



*The assessment of practical skills in student nurses.*

DAVENHALL, Ella.

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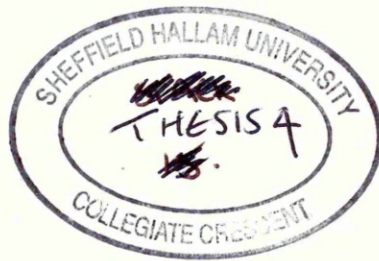
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THE ASSESSMENT OF PRACTICAL SKILLS  
IN STUDENT NURSES

By

ELLA DAVENHALL

being a thesis submitted in partial  
fulfilment of the requirements for  
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## ABSTRACT

TITLE: The Assessment of Practical Skills in Student Nurses.

AUTHOR: Ella DAVENHALL.

RATIONALE: During the last decade assessment of clinical skills in student nurses preparing for state registration has undergone a number of developments. According to contemporary literature, written examinations, which represent one feature of assessment for state registration, often bear little relationship to the level of nursing skills demonstrated by a student in the clinical setting. Having observed contemporary methods of clinical assessment, the researcher here explores the theoretical and practical considerations underlying these methods; their reliability and validity; and the related question of what could constitute useful and appropriate instruments for assessment of clinical nursing skills.

NATURE, SCOPE AND METHOD: Two methods of clinical assessment in general use were explored, employing guided interviews with a sample of senior nursing staff regularly involved in clinical assessment (N = 44). This was a sample of ward sisters located in four centres: Centre A, an established teaching hospital (N = 14); Centre B, a busy district general hospital (N = 8); Centre C, a new post-graduate medical school hospital (N = 12); and Centre D, a small suburban general hospital (N = 10). Following a review of the literature, a guided interview schedule was developed by means of preliminary unstructured discussion with assessors in order to establish general categories; followed by a small pilot study. Interview data were stored on audiotape and comparisons made between responses from assessors in the four centres. The researcher wished to collect accurate information in respect of specific issues involved in the current procedures. Interviews were wide-ranging, covering numerous aspects of assessment as these affect student, assessor and patient; and the instruments currently used. Numerical data is supported by anecdotal material illustrative of typical responses. Additionally to the interviews, a retrospective analysis of specimen assessments carried out for a specific group of third-year students was undertaken in order to obtain data on reliability and validity of such assessments.

FINDINGS: These illustrate a variety of strengths and weaknesses in current assessment procedures as perceived by senior clinical nurses: and serve to emphasise issues requiring further study. Of greatest interest are implications for preparation, training and continued development of clinical assessors. Respondents viewed both current assessment systems critically; and a specimen analysis illustrated the shortcomings of progress assessments. Inferences were drawn from the data regarding potential future ways of improving organisational, assessmental and educational aspects of clinical nurse assessment.

## ACKNOWLEDGEMENTS

I would like to express my appreciation and thanks to my Director of Studies, Pat Ashworth, for her most valuable help and guidance: to my internal research supervisors, Val Reed and Cynthia Fox, and to my many friends and colleagues for their keen interest and support: and to Di Juniper, who offered so much help in setting up the study, and who continued throughout to offer encouragement and to maintain interest in its progress.

Lastly and very importantly, I am indebted to all my nursing informants at all levels of the profession; without whose time, patience and involvement the study could not have taken place.

Harrow Nurse Education Centre,  
Northwick Park Hospital,  
Harrow, Middlesex.

July, 1985.

## NOTE ON TERMS USED IN THE STUDY

Several terms and abbreviations which are used occasionally in the following report are probably best defined initially, for reasons of clarity. These are:

### Administrative nursing staff:

(occasionally 'administrative staff' or 'nurse managers'). These terms refer to nurse managers above the rank of ward sister or charge nurse, whose main responsibilities are in middle or higher nurse management; and who are not normally ward-based.

### Educational staff:

This term refers to nurses who are usually also qualified nurse tutors or clinical teachers. Tutorial staff are normally based in the nurse education centre or school of nursing, with main responsibility for the academic and theoretical education of student nurses; though they may also participate sessionally in the ward-based clinical education of student nurses. Clinical teachers are also normally based in the nurse education centre or school of nursing; but have a substantial input to the ward-based clinical education of student nurses.

### E.N.B.:

(occasionally 'the English National Board'). These abbreviations refer to the English National Board for Nursing, Midwifery and Health Visiting; which is the current statutory controlling body for the nursing and related professions in England, deriving its powers and functions from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (U.K.C.C.).

### G.N.C.:

This abbreviation refers to the General Nursing Council for England and Wales; the former statutory controlling body for nursing in England and Wales.

### Qualified nursing staff:

(occasionally 'senior qualified staff' or 'qualified members of the ward team'). These terms refer to qualified nurses (e.g. R.G.N., S.E.N.) below the rank of ward sister or charge nurse, who are established members of the ward team; and who, though not formally recognised as clinical assessors, may from time to time participate in assessments by contributing information or observations for the guidance of official assessors.

INTRODUCTION

1.1 During the last decade, the assessment of clinical skills in student nurses in preparation for state registration has undergone a number of developments. The move from practical examinations carried out in the controlled surroundings of a school demonstration room to the staged assessment of skills in the clinical setting has raised a number of issues. One of the most important considerations concerns the apparent lack of valid and reliable instruments available for this purpose.

1.2 The researcher, having had the opportunity to observe the effects of these developments over a number of years at a practical level, became interested in exploring the theoretical and practical considerations of assessment in an effort to throw further light on this apparently resistant problem (85, 44, 3, 67).

- 
- (85) WOOLLEY, A.S. (1977):  
The long and tortured history of clinical evaluation.  
Nursing Outlook, Vol 25, No 5, pp 308-315.
- (44) KRUMME, U.S. (1975):  
The case for criterion-referenced measurement.  
Nursing Outlook, Vol 23, No 12, pp 764-770.
- (3) ANDERSON, D.M., and SAXON, J. (1968):  
Performance evaluation of nursing students.  
Nursing Outlook, Vol 1, No 5, pp 55-58.
- (67) RINES, A.R. (1963):  
Evaluating student progress in learning the practice of nursing.  
Columbia University: Bureau of Publications, Teachers' College.



1.3 Paper and pencil tests, the use of which represents one aspect of the process at present in use for the state registration of nurses in the United Kingdom, often bear little relationship to the level of nursing proficiency possessed by a student in the clinical situation (5, 9). The need for valid and reliable practical assessment methods is therefore of prime importance.

#### PURPOSE

1.4 The purpose of this study was to seek answers based on systematic enquiry to the questions:

What are the strengths and weaknesses of present methods used to assess practical skills in student nurses?

Are there ways in which present methods of assessment of clinical skills of student nurses might be improved and what might be proposed as improvements?

#### OBJECTIVES

1.5 The more specific objectives were:

- a. To identify and describe strengths and weaknesses of methods of assessment of the practical skills of student nurses in use at present, excluding continuous progressive assessment, according to published literature;

- 
- (5) BENDALL, E.R.(1975):  
So You Passed, Nurse.  
London: Royal College of Nursing.
  - (9) BOREHAM, N.C. (1977):  
The use of case histories to assess nurses' ability to solve problems.  
Journal of Advanced Nursing, Vol 2, pp 57-66.

- b. To identify strengths and weaknesses of methods of assessment in use at the present time, as described at interview by trained nurses who are involved in the process of assessment at a practical level;
- c. To identify and describe suggested areas of improvement in present methods of assessment, by analysis of the literature and interviews with clinical nursing assessors in (b), above;
- d. To investigate the validity and reliability of the completed progress assessment form, by analysis of samples drawn from the centres included in this study.

1.6 The overall aim of this study essentially involved an investigation into the assessment of clinical practice in basic nurse education. Clearly, this was a broad aim encompassing the whole spectrum of clinical skills and attitudes involved in clinical practice. The dearth of previous research in this area of nurse assessment made it impossible at this stage to identify a narrower field of investigation.

#### THEORIES OF LEARNING AND ASSESSMENT

1.7 The assessment of practical or clinical competence is a complex and difficult process in any educational environment; and this was reflected in the available literature on student nurse assessment. Whilst considerable research had been carried out into methods of assessing intellectual aspects of learning, much less had been attempted on the assessment of practical skills. Techniques of assessment devised in this area would appear to be relatively specific to the training context; and less

generalisable than techniques for assessment of intellectual attainment (36).

1.8 Woolley (85) identifies two areas of difficulty encountered in attempting to assess nursing practice.

These include:

(1) The nature of nursing

The imprecise basis of much nursing knowledge and practice make it difficult to define universally applicable standards of clinical practice. Additionally, the range and variety of nursing practice existing in training schools makes the problem more complex still. The author speculates on the feasibility of universal standards, suggesting that possibly the dichotomy of 'general' versus 'specific' techniques is a fundamental issue in clinical nursing assessment.

(2) Trends in recent educational development

During the last two decades, considerable advances have occurred in curriculum development, design and innovation in nurse education. Notably, the work of Mager (53) and Gagné (20) provided the basis of the educational objective-setting exercise which continues to develop. The move from teacher-centred to student-centred learning and the increasing study of androgogy have assisted growing developments in nurse education. However, the majority of these developments have been concerned with the acquisition of the cognitive knowledge base in nursing. By contrast, the important issues of ward learning objectives and the measurement or assessment of related clinical skills in learners have not yet come into full focus as critical areas of research.

1.9 An essential aspect of the study of the learning process relates to the methods employed to establish the degree of progress being made by learners. In nursing

- 
- (36) KEHOE, D.M. and HANBER, T. (1979):  
Principles of Assessing Nursing Skills.  
London: Pitman Medical.
- (85) WOOLLEY, A.S. (1977):  
The long and tortured history of clinical evaluation.  
Nursing Outlook, Vol 25, No 5, pp 308-315.
- (53) MAGER, R.F. (1975):  
Preparing Instructional Objectives.  
San Francisco: Fearon Publishing Inc.
- (20) GAGNÉ, R.M. (1970):  
The Conditions of Learning.  
New York: Holt, Rinehart and Winston.

education, techniques for measuring intellectual attainment continue to be developed (cf e.g. S10, S16); but with regard to assessment of progress in the acquisition of clinical nursing skills, this has not so far been the case in the experience of the researcher during many years spent in theoretical and practical education of learner nurses. Practical assessment is carried out to provide evidence that a student nurse is mastering the practice of nursing to a stated extent.

#### LEARNING THEORY:

1.10 The nature of learning has been extensively researched: and the volume of published material illustrates its complexity and its importance to the scientific community. Much of the available material is concerned with classical theories established by scientific research during the first half of the twentieth century. These experimental studies form the basis of modern approaches to explaining the phenomenon of learning. There is no single theory which has gained general acceptance: and educational psychologists tend to use the word as an introduction to a wide-ranging discussion of the various mechanisms by which learning is thought to take place (30).

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(S10) DINCHER, J. and STIDGER, S. (1976):

Evaluation of a written simulation format for clinical nursing judgement.  
Nursing Research, Vol 25, No 4.

(S16) HUCKABAY, L.M. (1978):

Cognitive and affective consequences of formative evaluation in graduate nursing students.  
Nursing Research, Vol 27, No 3, pp 190-194.

(30) HILL, W.F. (1980):

Learning: a survey of psychological interpretations.  
London: Methuen.

1.11 Some definitions of the word "learning" are:

A relatively permanent change in behavioural tendency that has come about as a result of reinforced practice (14).

A change in human disposition or capability which can be retained (20).

A relatively permanent change in behaviour that occurs as a result of prior experience and is not due to maturation, disease or physical damage (28).

1.12.1 The most influential theories currently in use to explain learning as defined are classified according to the major differences in belief about the mechanisms involved and how learning takes place. There are two main approaches included in the classification which are not mutually exclusive. The connectionists believe that learning occurs as a result of links between stimuli and responses. These connections can be identified by a variety of labels, such as habits, conditioned responses and stimulus-response bonds. Psychologists such as Thorndike, Pavlov, Guthrie and Skinner are the leaders of this school; and dominate the development and explanation of learning theory during the first half of this century (29).

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(14) DeCECCO, J., and CRAWFORD, N. (1974):  
The Psychology of Learning and Instruction.  
(Second Edition).  
Englewood Cliffs, New Jersey: Prentice-Hall.

(20) GAGNÉ, R.M. (1970):  
The Conditions of Learning.  
New York: Holt, Rinehart and Winston Inc.

(28) HILGARD, E.R., and ATKINSON, R. (1975):  
Introduction to Psychology.  
New York: Harcourt Brace Jovanovich.

(29) HILGARD, E.R., and BOWER, G.H. (1975):  
Theories of Learning.  
Englewood Cliffs, New Jersey: Prentice-Hall.

1.12.2 E.L. Thorndike was a pioneer in experimental animal psychology. His monograph entitled 'Animal Intelligence' is one of the most renowned classics in the field (80a). It is to Thorndike that we owe the term connectionism; though his study of the 'pure' psychology of learning, and his explanation in terms of the mechanical 'stamping-in' of S-R (stimulus-response) connections, have been both praised and condemned over the succeeding years.

1.12.3 Pavlov's experiments on classical conditioning in dogs established several principles used to explain habit formation (59). E.R. Guthrie first published his own definitive work on learning theory in 1935; the basic principles of which are similar to that of conditioning described in the foregoing examples ('A combination of stimuli which has accompanied a movement will, on its recurrence, tend to be followed by that movement') (24).

1.12.4 Skinner's theory, like that of Thorndike, emphasised connectionism and reinforcement as basic factors in learning (76) (see also pp 170-175, below).

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(80a) THORNDIKE, E.L. (1911):  
Animal Intelligence.  
New York: The Macmillan Company.

(59) PAVLOV, I.P. (1927):  
Conditioned Reflexes.  
New York: Oxford University Press.

(24) GUTHRIE, E.R. (1952):  
The Psychology of Learning (Revised Edition).  
New York: Harper and Row.

(76) SKINNER, B.F. (1957):  
The Behavior of Organisms.  
New York: Appleton-Century-Crofts.

The second approach describes perceptions of experience as the causative factor to explain learning. These theorists are more concerned with perception, attitudes and beliefs that individuals have about their environment (31).

1.12.6 The Gestalt psychologists who were active in the first quarter of the twentieth century and E.C. Tolman (1886-1959) were early key influences in this group of theorists. The Gestalt psychologists were more concerned with perception and its effect on learning. Their emphasis was on whole systems; and consequently the Gestalt approach to learning is that it is not a matter of adding or subtracting as in connectionism, but of change through new experience or the passage of time. A number of attempts have been made to combine the advantages of connectionism and cognitive theories.. Edward Tolman argued that human beings act on beliefs, express attitudes and strive towards goals; and developed a theory which recognises these aspects of learning (81).

1.13 Recent research has tended to concentrate on the application of clinical theories to practice. Much of the earlier work concentrated on experimental studies, either concerned with laboratory animals or confining itself to

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(31) HILL, W.F. (1981):  
Learning, a Survey of Psychological Interpretations.  
London: Methuen.

(81) TOLMAN, E.C. (1932):  
Purposive Behaviour in Animals and Men.  
New York: Appleton Century Crofts.

the study of learning in children (62). The extensive research in the formal school setting in primary and secondary school children has influenced curriculum development in nursing.

1.14 Unlike the extensive information available to explain learning in the early developing years, the subject of learning in the adult or older age range is apparently lacking in comparison. According to Lovell, the prodigious fundamental learning rapidly acquired in childhood is followed by a further set of biological, social and psychological adjustments at puberty, i.e. 11 - 16 years (50). From this stage, the juvenile moves into the adult phase of life and although adults are likely to go on learning throughout the whole of their lives, there is little learning that is as important and fundamental as that which takes place in childhood. The previous experience of the adult can have a great influence on the effectiveness of his learning and the higher his formal educational level, the better he is likely to cope with learning as an adult. Therefore, the adult comes to training with an already defined intellectual framework

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- (62) PIAGET, J. (1951):  
The Psychology of Early Childhood.  
London: Routledge and Kegan Paul.
- (50) LOVELL, K. (1980):  
Educational Psychology and Children.  
London: University of London Press.



and an existing knowledge base. An adult who has had successful educational experiences in childhood is likely to approach a new learning experience positively (31). Learning in the adult builds upon an established framework and is concerned with acquiring knowledge and larger repertoires of response (31, 71).

1.15 It is clear from the available literature related to learning theory that the means by which student nurses learn is complex. That learning takes place is established but the processes by which this occurs are not yet fully understood. The process of practical assessment which is used extensively in nurse training is aimed at collecting accurate evidence to demonstrate that the student is learning. The two methods by which this evidence is collected at present specify to some extent what is being assessed. The lack of specific criteria for pass/fail performance using GNC staged assessments and the apparent problems associated with progress assessment forms have raised serious questions about the validity of instruments at present in use (48, 16).

- 
- (31) HILL, W.F. (1981):  
Learning: a survey of psychological interpretations.  
London: Methuen.
- (71) SCHWIRIAN, P. (1981):  
Towards an explanatory model of nurse performance.  
Nursing Research, Vol 30, No 4, pp 247-253.
- (48) LONG, P. (1976):  
Judging and reporting on student nurse clinical performance: some problems for the ward sister.  
International Journal of Nursing Studies, Vol 13,  
pp 115-121.
- (16) EXTON-SMITH, J. (1976):  
Management of ward-based assessments.  
Nursing Times, Vol 72, No 9, pp 349-350.

1.16 Practical assessment is one part of the learning process in that it is concerned with collecting and interpreting information after first defining a level of performance. Mager (1961) and his work on behavioural objective setting in general education greatly influenced early attempts at deciding more scientifically what a student had to achieve in order to demonstrate that learning had taken place (52). Much of his work was concerned with classroom education although this has been applied to practical skill learning in nursing. More recently, the work of Gagné (1969), Glaser (1972) and Littock (1977) has further developed the practical application of learning theory with the "model of instruction" approach to learning (20, 22).

1.17 Inherent in this approach is the proposition that individual differences in ability produce different patterns and speeds of learning. Although earlier instructional models concentrated on curriculum design and educational programming using specific objectives this also resulted in the widespread use of programmed learning packages and teaching machines. The emphasis on the learning of cognitive information was of particular

- 
- (52) MAGER, R.F. (1961):  
Preparing Objectives for Programmed Instruction.  
San Francisco: Fearon Publishing Company.
- (20) GAGNÉ, R. (1970):  
The Conditions of Learning.  
New York: Rinehart & Winston Inc.
- (22) GLASER, B.G., & STRAUSS, A.L. (1979):  
The Discovery of Grounded Theory.  
New York: Aldine Publishing Company.

use in the classroom, rather than in a practical setting.

1.18 Gagné's work was a development of the earlier connectionist theories. He turned from the scientific study of the psychology of learning to the practical task of training fighter pilots in World War II. His experience at observing directly the results of the teaching of complex technical tasks stimulated his interest in making traditional learning principles more applicable to training tasks. From this came his theory of instruction which describes what he saw as the required steps involved in learning. The principle of progressing from simple to complex learning has wide application for the purposes of instruction (20).

1.19 Further work describes the outcome of this instructional model when applied correctly. Five types of learning outcome are described; the learning of motor skills; verbal information; intellectual skills; attitudes and cognitive strategies. Gagné (1962) reviewed the successful use of practical simulation in training for technical skills and performance assessment as a prelude to mastery learning. Writers on nursing topics

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(20) GAGNÉ, R. (1970):  
The Conditions of Learning.  
New York: Rinehart & Winston Inc.

refer to the use of simulation techniques for the purpose of teaching and assessing nursing skills (34, 70, 46).

1.20 Given that learning involves changes in behaviour (see definition on page 6), then assessment procedures should provide evidence that this is so. The use of instructional models ensures that the student receives the relevant information in order to learn (6). The specification of what the student is expected to be able to perform as a result of instruction is essential if assessment procedures are to develop the validity and reliability which is apparently lacking at the present time.

#### DEFINITIONS

1.21 A number of words are used both generally and in the literature which are not always defined and which are sometimes used interchangeably. Words such as "assessment" and "evaluation" are commonly used in this context, but the exact meanings are not always clearly

- 
- (34) INFANTE, M.S. (1975):  
The Clinical Laboratory in Nursing Education.  
New York: John Wiley & Sons.
- (70) SCHNEIDER, H.L. (1979):  
Evaluation of Nursing Competence.  
Boston: Little Brown & Co.
- (46) LENBURG, C.E. (1979):  
The Clinical Performance Examination.  
New York: Appleton-Century-Crofts.
- (6) BENDALL, E.R. (1976):  
Learning for Reality  
Journal of Advanced Nursing, Vol.1, pp 3-9.

established by authors. This produces uncertainty and influences the situation adversely. The words used in this study are derived from the literature reviewed and are given the following definitions:

### ASSESSMENT

1.22 This word is given various meanings, both in general and nursing terms. The dictionary definition "to fix amount of" (Concise Oxford Dictionary, 1949) implies that there is some kind of measure associated with the word. In nursing, the word "assessment" has been used since the early 'seventies to refer to the practical tests undergone by students in the clinical area during training.

1.23 Assessment used in this sense places more emphasis on a step-by-step approach to practical tests during the course of training which are designed to indicate strengths and weaknesses, and to provide remedial help where necessary to a student who is practising nursing skills in the clinical setting. This form of testing is referred to as "formative", and is designed to indicate strengths and weaknesses (32, 54). Generally, nurses associate assessment with a kind of "weighing up" of information collected in various ways in order to make judgements about performance.

- 
- (32) HUCKABAY, L.M. (1979):  
Cognitive-affective consequences of grading versus non-grading of formative evaluation.  
Nursing Research, Vol 28, No 3, pp 173-178.
- (54) MORGAN, B., LUKE, C., and HERBERT, J. (1979):  
Evaluating clinical proficiency.  
Nursing Outlook, 27(8), pp 540-544.

referring to the "nursing process" approach to care. Here it has been defined as the collection and inspection of information in order to identify and validate problems (42). This two-stage activity is seen as the collection of subjective and objective information in the form of observable cues followed by analysis. Inferences are made from observable cues in order to identify care problems. A variety of skills are involved in this complex procedure and the same applies to the practical assessment of nursing skills. The nature of the information collected and its interpretation is the central issue with which this study is concerned.

1.25 The term "evaluation" is used widely in respect of clinical assessment (18, 17, 85, 32, 2). The dictionary

- 
- (42) KRATZ, C. (1979):  
The Nursing Process.  
London: Bailliere Tindall.
- (18) FLANAGAN, J.C. (1954):  
The critical incident technique.  
Psychological Bulletin, 51, pp 327-358.
- (17) FIVARS, G., and GOSNELL, D. (1966):  
Nursing Evaluation: The Problems and the Process.  
New York: Macmillan.
- (85) WOOLLEY, A.S. (1977):  
The long and tortured history of clinical evaluation.  
Nursing Outlook, Vol 25, No 5, pp 308-315.
- (32) HUCKABAY, L.M. (1979):  
Cognitive-affective consequences of grading versus non-grading of formative evaluation.  
Nursing Research, Vol 28, No 3, pp 173-178.
- (2) ADDERLEY, B.V., and BROCK, A.M. (1977):  
Evaluating clinical performance in nursing.  
Journal of Advanced Nursing, Vol 2, pp 355-363.

definition "to work out the value of", "to find numerical expression for", "to ascertain amount of", (Concise Oxford Dictionary, 1949, p.409), tends to overlap with the definition of "assessment" as noted earlier.

1.26 Bower (1974) defines evaluation as the act or result of making a judgement, appraisal or interpretation and describes two types, both of which, she suggests, should be used. One type measures performance against specified criteria (i.e. criterion-referenced evaluation); whilst the other type compares performance with that of established normative groups (i.e. norm-referenced evaluation). One clear difference between assessment and evaluation is that evaluation is concerned with the precise statement of programme, course or unit objectives on a prescriptive basis (2). The close relationship between objective settings, learning experiences and evaluation procedures underlines the concern with information of a specific nature. Although both assessment and evaluation procedures are concerned with the

- 
- (10) BOWER, F.L. (1974):  
Normative or criterion-referenced evaluation?  
Nursing Outlook, Vol 22, No 8, pp 499-502.
- (2) ADDERLEY, B.V., and BROCK, A.M. (1977):  
Evaluating clinical performance in nursing.  
Journal of Advanced Nursing, Vol 2, pp 355-363.

collection of information, assessment seeks information of a general descriptive nature (42, 51, 33, 66).

Evaluation is seen as an on-going process concerned with gathering and analysing information to aid in decision making. Assessment is part of evaluation but is seen as a general systematic procedure for collecting data to describe behaviour. One aspect of importance to both activities is the concept of measurement which involves the use of numbers or grades to describe an activity (44). Rines (1963) sees evaluation as an intellectual exercise and assessment as a practical activity aimed at collecting evidence for the purpose of evaluation (67). She sees the techniques involved in evaluation as possessing greater dimensionality and that the process is concerned with the broader aspects of training, such as syllabuses,

- 
- (42) KRATZ, C. (1979):  
The Nursing Process.  
London: Bailliere Tindall
- (51) LYNCH, E.A. (1978):  
Evaluation: principles and processes.  
New York: National League for Nursing, 23, pp 17-21
- (33) HUCKABAY, L.M. (1980):  
Conditions of Learning and Instruction in Nursing.  
St. Louis: C.V. Mosby Company.
- (66) REZLER, A.G., and STEVENS, P.J. (1978):  
The Nurse Evaluation in Education and Service  
New York: McGraw-Hill
- (44) KRUMME, U.S. (1975):  
The case for criterion-referenced measurement.  
Nursing Outlook, Vol 23, No 12, pp 764-770
- (67) RINES, A.R. (1963):  
Evaluating Student Progress in Learning the Practice of Nursing.  
Columbia University: Bureau of Publications, Teachers' College.



curricula, clinical allocations and/or modules of experience.

1.27 Educational psychologists use the words in a more scientifically precise manner. In this sense, evaluation refers to the systematic process of determining the extent to which educational objectives have been met (23).

### SKILLS


1.28 The word "skill" in this study refers to the three main elements generally regarded as components of skilled activity for the purposes of assessment. These components are cognitive, affective and psychomotor skills.

1.29 Human abilities have been classified for the purposes of educational measurement as indicated in the following table (8, 41, 74):

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- (23) GRONLUND, N.E. (1971):  
Measurement and Evaluation in Teaching (Second Edition)  
New York: Macmillan.
- (8) BLOOM, B.S. (1956):  
Taxonomy of Educational Objectives: Handbook I,  
Cognitive Domain, and Handbook II, Affective Domain.  
London: Longmans Green.
- (41) KRATHWOHL, D.R., and BLOOM, B.S. (1964):  
Taxonomy of Educational Objectives: Affective Domain.  
New York: David McKay.
- (74) SIMPSON, E.J. (1977):  
The classification of educational objectives:  
psychomotor domain.  
Illinois Teacher of Home Economics, Vol 10,  
pp 110-114.

Table 1.1

COGNITIVE, AFFECTIVE AND PSYCHOMOTOR DOMAINS (after Bloom, 1956).

<u>Cognitive Domain</u>	<u>Affective Domain</u>	<u>Psychomotor Domain</u>	<u>Higher Skills</u>
Evaluation Synthesis Analysis Application Comprehension Knowledge	Organisation Conceptualisation Valuing Responding Receiving	Weighing Testing Reassuring Preparing Measuring Lifting Explaining Dressing Connecting Comforting Assisting Assembling Admitting Administering	 Basic Skills

1.30 Abilities at the lower end of the cognitive domain can be measured, in particular the retention of knowledge. The components of the affective domain lend themselves to assessment rather than measurement but the elements in the psychomotor domain can be measured.

#### ASSESSORS

1.31 For purposes of this study assessors fall into two categories:

- 1) Ward sisters in charge of wards where learners are allocated in order to gain experience leading to qualification. The type of assessment carried out is called "progress assessment" and involves a confidential written report which is completed at the end of a period of eight to twelve weeks on average. With few exceptions, this method is used widely throughout England and Wales, but the forms in use vary. All ward sisters participate in this activity.

2) In order to ensure that training would be provided for those carrying out staged assessments, the GNC established an official panel of those suitably trained and experienced. Entrance to the panel is encouraged but not mandatory for all trained nurses who are involved in learner areas. Minimum qualifications for the panel are now laid down by individual training schools as advised by the ENB. The abbreviation 'ENB' refers to the English National Board for Nursing, Midwifery and Health Visiting which has now superseded the GNC through the 1979 Act. Training is provided and potential assessors are interviewed by directors of nurse education acting with appropriate members of service nursing staffs. Successful applicants are then asked to participate in staged assessments in their ward area within the relevant health authority. Assessors suitable for this activity are ward sisters who have usually had a minimum of two years experience in post and anyone above this grade actively involved in the practical training of students.

#### CONTINUOUS ASSESSMENT

1.32 To date, twelve schemes only have been approved for the use of continuous assessment in England and Wales.

Although it is still in the developmental stage, it has been under consideration since the first experimental modular training schemes were established ten years ago (43). Generally, this system phases out the two methods in use at present in favour of a continuous monitoring system.

1.33 This system is based on assessing nursing skills against a set of previously developed objectives. An

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(43) KRATZ, C. (1981):  
Continuing assessment.  
Nursing Times, Vol 1, No 13, Educational Supplement.

objective describes an intended result (53); and in the case of performance objectives the required level of competence must be demonstrated by the student as one component of the overall specification of competence during one module. Over recent years, trained nurses have begun to specify in behavioural terms the scope of possible learner outcomes in a ward or department; and this skill is gradually developing. Some schemes have decided to retain the progress assessment form and have drawn up practical schedules for guidance expressed in clinically objective terms. Some centres are in the process of developing separate instruments for purposes of continuous assessment. One published article describes a pilot study testing such instruments based on 'A specification of nursing competence' (86), the main headings of which were incorporated in the trial instrument. The final report is not yet available (86).

1.34 An important strength of this method is that trained nurses are now paying more attention to describing a range of student behaviours prospectively and using these as a measure against which to assess individual students. This can reduce subjectivity of assessment and

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(53) MAGER, R.F. (1975):  
Preparing Instructional Objectives (Second edition).  
San Francisco: Fearon Publishing Inc.

(86) YOUNG, A.P. (1980):  
Progress and problems of continuous assessment.  
Nursing Times, Occasional Paper, Vol 76.

reduce some error. However, in the first of three papers describing a pilot study of one method of continuous assessment, Young and Morgan identify the main problems associated with GNC/ENB assessments as:

- 1) lack of feedback to student nurses;
- 2 the inaccuracy of a system in which only a very small part of total performance in the overall training programme is considered for assessment purposes (87).

These issues were further explored by the present researcher in formulating the questionnaires for the current study.

