1% (n=8) identified that sometimes this occurred and a further 5.4% (n=6) responded 'yes' to this question. A similar question posed to the students indicated that 71% (n=76) had not had their profile signed by a registrant who had not worked with them, whilst 26.6% (n=28) of the sample acknowledged that this has occurred. Again the experience of students from different branches varied (Table 9) although the results were not statistically significant:

Table 9: Cross tabulation of Student Branch versus Having Practice Profiles Marked By a Mentor Who Has Not Worked With Them

			Have you had your practice profiles marked by a mentor who has not worked with you		Total
			Yes	No	
Student branch	Adult	Count	22	53	75
		% within Student branch	29.3%	70.7%	100.0%
	Mental Health	Count	3	17	20
		% within Student branch	15.0%	85.0%	100.0%
	Child health	Count	3	6	9
		% within Student branch	33.3%	66.7%	100.0%
Total		Count	28	76	104
		% within Student branch	26.9%	73.1%	100.0%

Summary

Five key areas emerged from the findings: questions around mentor education indicated that participation in updates was high although the sampling process may have introduced some bias. The findings around support for practice education was more mixed; mentors appeared to want more support than was available and student experience varied according to branch – Mental Health students feeling most supported and Child Health the least. The use of neutral grades was high in both mentor and student groups indicating some cause for concern. Perception on use of the profile in terms of whether it was fit for purpose indicated positive responses overall but some confusion from both students and mentors as to the status of the written sections in comparison with skills performance; the latter was perceived as the top priority.

The fourth area focused on how grading 'worked' and yielded some valuable perceptions. Generally respondents liked and wanted to grade or be graded in practice. Whilst the majority of mentors claimed to use the descriptors and found them useful, the number who did not use them was of concern. There were mixed perceptions of the appropriate use of second marking, some students perceiving that they were given middle grades due to logistical problems in accessing second markers, although this was not supported by the mentor data. The majority of mentors expressed confidence in grading students. However a significant minority responded neutrally or negatively or did not answer the question when asked whether they felt confident to fail a student. This finding is important when considered alongside the neutral response to feeling supported.

Finally accountability for assessment practice appeared strong, although at times profiles were signed by staff who had not worked with the student. It is unclear however whether these mentors were primary mentors or those functioning as second markers.

5   Discussion

Overall the evaluation indicates that the assessment scheme used to grade practice skills and competencies in pre-registration nursing programmes at Bournemouth University appears to be generally successful, both in terms of fitness for purpose and acceptability to users. The findings from the small, qualitative evaluation (Scammell et al., 2007) are in many areas supported; some of the logistical issues identified then appear to be less significant now. Data has been added from two further Nursing Branches and supports in the main the Adult Branch perspective reflected in Phase One. There are some experiential differences between Branches concerning support and accountability that are worthy of further exploration.

The purpose of this section is to explore a number of issues arising from the findings and to place these in the context of other literature before offering some conclusions and recommendations. These issues broadly relate to quality assurance processes and the role of mentor and student education concerning practice assessment.

Quality assurance issues

Design of assessment tool

Calman et al. (2002) argue that practice assessment is open to risks such as observer bias, poor reliability and validity and ineffective documentation. Design of the assessment tool can be vital in addressing aspects on these concerns. The limited research in this area indicates that clear criterion against which a student's performance can be measured (Gopee, 2008) are essential. Prior to the introduction of numerical grades, mentors in effect 'graded' student performance but on a pass/fail basis. This judgement was just as value-laden but arguably less constructive in terms of feedback for the student. In the practice profile in order to make this judgment as transparent as possible, descriptors for each grade are provided. When the mentor allocates the grade, this should be done with reference to the descriptors. The level descriptors give guidance of expectations at each grade that could be awarded; this also assists in increasing the reliability of the assessment process.