#### LITERATURE REVIEW: ENGLAND AND WALES

1.35 Though extensive, the topic has so far produced little published research. Thus the literature review produced numerous papers related to clinical assessment; but few could be of direct use due to lack of a research base for the work described. However, issues raised in the research-based literature were helpful to the present researcher in developing the questionnaires employed in the current study.

#### DEVELOPMENT OF ASSESSMENT METHODS IN ENGLAND AND WALES

1.36 The development of the two commonly-used methods of practical assessment in nursing in England and Wales has stemmed from two sources. The GNC/ENB 'staged' method

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(87) YOUNG, A.P. and MORGAN, W. (1978):  
Continuous assessment for nurses in the Thomas  
Guy School of Nursing (1).  
Nursing Times, Occasional Paper, Vol 74, No 51.

has arisen from the requirements for state registration inherent in the Registration of Nurses Act 1919 (1). Progress assessment of nurses has developed out of a parochial need to provide a useful interim assessment of the day-to-day practical activities and abilities of students undergoing the process of training for state registration.

1.37 Organised training for students began in 1860 (4) but the struggle for standardisation through state registration took another fifty years and an Act of Parliament (1919). This Act brought about the establishment of the General Nursing Council for England and Wales (hereafter referred to as the GNC) and its powerful Training and Examination Committee. The statutory responsibilities of the GNC were passed to the English National Board by the 1979 Nurses, Midwives and Health Visitors Act.

1.38 Early practical examinations consisted of a short two-staged system, i.e. Preliminary and Final State Examinations conducted mainly by doctors and experienced nurses appointed by the GNC (First Draft Syllabus, 1924). The Nightingale School at St Thomas' Hospital had developed and used this approach for a number of years prior to its

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(1) ABEL-SMITH, B. (1960):  
A History of the Nursing Profession.  
London: Heinemann.

(4) BENDALL, E.R. and RAYBOULD, E. (1969):  
The History of the General Nursing Council for  
England and Wales.  
London: H.K. Lewis.

introduction nationally by the GNC. Doctors at that time also carried out oral question and answer tests for nurses (4).

1.39 This system was used until 1950 when oral examinations were discontinued and the duration of the practical examination was extended slightly. The first moves towards the transferring of overall responsibility for the assessment of students from the GNC to individual training schools came in 1960. The Preliminary State Examination which candidates had to pass was discontinued. The Hospital Intermediate Examination was introduced. This examination came later in training and had to be passed at the first attempt by the candidate. The State Final Practical Examination was also changed slightly in that the numbers of candidates per hourly examination was reduced from four to two. Also at this time the 1962 Syllabus of Training was introduced with its emphasis on integration of subjects for the purpose of examination and training (4).

1.40 The practical examinations were carried out in practical rooms in schools of nursing. Two candidates were tested by two examiners who tended to be matrons appointed by the GNC. The examinations were structured

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(4) BENDALL, E.R., & RAYBOULD, E., (1969):  
The History of the General Nursing Council for  
England and Wales.  
London: H.K. Lewis.

and strict timing was adhered to. During the first half hour, the students would be examined individually using a practical task approach. A particular tray or trolley setting would be prepared by the student and then a period of questions and answers ensued. During the second half of the examination, the students would work together on a patient-centred assignment. This might involve a volunteer patient in an effort to create authenticity. This type of examination demonstrated knowledge rather than clinical expertise (9), and the system was greatly criticised for its lack of relevance to the realities of practical performance (4). As a direct result of this growing concern, this form of examination was gradually phased out and replaced by a four-part practical staged assessment carried out in the clinical situation leading to state registration.

#### PROGRESS ASSESSMENT FORMS

1.41 At the same time, but independently, the question of regular ward reports on nurses' progress was becoming of increasing concern amongst senior nurses. As a direct result of a national project (Kings Fund Interim Report, 1965) which was designed to illustrate the types of reporting procedures and methods in use at that time and

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- (9) BOREHAM, N.C. (1977):  
The use of case histories to assess nurses' ability to solve problems.  
Journal of Advanced Nursing, Vol 2, pp 57-66
- (4) BENDALL, E.R. and RAYBOULD, E. (1969):  
The History of the General Nursing Council for England and Wales.  
London: H.K. Lewis.



revealed a confused situation, a national form was produced which is still widely used though not standardised. (See Appendix C for full report).

1.42 A follow-up survey three years later involving the same hospitals revealed that some progress had been made since 1965. The results did not produce any great changes but it was evident that there was increasing awareness of the importance of the issue. A joint working party was set up by the Kings Fund and the GNC to explore the possibility of producing a standard form (39).

1.43 Eventually, a form which had been developed over some years at the United Liverpool Hospitals was modified and adopted for use (37). The twenty-five-item report is a modification of the Likert scale system (47). Five categories under the headings Application to Work; Quality of Work; Attitude to Patients; Attitude to Co-workers; and Professional Behaviour are included, with sections for comments in each. The five-point scale has 'average' at the mid-point with two tendency scores to x or to y. The

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- (39) KINGS FUND (1968):  
A Study of Student Nurses' Progress: Final Report.  
London: Kings Fund Foundation
- (37) KING, H.M. (1968):  
Ward reports: an effort to be fair.  
Nursing Times, Occasional paper, pp. 21-24
- (47) LIKERT, R.A. (1932):  
A technique for the measurement of attitudes.  
Archives of Psychology, No 140.

'x' scores indicate excellence and the 'y' scores are unacceptable. The items are general statements which the ward sister ticks. An overall grading on the front of the form also has five possible scores. The two scales do not correspond exactly - for example, the overall mid-point is 'good - satisfactory' whereas elsewhere it is 'average'. The terms used in the scale are not defined. The form is meant to be used to assess progress made by learners during a clinical allocation which on average is eight to twelve weeks. It is used at all stages of training (see Appendix D ).

1.44 Likert scales are widely used in attitude and opinion surveys. Scales of this nature, to be valid, should consist of declarative statements expressing a viewpoint on a topic. Respondents are asked to agree or disagree with opinions expressed in each item. The construction of such scales is subject to piloting of items focussing on one concept (63). Five-point scales are traditionally used, but they can be extended. Careful preparation in the development phase is essential for the scale to be reliable and to possess validity. There is no evidence available to the researcher in respect of how the aforementioned student assessment instrument was constructed.

1.45 Extra sections are available on the 'progress assessment' form for preliminary interviews: and sections

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(63) POLIT, D., & HUNGLER, H. (1978):  
Nursing Research Principles and Methods  
(Second Edition).  
New York: Lippincott.

for comment by student, nursing officer and tutor. The reports are confidential and completion is the responsibility of the ward sister. Over a standard general training programme, some twelve progress reports are completed for each student. These reports are considered, together with the results of staged assessments, as evidence of the student's overall level of competence in nursing practice, and of her eligibility for state registration, given that she passes the written examination.

1.46 In 1973, the GNC Research Unit conducted an evaluative study of the use of the 'progress assessment' form, the respondents being 829 ward sisters. Six hundred and thirty-three respondents completed a questionnaire and 196 were interviewed. Three main areas of concern were revealed: i.e. organisational variables (e.g. length of the clinical allocation and staffing levels); ability of the rater to make an assessment; and the overall purpose of the assessment. Other areas of concern involved the use of undefined terms such as 'average' and 'satisfactory'; the ambiguity of some statements; and the use of extreme measures (48). These factors are further considered in the present study. Rines (1963) has expressed the view that the only justifiable descriptors for student behaviour whilst learning the practice of nursing are the terms 'satisfactory' and 'unsatisfactory'. She recommends that anecdotal records, checklists, rating scales, student self-evaluations and patients' observations all be used to

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(48) LONG, P. (1976):

Judging and reporting on student nurse clinical performance: some problems for the ward sister. International Journal of Nursing Studies, Vol 13, pp 115-121.

give a complete picture of the student's behaviour, as long as they are not used to compare the student's performance to that expected of a qualified nurse (67).

1.47 In the GNC study just cited, there did not appear to be any consensus amongst respondents as to what was being assessed. In view of this, Long (1975) posits that the preparation and education of raters is an important factor in the success of any method used (47a). Following her analysis of completed forms, this author expresses doubts regarding the reliability of this method of assessment, which had previously been under discussion by the GNC for some years in a series of related circulars (21).

1.48 Long's categorisation of variables is given here, since it proved helpful in designing the present research instrument. It includes:

i) Organisational Variables:

(i.e. those influencing satisfaction/dissatisfaction with the assessment)

- length of allocation to the ward
  - use of internal rotation and its effect upon observation of students
  - number of learners, with seniority indicated
  - ratio of trained staff to student nurses
  - design and layout of the ward
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(67) RINES, A.R. (1963):

Evaluating Student Progress in Learning the Practice of Nursing.  
Columbia University: Bureau of Publications.

(47a) LONG, P. (1975):

The Assessment of Student Nurses' Clinical Performance. (Unpublished report of a survey undertaken for the General Nursing Council).

(21) GENERAL NURSING COUNCIL (1969,1972,1974,1975):

Circulars Nos. 69/4/3; 72/3/6; 74/8/16; 75/43/A.  
London: GNC for England and Wales.

- opinions of the form
- administration and involvement of others

iii) Purpose of Assessment:

- what is being assessed, and why?

GNC STAGED ASSESSMENT

1.49 The lack of clear-cut criteria for judging general and specific skills was a known problem which was beginning to receive an increasing amount of attention in the late 'sixties. Another concern expressed referred to the screening process which is an important aspect of examination. The earlier system did not discriminate sufficiently between standards of practical performance in candidates at pass/fail levels (11).

1.50 The effort by the GNC to develop a more effective method of practical assessment of student nurses was based on the findings of a small pilot scheme. The scheme tested the feasibility of ward-based examinations, which would have transferred the existing system to the ward from the demonstration room. The concept of the summative examination was to be retained (11).

1.51 Some experience had already been gained following the introduction of the 1962 Syllabus for Pupil Nurses which involved ward practical examinations. The GNC for Scotland had introduced a final practical examination in 1963. The ensuing pilot scheme involved four hospitals in England and Wales, using the experience gained in these two previous implementations. The

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(11) BRIGGS, M.R. and MAGUIRE, J.M. (1968):  
Towards a ward-based final practical examination.  
Nursing Times, Vol 64, No 29, pp 109-111.

gradual transfer of responsibility for practical examination from the GNC to training schools was recognised as desirable and inevitable (11). Following this pilot scheme, though the new scheme would have its problems, the clinical setting was more realistic in that the student would be examined where she nursed her patients. Also at this time, the patient-centred approach to care was beginning to develop. The work being carried out in the United States on nursing models may have influenced the timing of this development (65).

1.52 Acting upon the findings of the pilot scheme and 'trends in examining procedures in other fields of education' (21), the current system began to develop. The concept of the examination was to go, making way for practical assessment. The tests are based on direct observation of the student working in the clinical area. Four aspects are assessed in separate stages, during the second part of training. The aspects mentioned represent 'proficiency which is particularly relevant to registration (21)'. Four tasks, including a patient-centred assignment and one a ward management assignment, are the

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- (11) BRIGGS, M.R. and MAGUIRE, J.M. (1968):  
Towards a ward-based final practical examination.  
Nursing Times, Vol 64, No 29, pp 109-111.
- (65) RANDELL, B., TEDROW, M.P., and VAN LANDINGHAM, J.  
(1982):  
Adaptation Nursing: The Roy Conceptual Model  
Applied.  
St. Louis: C.V. Mosby.
- (21) GENERAL NURSING COUNCIL (1969, 1972, 1974, 1975):  
Circulars Nos. 69/4/3; 72/3/6; 74/8/16; and 75/43/A.  
London: The General Nursing Council for England  
and Wales.

areas of nursing currently sampled. Assignments include demonstration of aseptic technique; carrying out a medicine round; planning and giving care to a patient during a span of duty; and a communication and organisation assessment, involving a group of from ten to twelve patients during a span of duty.

1.53 This system began to be implemented in 1973. The principle of delegation of responsibility for this process is a major consideration. The feasibility of national control of assessments is a key issue, and remains so.

1.54 Initially the control was kept by the GNC who at that time ruled that trained nurses involved in the new assessment procedures had to undergo a course of preparation for the role. Following this, potential assessors were then interviewed by members of the GNC and suitability assessed. If the candidate satisfied admission criteria, then her name was included on the Panel of Assessors, for which additional duty members were initially paid a small sum of money (21).

1.55 Potential assessors were judged on clinical experience and involvement with the practical training of nurses. Admission to the panel is not a compulsory requirement for ward sisters; an anomaly which is a key

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(21) GENERAL NURSING COUNCIL (1969, 1972, 1974, 1975): Circulars Nos. 69/4/3; 72/3/6; 74/8/16; and 75/43/A. London: The General Nursing Council for England and Wales.

issue in the present study (16). The responsibility of preparing assessors and maintaining the Panel of Assessors lists now rests with directors of nurse education. The number of trained assessors on wards used for training is a significant factor in this discussion. There is evidence to suggest that ward sisters now accept the importance of this role more readily: and that there is an increasing amount of confidence in this particular aspect (13). The GNC/ENB emphasises the sharing of responsibility in the administration of the four practical tests.

1.56 The extent to which this method of assessment represents evidence of ability has been a cause for concern since its implementation. The validity and reliability of the instruments used by the various schools of nursing (see Appendix E) are called into question in this study. Each centre included in the present study used different procedures. The referral of students is an important aspect of the current system and is investigated in this study. The learner is given more than one chance to pass. This represents an inherent strength and also an improvement on the former system which was examination orientated, thus operating a pass/fail system. This inherent strength can only be so if the measures employed in the assessment have validity.

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- (16) EXTON-SMITH, J. (1976):  
Management of ward-based assessments.  
Nursing Times, Vol 72, No 9, pp 349-350.
- (13) CHOPPIN, B. and ORR, L. (1983):  
Aptitude Testing at Eighteen Plus.  
Slough: National Foundation for Educational Research.



1.57     Exton-Smith describes the implementation of staged assessments in one school of nursing. Six critical areas are mentioned as a result of an exercise completed by some senior students (16).

1. The artificiality of these assessments.
2. Possible anxiety felt by patients.
3. Poor response to Ward Sister involvement in this activity, and involvement of tutorial staff which is not seen as "meaningful".
4. Poor teaching at ward level particularly for Communication and Organisation section of ward-based assessments.
5. Lack of clinical teaching facilities.
6. Too much reliance on task-centred nursing.

1.58     Out of this work came a further study carried out in response to the uncertainty felt by assessors as to what was actually being assessed (75). This was an attempt to introduce the critical incident technique pioneered by Flanagan in World War II (18, 17). Ward sisters were invited to specify nursing activities in terms of desirable and describable categories. As in

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- (16)     EXTON-SMITH, J. (1976):  
Management of ward-based assessments.  
Nursing Times, Vol 72, No 9, pp 349-350.
- (75)     SIMS, A.J. (1976):  
The critical incident technique in evaluating student nurse performance.  
International Journal of Nursing Studies, Vol 13, pp 123-130.
- (18)     FLANAGAN, J.C. (1954):  
The critical incident technique.  
Psychological Bulletin, 51, pp 327-358.
- (17)     FIVARS, G. and GOSNELL, D. (1966):  
Nursing Evaluation: The Problems and the Process.  
New York: Macmillan.

other studies, which were exploratory, the findings did not produce a strong case for the use of this technique (67). The main criticism here is the lack of specified criteria and the comparison of activity of a student nurse with that based on the performance expected of a trained nurse. Despite similar inherent weaknesses, staged and progress assessment complement each other in providing different types of information about clinical performance.

#### REVIEW OF NORTH AMERICAN LITERATURE

1.59 The search for reliable and valid assessment methods in North America has been pursued extensively (85, 27, 67, 44, 57). Support can be found in the literature for a variety of methods used for the task of practical assessment. Concern about the inadequacies of earlier methods resulted in the gradual development of instruments in much the same way, though on a larger scale, as in England and Wales. Similarly, the ever-

- 
- (67) RINES, A.R. (1963):  
Evaluating Student Progress in Learning the Practice of Nursing.  
Columbia University: Bureau of Publications, Teachers' College.
- (85) WOOLLEY, A.S. (1977):  
The long and tortured history of clinical evaluation.  
Nursing Outlook, Vol 25, No 5, pp 308-315.
- (27) HAYTER, J. (1973):  
An approach to laboratory evaluation.  
Journal of Nursing Education, pp 17-22
- (44) KRUMME, U.S. (1975):  
The case for criterion-referenced measurement.  
Nursing Outlook, Vol 23, No 1, pp 764-770.
- (57) PALMER, M.E. (1959):  
A method of determining grades for clinical performance.  
Nursing Outlook, Vol 7, No 8, pp 468-470

changing nature of the theory/practice mix has also influenced the development of assessment instruments.

1.60 Overall, the development of methods of assessment falls into two broad categories: i.e. the search for norm-referenced instruments on the one hand; and for criterion-referenced instruments on the other. Norm-referencing is based on the comparison of an individual's performance with an established or 'standard' group norm; and its main purpose is to establish an individual's performance in relation to others. It tells little of the individual's degree of competence or capability, or the amount of learning that has taken place (33). According to Krumme, norm-referenced instruments fail to provide adequate measurement of the quality of nursing care (45). This approach has been adopted in the 'progress assessment form' used in the United Kingdom. It is intended to give an overall assessment of the nurse's performance in a clinical allocation. One of the problems so far encountered is the problem of deciding on what the norm is in this case (49). A strong reason for using this

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- (33) HUCKABAY, L.M. (1980):  
Conditions of Learning and Instruction in Nursing.  
St.Louis: C.V. Mosby Company.
- (45) KRUMME, U.S. (1976):  
The case for criterion-referenced measurement.  
Nursing Outlook, Vol 24, No 1, pp 26-31.
- (49) LONG, P. (1976):  
Student nurse assessment.  
Nursing Times, Vol 72, No 14, pp 552-555.

technique is for predictive purposes regarding pass or failure. Disadvantages for the learner are the strong competitive aspects of this system which blocks peer group learning (10). Examples of instruments based on this approach are the Jamison Rating Scale (35); the Slater Nursing Competencies Scale (77); and the Wandelt Patient Care Scale (84). All these instruments are based on direct observation which is time consuming and a critical factor against its general use. Failure to describe desired behaviours for rating scales has also led to problems of doubtful validity of these methods.

1.61 Criterion-referenced methods on the other hand refer to those testing situations where an individual's performance is compared against a set target or behavioural objective. It tends to give the student a sense of achievement and tends to decrease competitiveness and

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- (10) BOWER, F.L. (1974):  
Normative or criterion-referenced evaluation?  
Nursing Outlook, Vol 22, No 8, pp 499-502.
- (35) JAMISON, L.M. (1950):  
Rating student achievements in clinical experience.  
American Journal of Nursing, 50, pp 17-22.
- (77) SLATER, D. (1967):  
The Slater Nursing Competence Scale.  
Detroit, Wayne State University.
- (84) WANDELT, M.A. and STEWART, D. (1975):  
The Slater Competencies Rating Scale.  
New York: Appleton-Century-Crofts.

increases co-operation (33, 7). Critical incident techniques referred to previously, developed by Flanagan during World War II, and built upon by Fivars and Gosnell (1963) were the forerunners of this approach to assessment. Its popularity was shortlived because it was considered to be time-consuming and laborious, and the problem of how or whether to grade the data was never discussed (85). Some years later Sims conducted a study in eight hospitals in which ward sisters were asked to participate in a project testing the feasibility of critical incident methods, based on Flanagan's work (75). This exploratory study concluded also that preoccupation with the detail of incident analysis undermines the feasibility of this approach.

1.62 The basis of criterion-referenced instruments is a rating scale completed by observers. The instrument is used as a standard against which to judge whether the nurse has met the performance criterion specified before-

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- (33) HUCKABAY, L.M. (1980):  
Conditions of Learning and Instruction in Nursing.  
St. Louis: C.V. Mosby Company.
- (7) BEVIS, E.O. (1978):  
Curriculum Building in Nursing: A Process.  
St. Louis: C.V. Mosby Company.
- (85) WOOLLEY, A.S. (1977):  
The long and tortured history of clinical evaluation.  
Nursing Outlook, Vol 25, No 5, pp 308-315.
- (75) SIMS, A.J. (1976):  
The critical incident technique in evaluating  
student nurse performance.  
International Journal of Nursing Studies, Vol 13,  
pp 123-130.

hand. Performance criteria for tasks are described and achievement by each student is measured against them. An example of such a criterion measure is the Professional Practitioners' Performance Rating , which describes optimal performance of tracheal suctioning; the administration of tube feeds; and of oral and intramuscular medication. Criteria for developing this particular task analysis were derived from the literature (15). Later development of such instruments, in terms of stipulated standards of patient care rather than in terms of task construction, has resulted in increased consideration of both cognitive and interpersonal aspects of nursing activities: and Phaneuf's 'nursing audit' serves to exemplify this latter approach (61).

1.63 The instruments discussed so far are all concerned with nurse assessment in the clinical setting. The advantages of assessing clinical activities in this way have been the focus of considerable discussion in nursing journals (cf, e.g., 11). In North America, the use of

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- (15) DUNN, M.A. (1970):  
Development of an instrument to measure nursing performance.  
Nursing Research, Vol 19, pp 502-510.
- (61) PHANEUF, M.C. (1972):  
The Nursing Audit: Profile for Excellence.  
New York: Appleton-Century-Crofts.
- (11) BRIGGS, M.R. and MAGUIRE, J.M. (1968):  
Towards a ward-based final practical examination.  
Nursing Times, Vol 64, No 29, pp 109-111.

other settings for this purpose has support in the literature. One of the chief criticisms of present methods concerns the time-consuming elements associated with observation in the clinical setting. Since one of the principles of assessment should be to gather as much valid information as possible in order to obtain a reliable measure of competence, many complementary instruments may need to be employed.

1.64 Students need an opportunity to try, to practise, to fumble and to fail sometimes as part of the learning process, without being judged while doing so. The 'when' of clinical assessment is debatable; but any method must take account of learning time which is an essential component of the learning process (20). For this reason, strong cases for assessing skills in the simulated clinical setting are expressed (46, 70), in an attempt to provide useful information about practical skill development in students. An essential aspect of this approach is the

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- (20) GAGNÉ, R.M. (1970):  
The Conditions of Learning.  
New York: Holt, Rinehart and Winston Inc.
- (46) LENBURG, C.E. (1979):  
The Clinical Performance Examination.  
New York: Appleton-Century-Crofts.
- (70) SCHNEIDER, H.L. (1979):  
Evaluation of Nursing Competence.  
Boston: Little Brown and Company.

provision of useful information to ward staff about the student's abilities, a factor which is lacking in the present system (88). The use of videotapes in developing simulated practical situations for the purposes of assessment and other approaches to this problem are well documented: and there is evidence that, whilst such activities are likely to contribute to an overall assessment of student skills, they may not adequately reflect actual performance in the practical situation (60).

#### SUMMARY

1.65 The literature search revealed many references to the topic under review. There are many papers expressing opinions about practical assessment methods in England and Wales. This underlines the concern felt by many regarding the importance of this aspect of nursing. The fact that research-based papers are less common reflects the complexity of the subject.

1.66 The search for valid and reliable assessment instruments has been pursued vigorously in North America; but there is apparently no written evidence to support general acceptance and use of any one particular approach. Much of the reported activity is centred around the design of assessment instruments, rather than describing the weak-

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- (88) YOUNG, A.P. and MORGAN, W. (1978):  
Continuous assessment for nurses in the Thomas Guy School of Nursing.  
Nursing Times, Occasional Paper, Vol 75, No 1.
- (60) PEARSON, B.D. (1978):  
Evaluation of the nursing process through visual motion media  
International Nursing Review, Vol 25, No 4, pp 119-120.



nesses and strengths of existing methods. This study is concerned primarily with investigating the existing situation in England and Wales regarding the use of assessment methods, in order to reveal their strengths and weaknesses.

## SECTION TWO: RESEARCH DESIGN AND METHOD

2.1 As indicated in the previous section, the nature of the variables involved in practical nursing assessment are still not clearly understood. It is for this reason that otherwise competent and experienced trained nurses have difficulty in reaching agreement on specifying nursing competence for purposes of assessment. The present study concentrates mainly on collection of information from the group of nurse assessors most immediately concerned in this exercise. The lack of research information available meant that careful development of an appropriate research instrument, which would enable the researcher to collect reliable information of a descriptive and exploratory nature, was an essential precursor to the main study.

### METHOD:

2.2 Personal interview was chosen as the most suitable approach available in order to generate the types of data necessary to answer the main research questions. The lack of sufficient information on which to base an appropriate interview schedule required extensive preparation, pre-piloting and piloting. The approach used was a systematic personal interview to provide both structured and relatively unstructured information. Both closed- and open-ended questions were used with verbal probes in order to produce both general and more focussed information. It was anticipated that the unstructured data would lend itself to further analysis in areas of interest considered potentially useful sources of further relevant data.

2.3 The known disadvantages of the method chosen were considered during the development of the interview schedule. Problems of erroneous interpretation in terms of (e.g.) the Hawthorne effect (68), together with the time-consuming nature of this approach, were encountered during the pre-pilot and pilot phases. However, it is considered that no alternative method would have been more effective, bearing in mind the descriptive nature of the study.

2.4 An important issue related to the question of practical assessment concerns the value of the completed progress assessment form. This raises serious concern because of its extensive use in nurse training schools in the United Kingdom. This prompted the researcher to carry out a subsidiary investigation within the framework of the present study, the objective of which was to establish the extent to which the widespread dissatisfaction felt by assessors, both with the discriminative capabilities of progress assessment forms, and with their seeming lack of developmental or practical implications for the student, is justified.

2.5 This subsidiary investigation took the form of an initial item frequency analysis, based upon 623 completed progress assessment reports available for newly-qualified student nurses in Centres A and C of the study (cf Section

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(68) ROETHLISBERGER, F.J., & DICKSON, W.J., (1939):  
Management and the Worker. An account of a research  
program conducted by the Western Electric Company.  
Hawthorne Works, Chicago.  
Cambridge, Mass.: Harvard University Press.

Three, Paras. 3.87-3.101). Data obtained from the two centres were subsequently compared.

#### CONSTRUCTION AND DEVELOPMENT OF INTERVIEW SCHEDULE:

2.6 There are two methods of practical assessment in general use in the United Kingdom: progress assessment, which is the responsibility of individual schools of nursing, and concerns itself ostensibly with the progress of individual student nurses throughout their training: and statutory (ENB) assessment, which is a fourfold functional assessment of learners' work carried out for purposes of statutory registration (cf Section One, pp 22-35, for further details of the development and operation of these types of assessment). Information was collected about both types; and for this reason the interview schedule was developed in two separate sections. Although all respondents were eligible to participate in Section One of the schedule (that for progress assessors), they did not necessarily qualify to participate in Section Two (that for ENB assessors). It would have been desirable to interview a total sample of respondents who met the requirements for both sections. This proved not completely possible: thus three respondents in the main sample of forty-four were not ENB assessors.

2.7 Initially, general categories of possible questions were sought using two approaches. First, the literature was searched in order to find research papers related

to both types of assessment. Having drawn up the list of broad general categories from this source, further information was sought from nurses involved in assessments at ward level. Respondents who worked in a variety of clinical settings were contacted in order to produce a range of opinions based on differing experience. At this stage a student nurse, three ward sisters, a clinical teacher, a nurse tutor and a nursing officer agreed to give their views, which were recorded on audiotape. Two of the resultant interviews involved groups of three respondents. As a general guide, the progress assessment form itself and the main issues found in the literature were discussed. The interviews were unstructured, encouraging respondents to comment widely and to speak freely in the assurance that all discussions were confidential.

2.8 These audiotaped discussions were subsequently analysed to identify general themes and points of interest and controversy. This resulted in a list of possible categories for inclusion in the pilot instrument. The lack of previous research-based material influenced the design of the instrument and meant that general categories only could be used. The scope of possible categories was extensive; and therefore the instrument was restricted to collecting information of a general rather than of a specific nature. The length of the instrument was of concern in that the two types of assessment were both included; and this could without care have resulted in a long and unrealistic interview schedule. The instru-

ment was finally shortened to allow an interview time of approximately forty minutes.

2.9 The sample of content areas to be included in the pilot instrument was first considered by employing a 'table of specifications'. This procedure is a guide to the construction of interview schedules and questionnaires, which is designed to ensure that the overall aims of a survey can be achieved by selection of appropriate content areas (63). The first estimate was as follows:

Table 2.1: Table of Specifications (after Polit and Hungler, 1978): First Estimate.

CONTENT CATEGORY:	Estimated number of questions:
1 Background information	5
2 Facts about assessment	5
3 Belief about what the facts are	5
4 Attitudes, feelings, opinions about assessment	10
5 Reason for attitudes	10
6 Level of knowledge of assessment	5
7 Suggestions/ideas about possible improvements	5
TOTAL:	45

2.10 The instrument needed to be constructed in such a way that accurate descriptive data related to the research questions could be collected. Thus the purpose of the 'table of specifications' was to reduce imbalance in the

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(63) POLIT, D., & HUNGLER, H., (1978):  
Nursing Research Principles and Methods.  
(Second Edition).  
New York: Lippincott.

areas covered by the instrument. The main areas of concern indicated by the literature and by pre-pilot discussions appeared to be related to assessment skills and assessment attitudes. For this reason, it was decided that these categories would be allocated more items in an attempt to explore them in some depth.

2.11 Employing this estimate and the list of possible content categories, the first draft interview schedule was constructed. As far as was possible, structured questions were used, with 'probe' questions in content categories 4 and 5 (cf Table 2.1). Questions requiring alternative category ('yes'/'no') responses were written; and depending on the nature of the response, further information was sought by asking the respondent to expand on her answer.

2.12 When the first questions were drafted, and before the first pilot was undertaken, the wording of items was reconsidered in order to clarify questions and to reduce ambiguity and bias. For this purpose the questions were read out to a number of trained nurses not involved in the study; and their interpretations noted. This proved to be a helpful process, and resulted in changes in specific questions. Some questions were omitted because their content was being covered elsewhere in the schedule.

2.13 When completed the first draft did not correspond to the estimated number of items in the initial estimate using the 'table of specifications'. Differences were as illustrated in the following comparative table:

Table 2.2: Table of Specifications: Comparison of

First and Final Draft Interview Schedules.

CONTENT CATEGORY	PH	FIRST DRAFT:		FINAL DRAFT:	
		PAC:	ENB:	PAC:	ENB:
1 Background information	5	5	5	2	0
2 Facts about assessment	5	19	14	23	13
3 Belief about the facts	5	2	7	3	9
4 Attitudes, feelings, opinions	10	12	2	12	2
5 Reasons for attitudes	10	3	3	3	5
6 Level of knowledge	5	5	7	6	6
7 Suggestions for improvements	5	2	2	2	2
TOTAL:	45	48	40	51	37

(CODING: PH = first estimate of items based on Polit and Hungler; PAC = progress assessment; ENB = ENB assessment).

2.14 The main initial estimate/first draft differences concerned categories 2, 4 and 5; and stemmed from the order and presentation of questions. During pre-piloting of questions it became clear that the question order was important, in that the flow of responses could be interrupted by the need to explain to a respondent that more discussion of a particular item would be raised later in the interview; and this necessitated the rearrangement and conflating of certain items.



2.15 This was a small-scale study conducted as far as possible under similar conditions to those anticipated in the main study, undertaken with a view to revealing and correcting any problems before the main study; and in particular to permit final revision of the interview schedule. According to various authorities, the size of such a pilot sample should be not less than one-tenth of that proposed for the study proper (cf e.g. 82). In the present case, ten pilot interviews were conducted, comprising a sub-sample one-quarter the size of the proposed total sample.

2.16 The pilot work was carried out in a small health district separate from the main study area. Letters explaining the purposes of the pilot study were written to the District Nursing Officer and to the Director of Nurse Education, who both gave their formal support to the study. Lists of ward sisters working in three selected clinical areas, and of ENB assessors working in the areas, were compiled. Potential respondents (largely a convenience sample due to lack of wider choice) were approached informally as a preliminary to formal interview arrangements.

2.17 After explanation of the study to each ward sister selected, the arrangements for interview were made. Although no problems were encountered in finding possible

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(82) TREECE, E.W., & TREECE, J.W., (1973):  
Elements of Research in Nursing.  
St Louis: C.V. Mosby.

participants for Section One of the interview (that for progress assessors), potential participants for Section Two (that for ENB assessors) were relatively few. Initially it appeared that this might be a problem in the main study and tend to reduce the possibility of obtaining comparative data for these groups. However, in the main study only two members of the sample interviewed were not ENB assessors: and one of these was in the process of preparation to become an ENB assessor.

2.18 The procedure for arranging interviews was time-consuming and not helped by heavy snow falls in a semi-rural area, which resulted in several postponements. However, respondents were generally interested in the study and keen to participate. Finding suitable rooms for the interviews was difficult; and at times interruptions occurred which tended to disrupt the proceedings. Noise was a problem, especially due to the tape recorder's propensity for amplifying distant noise. Trying to arrange the furniture appropriately in a room with one electric socket hidden in a corner can also cause difficulties in respect of the final quality of tape-recorded interviews. Respondents in the pilot study showed no undue concern regarding the presence of the tape recorder after being assured regarding the confidentiality of the interview. The quality of the recording in one interview was very poor and can only be attributed to the type of audiotape used on that occasion.

2.19 The time taken for each interview in the pilot study ranged from approximately forty to approximately sixty minutes; with the exception of one interview which took much longer due to the uncertainty felt by the respondent concerning assessments in general. During the interviews, blank progress assessment forms were available for reference purposes. On completion of each interview, coded responses were checked and unstructured answers analysed, with extracts written in checklist form with tape counts available for retrieval purposes. This information was then further analysed, and emergent categories were incorporated into structured checklists under the content category headings (cf Table 2.1). Subsequently the taped extracts were played back to three experienced nurses not connected with other aspects of the study, who were asked to check their interpretation of the meaning of specific responses on the structured checklist. This resulted in a number of completed checklists which were then used to estimate equivalence of responses; an important aspect of reliability in studies of this type.

2.20 From these data it became evident that some previously unstructured questions could be structured with advantage: e.g. Questions 5, 9 and 12 of Section One. Similarly, some structured questions could be revised to be simpler, in that a more direct question would give the required information: thus the structured Question 5 could be reduced to: 'How many weeks are students allocated to your ward? Does this period vary?'. Some struc-

tured questions asking for alternative ('yes'/'no') responses needed a third category added for the benefit of the small proportion of respondents who could not be sure of their answer: as in (e.g.) Section One, Question 22. Some questions needed to be rephrased because the responses revealed that there was bias in the way in which they were being asked: e.g. Section One, Question 36 needed to be rephrased as 'Do you complete the (assessment) form with the learner present?' (All of the respondents filled in the form before seeing the learner; and the wording of the original question had tended to suggest that this was not ideal practice!) Section One, Question 14 was taken out because it was not understood; and the data implicit in this question was covered elsewhere (cf amended interview schedule, Appendix B).

#### FURTHER NOTE ON ANALYSIS OF INTERVIEWS:

2.21 The demands of data analysis were considered at every stage in the evolution of the interview schedule, from early discussions through the pilot stage to its final form in the main study. The process of content analysis is defined as a procedure for the categorisation of verbal or behavioural data for purposes of classification, summarisation and tabulation (19). In this study, the interviews included two types of question: (A) structured questions with coded responses (coding is the process

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(19) FOX, D.J., (1976):  
Fundamentals of Research in Nursing (Third Edition).  
New York: Appleton-Century-Crofts.

by which basic information is transformed into symbols suitable for analysis); and (B) 'probe' questions which could not be pre-coded. Structured questions are generally speaking more efficient than open-ended ones, where efficiency is defined in terms of the number of interview items needed to measure or describe particular characteristics, attributes or factors (63). This is an important aspect of a study such as the present one, in that there must obviously be a balance between the efficiency of the instrument (which influences the time which it takes to administer) and the completeness and relevance of the information obtained. The purpose of the non-coded 'probe' questions was to produce more information than was volunteered during the first reply; and natural 'probes' only were used so that minimal bias was introduced into the administration of the schedule. The additional data collected as a result of such 'probe' questions was categorised where possible after collection during the formative (pre-pilot and pilot) stages of the investigation.

2.22 As a result of the pilot investigation, it became possible to determine the final procedures for interviewing during the main study. During this phase, responses to questions were recorded in their entirety on to audio-tape, as in the pilot study. Among the main advantages of this method is that, during the interview, time is saved;

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(63) POLIT, D., & HUNGLER, H., (1978):  
Nursing Research Principles and Methods  
(Second Edition).  
New York: Lippincott.

spontaneity is preserved; and the researcher is free to observe non-verbal concomitants of the interview situation. Among disadvantages are the need for selectivity in choosing a machine capable of good quality reproduction of voices and with a revolution counter so that specific locations in the tape may be readily found: and that a considerable amount of time and skill are necessary to analyse responses after the interview has taken place: a fact which became evident during subsequent reliability checks carried out with other analysers. The interview itself was designed to be administered in some forty to sixty minutes: and on average this was the case in the practical context of the main study.

2.23 The final coding frame consisted of a simple numerical sequence for the structured questions which form the greater proportion of the interview schedules. The problem of coding the unstructured questions was approached as described in Para. 2.19 above. The tapes were played over several times and possible category headings were sought for and listed. Particular themes were noted by working systematically through each recording. The reliability of the emergent categories was examined by preparing category checklists, which were checked by three independent raters not involved otherwise in the study. For this purpose, checklists employing alternative (agree/disagree) responses were used; and an index of agreement between the raters was calculated, employing the equation:

$$\text{Agreement Index} = \frac{\text{Number of agreements}}{\text{Number of agreements} + \text{Number of disagreements}}$$

following concurrent ratings carried out in response to identical sections of tape-recorded interview. Initial indices obtained for the three independent raters were  $17/17+2 = 0.89$ ;  $4/4+1 = 0.80$ ; and  $10/10+1 = 0.9$  respectively. Since interview bias and error are particular hazards in this type of study, similar checking procedures were included at intervals throughout the main phase, yielding consistently high indices of inter-rater reliability.

#### VALIDITY OF INTERVIEW SCHEDULE:

2.24 Three types of validity well-described in the literature are content validity; criterion-related validity; and construct validity (cf, e.g., 63). The present study is exploratory in nature and intended to establish a basis for further work: therefore the establishment of content validity was considered to be an important first step. Content validity is an important characteristic of questioning techniques; and refers to the extent to which the instrument concerned genuinely measures the factors under study. Thus the content of the instrument must be closely related to that which is being measured. An opinion from a group of experts as to whether the content of the instrument is appropriate must be sought. This was the approach to content validity used in the present study. Following its design, a group of research nurses

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(63) POLIT, D. and HUNGLER, H. (1978):  
Nursing Research Principles and Methods.  
New York: Lippincott.

schedule. Their comments supported the validity of its content in terms of current issues in nursing assessment.

2.25 Criterion-related validity refers to an attempt by the researcher to establish a relationship between the instrument and some other criterion. The instrument is said to be valid if scores correlate highly with this criterion. In the present instance, such a criterion would have to involve reliable and valid assessment methods which are not at present available. There are indications from the subsidiary item-analytic study carried out in conjunction with this survey that the establishment of effective criterion-related assessment is a priority area for research pursuant to the present study (cf Section Three, Paras. 3.87-3.101).

#### THE MAIN STUDY:

2.26 For purposes of the main study three metropolitan health authorities, two of which are teaching districts (\*), agreed to allow the researcher access to nursing staff. The catchments were selected partially for convenience and partially for their representativeness, in that both progress assessments and ENB assessments are regularly carried out in all three districts. Because in practice the 'key' figure in assessment procedures is the ward sister, it was decided to concentrate the study on this

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(\*) The term 'teaching district' is applied to health authorities within whose remit falls the responsibility for one or more medical teaching hospitals.



group. Arrangements were made for the research plan to be considered and approved by the District Ethical Committee in each participating authority.

2.27 Four representative learning centres (including a well-established teaching hospital; two well-established general hospitals; and a new district general hospital) were approached, and agreed to participate in the main study, following thorough discussion of its nature with members of the nurse management structure in each case. The original intention was to limit the study sample to three specified clinical areas in each centre; but this proved not to be possible since such a restriction would have reduced considerably the number of ENB assessors available to participate in the study. Approximately one-quarter of the total sample of assessors was selected from each centre, thus allowing for some locational comparisons to occur.

#### SELECTION OF SAMPLE:

2.28 The final sample of nurse assessors (N=44) consisted of qualified and experienced ward sisters who met the criteria for participation in the study, in that all of them were regularly involved in progress assessment of student nurses; and all except three were also recognised ENB assessors. For sampling purposes, a list of all eligible assessors working in the four centres was compiled. A simple quasi-random sampling was used, in which the names of eligible assessors who were on duty during a particular shift were written on separate slips of paper.

Following random withdrawal of one slip from the total number of slips, the assessor concerned was approached personally by the researcher and asked if she would be willing to participate in the interview scheduled for that day. The main aims of the interview were explained to each potential respondent and the option to refuse participation was made clear. The assessor was also assured of the confidentiality of the interview; and told that all participants would be informed of the findings on completion of the study. The researcher had no prior knowledge of any member of the sample thus selected, further details of which are given in Section Three, Paras. 3.3-3.6, below.

#### CONSTRAINTS ON SAMPLING AND ON INTERVIEWS:

2.29 The sampling process was inevitably affected to some degree by constraints related (A) to the interview method; (B) to accessibility of respondents; and (C) to the timing of interviews. Thus the method of individual interviews followed by subsequent analysis of audiotaped data is highly time-consuming; and itself placed practical limits on the amount of interviews which could realistically be undertaken. Access to the various groups of respondents was not always easy since the collaborating establishments, though situated in the metropolitan area, were not particularly accessible in terms of travelling. Although unit managers were aware of the study and co-operated fully in allowing access to prospective participants, and duty rotas were generally available two to

three weeks in advance of the date, there were problems in that last-minute changes due to a variety of reasons could alter the rotas. This, together with occasional ward activities or other meetings, meant that duty rotas did not necessarily correspond to what was actually happening on the ward; and sometimes meant that no interviewing could take place on a particular occasion. This limitation affected the duration of the data collection phase considerably. The amount of time spent in travelling to and from the centres was considerable: and when there were difficulties of this nature then whole afternoons could be wasted.

2.30 Optimal timing of interviews for the convenience of busy wards inevitably led to a certain periodicity of sampling. Thus all interviews were necessarily scheduled to take place between 2pm and 4pm each day, since this was acceptable to the ward sisters, taking into account workload and staffing levels. However, this effect was compensated to a degree by the impact of variable shift-working in the four centres under study.

2.31 The environment in which the interviews were carried out required a great deal of organisation in an attempt to achieve as much consistency as possible. Arrangements for the availability of suitable rooms with electric points were made in advance. However, these arrangements sometimes had to be changed at the last minute - a state of affairs which could have influenced adversely the outcome of the interviews concerned. Interruptions were minimised; but were disruptive when

they occurred, which was usually during particularly busy periods on the ward.

#### METHOD:

2.32 The method of preparation for, implementation and subsequent analysis of, interviews has already been discussed at length (cf Paras. 2.19-2.23 above). There was no significant departure from this procedure during the main study.

#### LIMITATIONS OF THE STUDY:

2.33 The study is preliminary and can only result in relatively general indications on which to base more sophisticated designs for further research. The effect of the small sample size must influence the validity of the findings overall: and therefore this represents a limitation which should be borne in mind when considering the findings presented in Section Three.

LOCATION AND SIZE OF SUB-SAMPLES:

3.1 The interviews were conducted in four centres as previously discussed. The original idea was to choose centres that could be compared. For this reason, a well-established teaching hospital, two well-established general hospitals, and a newly-founded district general hospital with a strong medical research bias were included as follows:

Table 3.1: Size of Sub-samples in the Four Study

Locations (total N=44).

CENTRE:	A:	B:	C:	D:
TYPE:	Teaching Hospital	General Hospital	New D.G.H.	General Hospital
N =	14	8	12	10

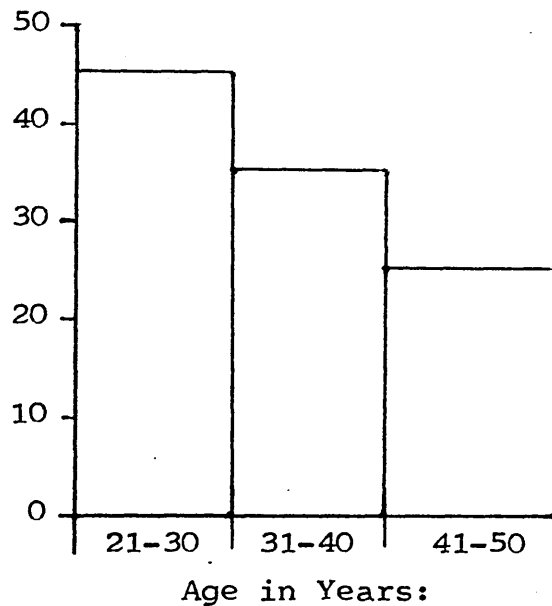
3.2 Centres A and B shared the same district school of nursing and so used identical assessment procedures which varied somewhat from the 'standard' five-point progress assessment as used in Centres C and D (cf Paras. 3.87 et seq., below). The instrument used consisted of two separate but complementary interview schedules which were developed concurrently (cf Paras. 2.19-2.23, above). The number of each item refers to its number in the relevant interview schedule (cf Appendix B). Unless otherwise stated, the resultant frequency data was analysed by means of a chi-squared two-cell contingency test (cf Appendix F).

## CHARACTERISTICS OF THE STUDY SAMPLE:

### AGE GROUPS:

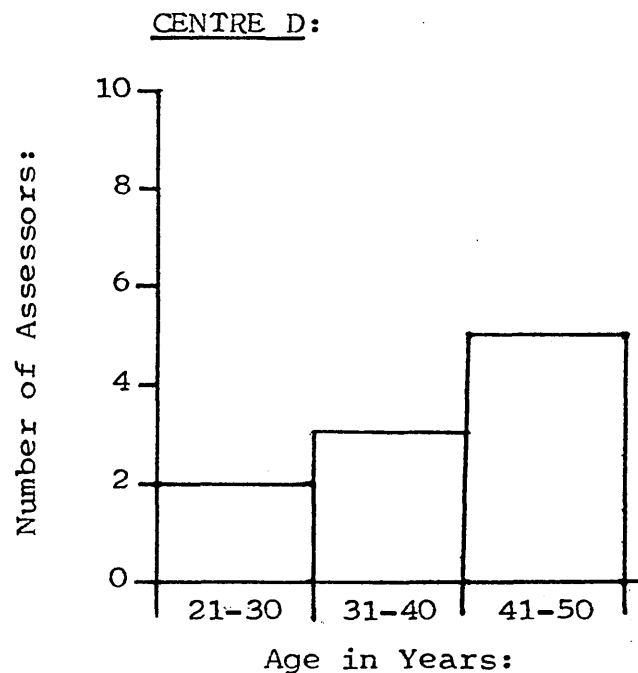
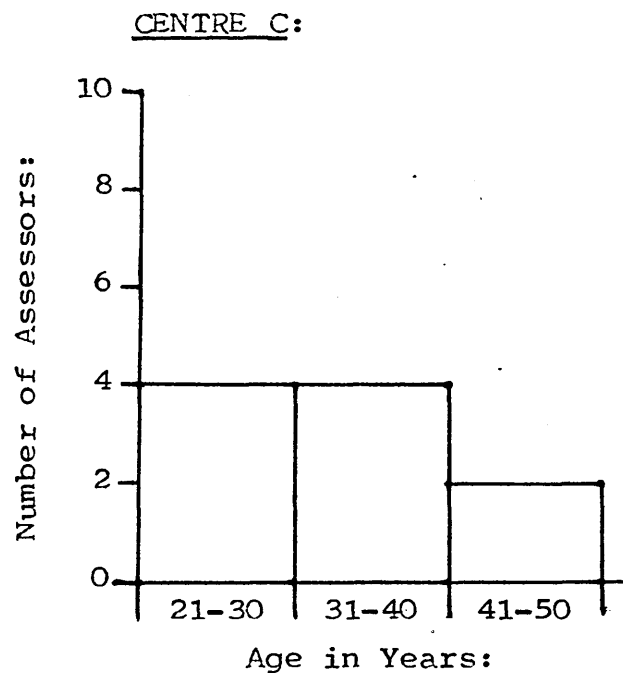
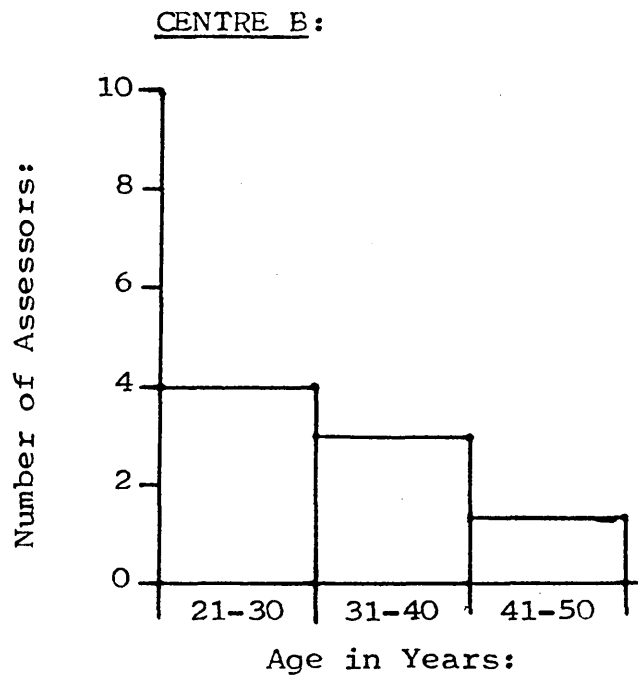
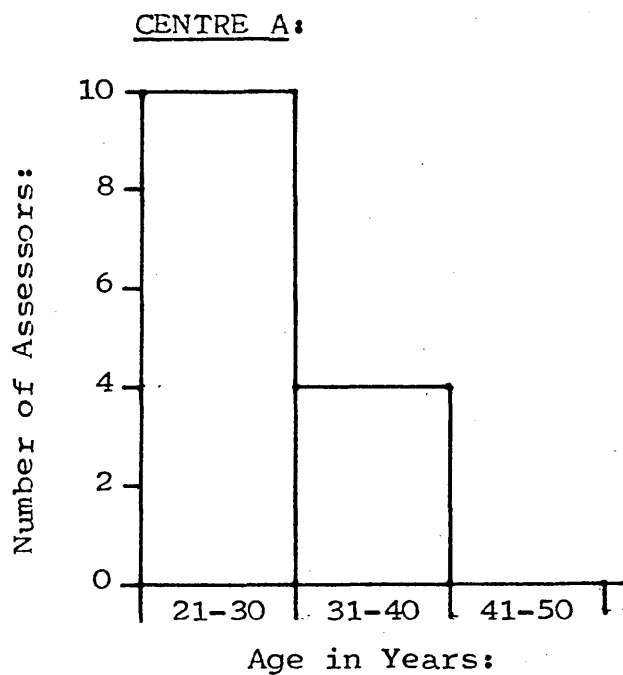
3.3 Forty-five point five per cent of assessors were in the age-group 21-30 years; with a further 34.1 per cent in the age-group 31-40 years. The remaining 20.4 per cent were in the age-group 41-50 years (cf Figure 3.1):

Figure 3.1: Percentage of Sample by Age-group.



In Centre A, ten assessors were in the age-group 21-30 years and the remaining four in the age-group 31-40 years. In Centres B and C the distribution was more equable between these two age-groups, with one and two assessors respectively in the age-group 41-50 years. In Centre D this tendency for assessors to be in the two younger age-groups did not hold good, with five of ten assessors in the age-group 41-50 years and three of the remaining five in the age-group 31-40 years (cf Figure 3.2):

Figure 3.2: Distribution of Age of Assessors by Centre.



PERIOD WHEN TRAINED:

3.4 Thirty-two per cent of assessors had trained in the period prior to 1969, or in 1969 itself. Sixty-six per cent had trained during the period 1970-1979. Only one assessor had trained in the period 1980 or later.

POST-BASIC QUALIFICATIONS IN THE SAMPLE:

3.5 Seventy-seven point three per cent of assessors had undertaken study for post-basic qualifications subsequent to basic professional training. Thus a significant majority possessed such qualifications (chi-squared = 12.023, df 1,  $p < 0.001$ ):

Table 3.2: Summary of Basic and Post-basic Qualifications in the Sample.

POST-BASIC REGISTRATION:

<u>QUALIFICATION:</u>	<u>NUMBER:</u>
State Certificated Midwife (SCM)	2
Registered Mental Nurse (RMN)	2
Registered Sick Children's Nurse (RSCN)	2
Orthopaedic Nursing Certificate (ONC)	1
Registered Nurse for Mentally Handicapped (RNMN)	1
Registered Clinical Nurse Teacher (RCNT)	1
District Nursing Certificate (DNC)	2

(NE: All of the group were Registered General Nurses (RGN): and ten of the group were RGN only).

COURSES IN ENB CLINICAL NURSING STUDIES:

<u>QUALIFICATION:</u>	<u>NUMBER:</u>
Nursing Care of the Elderly	2
Intensive Care Nursing	4
Neuromedical/Neurosurgical Nursing	2
Oncology Nursing	3
Cardiothoracic Nursing	2
Coronary Care Nursing	1



### ASSESSMENT EXPERIENCE:

3.6 All members of the total sample (N=44) had written progress assessment forms for student nurses at some time. Ninety-five point five per cent had also carried out GNC/ENB assessments; with only three members (at Centres A and B) not having done so. The distribution of assessment experience was tri-modal in each case, peaking at 1, 3 and 7 years in respect of progress assessment (cf Figure 3.3); and at 1, 3 and 5 years in respect of GNC/ENB assessment (cf Figure 3.4):

Figure 3.3: Progress Assessment Experience in Years  
(total sample N=44).

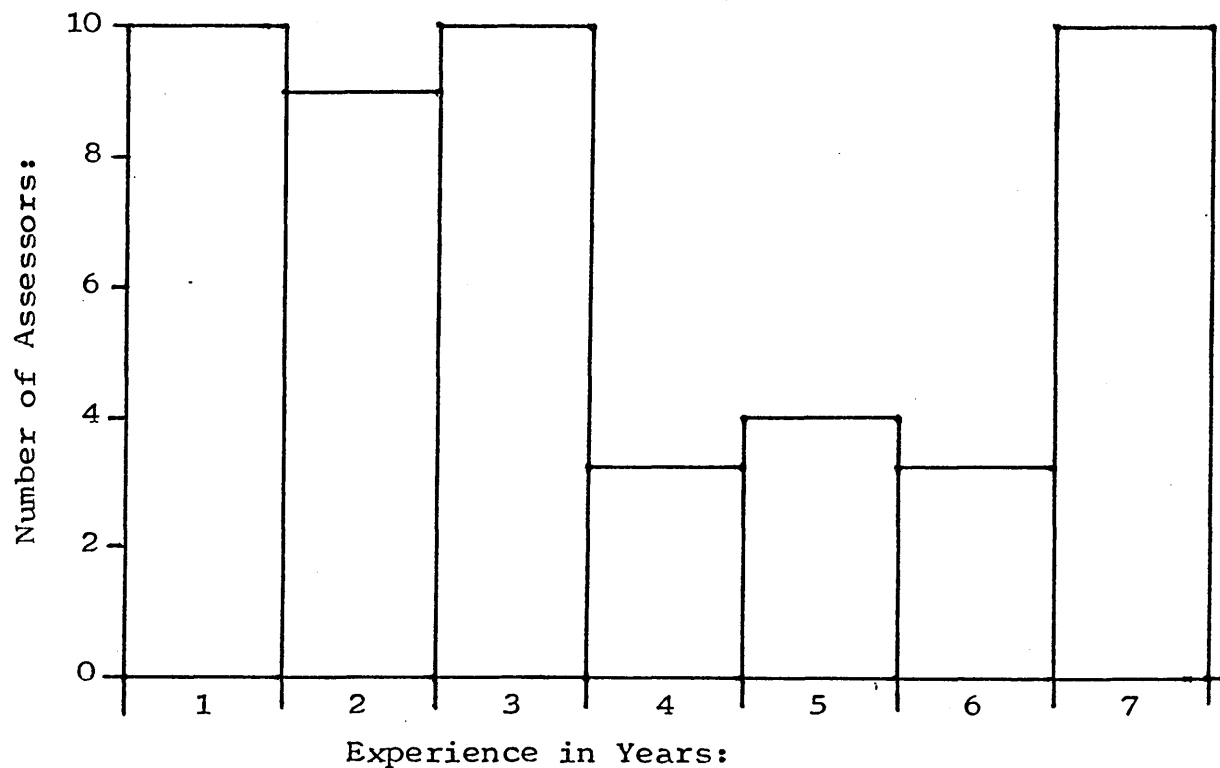
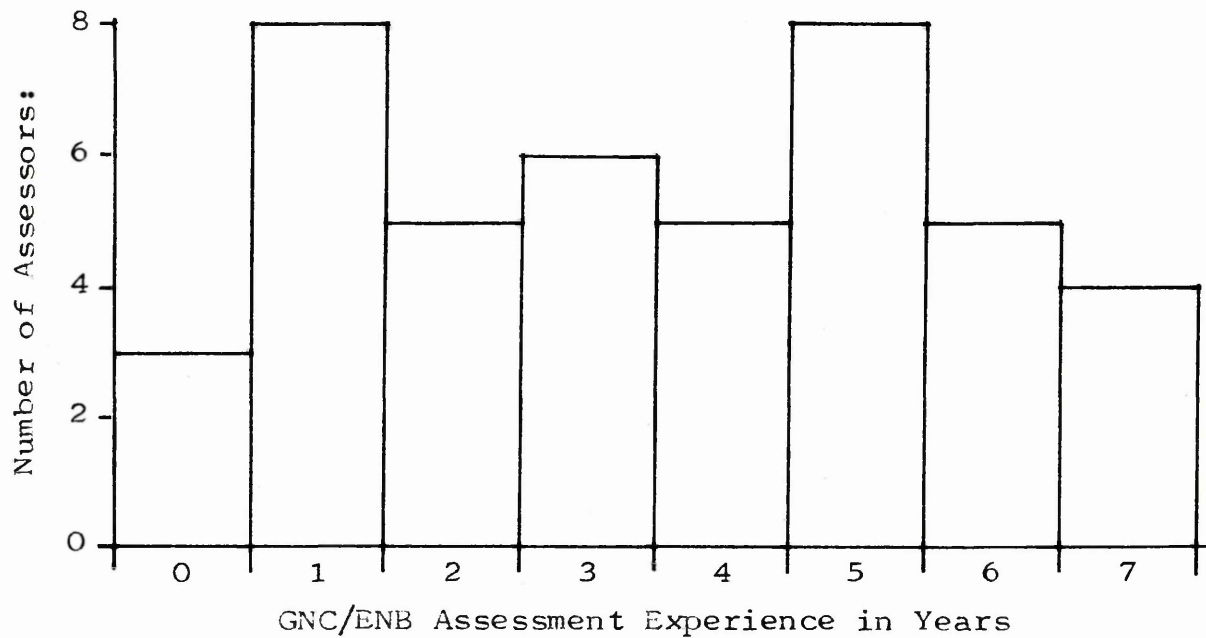


Figure 3.4: GNC/ENB Assessment Experience in Years

(total sample N=44).



ANALYSIS OF RESPONSES TO GUIDED INTERVIEWS:

SECTION ONE: ADMINISTERED TO ALL NURSE ASSESSORS

FACTS ABOUT COMPLETING PROGRESS ASSESSMENT FORMS:

Question One: How long have you been completing these forms?

3.7 Forty-five point five per cent of assessors had two or three years' experience in completing progress assessment forms. Only 9 per cent (i.e. four members from Centres A and B) had had less than this amount of experience. A further 45.5 per cent had had between four and ten years' such experience. The range of experience was from six months to seven years. No informant in Centres A and B had had more than six years' experience; whilst 22.7 per cent (situated in Centres C and D) had had upwards of seven years' experience.

Question Two: Did you receive any preparation for the task?

3.8 Sixty-eight point two per cent of the total sample stated that they had received 'no preparation' for the task of completing assessment forms. The number who had received no preparation was significantly greater than the number who stated that they had received preparation (chi-squared = 5.114, df 1,  $p < 0.05$ ). Of those who had received some preparation, twelve felt that it had been helpful; and five felt that it had not been helpful.

INTERVIEW:

A10: 'Yes I did. We had a training afternoon, I think, because I was quite new to the role of ward sister. Very often you're first sort of thrown in. It made you sit back and take stock. I think they're very difficult things to do'.

C5: '(I was given a) King's Fund booklet. Not before I started. We had had a refresher. It was not helpful because the difficulties were not solved. It just told you how to fill them in, not where your difficulties were and how to solve those, in that lots of things didn't fit in'.

Preparation for the task of assessing student nurses' progress over a period of time in the sample was scant. This preparation characteristically consisted of short study periods concerned primarily with administrative aspects of the assessment form itself. There appeared to be a general lack of discussion on the processes underlying this type of assessment. There was no indication of any form of ongoing review or continuous training programme for assessors. Although both staff nurses and enrolled nurses were often included in the activity of assessment, neither of these grades appeared

to receive any formal training or instruction in the principles involved.