Of course reliability is only possible if the descriptors are used; the evaluation identified that 71.4% (n=80) of mentors and 74.8% (n=80) of students sampled acknowledged using the level descriptors. Whilst a positive outcome, improvement is necessary as all parties need to feel confident that expectations of competency

are consistently applied regardless of placement area or mentor. If the descriptors are not used, it is of concern how the judgement of competency is being made; 'gut feeling' perhaps? It would be naïve to suggest that this is not part of the process but in order to counter observer bias the assessor must compare their 'feelings' against external written criteria in order for their judgement to be valid. Similar issues have been reported in other studies; Bondy (1983) found that if the conditions for grades given were vague or if assessors did not use these descriptors, then reliability was compromised.

It is vital that the descriptors are fit for purpose and are easily understood by both students and mentors utilising them in practice. This is important on two counts; first to ensure public safety and second because practice achievement is awarded academic credit and therefore grading contributes towards the students' final classification at the end of the programme. Perceptions of the usefulness of these descriptors may have been a contributing factor in usage; Higgins (2000) notes that sometimes the academic language used within assessment tools can lead to misinterpretation.   In light of this it would be beneficial for the HEI work with mentors and students when reviewing and redesigning the level descriptors to ensure that what is produced is meaningful to those who will be using them. However as Reilly & Oermann (1992, p421) reminds us grading comprises 'quantitative symbols of qualitative dimensions of behaviour' … 'a letter or number (is used to) convey a complex and diverse array of competencies and attributes'. This is quite a challenge, as the aim is that the grade with experience can be clearly understood by users. 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.

When good descriptors have been designed, the next challenge is that they are used to accurately reflect observed behaviour. The evaluation team was keen to explore the extent to which mentors and students perceived that the feedback matched the grade awarded: Phase One identified that students believed that grades awarded did not always reflect the feedback they received. This mismatch was supported by the results of Phase Two; 89.3% (n=100) of mentors perceived that feedback given matched the grade awarded compared to only 60.7% (n=65) of students. These findings support similar findings in the Australian study by Glover et al. (1997); these authors linked this finding to the need for stronger quality

assurance processes. At Bournemouth University this has been addressed to some extent: whist HEI staff do not change grades awarded as this is not their role, the practice unit team review all profiles for issues such as these and feed these back to the mentors involved, as well as provide a report for use in future mentor update sessions.

None the less the evaluation provides few clues as to why comments and grades do vary in this way; One possibility maybe that as the grading scheme is relatively new, some mentors may lack confidence to award the full spectrum of grades available, but want to 'tell' the student how good they are; a similar trend is apparent with new markers of academic work. Conversely it may be that mentors are uncomfortable providing constructive feedback as this has been identified in other studies (Bray & Nettleton 2007; Gray & Smith 2000). It seems that more robust processes may be required; for example students may perceive that they are unjustly treated during the assessment process and require some simple no-blame appeal system. Equally mentors require the support mechanisms and education to enable them to more clearly communicate and justify the grade they award. The evaluation highlighted that mentors desired more support than was currently available, although the nature of this was not clear.

Quality assurance processes in the HEI and placements
No matter how well-designed the assessment tool may be it has to be implemented on a raft of robust quality assurance processes. One issue of pertinence to reliability is that of second marking processes. When exploring the frequency in which mentors allocated marks that required second marking, 41.1% (n=46) of the mentor sample identified that they did not frequently allocate marks that required second marking; this was attributed to the fact that students did achieve grades that required second marking (extreme ends of the range). This is interesting as data from the programme team in Phase One of the evaluation supported the view that the introduction of grading of practice may increase the students overall marks at the end of the programme (Scammell et al. 2007). Indeed the students in both phases perceived that they merited higher grades that required second marking but for logistical reasons this was not awarded. It could be that inexperienced students, unaware of the full scope of potential practice may perceive they could not do 'much more'. On the other hand mentors may be expecting too much; if in doubt it is hoped that mentors would consult a senior colleague for advice, hence the value of second marking; an important second opinion. This can only strengthen reliability.