Question Three: How many students can you expect to be allocated to your ward at any given time?

3.9 Taking all locations, the modal allocation of students to a ward at any one time was five; the general allocation was higher in Centres C and D, but there the allocation was never less than four or more than six. In Centres A and B the range was greater, ranging from three to 'seven or more'; with 'seven or more' the modal figure.

3.10 A considerable number of questions asked related to the training and allocation of learners. A variety of aspects were included in order to try to establish the size of groups of students, especially in terms of their ratio to trained staff. Included in this aspect were questions which were intended to establish the workload on a particular ward; the size and complexity of the working situation; and therefore the related factors likely to influence the assessment process.

Question Four: For assessment purposes, do you feel that these numbers are suitable?

3.11 Only three assessors felt their student numbers were 'too few' for assessment purposes; whilst eight felt there were 'too many' (six of these were located in Centres A and B). Seventy-three per cent of the total sample felt that the number allocated were 'about right' for assessment purposes. There was a significantly higher

frequency of 'about right' responses than of any other types of response (chi-squared = 9.302, df 1,  $p < 0.01$ ).

INTERVIEW:

- A5: 'Two to four third-year students for seventeen weeks would be okay'.
- A10: 'On average we have four to five students. For this type of ward it's just about right'.
- B13: 'To do it as well as I'd want ... it's very taxing to do so! Given an average week, I could do four'.
- C5: 'This is an easy part of looking after the learners - not a difficulty'.

The ratio of trained staff to learners is a key issue for purposes of assessment. The common criticism, which concerns the lack of opportunity for trained staff to supervise, and therefore to observe, students directly, clearly relates to the eventual quality of the assessment being made. This aspect deserves further research. The frequently far-from-optimal ratio of trained to untrained staff in the ward situation must also exert an important influence on the quality of assessment. A further important aspect of such ratios concerns the stages in training at which a student is assessed. Thus the all-important performance expectations for each group of students are not specified in the forms currently used. In wards where the students to be assessed were at differing stages in their training, assessors expressed concern about the methods used.

Question Five: What stage(s) in training do the students tend to be at?

3.12 A significantly higher frequency of assessors stated that they assessed either first-year or third-year students rather than second-year students (chi-squared = 23.674, df 1,  $p < 0.001$ ); or a 'mixture' of students (chi-squared = 12.756, df 1,  $p < 0.001$ ) more frequently than second-year students. For the assessors in the present study, the term 'mixture' also tended to refer predominantly to first- and third-year students. No appreciable difference in this pattern was discernable in any of the centres (cf Figure 3.5).

Question Six: Are your students allocated for a set number of weeks?

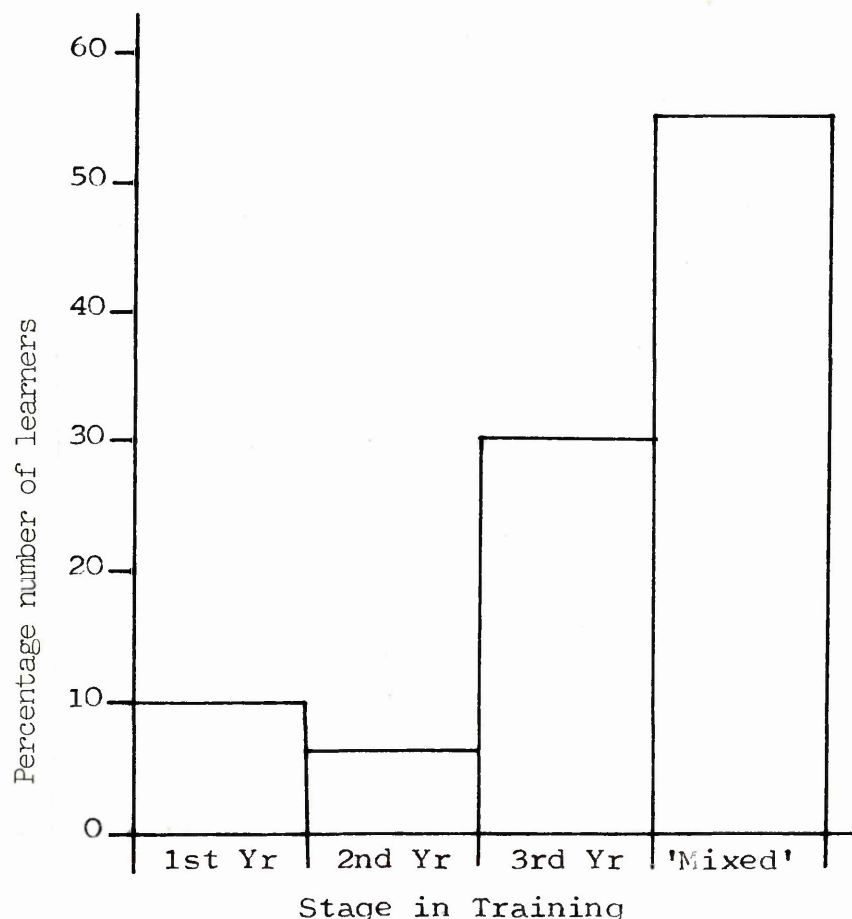
3.13 Ninety-three per cent of the total sample of assessors stated that students were allocated to wards for a set number of weeks. Allocations ranged from six weeks to 'twelve weeks or more'; with a modal figure of six to seven weeks and a sub-modal of eight to ten weeks. Only 6.8 per cent of assessors (located in Centres A and B) stated that students were allocated for more than twelve weeks. No allocation was for less than six weeks.

Question Seven: Is there enough time really to get to know the students' work in order to assess them in this way?

3.14 A significantly higher frequency of assessors stated that there was adequate time to 'get to know' a

Figure 3.5: Stages in nurse training of students

allocated for assessment.



student prior to assessment than made any other response (chi-squared = 9.302, df 1,  $p < 0.01$ ). Eight assessors felt there was not enough time; and five of these were located in Centres A and B. A further four assessors felt rather ambivalent about it - 'sometimes' there was time.

INTERVIEW:

A5: 'Yes (seventeen weeks); though two weeks is (spent) in the community'.

A10: 'No - I hardly ever see them' (twelve weeks).

(NB: Both of these comments came from assessors working in the same specialty).

C5: 'No - I can't do them by myself. (I) have to have discussions, in that their behaviour to me is often different from their behaviour with the rest (of the staff)'.

D5: 'I think you do (have time)'.

The time available for student assessment is an important area of enquiry. In the sample, opinions varied concerning the adequacy of actual contact with students in a day-to-day work situation; though most respondents were satisfied with the overall length of time of student allocations. There was a strong tendency for assessors to rely upon the support of other trained staff in obtaining information concerning a student's progress. There was, however, no indication that other learners were involved in this process.

Question Eight: Does a system of internal rotation operate for students on your ward?

3.15 Sixty-one point four per cent confirmed that a system of internal rotation for students existed on their wards. Thirty-eight point six per cent stated that this was not the case in their wards. The question on internal rotation of students was included in an attempt to estimate the time actually available for the assessor to observe students. The amount of time available for this activity was seen as a source of dissatisfaction among assessors; and hence as a factor in the need for support from other trained members of the nursing team in this activity. However, the assessors generally felt that it was their job to fill in the progress assessment form and to carry out the related interview with the student alone. In this



situation, the assessor's limited contact with the learners tends to beg the question of the eventual value of the completed assessment form as an effective assessment by the individual concerned.

Question Nine: How many trained staff (including part-time staff) are usually on your ward for the periods listed?

3.16 The modal figure of trained staff reported as on the wards during the morning shift was three; and during the evening shift two. The range for the morning shift was from one to five; and for the evening shift from one to four. The figure for Centre D morning shift was the lowest, with never more than two trained staff reported as being on either the morning or the evening shift.

Question Ten: How satisfied are you with the amount of contact you have with your learners?

3.17 Only 9 per cent of assessors (in Centres B and C only) reported themselves as 'very satisfied' with the contact achieved. Fifty-two point three per cent said they 'would prefer more contact'; and the remaining 38.6 per cent were frankly dissatisfied, stating they had 'limited contact only'.

INTERVIEW:

A5: 'Yes, (I'm) satisfied'.

A10: '(I'm) satisfied, but would prefer more (contact)'.

B13: '(There's) not enough time to devote to teaching and supervision'.

C5: 'I have less contact now that I have a second sister'.

(cf also comments in Para. 3.15 above regarding the issue of contact with learners).

Question Eleven: What types of illness do your patients suffer from?

3.18 The various centres were reasonably balanced regarding assessors on medical wards (32 per cent) and surgical wards (29.5 per cent). There were three assessors on geriatric wards in Centres A and B, but none in the sub-samples from Centres C and D.

Question Twelve: What sort of layout do you have on your ward?

3.19 Significantly more assessors were located either on Nightingale-type or bay-type wards than were located on any other type (chi-squared = 14.204, df 1,  $p < 0.001$ ). This amounted to 79.5 per cent of the total sample. There were no assessors located on 'race-track' type wards. Five assessors were located on 'L'-shaped wards; but there was no such ward in Centre C. Four assessors were located in cubicalised wards - two in Centre A and two in Centre C.

Question Thirteen: Do you feel that this layout gives enough opportunity for observing the student?

3.20 In Centres A and B significantly more assessors were satisfied with the suitability of the layout for assessing students than were dissatisfied (chi-squared = 7.682, df 1,  $p < 0.01$ ). However, in Centres C and D

the situation was reversed, with significantly more assessors expressing ambivalence or dissatisfaction with the layout than was the case in Centres A and B (chi-squared = 4.5, df 1,  $p < 0.05$ ).

INTERVIEW:

- A5: '(I) can't imagine any other layout that would do'. (Nightingale-type ward).
- A10: 'It does, certainly'. (Nightingale-type ward).
- B13: '(There is) not so much opportunity as there could be'. (L-shaped layout).
- C5: '(It is) very difficult. It has to be active observation, not passive. You have to go and find out'. (L-shaped layout).

Though Nightingale-type wards were strongly favoured for observational purposes, some assessors based in these wards expressed dissatisfaction at the (to them) lack of opportunities to observe students for purposes of assessment in these wards.

Question Fourteen: What average stay do you expect of your patients?

3.21 Eight assessors were located on 'short-stay' wards; seven on 'medium-stay' wards; and two on 'long-stay' wards. A significantly greater frequency of assessors were located on wards which they described as 'mixed' in terms of length of stay than on any other type of ward (chi-squared = 9.257, df 1,  $p < 0.01$ ). 'Medium-stay' wards were not represented in Centre C; and 'long-stay' wards were not represented in Centres B and C.

Question Fifteen: In your opinion, how would you describe the workload on your ward?

3.22 Ninety-three point two per cent of assessors described their workload as either 'heavy' (41 per cent) or as 'mixed' (53.2 per cent). This was significantly more than described their workload as 'medium' (chi-squared = 9.333, df 1,  $p < 0.01$ ). The changing pattern of clinical practice has reduced average length of in-patient stay. Here the researcher was concerned to find out if this had affected learning opportunities in terms of continuity. Responses to the questions concerning workload and patient throughput did not, however, produce any evidential opinions to support the view that learning and performance improve when the nurse can follow the progress of an individual patient throughout the course of a specific illness or operative regime; though this indicates nothing regarding the less tangible aspects of attitude and professional adjustment occurring under these different conditions.

Question Sixteen: Does the pace of work affect student assessments in any way?

3.23 Significantly more assessors felt that the pace of work on their wards affected student assessments than felt that this was not the case (chi-squared = 12.023, df 1,  $p < 0.001$ ).

INTERVIEW:

A5: 'Not really. Students are very confused to begin with (but) in the seventeen weeks (of the allocation) they change a lot'.

A10: 'Yes it does. They (the students) find it difficult to adjust. They come into a situation where there are a lot of trained staff. They lose their feet for a bit. I know that some of them have been quite unhappy here'.

B13: 'Not usually - there's always enough work to watch!'.

Question Seventeen: Do you aim to have the (progress assessment) forms completed by a certain time?

3.23 Ninety-three point two per cent of assessors stated that they aimed to have the progress assessment form completed by 'a certain time' in the allocation.

INTERVIEW:

A5 'I complete it on the last day'.

A10: 'I do an interim report in pencil. I try to complete it about a week before (the student leaves the ward)'.

C5: '(The) first preliminary interview (is done after) one to two weeks. (The) final (report is) done in (the) last week (of the student's allocation) if things are as they should be'.

Almost all of the respondents completed the assessment forms and saw the students by the end of each allocation. However, not all preliminary interviews were completed. It is therefore a largely retrospective, summative report which is given to the student. Therefore the amount of guidance and help which it is possible to offer during her stay on the ward is open to question. Here again, the issue is that of interpretation of the nature and purposes of nurse assessment by those involved; and of its value to the student as a means of learning on a progressive basis. The progress assessment forms were apparently never completed with the learner concerned present.

Question Eighteen: How long on average do you spend filling in the (progress assessment) form?

3.25 The modal period spent filling in the progress assessment form was 'ten to twenty minutes' (38.6 per cent of sample); with a sub-modal of 'twenty to thirty minutes' (25 per cent of sample). A further 23 per cent of the sample spent 'between five and ten minutes' filling in the form. Only three assessors spent less than five minutes filling it in; with a further three taking between half-an-hour and a full hour to do so. The range was from less than five minutes to one hour (cf Figure 3.6).

INTERVIEW:

A5: '(I spend about) ten minutes. (I) never do an interim report'.

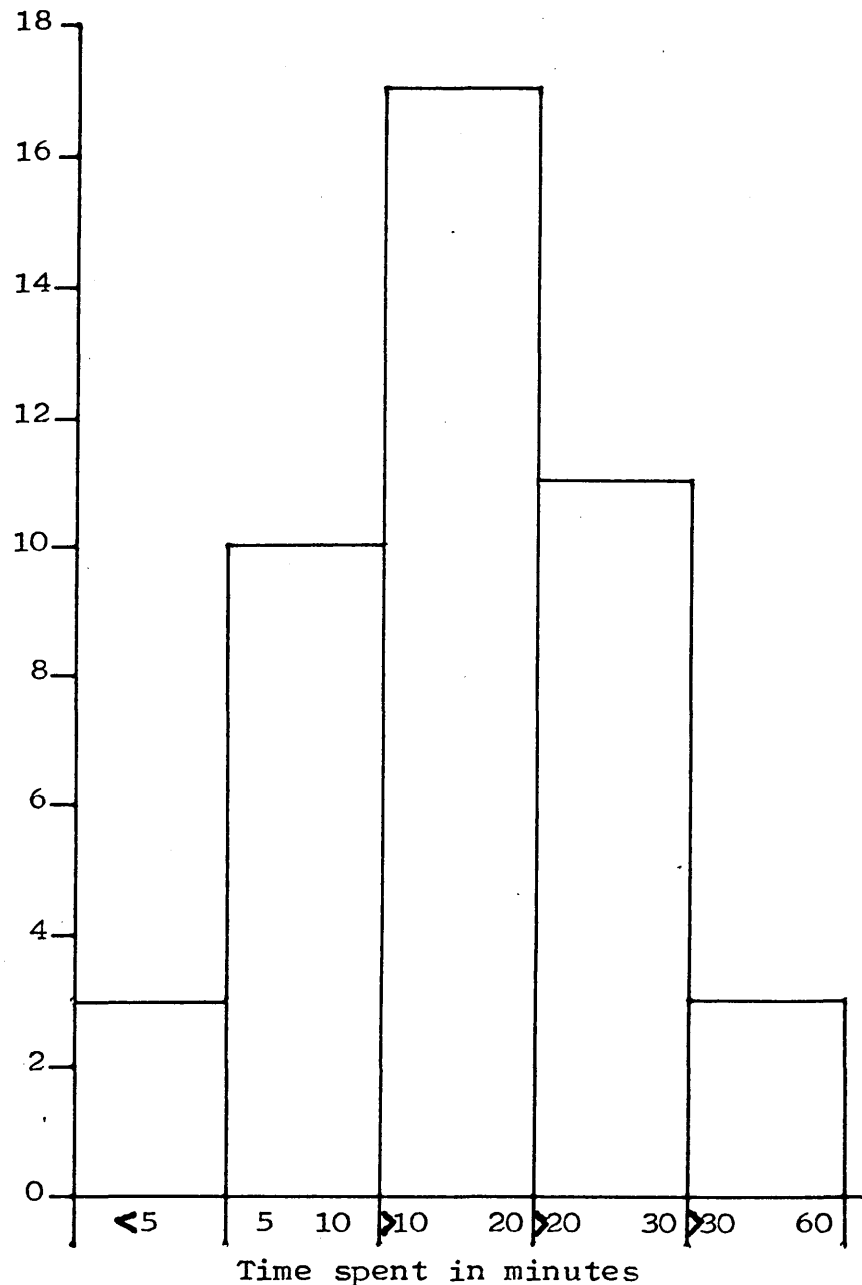
A10: '(I spend) about half-an-hour'.

Whereas according to the literature this has been a major problem, respondents in the present sample saw no difficulty with time in respect of filling in the progress assessment form, or in discussing the report with the student concerned.

Question Nineteen: How long do you usually spend discussing the report with the student?

3.26 Forty-one per cent of assessors spent a few minutes only discussing the report with the student; with a further 41 per cent allocating 'up to half-an-hour' for this task. Only 18 per cent of assessors spent between half-an-hour and a full hour discussing the report - significantly less than either of the other categories (chi-squared = 16.568, df 1,  $p < 0.001$ ).

Figure 3.6: Time Spent by Assessors in Completing the Progress Assessment Form.



Question Twenty: Do you always manage (to conduct) an initial and a final interview?

3.27 Significantly more assessors stated that they always managed to complete both an initial and a final interview with the student than stated otherwise (chi-squared = 7.605, df 1,  $p < 0.01$ ); including all assessors

from Centre D. Twenty-two point seven per cent of assessors frankly admitted that they were unable to do this; with the remaining 13.6 per cent stating that they 'mostly' completed such interviews.

Question Twenty-one: Suppose there is a work problem with a student, how do you approach this in respect of the form?

3.28 In the event of work problems arising with a student, 91 per cent of assessors stated that they would personally counsel the student and try to help. If additional help were needed, 52.3 per cent were unanimous that they would seek this from the clinical teacher rather than from either the nurse tutor or the nursing officer, neither of whom were cited as sources of help in this context (!). Only one-fifth (20.4 per cent) of assessors stated that they would '... make a point of working with' the girl concerned.

INTERVIEW:

A5: 'I would give (the student) enough time to settle down; and then, when I decided that (she) had had enough time, I would sit down and talk to (her) about how (she) felt (she) was doing. With (such a student) I would probably fill in the back (of the assessment form) as a sort of half-way assessment. Sometimes through my own fault I don't recognise a problem until it's a bit late on'.

A5: 'Problems would be discussed at preliminary interview. (I would advocate) counselling and an additional interview. If she doesn't improve I would ask the clinical teachers to become involved. The fault may be ours'.

A10: 'I like to deal with problems as they come. (It) doesn't usually become apparent for two or three weeks. I have contacted the (nurse training) school in some cases'.



B13: '(I would opt) not to use the form; (but rather) talk to the person and take time with (her)'.

The assessors in this sample saw themselves as the 'prime movers' in the case of responding to student learning problems. Almost exclusively, counselling was the method chosen with which to attempt to solve such difficulties. The group did not feel the need to go outside their own ward areas in order to seek help or support. Problems were contained within the control of the ward sister. The length of time taken in getting to know students as individuals, and the problem which this may cause in a busy ward for the assessor, is related to this question (cf also comments in Paras. 3.15 and 3.17 above, regarding the related problem of achieving adequate contact with learners).

Question Twenty-two: Would prior knowledge of students in respect of work performance be helpful for assessment purposes?

3.29 A significantly higher frequency of assessors felt that prior knowledge of a student in respect of work performance would not be helpful for assessment purposes than felt it would be helpful (chi-squared = 5.921, df 1,  $p < 0.05$ ). Six assessors (three each from Centres C and D) felt unsure about whether or not such knowledge would be useful.

INTERVIEW:

A5: 'Yes (it would)'.

A10: 'In a way I think a clean sheet (is better). You can be very influenced by what others think'.

B13: 'No (it would not be useful)'.

C5: '(A knowledge of her previous) work experience, as opposed to work performance, would be useful'.

Comparison of the responses to this question and to the similar question asked about staged ENB assessments (cf Questions 10 and 11 of Section Two, Paras. 3.64 and 3.65, below) is interesting. There was, in the case of progress assessments, a strong feeling that the 'clean slate' approach was essential; though for staged assessments prior knowledge of the student was considered essential. One view expressed in connection with progress assessments was that 'the students wouldn't like it' if it were known that information regarding their progress was being formally exchanged between ward sisters in this way (e.g. Interview D5 concerning this question).

Question Twenty-three: What happens to the (assessment) forms when they are completed?

3.30 Forty-seven point seven per cent of assessors sent the progress assessment forms back to the school of nursing; 31.8 per cent handed them to the student concerned; and a further 31.8 per cent gave them to the nursing officer concerned. In Centres C and D the process was variable, involving all three agents to some degree; but in Centres A and B the student was not involved in disposal of the assessment forms.

Question Twenty-four: Do you generally receive feedback from this activity (i.e. student assessment)?

3.31 All assessors were unanimous that they did not receive any feedback at all from the activity of assessment. Feelings regarding this lack of discussion and help were predominantly negative. Such lack of feedback may be responsible for lack of educational initiatives in clinical nursing assessment at ward level.

BELIEFS CONCERNING THE FACTS OF ASSESSMENT:

Question Twenty-five: What do you feel is the overall purpose of assessing students in this way?

3.32 Seventy-seven point three per cent of assessors felt that the benefit of the assessment was felt by the student nurse - significantly more than felt it to be useful for any other purpose ( $\chi^2 = 5.020$ ,  $df\ 1$ ,  $p < 0.05$ ). Twenty-five per cent felt it was useful 'for school records'; and 6.8 per cent felt it was useful for other records. A further three assessors (in Centres A and C) felt that it served no useful purpose whatever.

INTERVIEW:

- A5: 'It should be to give the tutor and student an idea of how they are doing. I don't think they (the students) get enough feedback on how they are doing'.
- A10: '(For) multiple reasons really. You certainly have to assess them to give them guidelines. There must be some sort of feedback between school and service (areas)'.
- B13: '(The purpose is) to give the student an awareness of how well (she is) performing, (by) explaining aspects of their work that are good and aspects of their work that need a little more attention'.

- C5: '(The purpose is) to let them know how they're progressing; and where they can (should) spend time on other things ... as a boost (to performance in practical areas)'.  
D5: 'I was prepared to be very critical of the forms - but I find them helpful. It's better dealing with principles'. (NB a different progress assessment form is used in Centre D to that in use in other centres in the study).

Although a large proportion of assessors felt that progress assessment was for the benefit of the student nurse, evidence in support of this view was not forthcoming from the related item frequency analysis of progress assessment forms carried out in Centres A and C (see Para. 3.87 et seq, below).

Question Twenty-six: What do you feel is the value of the completed (assessment) form in respect of the training of students?

3.33 Fifty-four point five per cent of assessors felt that the completed form was of some value in respect to the students' training; whilst the remaining 45.4 per cent felt it to be of no value in this respect.

INTERVIEW:

- A5: 'No - the particular (assessment) form as it's laid out is completely useless!'.  
A10: 'I'm not so sure about (the value of) that particular form'.  
B13: 'If it's filled in properly, yes: (but) if care isn't taken, (then) it's just a formality'.  
C5: 'The value lies in the discussion that takes place - not (in) the document'.

Having said that the value of the exercise was primarily student-centred, opinion of the assessors about the value

of the completed assessment form is clearly ambivalent.

Question Twenty-seven: Which of the following would you feel most accurately reflects your feeling: Do you feel that progress assessment of student nurses is (A) the most important part of your job? (B) ranks equally with other important aspects? (C) is less important than some aspects? (D) uncertain?

3.34 No assessor felt assessment to be the most important part of her job; but 79.5 per cent felt it to rank equally with other important aspects. Eighteen per cent felt it to be less important than some aspects; whilst one assessor (in Centre B) was uncertain as to its status as a professional activity.

INTERVIEW:

A5: 'I'd like to think (B) - that it ranks equally with other important aspects: but it probably ends up as (C) - is less important than some aspects. It may not work out'.

C5: 'I'm there for the (benefit of) the patients primarily...so I think it's less important'.

Question Twenty-eight: Given the sort of nursing that you are involved in, what are your feelings about the time that this assessment takes?

3.35 Fifty per cent of assessors felt that they had sufficient time for this activity; whilst the remaining 50 per cent felt that they had insufficient time. There were no discernible locational effects between centres in this respect. This equal split of responses appears to conflict with earlier answers related to the temporal aspects of assessing (cf Para. 3.25 above).

Question Twenty-nine: How much time do you feel is spent actually observing the student?

3.36 Thirty-eight point six per cent of assessors stated that they 'didn't know' how much time they spent observing a student for assessment purposes. A further 27.3 per cent stated that they spent 'a lot of time' in this activity; with 18.2 per cent settling for 'a reasonable amount' of time. Eleven point four per cent frankly stated that they did not spend enough time in this activity.

INTERVIEW:

- A5: 'I think you have to work with other people and therefore you form conclusions. Other nurses give you feedback and patients give you feedback. I don't think I could sit down and observe!'.
- A10: 'It's very difficult. I find it a big problem motivating staff nurses to work with students. They are not used to it'.

B13: 'They (i.e. other members of nursing staff) consciously observe that things are done. They tend to look for signs. When you are doing things (other nurses) are aware that students need to do things; and they will seek them out ... and they (the students) can work with them'.

C5: 'I don't know that I observe them (purely) for the purposes of this document. They have to do their work correctly. I work with them ... therefore seeing what they're doing - not just the finished results'.

D5: 'I don't think we spend enough time (in observing students)'.

The respondents experienced difficulty in answering this question. Having seen earlier that the general feeling was that the assessor was limited in her opportunities to observe the learner nurses (cf e.g. Para. 3.17 above), the responses to this question indicate less certainty that this is the case. One respondent (Interview C5) stressed the importance of the process by which the student carries out clinical tasks, rather than simple observation of the finished product.

Question Thirty: Do you involve other trained nursing staff in your ward when you are preparing reports (on students)?

3.37 Ninety-five point five per cent of assessors stated that they involved other trained members of staff during preparation of student progress reports. Only two assessors (in Centres A and B) stated that they did not do so. However, only 11.4 per cent of assessors (in Centres A and C) allowed the staff concerned to write on the progress assessment form themselves.

INTERVIEW:

A5 'Yes - (but) I probably wouldn't ask every member (of the trained staff to do so)'.

There was an obvious team approach to this aspect, which accords well with the comments on shared observational work in Para. 3.36. However, the approach appeared to be somewhat casual and unstructured; with a reluctance to allow other trained members of staff fully to participate in completing the progress assessment forms (cf also Para. 3.15, above).

Question Thirty-one: Apart from the help given by you, is there any other training available for your staff in assessment techniques?

3.38 In only 6.8 per cent of cases was the occurrence of training for staff in assessment techniques other than that given by the assessors themselves reported (in Centres A and C). This general lack of training in assessment techniques for other participant grades of trained staff has already been noted in Para. 3.8 above.

Question Thirty-two: Regarding the (assessment) form itself, do you find it (A) a useful form? (B) of some use? (C) of little use? (D) of no use?

3.39 Fifty-six point eight per cent of assessors felt that the assessment form was 'of some use'; with a further 25 per cent regarding it as frankly useful. However, a substantial minority of 18 per cent regarded the progress assessment form as of little or no use.

INTERVIEW:

A5: '(It is) of little use'.

C5: '(It is) of some use, because it gives you a base for discussion. How useful it is to people who are not party to that discussion, I don't know. The filled-in form doesn't tell you very much!'



Again, this equivocal response should be seen in the light of the issue of subjectivity of assessment procedures discussed in the related item frequency analysis of completed progress assessment forms (cf Para. 3.87 et seq below). Tacit implications of this subjectivity are sounded in the comments made by respondent C5, above.

Question Thirty-three: Is the comments section a part (of the assessment form) that you use?

3.40 Seventy-seven point three per cent of assessors stated that they used the comments section of the progress assessment form regularly. A further 20 per cent used it 'sometimes'; and one assessor (in Centre B) used it 'only rarely'.

INTERVIEW:

A5: '(It is) the only thing I do use. I never give people Y grades' (i.e. 'Poor').

C5: 'Ticks don't indicate anything - therefore words are useful'.

The two interviews quoted above are of considerable interest, in that they throw light upon the intuitive reaction of many assessors towards the formal properties of the progress assessment form. There is thus a widespread feeling that the form is both subjective (Interview A5) and imprecise in its assessment categories (Interview C5). (cf also comments in Para. 3.39 above; and in Paras. 3.87 et seq below).

Question Thirty-four: And the columns - do you find the horizontal ones (assessment categories) useful?

3.41 Fifty per cent of assessors stated that they found these useful; whilst the remaining 50 per cent stated that they did not. See also comments in Paras. 3.39, 3.40 above:

and 3.42 below.

Question Thirty-five: Do you feel that the length of the form is right?

3.42 Seventy-five per cent of assessors felt that its length was 'about right'; a significantly higher frequency than for any other category of response in this question (chi-squared = 10.023, df 1,  $p < 0.01$ ). Four assessors (in Centres A and C) felt that it was too long; whilst three assessors (in Centres A, B and C) felt that it was too short. Four assessors (in Centres A, B and D) were unsure on this point. The assessment form itself is another area of concern according to the literature. Feelings about the form were not strong in the present sample; and respondents tended to be vague, mostly seeing the assessment form as somehow separate from the nursing activity which it purports to describe and characterise. There was a general view that the assessment form was useful 'as a guide to discussion'.

Question Thirty-six: Do you complete the form with the learner present?

3.43 Only two assessors (in Centres A and D) completed the form with the learner present. The remaining 95.5 per cent of assessors stated that the learner was not present when they completed the assessment form.

Question Thirty-seven: Does the nursing officer get involved at any stage (in the assessment process); e.g. interviews; completion of form; observation?

3.44 All assessors were unanimous in stating that the

nursing officer did not become involved at any stage of the assessment process. See also the rather protectionist attitudes demonstrated in Para. 3.28; and the tacit exclusion of nursing administrative grades from the assessment context in Para. 3.46.

Question Thirty-eight: Are the teaching staff involved (in the assessment process)?

3.45 Only five assessors (in Centres A and C) stated that the teaching staff would become involved in the assessment process. The remaining 88.7 per cent were clear that this did not happen in their case.

INTERVIEW:

C5: 'Teaching staff? Not at all - it's our assessment!'.  
'

Question Thirty-nine: Once the (assessment) forms are sent in, do you get an opportunity to discuss the completed form?

3.46 Only two assessors (in Centre A) stated that they were given an opportunity to discuss the completed progress assessment forms. The remaining 95.5 per cent of assessors were clear that this did not happen in their case. This lack of any further discussion once the assessment forms had left the ward was disturbing. Some assessors explained that they avoided writing any critical comments on the form because of the possibility of 'over-reaction' by nurse managers and by tutorial staff.

## FACTORS AFFECTING CURRENT ATTITUDES TO ASSESSMENT:

Question Forty: When you were a student, were you assessed in the same way as you currently assess students?

3.47 Thirty-one point eight per cent of the sample stated that they themselves had been similarly assessed; whilst 66 per cent had not. In Centres A and B there was no significant difference between the frequencies of those who had been similarly assessed and those who had not. However, in Centres C and D those who had not been so assessed were significantly more frequent than those who had (chi-squared = 6.857, df 1,  $p < 0.01$ ).

Question Forty-one: Do you feel that the way in which you were assessed was satisfactory?

3.48 Forty-three point two per cent of assessors were satisfied with the way in which they had been assessed as students; whilst 50 per cent were not. There is a trend (not reaching significance) for assessors in Centres A and B to be more satisfied, and those in Centres C and D to be less satisfied, in this respect.

### INTERVIEW:

C5: '(It) depended on the person doing it.  
Sometimes it wasn't worth having at all!'

Question Forty-two: The present system, in your opinion, is (A) adequate? (B) not adequate? (C) not sure?

3.49 Forty point nine per cent of assessors felt that the present system is 'not adequate'. A further 40.9 per cent felt it to be 'adequate'; whilst the remaining 18.2 per cent were 'unsure'.

INTERVIEW:

- A5: '(It is) not adequate'.
- A10: 'I don't think the system is entirely adequate'.
- B13: '(It is) not really adequate'.
- C5: '(I am) not really sure, because it depends on whether you put enough (effort) in yourself. The system isn't foolproof; and people can put a row of ticks down in five minutes and take five minutes to read it. That is completely useless'.

The ambivalence felt by assessors about the general procedure of progress assessment here once more illustrates the widespread uncertainty felt about the purposes of this activity (cf e.g. Paras. 3.24, 3.32, 3.33 above).

KNOWLEDGE OF ASSESSMENT PROCEDURES:

Question Forty-three: What aspects of the students' work do you look at in order to carry out this assessment?

3.50 When asked which student attributes they sought in making an assessment, 54.5 per cent of assessors cited 'interpersonal skills'; 43.2 per cent cited 'individual attributes'; with one assessor citing a further category of 'interest in her work'. Forty-seven point seven per cent cited 'ability to give basic care'. There did not appear to be any specific locational effects between the centres.

INTERVIEW:

- A5: '(With) the 'third-years' that I get, I'm going to be looking at different things than I would be looking out for (in) a 'first-year'. Perhaps some different type of form that one had for a different year (would be helpful - possibly a 'third-year' form) looking far more for initiative ... what's

A5: generally going on (in the students')  
cont'd preparation for (to become) staff  
nurses. (Perhaps things such as) ability  
to get on ... organise ... potential (as  
a staff nurse) etcetera'.

A10: '(I) obviously have to think about stages  
of training. Lots of things (are involved)  
really: (such as) how she relates to people;  
how she can make decisions about things;  
her standards of care; (and) how (well) she  
relates theory to practice'.

B13: '(I look for) practical skills; communi-  
cation skills; (and her) attitude in  
general'.

C5: '(I look for) how they arrange their work;  
how they talk to patients; how they docu-  
ment their work; and how they get on with  
others'.

The responses to this question also produced a lengthy  
list of further items (including, e.g.: obedience; the  
little things; relating theory to practice; ready will;  
'I have an ideal standard which I expect nurses to reach';  
muscles; sense of humour; trust; how much confidence they  
give the patient; confidence to say that they can't do  
things) which were not related to the assessment report  
form per se.

Question Forty-four: (on use of the assessment form)

Are the five vertical categories helpful for the purpose  
of assessment?

3.51 Because of the type of assessment form used there,  
this question was not applicable in Centre D. Seventy-  
six point five per cent of assessors to whom it was  
applicable said that the vertical categories were helpful;  
a significantly higher frequency than for all other cate-  
gories of response (chi-squared = 8.5, df 1,  $p < 0.01$ ).  
Four assessors (in Centres A, B and C) answered with a

categorical 'no'; whilst a further four (in Centres A and C) were either 'not sure' or 'didn't know'.

Question Forty-five: In your opinion, are the items on the assessment form representative of the usual student activities?

3.52 Fifty-nine point one per cent of assessors felt the items to be representative of students' activities; whilst the remaining 40.9 per cent did not feel them to be so representative. In Centres A and B, twice as many assessors felt the items to be representative when compared with those who did not; whilst in Centres C and D, those who felt them to be representative and those who did not were equally divided.

INTERVIEW:

B13: '(These categories are) not adequate; but I haven't thought of alternatives!'.  
'

The relationship between the results of this analysis and that of Question 42 is somewhat conflicting. The variation in assessment forms used between the centres must be considered as a possible factor here.

Question Forty-six: Do you find some things on the (assessment) form easier to answer than others?

3.53 Eighty-one point eight per cent of the total sample agreed that some items were easier to answer than others; whilst 13.6 per cent disagreed.

INTERVIEW:

A5: 'Some of (the items) are quite useful to look at. I just don't think there's enough leeway. I prefer to comment (verbally)'.  
'

B13: 'Yes (some items are easier). One of the easiest ones is Number 15 (\*): and Number 21 (whether they respond to criticism) is easy. Number 24 (\*) to me, seems really quite irrelevant'.

Responses to this question varied. The majority of positive responses were not task-oriented, but were more concerned with the development of interpersonal skills within the ward team. Here the student nurse's ability to get on well with other staff appeared to be accorded more importance than her all-round performance as a nurse, especially in task-oriented areas. (cf also Para. 3.50 above).

#### SUGGESTIONS AND IDEAS FOR POSSIBLE IMPROVEMENTS IN THE SYSTEM:

Question Forty-seven: Have you ever thought that this system could be improved? If you have, what would you like to see happen?

3.54 Fifty-three per cent of the total sample felt that the system could be improved; with 25 per cent stating that they had never thought about this.

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(\*) The items on the progress assessment form discussed here by respondent B13 are as follows:

Number 15:	Always applies his/her knowledge intelligently in the practical situation.	Generally fails to apply his/her theoretical knowledge intelligently in the practical situation.
Number 24:	Works well as a member of the nursing team.	Has difficulty in working as a member of the nursing team.



## INTERVIEW:

A10: 'I don't think I'd have a form like this. I'd use continuous assessment'.

B5: '(We should) scrap the form and try a new approach'.

B13: 'More emphasis should be placed on assessing progress. I've never worked with continuous assessment (methods), but I'd be interested (to do so). (I think there should be) a little more self-assessment (on the student's part)'.

C5: 'It needs improvement, but I wouldn't like to say how. We'd have to decide first what we want the nurse to achieve. I don't think that, if they get wonderful ticks in all the right columns, (that) this is what I want the nurse to achieve often!'.

Although the majority of respondents were convinced that the system of assessment should be changed, creative notions as to how this might be done were seldom forthcoming; though there are indications here that assessors are well aware of the lack of developmental properties in the existing progress assessment form; and are placing emphasis on the need for genuine assessments of progress during specific clinical placements; and on the need for students to be more closely involved in their own assessment procedures (cf evidence of similar attitudes emergent in relation to ENB staged assessments, in Para. 3.86 below).

## SECTION TWO: ADMINISTERED TO ENGLISH NATIONAL BOARD ASSESSORS ONLY.

Question One: How long have you been an ENB assessor?

3.55 Thirty-nine per cent of assessors had been ENB assessors for between one and two years; with 54 per cent having been ENB assessors from between three to six years.

Only 3 per cent of assessors (in Centres C and D) had been ENB assessors in excess of this time; with a total range of one to seven years (cf Figure 3.4, Page 67 above).

Question Two: How much preparation did you receive?

3.56 Eighty-seven point eight of assessors had received only a two-day course of preparation; a significantly greater frequency than had received any other form of preparation (chi-squared = 21.951, df 1,  $p < 0.001$ ). One assessor in Centre A and four assessors in Centre D had received 'other' preparation.

Question Three: Do you feel that you were well prepared?

3.57 Forty-eight point nine per cent of assessors felt that they had been 'well-prepared'; whilst 39 per cent thought that they had not been well-prepared; and 12.2 per cent felt only 'partly' prepared.

INTERVIEW:

- A5: 'I suppose so, yes - (that is) as well as one can be prepared in this type of assessment, which I don't agree with, anyway!'.  
A10: 'I think I was fairly lucky in the people I observed with. They gave me a lot of help. But I think that it (i.e. the efficiency of preparation) could be very dependent on that'.  
B13: 'No, I don't think it (the preparation) was comprehensive enough. (There were) no facilities to have practical experience'.  
C5: 'I found it difficult because I didn't prepare myself for (undertaking) assessments (although) I have since. It's very difficult to prepare for (carrying out) an assessment. There can only be (general) guidelines'.

The preparation of ENB assessors is the responsibility of individual directors of nurse education, who are accountable to the Board for maintaining a register of assessors; for providing suitable courses of preparation; and for holding discussions with groups of assessors at least once a year. The training programmes offered for assessors are provided by individual schools of nursing; and therefore both the subjects covered and the level of teaching vary from centre to centre. A selection interview takes place at some time after each preparatory course; and the individual concerned is either accepted as an assessor at that point; or given further advice in order to enable her to become eligible for acceptance. Such advice tends to relate to observing assessments taking place; and to gaining further related experience. The number of assessors who did not feel that they were well-prepared seriously calls into question the adequacy of the training under discussion.

Question Four: On average, how many assessments do you carry out?

3.58 Significantly more assessors carried out assessments on a monthly basis than on any other basis (chi-squared = 15.567, df 1,  $p < 0.001$ ). Four assessors (9 per cent) carried out assessments weekly; whilst a further six (14.6 per cent) carried them out annually. Data on the average number of assessments carried out by each respondent was sought because of the potential problem of lack of time for this activity. Unlike the situation with regard to progress assessment, this is a common problem according to many trained nurses.

However, the responses from the present sample do not support such a view.

Question Five: Have you noticed any particular pattern in the way that assessments occur?

3.59 Seventy point seven per cent of assessors had noticed 'no particular pattern' in the way in which assessments occurred - significantly more than those who had noticed a pattern (chi-squared = 10.811, df 1,  $p < 0.01$ ). No locational effects were noted between the centres.

Question Six: Are you happy with your involvement in ENB (staged) assessments?

3.60 Eighty point five per cent of assessors - a statistically significant majority) were 'happy' with their involvement in ENB assessments (chi-squared = 15.625, df 1,  $p < 0.001$ ) as regards time.

Question Seven: Do you assess for all four parts of the (staged) assessment process?

3.61 Fifty-three point six per cent of assessors stated that they assessed 'for all four parts' of the ENB staged assessments: whilst 46.4 per cent assessed for individual parts only. In this latter group, assessors often carried out one particular assessment only. The reasons for this relate to the content of the nurse training curriculum to some extent: but the resultant lack of practice for other aspects of the staged assessment appears to require further attention in some centres.

Question Eight: Of the four parts (of the staged assessment), do you have any preference for one part or another?

3.62 A significantly higher percentage (65.8 per cent) stated that they had personal preferences for specific parts of the ENB fourfold assessment ( $\chi^2 = 5.206$ ,  $df\ 1$ ,  $p < 0.05$ ).

Question Nine: Do you assess on your own ward?

3.63 Ninety-seven point six per cent of assessors stated that they carried out ENB staged assessments on their own ward. The great majority of respondents thus assessed their own student nurses in this situation. This feature was emphasised by the respondents. There was a strong feeling that the student was given opportunities to practise relevant skills beforehand, so that she would almost certainly succeed in her staged assessment. Prior knowledge of a student would often influence decisions made during assessment (cf also related comments in Para. 3.65; and the somewhat paradoxical comments in Para. 3.29).

Question Ten: Would you say that on average you know the particular student's work?

3.64 Ninety-seven point six per cent of assessors stated that, on average, they knew the work of the particular student concerned (cf comments in Para. 3.63, above).

Question Eleven: In your opinion, is there an advantage in knowing this?

3.65 Eighty-five point four per cent of assessors stated that they felt there was an advantage in this prior knowledge: a result which compares paradoxically with that for

INTERVIEW:

- A5: 'Yes (there is an advantage). I never take them (for assessment) unless (I know) they are going to pass'.
- A10: 'I think it's sometimes a disadvantage when you know that someone is a super nurse: and (yet) you know that on the day you have to be very honest (about what actually occurs)'.
- B13: 'You know their ways and manners, which might put you off if you didn't (know them before the assessment). You've learned to accept (them as people). You can (then) look at things more objectively, perhaps'.
- C5: 'With the present system, no (it is not an advantage to know them beforehand); because the nurses that are doing badly during an allocation can do well in the assessment and be passed!'.

Question Twelve: When the assessments are in progress, do you feel that they influence the ward generally?

3.66 Sixty-eight point three per cent of assessors stated that they felt the staged assessments exerted an influence on the ward generally whilst they were taking place - a statistically significant majority (chi-squared = 5.625, df 1,  $p < 0.05$ ).

INTERVIEW:

- A5: 'No - I don't think anybody knows that I'm doing them'.
- A10: 'The patients try to be very good!'.
- B13: 'People are very aware that they are going on. An artificial atmosphere (is created)'.
- C5: 'There's a high level of anxiety (felt) by everybody involved'.

Here the respondents expressed the view that the problem of 'artificiality' was the chief issue affecting current staged assessments.

Question Thirteen: Do you feel that they (the staged assessments) affect the patients at all?

3.67 Seventy-five point six per cent of assessors felt that the assessments exerted an effect on the patients - a statistically significant majority (chi-squared = 9.756, df 1,  $p < 0.01$ ). Respondents felt that patients generally enjoyed participating in such assessments.

BELIEFS ABOUT THE FACTS OF STAGED ASSESSMENT:

Question Fourteen: Which of the following ideally in your opinion should be carrying out the assessment of students in this way: (A) the ward sister? (B) the nursing officer? (C) the clinical teacher? (D) the tutor?

3.68 Ninety point two per cent of assessors felt that the ward sister should be one of the principle assessors: with 36.6 per cent nominating the clinical teacher as another. The nurse tutor and other combinations of staff were nominated with significantly less frequency (chi-squared = 5.263, df 1,  $p < 0.05$ ). All respondents put the ward sister first in importance; the majority feeling that she should function alone during this activity. This would appear to represent a considerable development in attitude towards professional autonomy on the part of ward sisters: since such was not the case in a study carried out some ten years ago (47a).

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(47a) LONG, P., (1975):

The assessment of student nurses' clinical performance.  
Unpublished report of a survey undertaken for the GNC.

Question fifteen: What do you feel is the overall purpose of assessing students' practical ability in this way?

3.69 Sixty-three point four per cent of assessors cited 'to make sure she's safe' as a main reason for carrying out staged practical assessments - a significantly higher frequency than for any other category (chi-squared = 5.297, df 1,  $p < 0.05$ ). Twenty-six point eight per cent felt it was 'to help the students'. Two assessors felt it was 'for records'; and three (from Centres B, C and D) felt it served no useful purpose at all.

INTERVIEW:

A5: 'The purpose is to make sure (that) the nurse is making an adequate performance in practical tests'.

A10: 'I suppose you're looking in detail at one aspect (of her work). (You are) homing-in in a more practical way, (to find out) how (well) she relates theory to practice'.

B13: 'It's an examination, not an assessment!'

Assessors were surer about the purposes of ENB staged assessments than they were about the purposes of progress assessment (cf e.g. Paras. 3.24, 3.32-3, 3.49, above). Again there is an indication in Interview B13, above, that some assessors are well aware of the relatively static, rather than developmental, characteristics of the current assessment situation.



Question Sixteen: Do you assess on your own generally?

and

Question Seventeen: Are you happy with this (arrangement)?

3.70 Ninety-seven point six per cent of assessors stated that they usually assessed student nurses on their own; with only one assessor answering a categorical negative.

3.71 Ninety-seven point six per cent of assessors stated that they were happy with this arrangement; with only one assessor (from Centre D) answering a categorical negative.

INTERVIEW:

C5: 'I choose to have someone with me if there is (likely to be) difficulty'.

Question Eighteen: Have you ever referred a student?

3.72 Fifty-six point one per cent of assessors had never had occasion to refer a student; whilst 43.8 per cent had done so. Of these latter, 24.4 per cent stated this to be a rare occurrence; 17.1 per cent an 'occasional' occurrence; and 2.4 per cent a 'frequent' occurrence.

Referral rates for ENB staged assessments are not available nationally; though the referral rates for the centres concerned in the study were negligible. Outright failure, resulting in discontinuation of nurse training, did not appear to occur at all. The system in use would appear to require further research.

Question Nineteen: Which in your view is the better setting for this assessment (practical room or ward)?

3.73 Ninety-five point one per cent of assessors felt the ward setting to be the optimal location for purposes of

staged assessments; with only two assessors (from Centre A) opting for the practical room in the school of nursing as a more appropriate setting.

Question Twenty: Can you mention any problems associated with using the ward as a setting for assessments?

3.74 Fifty-three point seven per cent of assessors could see no problems associated with using the ward as a venue for staged assessments; whilst the remaining 46.3 per cent could foresee the possibility of some problems occurring.

INTERVIEW:

- B15: 'It depends, usually because the student has gone around telling people. I can remember one time - every patient knew - the patient started laughing and everyone joined in. The patients sometimes love it - it all depends on how the nurse approaches it!'.  
C4: 'The patients always seem to be well aware of what's going on and seem to enjoy it'.  
D6: 'You have to make sure it was a day when staffing levels are good'.  
D10: 'We don't have the full cooperation of all other teams of staff on the ward, e.g. doctors and physiotherapists. You can understand why (not). It can be very difficult'.

## ATTITUDES, FEELINGS AND OPINIONS CONCERNING ASSESSMENTS:

Question Twenty-one: Do you feel that this aspect of your job is (A) important? (B) necessary? (C) not important? (D) unsure?

3.75 Eighty-five point one per cent of assessors regarded the task of staged assessment as either 'important' (58.5 per cent); or 'necessary' (36.6 per cent). One assessor in Centre B regarded it as 'not important'; and one assessor in Centre C was 'not sure'.

Question Twenty-two: What about the time taken to carry out these assessments: are there any difficulties in this respect in your experience?

3.76 Fifty-six point one per cent of assessors stated that, in their experience, there were difficulties concerning the amount of time taken up by assessments; whilst 43.9 per cent did not foresee such difficulties.

## REASONS FOR ATTITUDES TO STAGED ASSESSMENTS:

Question Twenty-three: As a student, were you assessed in this way?

3.77 Forty-six point three per cent of assessors had themselves been assessed in a similar way; whilst 51.2 per cent had not.

Question Twenty-four: Do you feel that the system is fair in respect (A) of patients? (B) of students?

3.78 Ninety point two per cent of assessors felt that the current system was fair with reference to patients; some feeling that the patients generally enjoyed parti-

icipating in such assessments (cf also Paras. 3.66, 3.67,  
above). The situation with regard to students was rather  
more equivocal, with 65.8 per cent regarding the current  
system as fair; and 34.1 per cent as unfair.

INTERVIEW:

- A5: 'No (it is not fair in respect of the  
student)'.  
'No (in respect of the patient - but) I  
can't think of any other way of doing  
it!'.  
  
A10: '(It is) not always fair for students.  
(It is an) unreal, unfair set-up'.  
'(Regarding the patients,) I don't know  
really; (I suppose it is) not too unfair;  
(except that) the care on these occasions  
will be superb; which is again unfair!'.  
  
B13: 'No (it is not fair), in lots of ways,  
because you don't get a good (i.e.  
realistic) assessment. They (the students)  
are nervous, not concentrating on the  
right things'.

A sizeable minority of more than one-third of respondents  
considered the undue stress and anxiety likely to be felt  
by students in an artificial setting as seriously calling  
in question the validity of the method in current use.

Question Twenty-five: Are ENB (staged) assessments more  
important than progress assessment in your opinion?

3.79 Forty-three point nine per cent of assessors felt  
that both types of assessment were of equal importance;  
with 24.4 per cent regarding ENB staged assessments as  
more important; and 26.8 per cent stating categorically  
that they were not more important. Four assessors (one  
in each of the four centres) were 'not sure'.

INTERVIEW:

- A10: 'To the nurse, they are (more important).  
(But there is) no difference (between  
them) really; (although) if the progress

A10: assessment report were improved, it  
cont'd would be (the) more important (of the  
two). I feel that progress assessment  
is more realistic. (For example) I had  
a student recently who did her drug  
round (staged assessment) okay, and she  
passed. At the next few drug rounds we  
did, she didn't know the answers to  
questions. I almost wished that I hadn't  
passed her! How they (the students)  
perform overall is most important'.

B13: 'For the student (the ENB staged assessment)  
is important. For me, the progress assess-  
ment report is more important'.

C5: 'These (the ENB staged assessments) are  
more important, because they mean that  
they are part of their (the students')  
state finals: but (as) to the training  
of the nurse, I don't know that they are  
any more important'.

The relative importance of ENB staged assessments as over  
against other types is a view subscribed to by only one-  
quarter of the current sample of assessors. A roughly  
equivalent number held them to be not more important;  
with a substantial majority opting for equality of  
importance as between ENB staged assessments and progress  
assessments.

Question Twenty-six: Would you say that you are (A)  
happy (B) unhappy (C) neither (D) other view, with the  
present arrangements for ENB (staged) assessments?

3.80 Sixty point nine per cent of assessors stated that  
they were 'unhappy' with current ENB staged assessments;  
with a further 38.8 per cent stating that they were  
'happy' with the current arrangements. Three assessors  
(from Centres B, C and D) remained neutral.

INTERVIEW:

A5: 'No (I am not) - because I always pass them'.

A10: 'I can say that I can accept them: but I am unhappy (with them) because they are set-up (and) unreal'.

B15: '(I am) unhappy with the (staged) assessments'.

Here a substantial majority of 60 per cent of the total sample of assessors are expressing unhappiness with the current arrangements for ENB staged assessments. The level of dissatisfaction demonstrated is much greater than that demonstrated in connection with progress assessment, where 60 per cent either felt it to be 'adequate' or else were 'unsure' (cf Para. 3.49 above). There is a nice distinction to be made here between the 'fairness' of the staged assessments as regards parity between students, as perceived by almost 66 per cent of respondents (cf Para. 3.78 above); and the efficiency and suitability of the staged assessments qua assessments, which appears to be called into question both in these responses and in the responses to the previous question (q.v.).

KNOWLEDGE OF ENB STAGED ASSESSMENTS:

Question Twenty-seven: Looking at each (staged assessment) form for the four stages (of the assessment), are you happy with their content?

3.81 In the case of each of the four assessments, a significantly higher percentage of assessors expressed themselves as 'happy' with the contents of the staged assessment forms than otherwise; as indicated below:

- (1) Aseptic Technique: 68.3 per cent (chi-squared = 10.028, df 1,  $p < 0.01$ ).
- (2) Medicine Round: 65.8 per cent (chi-squared = 8.027, df 1,  $p < 0.01$ ).
- (3) Total Patient Care: 68.3 per cent (chi-squared = 10.028, df 1,  $p < 0.01$ ).
- (4) Ward Management: 65.8 per cent (chi-squared = 10.617, df 1,  $p < 0.01$ ).

INTERVIEW:

A10: 'I think that it's incredible to use one form for all (of the assessments). (I am) not happy with the score system'.

B13: 'Not really (happy with content), because the comments on Section 4 could be better. (The form) should have different descriptions for each part (of the assessment). (The form also) needs (a) comments section: (and I am) not happy with the 'satisfactory/unsatisfactory' section'.

C5: 'Yes, (I find the form) very useful'.

There were few strong views concerning the efficacy of the staged assessment forms in use, which varied from centre to centre. Some of these are given above (cf also Para. 3.87 et seq below, concerning the efficacy of the progress assessment form).

Question Twenty-eight: Have you been involved in a situation where the student has been referred more than once?

3.82 Nineteen point five per cent (just under one-fifth) of assessors had been involved in repeated referrals - a significantly lower number than those who had not been so involved (chi-squared = 14.049, df 1,  $p < 0.001$ ).

Question Twenty-nine: Do you feel that the student should be given more than one chance to pass each stage?

3.83 Ninety-five point one per cent of assessors felt the

student should be allowed more than one attempt at each assessment. Only one assessor (in Centre D) dissented; with one assessor (in Centre D) unsure.

Question Thirty: What about borderline performance - is there help available to you to support you in this event?

3.84 Eighty point five per cent of assessors stated that there was no help or support available for them in dealing with 'borderline' performance on the part of a student - a statistically significant majority (chi-squared = 14.049, df 1,  $p < 0.001$ ).

INTERVIEW:

A5: 'The only point that bothers me (concerns) this particular girl (that) I passed; but about a week before she was due to leave the ward ... had had a fairly good relationship (sic). She was one of those 'not up to scratch' students; and I suppose I felt that I didn't want to upset her. A personal thing came into it'.

A10: '(Borderline performance) can be a great problem. (It has led to) a lot of heart-searching on a couple of occasions. (On such occasions, we) need some discussion, yes'.

B13: '(I) don't let people take the assessment ... if they're not going to pass!'

However, assessors also indicated that, in the main, they did not need help with ENB staged assessments: an interesting statement, in direct contrast to their feelings with regard to progress assessments (cf Para. 3.31 above).

Question Thirty-one: Do you get an opportunity to discuss the (staged) assessments, either formally or informally?

3.85 Ninety point two per cent of assessors stated that they never got an opportunity to discuss the assessments with anyone - a statistically significant majority (chi-



squared = 24.976, df 1,  $p < 0.001$ ) (cf Paras. 3.56, 3.57, above).

#### SUGGESTIONS AND IDEAS CONCERNING POSSIBLE IMPROVEMENTS:

Question Thirty-two: Have you ever thought that the way in which these assessments are carried out could be improved in any way?

3.36 Sixty-eight point three per cent of assessors stated that they had thought at one time or another about possible ways of improving the current system: whilst 31.7 per cent had not. Significantly more assessors had thought along these lines than had not so thought (chi-squared = 4.780, df 1,  $p < 0.05$ ). Of the 31.7 per cent who had not thought about improving the current methods, 19.5 per cent stated that they were 'happy with the way things are'; whilst 12.2 per cent stated that they were not.

#### INTERVIEW:

A5: 'The progressive assessment I used before I don't think is the answer. It took too long. (What we need is) a compromise of some sort. I would ideally like to see a form where (in which) one graded certain tasks, and (in which) there was some scope for discussing someone as an individual ... I'd like to see a more overall performance (specification)'.

A10: 'I'm fairly committed into looking into progressive assessment. It would be more realistic. Students would gain a lot more, especially in terms of teaching, because the two things are connected'.

B13: 'I'd like to see continuous assessment used'.

C5: 'A continuous assessment would be far fairer - difficult for us, but fairer (for the student). Because this (i.e. the current method) is only assessing the (student's) performance for a very short period: and they'd be very silly not to put on (their) best behaviour!'.

If dissatisfied, assessors in the sample generally saw the solution to their difficulties as lying in some form of continuous practical assessment. This reasonable opinion, taken together with related responses in Section One of the interviews (that for progress assessors), points up the relative lack of knowledge and skills in such types of assessment at present available to nurse assessors. Provision of adequate opportunities for the acquisition of such knowledge and skills is a necessary prerequisite before genuine progress can be made in the extremely important 'developmental' assessment of practical nursing skills.

#### THE PROGRESS ASSESSMENT FORM: A PRELIMINARY ANALYSIS.

3.87 Major criticisms of progress assessment forms in current use have been directed both at their structure and their content (16, 86). These are again implicitly criticised by respondents in the present study whilst discussing

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- (16) EXTON-SMITH, J. (1976):  
Management of ward-based assessments.  
Nursing Times, Vol 72, No 9, pp 349-350.
- (86) YOUNG, A.P. (1980):  
Progress and problems of continuous assessment.  
Nursing Times, Occasional Paper, Vol 76.


other issues related to report-writing and student assessment in general. Thus it becomes clear that, whatever their potential for use in developmental assessment, the current uses to which the forms are put are largely retrospective and summative (cf Para. 3.24). The opinions of assessors regarding the utility and value of the completed assessment form are highly ambivalent, ranging from 'of some value' (largely as an aid to discussion) through uncertainty to 'completely useless' and 'just a formality' (cf e.g. Para. 3.33).

3.88 In view of the widespread dissatisfaction felt by assessors, both with the discriminative capabilities of progress assessment forms, and with their seeming lack of developmental or practical implications for the student, the researcher felt it appropriate to attempt an initial analysis of selected groups of completed forms. Since a full-scale quantitative and qualitative analysis was clearly beyond the scope of the present study, it was decided to attempt an initial item frequency analysis, based upon complete 'sets' of progress assessment forms available for newly-qualified student nurses in Centres A and C. This analysis would, it was felt, provide some preliminary - though relatively gross and unrefined - data concerning broad discriminative capabilities of the forms; and hopefully would offer some indications for the direction of future, more detailed research.

#### DESCRIPTION OF FORM:

3.89 The basic progress assessment form used was that issued by the King's Fund Centre (cf Appendix D); consisting of a set or series of characteristics regarded as important features of nursing practice. These characteristics are arranged in a vertical column; and a learner's potential performance on each 'criterion' is set out in the form of a five-positional continuum, as follows:

Table 3.3: King's Fund Centre Rating Scale

X APPLIES (excellent)	TENDENCY TO X	AVERAGE	TENDENCY TO Y	Y APPLIES (poor)
				

Each learner is then rated on each characteristic by placing a tick in what the assessor considers to be the column which most appropriately describes her work, as in the example given in Table 3.3.

3.90 This rating scale has been much criticised by assessors in recent years, mainly because of the impreciseness of its supposed ordinal categories. For example, what does it mean to say that someone has 'a tendency to excellence' in any assessment category? Is she in fact 'excellent' (in which case she has been incorrectly assessed); or is she falling short of 'excellence' in some unspecified way? There is an obvious lack of clear, defining semantic categories for each supposed position on

the ordinal continua; so that it remains doubtful in any specific case whether genuine ordinal measurement has been achieved (78).