Interestingly students from the Mental Health Branch felt they most frequently received grades that required second marking, in comparison to Child Health students who perceived that they were least likely to receive a grade that required second marking, although this finding was not statistically significant. This apparent inequity across the branch programmes is worthy of further investigation.

The key point is that there appears to be a mismatch between the students and mentors perceptions of why grades are not allocated that require second marking. If it is indeed due to a lack of performance by the student then clearer feedback from the mentor is required to enable the student to understand why they have received a grade and indeed where future development can occur. This can be facilitated by utilising the principles set out in the ongoing record of achievement which advocates that mentors and students meet at the end of placements to document the students strengths and ongoing developmental needs which are then passed on to the next placement. However the issue of access to second markers as perceived by the students cannot be ignored and as such this required further discussion regarding the management of second marking by the programme team and practice partners.

Formative and summative feedback is another aspect of quality assurance processes. It would appear that continuous assessment of practice is occurring within practice for most as both mentor and students' responses indicated that students are assessed at numerous times during the placement. Indeed a study by Myall et al. (2008) identified that mentors perceive continuous assessment to be important; and may even become even more favoured in light of the introduction of the sign-off mentor role (NMC 2006), and the ongoing record of achievement (NMC, 2008). However in order to maximise the learning from continuous assessment, it is necessary that feedback is also provided to enable students to understand how to develop their skills further (Nichol & MacFarlane-Dick, 2006). This evaluation identified that whilst the majority of mentors and students identified that they gave or received feedback during the placement, 56.7% (n=59) of students identified that they only received feedback at the end of placement. This has implications; as Neary (2000) identifies the more immediate the feedback the greater the potential for learning. Providing feedback at the end of a placement denies students the opportunities to further develop their skills and confidence whilst in placements. In addition a further 12.5% of students (n=13) identified that they rarely received feedback at all; even the best students need to know their strengths and have areas of development. It is hoped that poor students do receive feedback as failure to do

so would have profound implications for the development of competence. However, it must also be acknowledged that the students may not have interpreted the mentors' feedback as 'feedback'. In order to maximise opportunities for students learning, the identification and provision of clear feedback to students is an essential aspect of the mentor role; equally students need to be adequately prepared for the assessment process used in practice in order to manage expectations.

Finally effective support processes for mentors and students clearly contribute to quality assurance. The evaluation indicated that the majority of support for mentors was provided not by the HEI but from clinical peers. Nettleton & Bray (2008) found that mentors perceived that an increase input from the HEI would improve the mentoring process; indeed in the evaluation the mentors wanted more support but did not specify from whom. The support mechanisms for practice education have changed significantly at Bournemouth during the period of this evaluation with the loss of some placement based practice education staff to be replaced by University Locality Coordinators (funded by the HEI) whose remit is to oversee the quality assurance processes. In addition all practice areas have an identified academic link, who they can contact to explore concerns about individual students in practice. It was not within remit of this evaluation to examine the extent to which these systems are effective. However what is clear is the support processes need to be understood and known by all parties and effective communication systems put in place to support those. The evaluation indicates that communication was perceived to be adequate between HEI and placement areas but there would appear to be scope for development.

Equally support for mentorship from placement providers is an essential component of quality assurance. Financial pressures within NHS Trusts, independent health care organisations and the cutting of the Benchmark price for undergraduate nurse education may impact on practice education support. This evaluation has highlighted some concerns over 'staffing' second marking; both HEI and placement providers need to monitor this as part of their on-going quality assurance mechanisms.

Support for students is also crucial particularly as placement experience presents considerable challenges and assessment brings with it some degree of anxiety. The findings indicated that students gained most support from work colleagues (83.3%; n=85), followed by friends (76.5%; n=78). Work colleagues presumably includes

mentors and members of the clinical team which is both expected and appropriate; problems may arise for students struggling in placement for whatever reason, as the fast pace of clinical practice may mean that the students' needs are not identified or met and could have implications for attrition. Mental Health students felt the most supported and Child Health students the least supported and this was found to be statistically significant. Clearly this is worthy of exploration by the branch programme teams in collaboration with placement providers.