3.91 Two related criticisms commonly advanced by assessors are, firstly, that this in-built impreciseness tends to deprive the rating scale of any developmental function in the student's training (i.e. it cannot be used for diagnostic or monitorial purposes): and, secondly, that it tends to encourage assessment based on perceived 'social desirability' rather than on objective performance criteria. Clearly an investigation of the developmental properties of the assessment are outside the scope of the present study, since it would require a detailed longitudinal analysis of individual 'sets' of assessments carried out in each of the four centres during the past three years. However, it was considered feasible to carry out a preliminary item frequency analysis based on assessment data obtained from two of the four centres and bearing more specifically on the postulation of 'social desirability' as a distorting factor in progress assessment.

#### PREDICTION:

3.92 In common parlance the term 'average' means 'the typical or normal amount, quality, degree, etc.' (e.g. of nursing skill) (25). It therefore follows that:

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(78) STEVENS, S.S. (1960):  
On the theory of scales of measurement. In DANTO, A.  
and MORGENBESSER, S., eds: Readings in the Philosophy  
of Science, pp 141-149.  
New York: World Publishing Company.

(25) HAWKS, P. ed (1979):  
Collins' English Dictionary.  
London/Glasgow: Collins Sons and Company.

- (1) if the term 'average' is being used objectively, then the majority of a sufficiently large pool of assessed items, taken from assessments carried out on a representative group of students, will be assessed as within this category;
- (2) conversely, if the term 'average' is being used pejoratively (i.e. if it is perceived as socially desirable to have students who are mainly 'better' than average) then the majority of a sufficiently large pool of assessed items, taken from assessments carried out on a representative group of students, will be assessed as 'better' than average;
- (3) if the term 'average' has an objective connotation, then its removal from an ordinal rating scale will result in a relatively equable distribution of items assessed in the two adjacent categories, with some skew towards 'better' in the case of a highly selected sample such as nurses in training;
- (4) conversely, if the term 'average' has a pejorative connotation, then its removal from an ordinal rating scale will result in items being massively assessed in the available 'better' categories.

#### METHOD AND FINDINGS:

3.93 For purposes of the item frequency study, Centres A and C were selected; the former because its assessors employ a four-column version of the King's Fund Centre rating scale from which the category of 'average' is excluded; and the latter because its assessors employ the standard, five-column, version (cf Table 3.3). Perhaps ironically in view of prediction (1) above, the reason for Centre A's abandoning the use of the 'average' category was said to be that a strong 'central tendency problem' had been noted. Unfortunately no written evidence existed to support this statement.

analysis carried out on complete individual 'sets' of progress assessments (consisting of eight or nine reports in each 'set') for members of four cohorts of recently qualified student nurses:

Table 3.4: Details of Cohort Samples in Item Frequency Study.

Centre	Cohort	No. of Students	No. of Reports	No. of items
A	A1	21	179	4918
C	C1	17	144	3888
C	C2	17	145	3915
C	C3	18	155	4185
-	-	73	623	16906

(NB: the term 'item' is applied to individual assessed items on the progress assessment scale. 821 (4.855 per cent) of total items remained unscored in the 'not applicable' category, employed when a particular item is either not observed or not available on the ward).

3.95 Assessed items were carefully tallied for each of the 623 assessment reports; and assigned to their appropriate assessment categories as follows:

Table 3.5: Table of Item Frequencies

Centre	X APPLIES (excellent)	TENDENCY TO X ←	AVERAGE	TENDENCY TO Y →	Y APPLIES (poor)
A (N = 21)	2764 (56.2%)	1885 (38.3%)	-	48 (1.0%)	3 (0.01%)
C (N = 52)	1917 (15.9%)	6951 (57.9%)	2389 (20.0%)	86 (0.7%)	11 (0.09%)

(NB: Percentages do not add up to 100 since in Centre A, 4.43 per cent of items and in Centre C, 5.28 per cent of items, remained unscored in the 'not applicable' category).

Here it should be noted that elimination of the 'average' category in Centre A appears to make no appreciable difference to the relative infrequency with which items are assigned to 'worse' than average categories. Conversely in Centre C, where the 'average' category exists, no fewer than 20 per cent of assessment items are assigned to this category. Further substantial differences between the Centres are seen in the relative frequency with which items are assigned to both 'X'-oriented categories, with a very much greater percentage in Centre A being assigned to the 'excellent' category (56 per cent as opposed to 16 per cent in Centre C).

#### IMPLICATIONS:

3.96 In general terms, the findings would appear to support predictions (2) and (4) (cf Para. 3.92); that is, that assessors tended to regard the 'average' category somewhat pejoratively as a minimal acceptable standard, rather than objectively, as a typical or normative grading for the majority of learner nurses. If this were not the case, then its absence in Centre A ought conceivably to have produced at least some downward scatter towards Y; and its presence in Centre C should have led to its wider use as an option for assessment in that setting.

3.97 These considerations apart, the results show a marked difference between gradings in the two centres, with Centre A having a far greater proportion of assessment items graded as 'excellent'. This observed difference may have occurred



- (A) by chance, when in fact there is no systematic difference between the centres;
- (B) as a result of the genuine superiority of students in Centre A over those in Centre C;
- (C) due to subjectivity of the assessment, with a systematic tendency of assessors in Centre A to grade their students less harshly than do assessors in Centre C;
- (D) due to relative lack of sensitivity of the four-point grading system employed in Centre A when compared with the five-point scale used in Centre C.

3.98 Chance is probably not the cause, since it is extremely unlikely that such a marked difference would occur had there really been no difference between the two centres; especially in view of the very large pool of assessment items involved. Unfortunately, due to the limitations of the present study, it is not possible to exclude factors (B) and (C) with such certainty. To do so would require further data. For example, concerning the potential - if unlikely - superiority of students in Centre A, it would be possible to obtain confirmatory data by comparing the results of progress assessment with those of a related but different assessment, such as the state final examination, which is independently assessed. Thus if students in Centre A also had better results in the independent assessment, then this would tend to support the hypothesis that they were indeed 'better' than the students in Centre C; and to indicate that the difference in progress assessment was also a product of this superiority. Again, the only way to assess the possibility of systematic differences in standards of assessment between the two centres as a potential contributory factor, would be to obtain data

on dual assessments of the same group of students carried out by assessors from both centres - yet here again the outcomes may be affected by the artificiality of such a situation. In fact, the likelihood is that any differences in standards of assessment between the two centres are random rather than systematic; and are thus insufficient to account for the marked differences observed.

3.99 In the absence of clear, objectively-stated criteria for each position on the assessment scale, the likeliest factors to be implicated would be a combination of assessor subjectivity (cf Para. 3.96) and the relative lack of sensitivity of the four-point grading system employed in Centre A. A possible explanation of why the results differ in the way they do is as follows: The absence of 'average' from Centre A's scale means that assessors see 'tendency to excellence' as the lowest acceptable grade; and are thus compelled to grade items as 'excellent' in order to indicate that a student is above the minimum acceptable standard. Hence the higher number of 'X' grades awarded in Centre A. Conversely, in Centre C the presence of 'average' in the scale enables the assessor to regard 'average' as the lowest acceptable grade and still be left with two grades to allocate to students who are better than 'average' as used in this sense. This in turn allows the assessor to be more discriminating in awarding the 'X' grade. Hence the lower number of X's awarded in Centre C. This argument would suggest that the four-point scale is less sensitive than the five-point scale; and that the five-point scale is therefore preferable to the four-point

scale. This interpretation appears quite reasonable; but it must rest on the assumption that factors A, B and C (cf Para. 3.97) are not influencing the results of assessment to any significant extent.

3.100 Bearing in mind the limitations of the data, the findings of this preliminary study would appear to emphasise assessment problems produced by the large subjective element in the system currently used. In the absence of clear, objectively defined and shared meanings for the various positions on the assessment scale, subjective and local interpretations arise which accord a pejorative connotation to the term 'average', within which category one might reasonably expect the majority of assessment items to be allocated if the term were being objectively used. Further problems appear to arise as an interaction of subjectivity with the relative sensitivity of the assessment scale when used either with or without the inclusion of the 'average' category. Thus the behaviour classified as 'excellent' or 'tending to excellence' in one context would be likely to be categorised more frequently as 'tending to excellence' or as 'average' in the other context. Though the study did not address the question of the validity and utility of the scale as a longitudinal assessment instrument, the issues of subjectivity and of sensitivity would clearly affect its use in this capacity. The above comments are necessarily based on the assumptions that the observed differences are not probabilistic; that they are not attributable to superior practical abilities in one centre; and are not due to any systematic trend to grade less rigorously

in one centre than in the other.

3.101 Whilst these assumptions are reasonable, they require further confirmatory research to be undertaken along the lines indicated in Para. 3.98 above. If confirmed, then the findings of this study would support the need for further research into the design and delivery of progress assessment; and into related educational methods for achieving more objective, uniform standards among assessors. Further research is also required into improving the properties of the assessment as a diagnostic and monitorial instrument of more direct relevance to the progress of the individual student than would currently appear to be the case (cf e.g. Paras. 3.24, 3.33, 3.87 above).

## SECTION FOUR: DISCUSSION.

4.1 The findings in the present study relate to two distinctive types of assessment procedures: i.e. the formative evaluations carried out in progress assessment; and the summative evaluations represented by various parts of the E.N.B. staged assessment. However, in terms of the major purpose and objectives of the present study (see Pages 2-3, above), issues to do with both types may be discussed under the following generic headings:

- A. Organisational Issues: that is, those findings which are predominantly concerned with the organisational contexts in which both types of assessment are carried out: e.g. throughput of students for various assessments in the ward environment; ratios of trained to untrained staff present in assessment wards; duration of student allocations; especially with regard to perceived inadequacies of the current situation and possible means of improving it.
- B. Assessment Issues: that is, those findings which concern the nature of the assessment procedures: e.g. performance criteria for the various stages of a student's training; duration of assessment discussions with students; utility or otherwise of current assessment forms; especially with regard to problematic issues where remedial action may be considered desirable.
- C. Educational Issues: that is, those findings which concern the preparation of senior nursing staff to carry out what is required of them in the way of assessment of students: e.g. nature and content of preparatory courses; perceptions of teamwork or unique responsibility in relation to assessment; awareness of difficulties; especially those issues where discernable improvements might be made.

The findings detailed in Section Three of this report

will thus be discussed under the above three headings; firstly, in relation to progress assessment; and secondly, in relation to E.N.B. staged assessments. As will be noted, these three major descriptive categories are not necessarily mutually exclusive: so that periodically a specific finding will be discussed under more than one head, in cases where it appears to be relevant to both (or all three) of the descriptive categories in which it appears.

#### FINDINGS RELATING TO PROGRESS ASSESSMENTS:

##### A. Organisational Issues:

A summary of organisational issues is given below:

Almost one-fifth of assessors felt that they had too many students to assess in this way (mostly in Centre A) (3.11). It was felt that less-than-optimal ratios of trained to untrained staff affect the quality of the assessment (3.11). There is a need to assess more second-year students if the process is to be genuinely developmental for students (3.12). There is a strong tendency to rely on the student's contact with other trained staff in the assessment process (3.14). Modal duration of student allocations is from six to ten weeks (3.13). The amount of time available to observe students was a source of dissatisfaction among assessors (3.15). Thirty-nine per cent of assessors had 'limited contact' only with students, and expressed dissatisfaction with this state of affairs. Only 9 per cent were 'very satisfied' in this respect (3.17). Ninety-three per cent of assessors described their ward workload as either 'heavy' or 'mixed' (3.22). This factor was felt to affect students who, on arrival on the ward, tended to 'lose their feet' for a time (3.23). Assessors generally felt that prior knowledge of a student's work was not helpful for purposes of this type of assessment. This could lead to student dissatisfaction if they knew that information was being formally exchanged between ward sisters for this purpose (3.29). Student nurses are largely uninvolved in the processing of their own assessment forms (3.30). Assessors receive no feedback from the process of assessment; leading to lack of educational initiatives at ward level (3.36, see also 3.46). There is 50 per cent ambivalence over the time available for progress assessments (3.35). It appears that students are not consciously observed for purposes of assessment alone (3.36). There is an obvious team

approach to progress assessments at ward level; but it appears casual and unstructured, without full participation by other team members, which assessors appear reluctant to allow (3.37, see also 3.15). The learner is scarcely ever present when the assessor completes the progress assessment form (3.43). There is a disturbing and massive lack of opportunity for assessors to discuss the completed progress assessment with administrative nursing staff (3.46). Most assessors are convinced that the system should be changed (3.54).

4.2 The impression held by almost one-fifth of assessors participating in this study that they had too many students to assess in this way may be considered of some practical significance, at any rate in the present context. Again, the ratio of trained to untrained staff is crucial to effective assessment; and here the finding suggests that staff involved suspect that impoverished ratios may be seriously affecting the quality of such assessments. The tendency to rely on the student's contact with other trained staff as a major source of feedback in the process of progress assessment also raises issues of concern for the validity of assessment.

4.3 The modal duration of student allocation was from six to ten weeks. In terms of effective learning, this period might well require reconsideration from an organisational point of view. What can be learned in this period, given the pressures and constraints on nursing time implied in assessors' comments? The rapid change-over from one module of experience to the next is considerable in terms of what can realistically be expected of a learner in any circumstances. For this reason, the

amount of time which an assessor can realistically devote to observing a student was felt to be unsatisfactory by over 90 per cent of the sample; with only 9 per cent of assessors expressing satisfaction in this respect. Workloads on training wards were described as being either 'heavy' or 'mixed', with students tending to 'lose their feet' for an indeterminate initial period during the placement. The reason for the inclusion of related questions was to try to gain an indication of pressure of work as a factor both in the availability of time in which to undertake observation for purposes of assessment; and as a factor in student adjustment to, and consequent benefit from, a given placement. Comments under these areas tend to point up the relative brevity of the experience; the detraction from the value of a placement which can result, from the student's point of view, due to the subtraction from an already brief placement of time required for initial adjustments; and the dissatisfactions felt by assessors with the length of their own involvement in any individual assessment situation.

4.4 The lack of involvement of students in the processing of their own assessments is worthy of further study. The view of progress assessments currently held by the E.N.B. is that they form a series of transactions in which each student should be fully involved: and this involvement might with advantage be recognised symbolically by having students closely concerned with the 'mechanics' and monitoring of their own assessments.



The current lack of involvement in this respect is also emphasised by the fact that students were hardly ever present when the assessor actually completed the progress assessment form. Equally unproductive is the current rarity of feedback and involvement experienced by assessors themselves. Responses indicated that it was rare for them to have the opportunity to discuss the completed progress assessment form with administrative staff: a state of affairs which is clearly unsatisfactory for a number of reasons, including lack of informed participation by administrative staff; lack of assessor motivation and support; and lack of administrative involvement with, or interest in, the formative aspects of this assessment as they impinge on the careers of individual students, as opposed to the summative, largely negative issue of whether or not the student has been a focus of 'problems' during his or her placement.

4.4 Finally, there is an obvious team approach to progress assessment at ward level; with assessors relying to a considerable extent on the observations of senior staff nurses and other experienced members of staff. At present, however, this system appears to be casual and unstructured, without full participation by other team members, which assessors appear reluctant to allow. If such a system is an essential feature of progress assessment, then it would seem appropriate that it should be accorded a degree of formal recognition, thereby assuring the provision of some suitable education and training in

the art of assessment for the staff involved.

Overview of Implications Regarding Organisational Issues:

1. There is a need in some assessment centres to look at the workload of progress assessment as it affects individual wards and individual assessors.
2. Similarly, in training areas where progress assessments regularly take place, the ratio of trained to untrained nursing staff should be agreed by consensus involving managers, teachers and assessors; and should be kept under review regarding its suitability for the specific assessment area.
3. The modal duration of learner allocations should be reappraised in the light of what can realistically be achieved by the student, bearing in mind the need for a 'settling-in' phase.
4. Student nurses should become more centrally involved in the process of monitoring and administering their own assessments; especially with regard to responsibility for disposal of relevant forms, and greater involvement in discussion with assessors during the actual completion of the progress assessment form.
5. In place of the present rather piecemeal arrangements, full participation in the assessment process by other senior trained nursing staff working in the ward or unit should be encouraged. Thus the existing team approach to progress assessment should become more formalised, with recognition of senior nursing staff contributions to assessment discussions and actual writing of the assessment form.
6. Assessors should be given an opportunity to discuss the completed assessment with administrative nursing staff as a part of this more formal structure.

B. Assessment Issues:

4.5 A summary of assessment issues is given below:

Performance criteria for the various stages of a student's training are not specified in the progress assessment procedure (3.11). Assessors appear to need more experience of assessing second-year student nurses in order to gain an overview of student development (3.12). Preliminary interviews with student nurses do not always occur as a

part of the assessment process (3.24). The progress assessment report is largely retrospective and summative in nature (3.24). This must raise questions regarding its value as a progressive assessment (3.24). The modal 10-20 minutes allocated for discussion of the assessment with the student appears to be a very short time (3.25). One-fifth of assessors find themselves unable to complete a preliminary interview with the student (3.27, see also 3.24). Seventy-seven per cent felt the progress assessment to be 'beneficial' to the student; but were vague as to why this was the case (3.32). Opinions as to the value of progress assessment were very ambivalent (3.33). Eighty per cent of assessors felt that progress assessment ought to rank equally with other important tasks (3.34). Only one-quarter of assessors regarded the progress assessment form as frankly useful. Most regarded it as a guide-line for discussion only (3.39). Almost four-fifths of assessors regularly used the 'comments' section of the form ('ticks don't indicate anything!') (3.40).

There is a widespread feeling among the assessors that the progress assessment form is both subjective and imprecise (3.40). There is a related ambivalence regarding the utility of the progress assessment categories (3.41). Three-quarters of assessors felt the length of the progress assessment form to be 'about right' (3.42). The learner is hardly ever present when the assessor completes the progress assessment form (3.43). Two-thirds of the sample of assessors had not themselves been similarly assessed; especially in the cases of the assessors in older age groups in Centres C and D (3.47). The group showed ambivalence regarding the appropriateness of the methods by which its members had been assessed: with more positive evaluations in Centres A and B among the younger assessors; and less positive evaluations among the older assessors of Centres C and D (3.48). There was reasonably complete ambivalence regarding the adequacy of the present system; with uncertainties regarding both its purposes and format (3.49, see also 3.24, 3.32, 3.33).

Attributes relevant to the progress assessment were ranked as follows: (1) interpersonal skills (54 per cent); (2) ability to give basic care (47 per cent); (3) individual attributes (43 per cent) (3.50). More than three-quarters of assessors considered the vertical categories on the progress assessment form as 'helpful' - that is, as a focus for discussion. Almost one-fifth said they were not helpful, or were not sure (3.51, see also 3.11). A substantial minority of assessors (41 per cent) felt the assessment items to be unrepresentative of student activities during placement on their wards, especially in Centres C and D (3.52). Items positively rated were those concerned with the development of interpersonal skills. The majority of positively-rated items were not task-oriented (e.g. 'the ability to get on well with others') (3.53).

Assessors were aware of the lack of developmental properties in the existing progress assessment form (3.54). Many assessors placed emphasis on the need for genuine assessments of progress during a student's allocation (3.54). Assessors tended to regard the category of 'average' pejoratively as a minimal acceptable standard (3.96, see also 3.92, 3.95). There is a marked difference between gradings in the two centres (A and C) involved in this part of the study. Centre A has a far greater proportion of 'excellent' gradings. Factors involved may include (e.g.) some degree of random error; genuine superiority on the part of students in Centre A; a subjectively less harsh grading in Centre A; and a lack of sensitivity in the four-point scale used in that centre (3.97). The potential superiority of students in Centre A needs checking by a cross-validated study based on related criteria (e.g. examination results) (3.98). Systematic differences in assessment standards as between the two centres need checking by means of synchronous dual assessment by both set of assessors on the same student group (3.98). In the absence of objective behavioural criteria at each category on the progress assessment form, the likeliest factors responsible for the observed differences are a combination of assessor subjectivity (cf. 3.96) and a related lack of sensitivity in the four-point scale used in Centre A (3.99).

These results emphasise problems of subjectivity and sensitivity (and possible interaction between these two factors) in assessments employing the current progress assessment form (3.100). Further confirmatory research is required along the lines indicated in 3.98 (3.101). If the problems of subjectivity and sensitivity identified in 3.100 are confirmed as major problems, then there is a need for further research into the design and delivery of progress assessment; into educational methods for achieving higher levels of reliability between assessors; and into improvement of the properties of the assessment as a diagnostic/monitorial instrument of more direct relevance to the progress of individual students.

4.6 Assessment issues emergent from the study may be discussed in relation to three interrelated areas: (A) those concerning the progress assessment instrument itself (cf Appendix D, pp. A40-A48, below); (B) those concerning the process of progress assessment; and (C) those concerning the attitudes of assessors towards

issues in (A) and (B). Regarding the nature of the instrument itself, a number of assessors expressed awareness of, and dissatisfaction with, the fact that specific performance criteria are missing from the format. As an assessment instrument, its categories tend to be retrospective and summative, not genuinely progressive; and as such it lacks the developmental properties necessary to assess progress during the student's placement. Although the scale offered has some features in common with Likert-type scales, it has the considerable disadvantage that no precise, operational meaning is assigned to even the fixed categories at either end of the assessment continuum, since the brief characterisations offered are open to considerable variations in subjective interpretation by assessors in various assessment centres. As a result of this imprecision, the 'unfixed' categories of 'tendency to X' and 'tendency to Y' become completely nebulous and lacking in definition as recognisable criteria.

4.7 These problems led numerous assessors in the study to express uncertainty regarding the format of the assessment instrument; with only one-quarter regarding it as frankly useful, and many expressing ambivalence regarding the utility of its categories. With regard to the vertical categories offered under major areas such as 'professional behaviour and attitudes'; 'application to, and quality of work'; 'attitude to patients' and 'attitude to co-workers' (cf pp. A40-A41), some informants regarded these as helpful as a focus for discussion;

although even here one-fifth of informants did not regard them as helpful for this purpose. A number regarded the categories as unrepresentative of student activities on their wards, especially in Centres C and D. When asked about this further, the assessors themselves ranked interpersonal skills highest in importance, followed by basic care skills; rating third the task-oriented individual capabilities with which a substantial part of the assessment form is concerned. There was a widespread feeling that the form's imprecision leads to the need to make fairly extensive use of the 'comments' section if any useful information regarding the student is to be communicated by the assessment ('tick don't indicate anything!').

4.8 The specimen analysis carried out on representative progress assessments undertaken in Centres A and C (cf pp. 119-120, above) tended to support the misgivings of assessors by displaying problems of subjectivity and sensitivity with the format (cf pp. 121-125 for full discussion). The category of 'average' was treated pejoratively as a minimal acceptable criterion; and there were differences in grading between the centres sufficiently marked to warrant further investigation, including possibly a study of synchronous dual assessments carried out by assessors from both centres, though it is recognised that such a study would pose numerous practical difficulties. Further studies also appear to be required into improving the properties of the instrument as a diagnostic and mon-

-itorial instrument of more direct relevance to the progress of the individual student than would currently appear to be the case. Apart from helping to increase the validity and reliability of such assessments, issues emergent from such research would have considerable educational implications for assessors if they were included as discursive material in preparatory courses.

4.9 Regarding the process of progress assessment, especially with regard to the need for it to be genuinely progressive, there would appear to be a need to assess more second-year students in a manner which will display the continuity of their professional development as well as outcomes of specific specialist placements. Throughout this study, the absence of second-year student nurses on the clinical areas involved was apparent. Given the limitation that conventional training wards were used deliberately in order to provide general descriptive data on assessments, this was predictable. However, it does highlight a feature of training schemes in operation generally. Since the issue of relevant E.E.C. directives in the mid-1970s, the need to add breadth to the training circuit has produced a tendency in the design of training programmes which has taken second-year students away from conventional training settings, 'farming them out' to specialist experience: e.g. in mental illness/mental handicap nursing; community nursing; and obstetric nursing. This observed absence of second-year students from the traditional training circuit, and thus from the gen-

eral discussion, raises a range of issues related to the continuity of their learning experience and its implications both from an educational and assessmental point of view. Prima facie, there would appear to be a need to promote continuity by identifying the relationship of second-year experience both to what has gone before, and to what will emerge during the third training year, in rather more precise and categorial terms than would appear to be the case at present. But this is naturally an issue beyond the scope of the present study.

4.10 If a genuine 'baseline' assessment of the capabilities of the student is to be carried out, then it is clear that the preliminary interview between student and assessor should form an important part of this process. According to the data of the present study, one-fifth of such preliminary interviews were not carried out, due to various factors including shortage of staff and pressure of work. This is a situation which obviously requires improvement. Similarly, discussions which do take place between student and assessor appear from the data to be relatively short, with a modal duration of twenty minutes: and these might with advantage be extended to permit a genuine depth exploration of the student's gains and problems during the placement, and to set the scene for the student's next placement by making her aware of areas on which she may need to concentrate to achieve improvement. A final related issue to do with the process of progress assessment concerns the rather disturbing fact



that, judging from the data of the present study, the student nurse seldom, if ever, appears to be present when the assessor completes her progress assessment form. This fact again tends to emphasise the largely retrospective and summative aspects of the assessment process as it currently occurs: and needs to be remedied if the assessment is to take on a genuinely developmental aspect for the student.

4.11 Regarding the attitudes of assessors towards progress assessment in the present study, there was a good deal of ambivalence arising from the foregoing issues. Thus whereas 80 per cent of assessors felt that progress assessment ought to rank as equally important with other important aspects of their role, opinions regarding the importance of progress assessment as it is actually practised were divided. Almost 80 per cent of informants felt it to be 'beneficial' to the student in some way; but were vague as to precisely how. In addition to the aspects of subjectivity and sensitivity of the instrument, and various perceived shortcomings of the process, of assessment involved, the origins of these attitudes may be to some degree inherent in their own early experiences of 'being assessed' (cf Paras. 3.47,48, above). Whatever the causes, there were clearly widespread ambivalences regarding both the purposes and the format of the present system.

1. There is a need to reconsider the format and categories of the progress assessment form.
2. These should be amended to specify performance criteria; and to include genuinely developmental and progressive (i.e. formative) features.
3. Categories in the progress assessment form should also be reconsidered in relation to representativeness of student nurse activities on the ward: and due weight should be given to the items relating to acquisition of interpersonal and basic care skills.
4. Reliability should be investigated using synchronous dual assessment studies involving assessors from more than one centre: possibly employing use of video playback techniques to help overcome attendant difficulties (cf, e.g., S20). Studies are also needed into improving the properties of the instrument as a diagnostic and monitorial device of more direct relevance to the progress of individual students, based on considerations in (1), (2) and (3) above.
5. The format and process of progress assessment should maintain continuity and indicate students' developmental progress throughout their education, whilst allowing for the specialist experience which they gain during the second year of the course.
6. All preliminary interviews with students should be regarded as essential baseline data for developmental assessment, and completed accordingly.
7. Discussions of the assessment with each student should be longer and in rather greater depth concerning her gains and current needs; and the areas requiring her special attention in future placements.
8. For similar reasons, the student nurse should preferably always be present when the assessor is completing her progress assessment form.

C. Educational Issues:

4.12 A summary of educational issues is given below:

Sixty-eight per cent of assessors stated they received no preparation to carry out progress assessments ( $p < 0.05$ ) (3.8). Five assessors (i.e. one-ninth of the sample) felt that the preparation they had received had not been helpful (3.8). This preparation had consisted only of

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administrative aspects to do with the completion of the progress assessment form (3.8). There had been a general lack of discussion of the processes of assessment in their preparation (3.8). Although RGNs and SRNs participated in progress assessments, they received no formal preparation for this role (3.8). Assessors generally felt that it was 'their job' to fill in the progress assessment form alone; an issue which may be considered to affect the validity of an assessment which relies to some extent on the observations of other members of the ward team (3.15). Students tend to 'lose their feet' at first during placements where a heavy workload is involved (3.22, 3.23).

The largely retrospective, summative nature of the report throws into question the validity of the progress assessment as a progressive (i.e. formative) process (3.24). Although the modal 10-20-minutes allocated for discussion of the assessment with a student appeared to be a very short time, assessors 'saw no difficulty' about this (3.25). Very little time was spent in discussing the assessment with the student nurse. Only 18 per cent of the sample spent a period in excess of half-an-hour doing this (3.26). Assessors did not feel the need to go outside the ward ambience for help in assessments (3.28).

Seventy-seven per cent of assessors felt the progress assessment to be 'beneficial' to the student nurse; but were vague as to why this was the case (3.32). Opinions as to the value of the progress assessment were very ambivalent (3.33). There was an obvious team approach to progress assessment at ward level; but it appeared to be casual and unstructured, without full participation by other team members, which assessors appeared reluctant to allow (3.15, 3.37). There was a general lack of training in assessment techniques for other grades of trained nursing staff (3.8, 3.38).

Administrative nursing staff appear to be excluded from the assessment process (3.28, 3.44, 3.46). There was also an 80 per cent exclusion of teaching staff from the assessment ('It's our assessment!') (3.45). There was a feeling that nurse managers might 'over-react' to critical comments made by the assessor on a student's performance (3.46).

There was a general dearth of creative ideas concerning how the present system might be improved, although many recognised that it needed improvement (3.54). There is a need for student nurses to be more closely involved in their own assessment procedures (3.54, 3.86). Assessors tended to regard the 'average' category (when it existed) pejoratively as a minimum criterion of acceptability (3.92, 3.95, 3.96). In the absence of objective behavioral criteria at each category on the progress assessment form, the likeliest factors responsible for the observed differences are a combination of assessor subjectivity (3.96); and a related lack of sensitivity in the four-point scale used in Centre A (3.99). If the

problems of subjectivity and sensitivity identified in Para. 3.100 are confirmed as major problems, then there is a need for further research into educational methods for achieving higher levels of reliability between assessors(3.101).

4.13 Of the issues concerning preparatory courses for assessors, it is worthy of note that 68 per cent of assessors in the present sample stated that they had received no preparation for their task as an assessor. Amongst those who had attended a course, there was some ambivalence regarding the helpfulness of the preparation received. Some stated that it had concerned administrative aspects (i.e., how to complete the form; who to send it to, and so on) only: and that there had been a lack of discussion of the psychological and practical processes involved in assessment: e.g. the tendency which some students might experience to 'lose their feet' when coming onto a busy ward; and the need for the assessor to be aware of this, and similar, personal stresses throughout the placement.