The finding that friends are another important source of support is not surprising but could perhaps be more formally utilised through practice-based peer assisted learning schemes; more experienced students supported by HEI staff could support more junior students.

Education in support of assessment in practice

Linked to effective quality assurance is the provision of education in support of practice learning. There is a considerable body of literature concerning the nature of mentorship including the need for initial and on-going education. This evaluation found an excellent uptake of updates but the findings are influenced by a sampling bias; they do not reflect the findings from Phase One which indicated a poor uptake of mentor update; this is more reflective of findings from other studies (Myall et al. 2008). Where attendance at updates was identified as problematic within Phase Two, this was largely due to difficulties in releasing staff from their clinical role, leading some mentors having to attend updates during their own time (12.5%; n=14). The evaluation indicates that the importance of effective education for mentors cannot be underestimated, particularly around the effective use of grading descriptors; this point was also made by Hillegas & Valentine (1986) in their study of grading practice in Australia.

Annual updating is mandatory to ensure that mentors are fit for their mentorship role. It should include knowledge regarding the students programme, statutory body expectations as well as opportunities for discussion regarding assessment of competence and fitness for safe and effective practice (NMC 2008:30). Mentorship is a professional responsibility with clear service benefits of a well socialised recruit (Hayes, 2005), however due to organisational constraints attendance at updates is sometimes problematic for staff. Factual information can be provided through e-learning strategies or where access to computers is problematic, through a distance

learning package. However this still leaves the expectation that mentors should have opportunities for discussion regarding the more complex facets of the mentorship role; this could be facilitated through group discussions in practice or where internet access is available through a discussion forum. Several delivery models are offered by Bournemouth and a comparison study is planned.

Data regarding the issue of preparing mentors with the skills to identify and if necessary fail students was evident and some useful findings emerged. The evaluation explored mentors confidence in failing students and the results identified that only 59.8% (n=67) of mentors within the sample indicated a confidence to fail students whose competence was in question. This finding supports research by Duffy (2003). It is of some concern as considerable focus has been placed on this issue in the intervening years since the Duffy report was published. The finding has both professional and moral implications; mentors may be exposing the public to risk especially if an incompetent student is allowed to enter the register. Further it seems unethical (as well as wasteful in financial and human terms) to fail students in the consolidation placement that have been previously
deemed competent in the required proficiencies.   This of course assumes that sign-off mentors will feel confident to fail students when necessary. 59.8% (n=67) of the mentors respondents indicated a wish for further education on 'failing to fail', an area of priority it is suggested for the university and practice partners.

The evaluation indicates that students also have educational needs in relation to practice assessment: 19.6% (n=21) of the student sample indicated that they did not know who to contact if they experienced a difficulty with their mentors, even though the students had been studying within the university for at least a year. Clearly the students have a responsibility to find out the information they need as they have contacts (personal and programme teachers, administrative staff) within the university. None the less channels of communication for students need to be more transparent; the inclusion of a flow chart within the practice profile articulating the process to students, as well as mentors may be a very useful development.

Summary
The Phase Two evaluation has been broadly supportive of the Phase One findings but has extended these to other nursing branches and has provided useful detail on some of the issues affecting the grading practice scheme. Quality assurance is a

prime concern: the evaluation has shown that reliability of the tool can be improved if the descriptors are clear and robust processes are in place to ensure these are consistently applied. Second marking is another feature of reliability and perceptions varied as to whether this was utilised as much as required; an issue for programme and placement staff to consider, particularly in the light of inter-branch discrepancies. Students and mentors should be encouraged to constructively make any concerns known.   Education around grading and support for mentors was another key area; there perhaps can never be enough support but if this is linked to concerns around failing students, this needs to be addressed. Overall the grading of competency in nursing practice yields far more benefits than problems. It is an innovative scheme, not without challenges; both evaluation phases provide valuable data to address these.