4.14 The findings make it clear that, in addition to a dearth of preparation for ward sisters acting as assessors in progress assessments, there is no preparation whatsoever for other senior trained staff - RGNs or SENs - who may from time to time participate in such assessments. This is clearly a deficit, especially in view of the reliance which assessors clearly place on the informal 'assessment network' in which such staff play an important part. The data would indicate a need for greatly increased provision of appropriate courses

both for assessors themselves and for collaborating members of the ward team. Regarding the content of such courses, a tendency towards a somewhat functional approach has been noted (cf Para. 4.13, above); and this may in some cases need counterbalancing with more discussion of the processes underlying progress assessment. For example, any current research into methods for achieving higher levels of reliability between assessors' ratings should become one of the focal discussion areas in future preparatory courses.

4.15 Of those educational issues concerning the process of progress assessment, a number are implicit in some of the organisational and assessment issues already discussed. Thus the validity of an assessment which relies to some extent on the observations of other members of the ward team is currently questionable if those members have received no adequate preparation for this task. There are a number of issues to do with the process of progress assessment which need raising to the level of conscious awareness of the group as a whole: e.g. the retrospective, summative nature of the report and the need for assessment of progress; the fact that currently very little time is spent talking with the student about her assessment; the need for some formalisation of the casual, unstructured approach involving other trained staff; the need for student nurses to be more fully involved in their own progress assessment procedures; the logical use of 'average' grades on the form; and issues

of subjectivity and sensitivity affecting the processes of progress assessment.

4.16 Regarding attitudes to progress assessment, it was noted that a high percentage of assessors felt that it was 'their job' to fill in the progress assessment form alone; felt 'no need' to go outside the ward ambience for help in progress assessments; and saw 'no difficulty' concerning the relatively brief discussions with student nurses concerning their progress assessment. These attitudes seem to reflect some degree of exclusiveness and complacency concerning some questionable aspects of the current situation which might with advantage be subjected to scrutiny in the educational context of the preparatory course. Similar considerations concern the current reluctance to allow full participation by other team members and the tacit exclusion of nurse managers and partial exclusion of teaching staff from the assessment situation on questionable grounds. Clearly the provision of adequate educational preparation and continued support could go some way towards dispelling ambivalence regarding the value of progress assessment; dealing with the widespread vagueness as to its 'beneficial' nature; and overcoming the general dearth of creative ideas in the group on possible ways of improving the present system, which exists in parallel with the group's recognition of the need for improvements.

## Overview of Implications Regarding Educational Issues:

1. All assessors should receive a preparatory course.
2. Where appropriate, the content of such courses should be reviewed to include (e.g.) a discussion of the psychological and educational processes underlying progress assessment.
3. These courses should be offered to all senior nursing staff collaborating in the process of progress assessment (e.g. RGNs and SENs).
4. Further research is required into educational methods of achieving higher levels of inter-assessor reliability: and a discussion of such reliability should become part of the focal content of preparatory courses.
5. Attention needs to be drawn to the requirement to improve the validity of an assessment which relies heavily on observations undertaken by non-assessing members of the ward team.
6. Attention should be drawn to the need to provide some qualitative indication of the student's progress during a specific allocation; since at present the instrument is used largely retrospectively and summaratively.
7. Where appropriate, preparatory courses should include some discussion of the logic of 'average' grades, to reduce their pejorative use as a minimal criterion of acceptability.
8. Attention of assessors should be drawn to potential problems of assessor subjectivity and (in certain cases) lack of sensitivity of the assessment instrument, as potential hazards in the use of the present assessment forms.
9. Shared completion of the progress assessment form by current assessors and senior qualified staff might be considered with regard to its potential benefits.
10. Other discussions which might with advantage be introduced into preparatory courses include: The possible value of looking outside the ward ambience for help and advice in connection with specific assessments; of longer discussion with each student regarding her assessment; and of the potential benefits accruing from full participation in assessments by other qualified members of the ward team.

11. The validity of ward-based assessments might be further improved by encouraging a 'partnership' in validation by discussion between assessors, educational and management staff.
12. Dearth of creative ideas regarding methods of improving progress assessment techniques may be partially overcome by inviting constructive suggestions from assessors and holding regular discussions of issues in progress assessment, such as those outlined in (11) above.

#### FINDINGS RELATING TO E.N.B. STAGED ASSESSMENTS:

##### A. Organisational Issues:

A summary of organisational issues is given below:

The majority (54 per cent) of assessors had had between three and six years experience as E.N.B. assessors. Only three per cent had experience in excess of this (3.55). The majority of assessors assessed approximately one student nurse per month ( $p < 0.001$ ). There was no evidence of lack of time for this activity in this sample (3.58). Seventy per cent of the sample noted no periodicity about E.N.B. staged assessments other than the monthly nature of assessments ( $p < 0.01$ ) (3.59). A majority of four-fifths were positively disposed towards carrying out E.N.B. staged assessments ( $p < 0.01$ ). Almost half of the sample carried out assessments for only one stage of the fourfold assessment (3.61). The resultant lack of practice in some assessments needs attention in some of the centres studied (3.61). Lack of general practice in all four of the assessments leads to a 66 per cent preference for doing specific assessments in the group (3.62). The great majority of assessors (97 per cent) assessed their own students on their own wards (3.63). Prior knowledge of a student's work would often influence decisions made during an assessment (3.29, 3.63, 3.65). The great majority of assessors (97 per cent) knew the work of the student concerned in the assessment (3.63, 3.64) and 85 per cent felt this to be an advantage (3.29, 3.65).

A 68 per cent majority of assessors felt that E.N.B. staged assessments exerted an influence on the ward, tending to produce a highly-charged, anxious, 'artificial' atmosphere ( $p < 0.05$ ). A majority felt the patients to be affected positively, tending to enjoy their participation in the assessment ( $p < 0.01$ ) (3.66).



3.67). All assessors put the ward sister first in importance as an assessor. Ninety per cent felt that she should be one of the principle assessors. A majority felt that she should function alone in this capacity. A further 36 per cent nominated the clinical teacher as another acceptable assessor (3.68).

A majority of 63 per cent cited 'safety' as the main reason for carrying out E.N.B. staged assessments ( $p < 0.05$ ) (3.69). Ninety-seven per cent of assessors carried out E.N.B. staged assessments alone (3.70); and were happy with this arrangement (3.71). The great majority of assessors (95 per cent) regarded the ward as the optimal location for E.N.B. staged assessments (3.28, 3.63, 3.68, 3.73). Opinions tended to be equally divided as to whether or not any problems were posed by use of the ward as a venue for staged assessments (3.74). More than half of the assessors (56 per cent) felt that time was a difficulty in carrying out E.N.B. staged assessments (3.76 - but cf. 3.58).

The majority of assessors (90 per cent) felt that E.N.B. staged assessments were fair in respect of patients, who it was felt generally appeared to enjoy participating (3.66, 3.67, 3.78). A sizeable minority of assessors (i.e. one-third) considered that the undue stress and anxiety likely to be felt by students in the 'artificial' setting of E.N.B. staged assessments seriously called into question the validity of the current method (3.78). A substantial majority (60 per cent) expressed their unhappiness with current methods, calling into question their efficacy and suitability (3.80).

The level of dissatisfaction demonstrated with E.N.B. staged assessments is much greater than that demonstrated in connection with progress assessments; where 60 per cent of assessors either felt them to be 'adequate' or else were 'unsure' (cf 3.49). Fairness on the one hand (cf. 3.78) and suitability as perceived by the assessors, must be distinguished here (3.80). Ninety-five per cent of assessors considered that more than one attempt to pass each stage of the E.N.B. assessment should be allowed to each student (3.83). A large majority of assessors (80 per cent) stated that no help or support was available to them in dealing with cases of 'borderline' performance in E.N.B. staged assessments (3.84). A further large majority (92 per cent) stated that they never got an opportunity to discuss the results of E.N.B. staged assessments with anyone ( $p < 0.001$ ) (cf also lack of training for assessors, 3.56, 3.57, 3.85).

4.17 Once again these issues may be considered separately in relation to the organisational processes of

E.N.B. staged assessments; and in relation to expressed attitudes towards the assessments. With regard to organisational processes, the majority of assessors were required to assess approximately once per month: and thus there is no evidence in the present data for lack of time or pressure of assessments which might lead to difficulties; although interestingly some 56 per cent of informants felt time to be a problem. Almost one-half of the sample assessed for one 'stage' only, with resultant lack of practice in assessing for other 'stages'; and here it might be considered that there is a need to consider diversifying the experience of those who currently assess for one 'stage' only, in the interests of versatility. Within the sample it was widely accepted that prior knowledge of a student nurse's work frequently influenced decisions nominally made within the formal context of the staged assessment: and it would seem appropriate to seek ways of formally recognising this aspect and the not inconsiderable role which it obviously plays in decision-making during staged assessments. As a corollary, the great majority of assessors assessed their 'own' student nurses on their 'own' wards: and 97 per cent had prior knowledge of the work of the student nurse to be assessed.

4.18 Some awareness on the part of the student nurse that this recognition is occurring - together with the employment of tension-reducing strategies and other

'de-fusing' techniques - could go some considerable way towards reducing the 'highly-charged', somewhat anxious and artificial atmosphere which, according to 68 per cent of the sample, is a common feature of the ward during staged assessments. Some assessors may achieve this result intuitively by the exercise of native social skills; but the group citing these tensions as a problem is sufficiently large to justify regarding them as a recurrent feature of the assessment situation; and as indicative of a need to include relevant 'social skills' material in the curriculum of preparatory courses for E.N.B. assessors - although this is more properly discussed as an educational rather than as an organisational issue.

4.19 A substantial majority of E.N.B. assessors carried out staged assessments alone; and were happy with this arrangement, although considerably less so with the lack of support (presumably management support) which they felt to be available to them in cases of 'borderline' performance. Similarly, 92 per cent of the sample stated that they were never given an opportunity to discuss the outcomes of specific staged assessments with management or educational staff.

4.20 Bearing in mind these dissatisfactions, it would seem appropriate to work towards the establishment of formal or semi-formal support groups whose function would be to offer advice and help to assessors dealing (inter alia) with problems of 'borderline' performance.

This same support group could then be available for routine discussion of all E.N.B. staged assessments occurring in relevant clinical areas - a resource which was clearly not available to informants in the present study. Any ward problems arising during staged assessments, or because of these assessments, might also become a focus of discussion for the support group, whose function would be to make informed suggestions for minimising such problems.

4.21 Regarding attitudes towards organisational issues, four-fifths of the sample were positively disposed towards carrying out staged assessments; with approximately two-thirds regarding 'safety' (to practice) as the main reason for carrying out such assessments. In spite of this positive orientation, approximately two-thirds of the sample were not entirely happy with the current process, feeling it to be lacking in efficacy or suitability in various ways. Issues tending to produce dissatisfaction included the potential reduction in validity of the staged assessment produced by the undue stress on the student nurse caused by the artificially 'charged' environment on the ward during assessments (cf. Para. 4.18, above); with one-third feeling this to be an important disadvantage. Despite such reservations, 95 per cent of the sample regarded the ward as the optimal location for such assessments, despite an ambivalence regarding possible related problems. An equally large majority favoured letting the

student nurse have more than one attempt at a specific staged assessment, should she fail to measure up at her first attempt. Indeed, all the reservations expressed about the current assessment process were expressed on the student's behalf; with 90 per cent feeling that staged assessments were 'fair' to the patient, in that they did not cause him or her undue stress; and that, in many instances, patients positively enjoyed participating in, and contributing to, the assessment. As previously noted in Para. 4.19, above, the importance of the ward sister as a main assessor was repeatedly stressed; with a consensus that she should function as such alone, and a 97 per cent majority who were happy to do so. However, one-third of the sample felt that perhaps the clinical teacher could form an acceptable alternative on occasions. As an adjunct to the discussion in Para. 4.17, above, it was noted that lack of wider practice led to a 66 per cent expressed preference for carrying-out specific 'stages' in the assessment (cf. that paragraph for a discussion of implications). Similarly, in connection with the discussion on the effects of prior knowledge of a student's work in that paragraph, it should be noted that 85 per cent of the present sample felt such prior knowledge to be an advantage.

#### Overview of Implications Regarding Organisational Issues:

1. Consideration should be given to diversifying the experience of E.N.B. assessors who currently assess for one 'stage' only, in the interests of assessor versatility.

2. Ways should be sought of formally recognising the positive role played in E.N.B. staged assessments by the assessor's prior knowledge of a student's work.
3. Student knowledge that this recognition is occurring, together with appropriate social skills awareness on the part of assessors, should go some way towards reducing the 'charged' atmosphere which appears to be common during staged assessments.
4. Establishment of a semi-formal or formal support group is desirable in order to offer advice and help to assessors during routine discussion of current E.N.B. staged assessments. Such a support group could also offer advice and help in connection with 'borderline' student performance; and could consider, and offer suggestions to minimise, any ward problems emergent during, or as a result of, E.N.B. staged assessments.
5. Such a support group could also form the nucleus of an assessment policy group which would include also management and education staff; and which would consider needs and resources for assessment; and make recommendations on these issues and on issues related to preparation and versatility of assessors.

#### B. Assessment Issues:

4.22 A summary of assessment issues is given below:

Some assessors were aware of the cross-sectional (i.e. summative), as opposed to longitudinal (i.e. formative) character of E.N.B. staged assessments (3.69). Forty-three per cent of assessors had referred students in the E.N.B. staged assessment. However, only two per cent regarded this as a 'frequent' occurrence. Twenty-four per cent regarded it as 'rare'; and 17 per cent as an 'occasional' occurrence. Outright failure in the assessments did not appear to occur in the present study (3.72). All assessors put the ward sister first in importance as an E.N.B. assessor. A majority felt that she should function alone in this capacity. A further 36 per cent nominated the clinical teacher as another acceptable assessor (3.68). A majority of 63 per cent cited 'safety' as the main reason for carrying out E.N.B. staged assessments ( $p < 0.05$ ). The great majority of assessors (95 per cent) regarded the ward as the optimal location for E.N.B. staged assessments (3.28, 3.63, 3.68, 3.73). There was a 95 per cent consensus that the task of carrying-out E.N.B. staged assessments is an 'import-

-ant' or 'necessary' aspect of the ward sister's role (3.75). Almost half of the sample (46 per cent) had themselves been assessed when students by means of similar methods. Just over one-half (51 per cent) had not (discrepant percentage due to non-response of one informant)(3.77). The relative importance of E.N.B. staged assessments as over against progress assessments is subscribed to by only one-quarter of the sample. An equivalent number felt they were not any more important than progress assessments: and a substantial majority opted for equality of importance as between the two types of assessment (3.79). A substantial majority of assessors (60 per cent) expressed unhappiness with the current arrangements for E.N.B. staged assessments, calling into question their efficiency and suitability (3.80). The level of dissatisfaction demonstrated with E.N.B. staged assessments is higher than that demonstrated in connection with progress assessments; where 60 per cent of assessors either felt it to be 'adequate' or else were 'unsure' - but fairness and suitability must be distinguished here (3.49, 3.78, 3.80).

A significantly higher percentage of assessors were happy with the content and format of the E.N.B. staged assessment report form than otherwise ( $p < 0.01$ ). Criticisms included (A) the undesirability of using one form for all four 'stages'; and (B) the need for a 'comments' section on the form (3.81). Just under one-fifth of assessors had been involved in repeated referrals - a significantly smaller number than those who had not been so involved ( $p < 0.001$ ) (3.82).

Ninety-five per cent of assessors considered that a student nurse should be allowed more than one attempt in each of the four stages of the assessment (3.83). Only one-fifth of assessors (19.5 per cent) were happy with the current situation as regards these assessments. Nearly 70 per cent of respondents had considered possible ways of improving the system: usually by means of some method of continuous assessment (3.86).

4.23 Again as with progress assessment, issues concerning E.N.B. staged assessments in the assessment area may be considered in terms of the instrument, the process of assessment, and attitudes related to the assessment. Significantly more assessors were happy

with the format and content of the report form than otherwise; a situation which contrasts markedly with their opinions in relation to the progress assessment form, which was severely criticised. There were however some criticisms of the format; chiefly relating to the undesirability of using one type of form to record the results of all 'stages' of the assessment, when in fact each 'stage' required its own specially-designed form; and the need for a 'comments' section in which to amplify qualitative aspects of the student nurse's performance. Thus it was felt that there was a need to reconsider the format of the assessment record in relation to each individual assessment; and to add a comment section to each format.

4.24 Some assessors showed awareness of the cross-sectional (summative), rather than longitudinal (formative) nature of the staged assessments; but felt that an instrument or process which is totally summative is possibly missing-out on the formative properties which are inherent in these assessment situations. Thus with regard to the process of assessment, as opposed to the instrument, only one-fifth of assessors were happy with the existing situation. Seventy per cent felt that it would be possible to improve the system, usually by capitalising on its more formative aspects through some form of continuous assessment. If this felt need to increase the longitudinal or developmental aspects of the assessment is accepted, then this might possibly



be achieved by means (e.g.) of periodic monthly appraisal against 'baseline' criteria obtained during the early stages of the placement. Such a system could be of particular value to 'borderliners' in helping them to pace themselves; and to achieve improvement through an increased awareness of progress.

4.25 Regarding the process of assessment, almost half the assessors had themselves been assessed in a similar manner when they themselves were student nurses. The location of staged assessments was, without exception, the ward itself. The ward sister functioned as main assessor. Ninety-five per cent of informants thought the ward to be the optimal location, subject to the considerations regarding some degree of 'artificiality' noted in Para. 4.21, above. Attitudes towards the role of the ward sister as main assessor have already been discussed in that paragraph. Incidents of referral in one or other part of the E.N.B. staged assessments appeared to be fairly common, with 43 per cent of assessors having been involved in referring a student nurse at one time or another. Conversely, outright failure in such assessments did not appear to occur: a situation understandable in view of the selective and self-selective processes leading up to the assessments. One-quarter of informants described the occurrence of referrals as 'rare'; 17 per cent considered that they occurred 'occasionally'; and only 2 per cent felt that they occurred 'frequently'. Just under one-fifth of assessors stated

that they had been involved in repeated referrals of the same student nurse. Ninety-five per cent of informants felt that more than one attempt should be allowed to the student nurse at each successive 'stage' of the assessment.

4.26 Note has already been taken of the degree of dissatisfaction with the current process of E.N.B. staged assessments, both in respect of their efficiency and suitability (cf Para. 4.24, above). With regard to their status in the eyes of the assessors, some 95 per cent of the sample considered the staged assessments to constitute an 'important' or 'necessary' aspect of the ward sister's role, as over against the 80 per cent who had stated that progress assessments ought to rank as important (cf Paras. 3.34, 4.11, above). However, only one-quarter of informants thought that E.N.B. staged assessments were more important than progress assessments. A further one-quarter stated unequivocally that they should not be considered more important: and the remaining half felt the two types of assessment to be of equal potential importance.

#### Overview of Implications Regarding Assessment Issues:

1. There is a need to reconsider the format in which the results of individual 'stages' of the assessment are recorded. There is a consensus that each 'stage' requires its own specially-designed form; Reappraisal of formats should recognise the need for a comments section in which to amplify qualitative aspects of the student nurse's performance during staged assessments.

2. There is a widespread view that an instrument which is totally summative is possibly missing-out on the formative properties which are inherent in these assessment situations. The longitudinal or developmental aspects of the assessment should be increased, possibly by means of periodic appraisal against 'baseline' criteria obtained during the early stages of each ward placement. Such a system could be of particular value to 'borderliners' in helping them to pace themselves; and to achieve improvement through an increased awareness of progress.

### C. Educational Issues:

4.27 A summary of educational issues is given below:

The great majority (87 per cent) of assessors had had only a two-day course in preparation for carrying-out E.N.B. staged assessments (3.56). More than 60 per cent felt ill- or partially-prepared for this task: a finding which calls into question the adequacy of current methods of preparation (3.57). The content and depth of two-day preparatory courses varied considerably from centre to centre in the study (3.57). Almost half of the sample carried out assessments for only one stage of the four-stage assessment (3.61). The resultant lack of practice in some assessments may need attention in some centres studied (3.61). Lack of more generalised practice in carrying-out all four stages of the assessment leads to a 66 per cent preference in the sample for doing specific stages of the assessment (3.62).

The opportunity to practice related skills on the ward made the students' passing the staged assessments very probable (3.63). Just over one-quarter of the assessors in the study felt that a main purpose of the E.N.B. staged assessments was 'to help the students' (3.69). Some assessors were aware of the cross-sectional (summative) as opposed to longitudinal (formative) characteristics of current E.N.B. staged assessments (3.69). Almost one-half of the assessors (46 per cent) had themselves been assessed in a similar way when they were student nurses. Just over one-half (51 per cent) had not (3.77). Assessors indicated that in the main they did not need help with E.N.B. staged assessments: a feeling in marked contrast with their feelings regarding progress assessment (3.31, 3.84). A large majority of assessors (92 per cent) stated that they never got an opportunity to discuss outcomes of E.N.B.

staged assessments with anyone ( $p < 0.001$ ) - see also findings concerning lack of training and education for assessors (3.56, 3.57, 3.85).

4.28 The above issues may be considered, firstly, as they concern the content and structure of preparatory courses for E.N.B. assessors; secondly, in relation to the processes of E.N.B. staged assessment; and thirdly, as they concern the general attitudes of the group towards E.N.B. staged assessment. Regarding preparatory courses, some 87 per cent of the sample had attended only a brief, two-day preparatory course: and there appeared to be some variability in the depth and curricular content of such courses, dependent upon the specific assessment centre in which they were convened. This led to more than 60 per cent of the sample feeling themselves to be either ill- or only partially prepared for their task as E.N.B. assessors; and consequently to their questioning the adequacy of such preparation.

4.29 There can be no doubt that, in cases where such dissatisfactions and self-questionings occur, they may well result in role-abridgement on the part of the assessors towards the more familiar and congenial stages of the assessment; and in feelings of insecurity and uncertainty, leading to negative attitudes towards the assessment. Equally importantly, the partial preparation described may produce significant lacunae in

assessors' knowledge and perceptions regarding the processes of assessment, leading at worst to less-than-adequate assessments; and at best to partial appreciation of the assessment situation, including reduced awareness of important contextual issues such as potential stress factors in the ward environment (cf Para. 4.18, above). Although the current situation was decidedly better than that obtaining in respect of progress assessment, where, it will be remembered, 68 per cent of the sample had received no preparation at all and there was ambivalence regarding the value of the preparation received (cf Para. 4.13, above), there is a clear need for all E.N.B. assessors to receive an adequate preparatory course, inclusive of materials on the psychological processes of assessment, such as the value of 'social skills' techniques in relation to the de-fusing of fraught assessment contexts (cf Para 4.18, above).

4.30 Concerning the process of staged assessment, it has already been noted that almost half the present sample assessed for one stage of the assessment only (cf Paras. 4.17, 4.21, above). This has already been discussed at some length under organisational issues: but educationally it might be considered that there is a need to consider diversifying the experience of those who currently assess for one 'stage' only, by arranging for them to have the opportunity to observe

appropriate role-models during assessment for other stages; followed by participation in dual assessment and individual practice. As with progress assessments, the content of preparatory courses should be widened where necessary to include aspects of all four stages.

4.31 The present findings make it clear that the opportunities given to student nurses to practice related skills prior to assessment in the realistic ambience of the ward make their passing E.N.B. staged assessments very probable (cf Para. 3.63, above). However, consultation with nurse management and nurse education staff concerning the outcomes of specific assessments should be the prerogative of the assessor, irrespective of whether or not problems are likely to ensue. From the assessor's point of view, such feedback is clearly desirable, both as validation of her current practice and as a consultative situation in which she can obtain advice or help should these become necessary.

4.32 These considerations make somewhat disturbing the finding that a large majority of the present sample (i.e. 92 per cent) apparently were never accorded an opportunity to discuss outcomes of specific E.N.B. staged assessments with anyone (cf Para. 3.85, above). One method of overcoming this problem has already been discussed under organisational issues (cf Paras.

4.19, 4.20, above); that is, by the establishment of a formal or semi-formal support group in order to offer advice and help to assessors during routine discussion of current E.N.B. staged assessments. All E.N.B. assessors should be recognised as members of such a support group, which should meet regularly to discuss relevant issues in assessment. In addition to clinical assessors, the group should include education and management resource members to help overcome the difficulties outlined in Para. 4.31, above.

4.33 Regarding attitudes to E.N.B. staged assessments in the present sample, some ambivalence was shown concerning the help required by assessors. Thus whilst more than 60 per cent of the sample said that they felt ill- or partially-prepared for this task, there was an equally paradoxical assurance that they did not need help with assessments (cf Para. 3.84, above). This is not a genuine paradox however, since in the first instance reference was being made to the nature and provision of available preparatory courses; whilst in the latter the focus was on whether or not assessors felt they would benefit from the help of another assessor during the actual process of assessment itself. More than one-quarter of the sample expressed the view that a main purpose of this assessment was '...to help the students': an objective which presumably could also be facilitated by means of the proposed assessors'

support group. Thus opportunities could be provided for student liaison with members of the support group. Student members could be invited to discuss with the group methods by which students may be best helped to overcome the tensions of staged assessment; and to gain maximum benefit from the assessment situation.

#### Overview of Implications Regarding Educational Issues:

1. All E.N.B. assessors should receive an adequate preparatory course, inclusive of materials on the psychological processes involved in assessment, such as the value of 'social skills' techniques in reducing tension in fraught assessment situations.
2. There is a need to consider diversifying the experience of assessors who currently assess for one stage of the assessments only: e.g. by arranging for them to have the opportunity to observe appropriate role-models during assessment for other stages; followed by participation in dual assessment and individual practice.
3. All E.N.B. assessors should be recognised members of the assessors' support group (cf Paras. 4.19, 4.20, above); which should meet regularly to discuss relevant issues in assessment. In addition to clinical assessors, the group should include education and management resource members to help overcome the difficulties outlined in Para. 4.31, above.
4. Opportunities should be provided for student liaison with members of the support group. Student members could be invited to discuss with the group methods for overcoming the tensions of assessment, and for ensuring that students gain maximum benefit from the assessment situation.



## SUMMARY:

4.34 In summarising the implications of the study, it should be borne in mind that, though technically two groups of assessors are being considered - i.e., those who undertake progress assessments and those who undertake E.N.B. staged assessments - in practical terms the individuals concerned are identical. In the present case this fact makes it possible to draw some useful cross-categorical conclusions involving both progress assessments and staged assessments as perceived by a constant group of respondents. This is also opportune in that the recently-projected autonomy of examining centres promulgated by the English National Board will make increasingly academic the currently-existing demarcations between the two types of assessors (80).

4.35 Regarding organisational issues, there would appear to be a need in some assessment centres to reappraise the workload of progress assessment as it affects individual wards and individual assessors. Similarly, in training areas where progress assessments regularly take place, the ratio of trained to untrained staff should be agreed by consensus involving managers, teachers and assessors; and should be kept under re-

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(80) THE ENGLISH NATIONAL BOARD (1985):  
Syllabus and Examinations for Courses in General  
Nursing (ENB 1985 (19) ERDB).  
London: The English National Board.

-view regarding its suitability for the specific assessment area. The modal duration of learner allocations should be reappraised in the light of what can realistically be achieved by the student, bearing in mind the need for a 'settling-in' phase. The complexity of the practical task awaiting assessors and their senior nursing staff during a relatively short placement is illustrated by the following quotation from one respondent:

'If you have so many nurses allocated to you - say, twelve - four may start together; then, two weeks later, the rest arrive. It takes a week to recognise a nurse - to fit a face to the name on the off-duty - and in fact some of them may not start until half-way through the week.

So, that leaves you with a week to assess eight nurses. By that time you've done the preliminary assessment on the first four; and you're trying to remember what you said to them!

So, at the end of eight weeks, you can't even expect to have worked with the same nurse twice; that is, worked with her for one shift to monitor her (work) for one shift.

You get your view of her from overall impressions and opinions from very junior staff nurses. Even the staff nurses can only work with the students a couple of times'.

4.36 Student nurses should become more centrally involved in the process of monitoring and administering their own assessments; especially with regard to the responsibility for disposal of relevant forms and greater involvement in discussion with assessors during the actual completion of the progress assessment form. Though this last issue was not raised in relation to

potential student involvement in the organisational contexts of E.N.B. staged assessment, there may well be germane issues for consideration in a further study.

4.37 Organisational issues regarding encouragement of recognition, competence and consultation on the part of assessors were well to the fore in both types of assessment situation. The contribution of senior trained nurses was frequently stressed with regard to progress assessment (cf Para. 4.35, above). In place of the present rather piecemeal arrangements, full participation in the assessment process by other senior trained nursing staff could be encouraged. Thus the existing team approach to progress assessment might become more formalised, with appropriate recognition of senior staff contributions to assessment discussions and to the actual writing of the assessment form.

4.38 With regard to issues of competence, the apparent dearth of creative ideas regarding methods of improving progress assessment techniques may be partially overcome by invitations from managers for assessors to make constructive suggestions on assessment: and by holding regular discussions of issues in progress and staged assessment. Consideration should be given to diversifying the experience of E.N.B. assessors who currently

assess for one stage only, in the interests of assessor versatility. Ways should be sought of formally recognising the positive role played in E.N.B. staged assessments by the assessor's prior knowledge of a student nurse's work.

4.39 With regard to issues of consultation, assessors should be given an opportunity to discuss the completed assessment with nurse managers as part of the more formal structure proposed. Establishment of a semi-formal or formal support group is desirable in order to offer advice and help to assessors during routine discussion of current assessments of both types. Such a support group could also offer advice and help in connection with 'borderline' student performance; and could consider, and offer suggestions to minimise, any ward problems emergent during, or as a result of, either type of assessment. Such a support group could also form the nucleus of an assessment policy group which would include also management and education staff: and which would consider needs and resources for assessment; and make recommendations on these issues and on issues relating to the preparation and versatility of assessors.

4.40 Regarding assessment issues, the data is supportive of proposed E.N.B. innovations; since it is clear that there is a need to reconsider both the format and categories of the progress assessment form; and

the format in which the results of individual 'stages' of the E.N.B. assessment are recorded. These should be amended to specify performance criteria, and to include genuinely developmental (i.e. formative) features. Each 'stage' in the E.N.B. assessment requires its own specially-designed form. Reappraisal of formats should recognise the need for a 'comments' section in which the assessor can amplify qualitative aspects of the student nurse's performance. Categories in the progress assessment form should also be reconsidered in relation to representativeness of student nurse activities on the ward; and due weight given to the items concerned with the acquisition of interpersonal and basic care skills.

4.41 There is in the present sample a widespread view that an instrument such as the 'staged' assessment, which is totally summative, misses the formative properties which are inherent in these assessments. Here the suggestion is, that longitudinal or developmental aspects should be increased, possibly by means of periodic appraisal against 'baseline' data obtained during the early stages of each ward placement. Such a system could be of particular value to 'borderline' students in helping them to pace themselves; and in helping them to achieve improvement through an increased awareness of personal progress.