Section 5 Conclusions and Recommendations

Conclusion

To recap, the aim of Phase Two of the grading practice evaluation was to explore:

- mentor and student experiences of using the assessment tool across all nursing branches
- quality assurance processes

The evaluation captured the views of mentors representing all nursing branches as well as students, with the exception of those from Learning Disability Nursing. The issues raised across the branches were broadly similar, notably that the notion of grading practice was welcomed as a means of valuing the practice element of the programme, although implementation was not unproblematic. These are reflected in the focus on the quality assurance processes and in fact this is where the branch experience differs most. Mental Health students felt the most supported in placement, were the most likely to receive grades that required to be second marked (indicating full use of the grading range) and were most satisfied that mentor comments matched the grades awarded. In contrast Child Health students were the least satisfied in all these parameters. Adult branch students were in the middle but there was significant use of the neutral score which indicates some room for improvement.

It can be concluded from the data from the mentors that experience across branches did not differ markedly. The sample accessed updates and most felt confident in grading practice. However almost 18% did not feel confident about failing students and almost another 20% gave a neutral response to this question, indicating a need for further staff development in this area as well as a review of processes designed to support mentors in making these judgements.

Recommendations

Whilst most mentors and students appeared satisfied with many aspects of assessment practice, there is scope for development. The evaluation process has highlighted the benefits of canvassing views from the users of the assessment tool and it is recommended that this is utilised in any review.

Drawing on the lessons from this evaluation, the following recommendations are offered for consideration by the programme team and the locality coordinator groups:

- Explore ways of engaging learning disability students in sharing their perspective on the practice assessment tool and processes.
- Increase transparency of communication channels between placement providers and the university regarding practice assessment.
    - Flowcharts or algorithms for mentors and students might be useful
    - Include these on the back of each practice profile
- Review support mechanisms for students within placements. Identify best practice and include minimal standards on the clinical audit documentation to increase parity between placements and branches.
- Investigate peer support schemes for students in practice which include preparation and support for those undertaking this role.
- Child Health programme team should review support for students with practice partners to identify specific issues for improvement.
- Review level descriptors with students, mentors as well as programme teams to ensure clarity of language and processes.
- Re-emphasise the use of descriptors in mentor education as well as student preparation for placement
- Review criteria and processes for second marking and emphasise within mentor education.
- Disseminate HSC audit of practice profiles on a placement provider organisation basis and include a focus on quality of feedback in relation to grade awarded.
- Review current practice around preparing and supporting mentors in failing students and develop an action plan for implementation over the next academic year.

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Appendix A: Mentor Questionnaire

Demographic data			
1. What branch of nursing students do you mentor? *(please tick all that apply)*			
Adult	☐	Child Health	☐
Mental Health	☐	Learning Disabilities	☐
2. What year of the programme are the nursing students you mentor? *(please tick all that apply)*			
Year 1	☐	Year 2	☐
Year 3	☐		
3. What type of Practice area do you work (E.g. community /medical etc)			
_____			
4. What kind of organisation do most closely identify with? *(please tick one box)*			
NHS (public sector)		☐	
Non-NHS (independent or private sector)		☐	
Other		☐ *(Please specify)*	
Mentor education and updating programmes			
5. What year did you qualify as a mentor?		(e.g. 2002) _ _ _ _	
6. What year did you last attend mentor updating?		(e.g. 2006) _ _ _ _	
7. Please think back to your last mentor updating – when did you attend? *(Please tick one box)*			
In work time		☐	
In your own time		☐	

8. How easy was it for you to get to the venue? *(Please tick one box)*

Very easy ……………………………………………… Very difficult

	1	2	3	4	5
	☐	☐	☐	☐	☐

9. If your attendance was difficult why was this? *(Please tick all that apply)*			
Long way to travel		☐	
Short of staff on the day		☐	
Emergency in practice area		☐	
Child care problem		☐	
Other	☐ *(Please explain)*		

Please Continue….
Communication and support

10. Do you know <u>who</u> to contact if you have any concern about a student you are mentoring? *(Please tick one box)*

Yes	☐ *(Please go to question 11)*	
No	☐ *(Please go to question 14)*	

11. Have you contacted this person in the last 6 months? *(Please tick one box)*

Yes	☐ *(Please go to question 12)*	
No	☐ *(Please go to question 13)*	

12. How did you contact this person? *(Please tick all that apply - then go to question 12)*

Email	☐	
Telephone	☐	
Other	☐ *(Please explain)*	

13. Why did you not contact this person? *(Please tick all that apply)*

I did not need to contact them	☐	
I did not know how to contact them	☐	

14. How well supported as a mentor do you feel when working in practice? *(Please tick one box)*

Very supported	…………………………………………			Not supported	
	1	2	3	4	5
	☐	☐	☐	☐	☐

15. If you feel supported in your mentorship role who provides this for you? *(Please tick all that apply)*

Work colleagues	☐	
Learning facilitators/Practice Educators	☐	
Link tutors	☐	
Family members	☐	
Friends	☐	
Other	☐ *(Please explain)*	

The practice profile tool

16. Does the tool cover everything you would like assessed? *(Please tick one box)*

Yes	☐	No	☐	
(Comments)				

Please Continue

17. Do you consider that the practice profile tool sufficiently enables you to assess student practice? *(Please tick one box)*

Yes		☐	
No		☐	

(Comments)

18. What aspect of the tool are you most satisfied with? *(Please explain)*

19. What aspect of the tool are you least satisfied with? *(Please explain)*

Assessment of practice

20. Have you used the level descriptors printed on page 9 in the front of the practice profile? *(Please tick one box)*

Yes		☐	
No		☐	

21. Did you find the level descriptors useful? *(Please tick one box)*

Yes		☐	
No		☐	
Not applicable		☐	

22. Are there any additional areas you would like included in the level descriptors? *(Please explain)*

23. How confident do you feel to <u>grade</u> student performance? *(Please tick one box)*

Very confident ...…………………………………………… Not confident

1	2	3	4	5
☐	☐	☐	☐	☐

24. Would you like more education on grading? *(Please tick one box)*

Yes		☐	

No		☐	
Please Continue….			

25. How often do you give grades that require second marking? *(Please tick one box)*

Frequently …………………………………………… Seldom

1	2	3	4	5
☐	☐	☐	☐	☐

26. If you do not give a grade that requires second marking, why is this? *(Please tick all that apply)*

Student performance does not meet criteria for marks that require second marking	☐	
No appropriately qualified staff on duty with you	☐	
It is too difficult to get work second marked	☐	
It takes too long	☐	
Other	☐ *(Please explain)*	

27. How confident do you feel to fail students? *(Please tick one box)*
Very confident …………………………………….………. Not confident

1	2	3	4	5
☐	☐	☐	☐	☐

28. Would you like more education about failing students? *(Please tick one box)*

Yes	☐	No	☐	

29. When do you grade the students practice? *(Please tick all that apply)*

Within the first week of the placement	☐	
In the middle of the placement	☐	
At the end of the placement	☐	
Other	☐ *(Please explain)*	

30. When do you usually give feedback to students? *(Please tick all that apply)*

Close to the beginning of the placement	☐ *(Please explain)*	
During the placement	☐ *(Please explain)*	
At the end of the placement	☐ *(Please explain)*	
I rarely give feedback	☐ *(Please explain)*	
Other	☐ *(Please explain)*	

Please Continue….			

31. In your view does the feedback you give match the grade you award? *(Please tick one box)*

Yes		☐ *(Please explain)*	
No		☐ *(Please explain)*	
I do not give feedback		☐ *(Please explain)*	

Accountability

32. Do you sign practice profiles for students when you have not worked with them? *(Please tick one box)*

Yes		☐	
No		☐	
Sometimes		☐	
(Comments)			

33. Are you aware that from 2007 students will have to be 'assessed and signed off as capable of safe and effective practice at the end of their programmes' (NMC 2006, p32) and that appropriately prepared mentors will be 'responsible and accountable' for doing this *(Please tick one box)*

Yes		☐	
No		☐	
I am now		☐	

34. Any further comments?

Thank you for completing this questionnaire			

Reference:
NMC, 2006. *Standards to support learning and assessing in practice.* London: Nursing and Midwifery Council

Appendix B: Student Questionnaire

Demographic data			
1. What branch of nursing do you most closely identify with? *(please tick one box)*			
Adult	☐	Child Health	☐
Mental Health	☐	Learning Disabilities	☐
2. What year of the programme are you in? *(please tick one box)*			
Year 1	☐	Year 2	☐
Year 3	☐		
Communication and support			
3. Do you know <u>who</u> to contact if you have any concern about your mentor or associate mentor? *(Please tick one box)*			
Yes	☐ *(Please go to question 4)*		
No	☐ *(Please go to question 6)*		
4. Have you contacted this person in the last 6 months? *(Please tick one box)*			
Yes	☐ *(Please go to question 5)*		
No	☐ *(Please go to question 6)*		
5. How did you contact this person? *(Please tick all that apply - then go to question 6)*			
Email	☐		
Telephone	☐		
Other	☐ *(Please explain)*		
6. Why did you not contact this person? *(Please tick all that apply)*			
I did not need to contact them	☐		
I did not know how to contact them	☐		
7. How well supported as a student do you feel when working in practice? *(Please tick one box)*			
Very supported ………………………………………… Not supported 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐			

Please continue …

8. If you feel supported as a student who provides this for you? *(Please tick all that apply)*

Work colleagues	☐	
Learning facilitators	☐	
Practice educators	☐	
Link tutors	☐	
Family members	☐	
Friends	☐	
Other	☐ *(Please explain)*	

The practice profile tool

9. What do you like most about the practice profile? *(Please explain)*

10. What do you like least about the practice profile? *(Please explain)*

Assessment of practice

11. Have you used the level descriptors printed on page 9 in the front of the practice profile? *(Please tick one box)*

Yes	☐	
No	☐	

12. Have you found the level descriptors useful? *(Please tick one box)*

Yes	☐	
No	☐	
Not applicable	☐	
(Comments)		

Please continue …			

13. How often do you receive grades that require second marking? *(Please tick one box)*

Frequently …………………………………………. Seldom

	1	2	3	4	5
	☐	☐	☐	☐	☐

14. When you have not received a grade that required second marking, why do you think this was? *(Please tick all that apply)*

My performance did not meet the criteria for marks that required second marking	☐	
Not enough appropriately qualified staff on duty	☐	
Its too difficult for staff to get work second marked	☐	
It takes too long	☐	
Other	☐ *(Please explain)*	

15. When do you receive feedback? *(Please tick all that apply)*

Close to the beginning of the placement	☐	
During the placement	☐	
At the end of the placement	☐	
I rarely get feedback	☐	
Other	☐ *(Please explain)*	

16. When is your practice graded? *(Please tick all that apply)*

Within the first week of the placement	☐	
In the middle of the placement	☐	
At the end of the placement	☐	
Other	☐ *(Please explain)*	

Please continue …

17. In your view does the feedback you get match the grade you are given? *(Please tick one box)*

Yes		☐	
No		☐	
(Comments)			

Accountability

18. Have you ever had your practice profile marked by mentors who have not worked with you? *(Please tick one box)*

Yes		☐
No		☐

(Please comment on the implications of this practice)

19. Any further comments?

Thank you for completing this questionnaire