4.42 All preliminary interviews with student nurses should be regarded as essential baseline data for developmental assessment; and completed accordingly. Discussions of the assessment with students should be longer, and go into rather greater depth concerning their gains and current needs; and the areas requiring special attention in future placements. For similar reasons, the student nurse should preferably always be present when the assessor is completing her progress assessment form.

4.43 The foregoing comments summarise findings and implications concerning the improvement of validity in the assessments. With regard to the investigation of reliability - and whatever may be the ultimate local format of assessments - there is a need for synchronous dual assessment studies involving assessors from more than one centre: and for studies into improving the properties of the instrument(s) used in formative evaluation as diagnostic and monitorial instrument(s) of direct relevance to the progress of individual student nurses.

4.44 Finally, with regard to educational issues, all assessors should receive an adequate preparatory course; which should also be offered to all senior nursing staff collaborating in student assessments (e.g. RGNs and SENs). These courses should include materials on

the psychological and educational processes underlying both types of assessment or their new analogues; and on associated assessment techniques, such as the value of 'social skills' methods as tension reducers in fraught assessment situations; the possible value of referring beyond the ward for help and advice in connection with specific assessments; the value of extended discussion with each student regarding her assessment; and of the potential benefits accruing from full participation in assessments by other qualified nursing members of the ward team. In connection with this last point, attention of course members should be drawn to the need to improve the validity of an assessment which relies heavily on observations undertaken by 'non-assessing' members of the ward team.

4.45 Other discussions which might with advantage be introduced into such preparatory courses include: the need to provide some qualitative indication of a student's progress during a specific allocation; potential problems of assessor subjectivity and the lack of sensitivity of current assessment instruments; the logic of 'average' grades; and the advantages of shared completion of the progress assessment form by current assessors and other senior qualified nursing staff involved.

4.46 There is a need to consider diversifying the

experience of assessors who currently assess for one stage only of E.N.B. staged assessments: e.g. by arranging for them to have the opportunity to observe appropriate role-models during assessment for other stages; followed by participation in dual assessment and individual practice.

4.47 All assessors should be recognised members of the assessors' support group (cf Para. 4.39, above); which should meet regularly to discuss relevant issues in assessment. In addition to clinical assessors, the group should include education and management resource members. The validity of ward-based assessments might be further improved by encouraging a 'partnership' in validation by discussion between assessors, educational and management staff. Opportunities should be provided for student liaison with members of the support group. Student members should be invited to discuss with the group methods for overcoming the tensions of assessment, and for ensuring that students gain maximum benefit from the assessment situation.

4.48 Further research is required into educational methods of achieving higher levels of inter-assessor reliability: and a discussion of such reliability should become part of the focal content of preparatory courses.



## RELATIONSHIP TO LEARNING THEORIES:

4.49 During the earlier discussion of learning theories (cf pp 5-13, above), it was noted that the process of practical clinical assessment is aimed at collecting accurate evidence to demonstrate that the student nurse is learning - i.e. that the process is continuous (cf Para. 1.15, Page 10). In that section a number of learning theories were outlined: and it is now both relevant and interesting briefly to trace their relationship to the findings and implications of this study.

4.50 Contemporary connectionist theories stress the inter-relatedness of learning and context (24); the central role played by feedback and reinforcement in its various forms (76); the provision of clear and unambiguous criteria which are shared with the learner (52); the assessment of sub-goals to criterion before moving on to attempt further learning (29); the facilitative effect of guidance which helps the learner to concentrate

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- (24) GUTHRIE, E.R. (1952):  
The Psychology of Learning (Revised Edition).  
New York: Harper and Row.
- (76) SKINNER, B.F. (1957):  
The Behavior of Organisms.  
New York: Appleton-Century-Crofts.
- (52) MAGER, R.F. (1961):  
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- (29) HILGARD, E.R. and BOWER, G.H. (1975):  
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on essentials (20a); and the importance of hierarchal arrangement of component tasks and sequences of operations within a larger task (the 'ladder principle' of learning) (20). Conversely, the Gestalt, cognitivist and 'field' theories stress the importance of arranging learning (and assessment) situations in order to promote creative understanding (11a) and lead to effective generalisation of knowledge and skills (84a); and of bearing in mind the part played by 'task completion' in relation to long-term retention of learned material (S34).

4.51 The findings of the present study make it clear that the above central tenets of learning theory are all violated to some degree by current assessmental practices as here described. Thus if such practice is examined in the light of 'key' phrases drawn from the literature, the following points are noted:

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- (20a) GAGNÉ, R.M. and BROWN, L.T. (1961):  
Some factors in the programming of conceptual learning.  
Journal of Experimental Psychology, Vol 62, pp 313-321.
- (20) GAGNÉ, R.M. (1970):  
The Conditions of Learning.  
New York: Holt, Rinehart and Winston Inc.
- (11a) BRUNER, J.S. (1960):  
The Process of Education.  
Cambridge, Mass: Harvard University Press.
- (84a) WERTHEIMER, M. (1945):  
Productive Thinking.  
New York: Harper.
- (S34) ZEIGARNIK, B. (1927):  
On the effects of complete and incomplete task handling.  
Psychologisches Forschung, Vol 9, pp 1-85.

'Inter-relatedness of learning and context...':

4.52 These appear to be seen rather less in terms of educational continuity; and rather more in terms of convenience for the ward sister/assessor. This is an understandable response from a sample of assessors who are clearly committed to the notion of practical nursing assessment as being the responsibility of the ward sister rather than that of the tutorial or any other staff; and who would logically opt for the setting most familiar to the ward sister, and from her point of view the most appropriate (see Paras. 3.28, 3.63, 3.68, 3.72, above). The implication here is the need to widen the assessors' notion of 'context' to include education staff as initiators, and administrative nursing staff as supporters, of a continuum of learning and related assessment experiences. This, it is envisaged, might be at least partially achieved by the regular discussion of issues in progress and staged assessment advocated in Paras. 4.38, 4.39, above: and by the opportunities to diversify her personal experience of staged assessments and to participate in assessment policy-making which it is suggested should be accorded to the assessor.

'Feedback and reinforcement...':

4.53 These both appeared to be singularly lacking both for assessor and student nurse. Thus assessors complained that they received no feedback on the outcomes of specific

assessments (cf e.g. Paras. 3.31, 3.46); and that they had no opportunity to discuss completed progress assessments with administrative nursing staff (cf Para. 3.46). Similarly, student nurses were largely uninvolved in the processing of their own assessment forms (cf Para. 3.30); were the subjects of unstructured and relatively covert observation by qualified nurses other than official assessors (cf Para. 3.37); were hardly ever present when the assessor completed the progress assessment form (cf Para. 3.43); and had only a very short discussion with the assessor on assessment outcomes (cf Para. 3.25): and indeed little initial discussion with her regarding the objectives of the ward placement (cf Para. 3.24). These factors may tend to give to the process of assessment a somewhat covert and fragmented character, both for the assessor and for the student; with both failing to grasp the significance of assessment as a continuous, progressive and integral part of the total learning experience. It may in fact be seen rather as a series of disconnected and (from the student's point of view) mysterious rites, bearing little practical relationship to clinical problem-solving on the ward. Here the implicit need is to turn this somewhat one-sided and imprecise process into a genuinely communicative situation for assessor and student: to some extent by means of the educational, discussion and support links discussed in Paras. 4.35, 4.37, 4.39, 4.44 and 4.47, above. From the student nurse's point of

view, increased involvement in monitoring her own assessment (cf Para. 4.36); and in preliminary, concurrent and final discussion of assessment objectives and outcomes with her assessor (cf. Para. 4.42) could do a great deal to dispel some current uncertainties; and to make the learning experience maximally interesting and useful to her; with assessment seen as both integral and relevant to the learning process.

'Provision of clear, unambiguous, shared criteria of learning...':

4.54 A number of the difficulties discussed in Para. 4.53, above, can be traced to the current unclarity of performance criteria in the instruments used (cf e.g. Para. 3.11); the lack of 'baseline' criteria obtained at initial interview with the student (cf Para. 3.24); and the general dearth of discussion with students on the objectives of assessment (cf Paras. 3.25, 3.27).

In aggregate, these factors appear to lead to considerable unclarity and ambivalence in the minds of assessors themselves regarding the purposes and suitability of current assessments - an attitude which recurs consistently throughout responses concerning both progress and staged assessments (cf e.g. Paras. 3.33, 3.34, 3.40, 3.41, 3.48, 3.51, 3.54, 3.96, 3.97, 3.69, 3.80, 3.86). A consideration of the theoretical literature, together with observations of clinical needs in a variety of contexts, lead the

present writer to opt for a form of continuous and integral assessment as most likely to produce the outcomes desirable both from educational and service viewpoints. Thus the outcome required is not the rather fluctuant comparison with other student nurses in a given cohort (to which current imprecise methods lend themselves); but, rather, firm evidence that performance is good; that predetermined criteria have been met; and that a specific level of attainment has been achieved by the individual student nurse in terms of such general criteria. Implications for improvement include, *inter alia*, the need to reconsider the format and categories both of progress and staged assessment instruments; to specify relevant performance criteria; to check reliabilities by means of synchronous dual assessment studies employing video playback; and to ensure the completion of all preliminary interviews and longer discussions with the student nurse on learning objectives and outcomes of her current ward placement (cf e.g. Appendix G, Page A77).

'Assessment of sub-goals...'; 'guidance towards essentials ...'; 'hierarchal arrangement of component tasks...':

4.55 All of the above components of cognitive-behavioural teaching-and-learning models appear impoverished in clinical assessment as described in the current study. Such components depend for their effect (i) upon the clarity and precision with which specific learning tasks are described and analysed; and (ii) upon a clear communication

of expectations and a shared perception of goals and outcomes between assessor and student nurse. Conversely, the present data make it clear (i) that there is currently no shareable taxonomy of learning associated with the assessments; since performance criteria remain unspecified for given stages of training: and (ii) that there is no consistently adequate communication between assessor and student nurse regarding intended goals and outcomes of clinical placements (cf e.g. Paras. 3.11, 3.24, 3.25, 3.40, 3.99). Implications for improvement include reconsideration of the format and categories of relevant assessment instruments as already discussed in Para. 4.54, above; increased discussion of goals and outcomes involving assessor and student nurse; and the alerting of all nursing staff who are either involved in, or likely to be involved in, progress and staged assessments, by means of the educational strategies previously outlined (cf also Appendix G, pp A77-A79, A80-A81).

'Arrangement of learning and assessment situations to promote creative understanding':

4.56 Clearly such arrangements are essential in order to facilitate effective learning; perception of relevance; and generalisation beyond the immediate confines of the assessment situation. Here many of the previously-discussed findings of the study are relevant; notably those concerning lack of clarity in assessment objectives

(cf e.g. Paras. 3.11, 3.33, 3.40, 3.41); the limiting of participation to ward-based staff (cf Para. 3.68); and lack of communication between assessor and student nurse (cf e.g. Paras. 3.25, 3.25, 3.27). The overall effect of such constraints is to weaken the perceived relevance and the practical effectiveness of ward-based clinical assessments; since it is manifestly unrealistic to expect student nurses to perform effectively unless they are aware (i) of the nature of the goals set for them; (ii) of the place and function of these goals in the continuum of their training; and (iii) of the continued clinical relevance of such behaviours outside the ambience of the immediate assessment situation..

Current indices of the narrow functional perception of staged assessment are the virtual exclusion of teachers and administrative nursing staff from participation in such assessments (cf Para. 3.68); and the largely retrospective and summative characteristics of both progress and staged assessments as these appeared to be implemented in the present study (cf e.g. Paras. 3.24, 3.40, 3.41, 3.49, 3.54, 3.69). The implications include the establishment of a shared taxonomy of learning for assessor and student, based on an unambiguous performance specification for each stage of clinical nurse training

and the encouragement in

educational courses for assessors of a broader perspective whereby assessment is seen as part of a continuum of training and educational experiences, initiated by educ-



ational staff; but incapable of sustenance or consolidation unless the process is continued in the clinical context of the ward placement.

4.57 As will be seen from the foregoing, the stated implications derived from the findings of the present study are based upon some well-established principles drawn from mainstream psychology of learning. In Paras. 4.49-4.56 above, an attempt has been made to illustrate the derivation of some example implications by relating them closely to their theoretical provenance in contemporary connectionist and Gestalt learning theory. Additionally, in relation to connectionist views on the need for clear, unambiguous shared criteria of learning, and to Gestalt views on the importance of good structure and continuity for meaningful learning, as well as to practical considerations both of educational and service needs, the writer would opt for a form of continuous and integral assessment as most likely to produce the optimal description of student nurse clinical learning.

## CONCLUSION:

4.58 The present study has been concerned with issues surrounding formative and summative evaluation of practical nursing skills in student nurses, as these were manifest in four assessment centres in the greater London area, and involving forty-four nurse assessors. Naturally, the results emergent from a small-scale study of this type must be viewed with the practical caution appropriate to attempted generalisations from small-sample data. Nevertheless, in the experience of the researcher, these results reflect and support more intuitive and observational assessments of current practice and opinion: and may serve as indicators for one potential direction to be taken by future, more detailed and extensive studies.

4.59 This small descriptive study has provided some contextual evidence regarding the current means by which student nurses are assessed in the clinical setting. The data collected indicate the complexity of the organisational, assessmental and educational issues involved: and go some way towards describing the current situation in respect of these two modes of practical assessment. They also serve both to illustrate some of the developments which have taken place during the last decade; and to indicate the need for some proposed innovations which might improve practical assessment in the contexts studied. The proposed innovations are relatively undemanding economically depending for

implementation on awareness of the issues involved, coupled with goodwill and commitment to seek practical solutions.

4.60 The proposed innovations are also illustrative of the types of change which will be necessary in order to facilitate recent policy developments in examination and assessment on the part of the English National Board for Nursing, Midwifery and Health Visiting. In a recent document, the Board sets out guidance to schools of nursing on the implementation of more autonomous modes of examination and assessment (80). The paper outlines the Board's plan for the gradual transition from current examination procedures to the progressive assessment of theory and practice to be administered by nurses in education centres in England. The plan further underlines the need to develop knowledge on which to base assessment policies. When the present study was conducted, various modes of continuous practical assessment were in process of development in English nurse education centres; and to date there are twelve such approved schemes in England. Approval for continuance of such schemes is granted by the English National Board when a scheme has been operational for one year, and where evidence of success can be demonstrated. Since the publication of the E.N.B. document on examination strategy encompasses progressive assessment, both in theory and in practice, it follows that a further

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(80) THE ENGLISH NATIONAL BOARD (1985):  
Syllabus and Examinations for Courses in General  
Nursing (ENB 1985 (19) ERDB).  
London: The English National Board.

period of development and consolidation is about to take place.

4.61 The findings and implications of the present study are timely in view of the current exploratory ethos in assessment; including the assessment of practical nursing skills. In questioning current systems by means of which clinical skills are assessed in student nurses, it is naturally necessary to offer constructive proposals based on research evidence rather than on unsupported conjecture. Though there has been gradual and continued development since these data were collected, not all of these developments have been investigated systematically against a background of research into the existing situation. Thus the current extensive piloting of possible progressive assessment schemes is at a 'polyglot' phase, displaying at the present time no unified policies or procedures for research-based innovation.

4.62 The issues summarised in Paras. 4.34 - 4.48, above, emerge from research-based information related to the purposes and objectives of the study (cf Section 1, Pages 2-3, above). These data could provide the basis for further research into this important aspect of nurse education. The findings strongly support the need to develop assessment knowledge and skills in qualified nurses from an early stage in their experience. In order to achieve this, there is a need to consolidate and to extend our existing knowledge of assessment, in order to

gain a more systematic understanding of this aspect of nurse education.

4.63 The central message emergent from the data of the present study was that clinical assessment of student nurses as carried out in the centres studied was a relatively fragmented, esoteric, covert and (as far as the student nurses were concerned) passive process. Great benefit could be forthcoming both to assessors and to student nurses if assessment were to follow a clearly-structured and progressive model; if uncertainty were to be reduced by promulgation of clear-cut performance criteria for each stage of training; if assessment were to be recognised as a shared and continuous activity integral to the learning process; and if student nurses were to become more fully involved in their own processes of assessment.

4.64 Such developments may be considered especially desirable in view of the English National Board's current guidance on curricula and assessment; which advocates the adoption of a problem-solving approach to nursing care (80). Within such a model, clinical assessment becomes part of a process applied by all nurses to the evaluation of their own standards of clinical care. It is seen as a universal and active function of nursing; and a function whose skills are to be acquired for their own intrinsic value, rather

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(80) THE ENGLISH NATIONAL BOARD (1985):  
Syllabus and Examinations for Courses in General Nursing (ENB 1985 (19) ERDB).  
London: The English National Board.

than for relatively limited, judgmental application by an assessor to recipient, rather passive learners. To be adequate within such a model, the clinical education of the student nurse must bring her by progressive stages to autonomous decision-making, based on continuous self-assessment; rather than to reliance on the received wisdom of others, however well-qualified and experienced. In working towards normative professional autonomy of this type, a clear, mutual taxonomy of clinical learning objectives, shared both by clinical assessors and by student nurses - not imposed by one group on the other in an atmosphere of uncertainty and ambivalence - is an important and crucial prerequisite.

4.65 The findings of the present small-scale study demonstrate the scope which exists for improving the organisational contexts of clinical assessment; the validity and reliability of the instruments used; and the educational preparation and support of present and future clinical assessors. There is a need to continue asking fundamental questions concerning the processes involved in assessing clinical nursing skills: and a clear strategy for research and development of assessment schemes is equally necessary. The present study may serve as a modest indicator towards one such approach.

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APPENDIX A: PRINCIPLE FINDINGS OF THE STUDY -  
A SUMMARY TABLE.

SECTION ONE: ON PROGRESS ASSESSMENT.

NO:	PARA:	FINDING:
(A)	<u>ORGANISATIONAL ISSUES:</u>	
6	3.11	Almost one-fifth of assessors felt that they had 'too many students to assess' in this way (mostly in Centre A)
7	3.11	In the opinion of the respondents less-than-optimal ratios of trained to untrained staff affect quality of assessment
9	3.12	There is a need to assess more second-year students if the process is to be genuinely developmental for students
10	3.14	There is a tendency for assessors to rely on students' contact with other trained nursing staff in the assessment process
11	3.13	Modal duration of student allocations is from six to ten weeks
12	3.15	The amount of time available to observe students was a source of dissatisfaction among assessors
14	3.17	39 per cent of assessors had 'limited contact' only with students, and expressed dissatisfaction. Only 9 per cent were 'very satisfied' in this respect
15	3.22	93 per cent of assessors described their ward workload as either 'heavy' or 'mixed'
16	3.23	This tends to affect students, who 'lose their feet' for a time
25	3.29	Assessors generally felt that prior knowledge of a student's work was not helpful for purposes of this assessment. This could lead to student dissatisfaction if they knew that information was being formally exchanged between ward sisters for this purpose
26	3.30	Student nurses are largely uninvolved in the processing of their own assessment forms

SECTION ONE: ON PROGRESS ASSESSMENT.

NO:	PARA:	FINDING:
(A)	<u>ORGANISATIONAL ISSUES (continued):</u>	
27	3.31	Assessors receive no feedback from the process of assessment; leading to lack of educational initiatives at ward level (cf also <u>Para. 3.46</u> )
31	3.35	There is 50 per cent ambivalence over the time available for progress assessment .
32	3.36	It appears that students are not consciously observed for purposes of assessment <u>alone</u>
33	3.37	There is an obvious team approach to progress assessment at ward level; but it appears casual and unstructured, without <u>full</u> participation by other team members. Assessors are reluctant to allow this (cf also <u>Para. 3.15</u> )
40	3.43	The learner is hardly ever present when the assessor completes the progress assessment form
43	3.46	There is a disturbing and massive lack of opportunity for assessors to discuss the completed progress assessment with administrative nursing staff
52	3.54	The majority of assessors are convinced that the system should be changed
(B)	<u>ASSESSMENT ISSUES:</u>	
8	3.11	Performance criteria for the various stages of a student's training are not specified in the progress assessment
9	3.12	There is a need to assess more second-year students if the process is to be genuinely developmental for students
17	3.24	A preliminary interview with the student as part of the assessment does not always take place

SECTION ONE: ON PROGRESS ASSESSMENT.

NO:	PARA:	FINDING:
(B) <u>ASSESSMENT ISSUES (continued):</u>		
18	3.24	The progress assessment report is largely retrospective and summative in nature
19	3.24	This must raise questions regarding its value as a <u>progressive</u> assessment
20	3.25	The modal 10-20 minutes allocated for discussion of the assessment with the student appears a very short time
23	3.27	One-fifth of assessors find themselves unable to complete a preliminary interview with the student (cf also <u>Para. 3.24</u> )
28	3.32	77 per cent felt the progress assessment to be 'beneficial' to the student; but were vague as to why this was the case
29	3.33	Opinions as to the value of progress assessment were very ambivalent
30	3.34	Eighty per cent of assessors felt that progress assessment <u>ought</u> to rank equally with other important tasks
35	3.39	Only one-quarter of assessors regarded the progress assessment form as frankly useful. Most regarded it as a <u>guideline for discussion</u> only
36	3.40	Almost four-fifths of assessors regularly used the 'comments' section of the form ('ticks don't indicate anything!')
37	3.40	There is a widespread feeling among the assessors that the progress assessment form is both <u>subjective</u> and <u>imprecise</u>
38	3.41	There is a related ambivalence regarding the utility of the progress assessment categories
39	3.42	Three-quarters of assessors felt the length of the progress assessment form to be 'about right'
40	3.43	The learner is hardly ever present when the assessor completes the progress assessment form

SECTION ONE: ON PROGRESS ASSESSMENT.

NO:	PARA:	FINDING:
	(B) <u>ASSESSMENT ISSUES (continued):</u>	
45	3.47	Two-thirds of the sample of assessors had not themselves been similarly assessed; especially in the case of the assessors in older age groups in Centres C and D
46	3.48	Group members showed ambivalence regarding the appropriateness of the methods by which they had been assessed: with more positive evaluations in Centres A and B among the younger assessors; and less positive evaluations among the older assessors of Centres C and D
47	3.49	There was a reasonably complete ambivalence regarding the adequacy of the present system, with uncertainty regarding both its <u>purposes</u> and <u>format</u> (cf also <u>Paras 3.24, 3.32, 3.33</u> )
48	3.50	Attributes relevant to the progress assessment were ranked as follows: (1) interpersonal skills (54 per cent) (2) ability to give basic care (47 per cent) (3) individual attributes (43 per cent)
49	3.51	More than three-quarters of assessors considered the vertical categories on the progress assessment form as 'helpful' - e.g. as a focus for discussion. Almost one-fifth said they were not helpful, or were not sure (cf also <u>Para. 3.11</u> )
50	3.52	A substantial minority of assessors (41 per cent) felt the assessment items to be unrepresentative of student activities during placement on their wards, especially in Centres C and D
51	3.53	Items positively rated were those concerned with the development of interpersonal skills. The majority of positively-rated items were not task-oriented (e.g. 'the ability to get on well with others')
55	3.54	Assessors were aware of the lack of <u>developmental</u> properties in the existing progress assessment form

SECTION ONE: ON PROGRESS ASSESSMENT.

NO:	PARA:	FINDING:
	(B)	<u>ASSESSMENT ISSUES (continued):</u>
56	3.54	Many assessors place emphasis on the need for genuine assessments of <u>progress</u> during a student allocation
58	3.96	Assessors tended to regard the category of 'average' pejoratively as a minimum acceptable standard (cf <u>Paras. 3.92 and 3.95</u> for evidence)
59	3.97	There is a marked difference between gradings in the two centres (A and C) involved in this part of the study. Centre A has a far greater proportion of 'excellent' gradings. Factors involved may include (e.g.) some degree of random error; genuine superiority on the part of students in Centre A; a subjectively less harsh grading in Centre A; and a lack of sensitivity in the four-point scale used in that centre
60	3.98	The potential superiority of students in Centre A needs checking by a cross-validation study based on related criteria (e.g. examination results)
61	3.98	Systematic differences in assessment standards as between the two centres need checking by means of synchronous dual assessment by both sets of assessors on the same student group
62	3.99	In the absence of objective behavioural criteria at each category on the progress assessment form, the likeliest factors responsible for the observed differences are a combination of assessor subjectivity (cf <u>Para 3.96</u> ); and a related lack of sensitivity in the four-point scale used in Centre A
63	3.100	These results emphasise problems of <u>subjectivity</u> and <u>sensitivity</u> (and possible interactions between these two factors) in assessments employing the current progress assessment form
64	3.101	Further confirmatory research is required along the lines indicated in <u>Para. 3.98</u>

SECTION ONE: ON PROGRESS ASSESSMENT.

NO:	PARA:	FINDING:
65	(B) 3.101	<u>ASSESSMENT ISSUES (continued):</u>  If the problems of subjectivity and sensitivity identified in <u>Para. 3.100</u> are confirmed as major problems, then there is a need for further research into the design and delivery of progress assessment; into educational methods for achieving higher levels of reliability between assessors; and into improvement of the properties of the assessment as a diagnostic/monitorial instrument of more direct relevance to the progress of individual students
(C)		<u>EDUCATIONAL ISSUES:</u>
1	3.8	68 per cent of assessors stated they received no preparation to carry out progress assessments ( $p < 0.05$ )
2	3.8	Five assessors (one-ninth of sample) felt the preparation they had received had not been helpful
3	3.8	This preparation had consisted of administrative aspects to do with the progress assessment form only
4	3.8	There had been a general lack of discussion of the <u>processes</u> of assessment in their preparation
5	3.8	Although RGNs and SENs participated in assessments, they received <u>no</u> formal preparation for this role
13	3.15	Assessors generally felt that it was 'their job' to fill in the progress assessment form <u>alone</u> ; an issue which may be considered to affect the validity of an assessment which relies to some extent on the observations of other members of the ward team
16	3.23	Students tend to 'lose their feet' at first during placements where a heavy workload is involved (cf also <u>Para. 3.22</u> )

SECTION ONE: ON PROGRESS ASSESSMENT.

NO:	PARA:	FINDING:
	(C)	<u>EDUCATIONAL ISSUES (continued):</u>
19	3.24	The largely retrospective, summative nature of the report throws into question the validity of the progress assessment as a <u>progressive</u> process
21	3.25	Although the modal 10-20 minutes allocated for discussion of the assessment with a student appeared to be a very short time, assessors 'saw no difficulty' about this
22	3.26	Very little time was spent in discussing the assessment with the student. Only 18 per cent of the sample spent a period in excess of half-an-hour doing this
24	3.28	Assessors did not feel the need to go outside the ward ambience for help in assessments
28	3.32	77 per cent felt the progress assessment to be 'beneficial' to the student; but were vague as to why this was the case
29	3.33	Opinions as to the value of the assessment were very ambivalent
33	3.37	There is an obvious team approach to progress assessment at ward level; but it appears casual and unstructured, without <u>full</u> participation by other team members. Assessors are reluctant to allow this (cf also <u>Para. 3.15</u> )
34	3.38	There was a general lack of training in assessment techniques for other grades of trained nursing staff (cf also <u>Para. 3.8</u> )
41	3.44	Nurse administrators appear to be tacitly excluded from the assessment process (cf also <u>Paras. 3.28, 3.46</u> )
42	3.45	There is also an eighty per cent exclusion of teaching staff from the assessment ('it's <u>our</u> assessment!')
44	3.46	There was a feeling that administrative staff might 'over-react' to critical comments on a student's performance



SECTION ONE: ON PROGRESS ASSESSMENT.

NO:	PARA:	FINDING:
	(C)	<u>EDUCATIONAL ISSUES (continued):</u>
54	3.54	There was a general dearth of creative ideas concerning improvement of the present system, although many recognised that it needed improvement
57	3.54	There is a need for students to be more closely involved in their own assessment procedures (cf also <u>Para. 3.86</u> )
58	3.96	Assessors tended to regard the 'average' category pejoratively as a minimum criterion of acceptability (cf <u>Paras. 3.92 and 3.95</u> for evidence)
62	3.99	In the absence of objective behavioural criteria at each category on the progress assessment form, the likeliest factors responsible for the observed differences are a combination of assessor subjectivity (cf <u>Para. 3.96</u> ), and a related lack of sensitivity in the four-point scale used in Centre A
65	3.101	If the problems of subjectivity and sensitivity identified in <u>Para. 3.100</u> are confirmed as major problems, then there is a need for further research into educational methods for achieving higher levels of reliability between assessors

SECTION TWO: ON E.N.B. STAGED ASSESSMENT.

NO:	PARA:	FINDING:
(A)		<u>ORGANISATIONAL ISSUES:</u>
66	3.55	The majority (54 per cent) of assessors had had between three and six years experience as ENB assessors. Only three per cent had experience in excess of this
70	3.58	The majority of assessors assessed approximately one student per month ( $p < 0.001$ ). There was no evidence of lack of time for this activity in this sample

SECTION TWO: ON E.N.B. STAGED ASSESSMENT.

NO:	PARA:	FINDING:
	(A)	<u>ORGANISATIONAL ISSUES (continued):</u>
71	3.59	Seventy per cent of the sample noted no periodicity about ENB staged assessments other than the monthly nature of assessment ( $p < 0.01$ )
72	3.60	A majority of four-fifths were positively disposed towards carrying out ENB staged assessments ( $p < 0.01$ )
73	3.61	Almost half of the sample carried out assessments for <u>only one part</u> of the four-fold assessment
74	3.61	The resultant lack of practice in some assessments needs attention in some of the centres studied
75	3.62	Lack of general practice on all four of the assessments leads to a 66 per cent preference for doing specific assessments in the group
76	3.63	The great majority of assessors (97 per cent) assessed their own students on their own wards
78	3.63	Prior knowledge of a student's work would often influence decisions made during an assessment (cf also <u>Para. 3.65</u> and the paradox in <u>Para. 3.29</u> )
79	3.64	The great majority of assessors (97 per cent) knew the work of the student concerned in the assessment (cf also <u>Para. 3.63</u> )
80	3.65	The great majority of assessors (85 per cent) felt this to be an advantage (cf. also the Section One paradox in <u>Para. 3.29</u> )
81	3.66	A 68 per cent majority of assessors felt that ENB staged assessments exerted an influence on the ward, tending to produce a highly-charged, anxious, 'artificial' atmosphere ( $p < 0.05$ )
82	3.67	A majority felt the patients to be affected positively, tending to enjoy their participation in the assessment ( $p < 0.01$ )

SECTION TWO: ON E.N.B. STAGED ASSESSMENT.

NO:	PARA:	FINDING:
	(A)	<u>ORGANISATIONAL ISSUES (continued):</u>
83	3.68	All assessors put the ward sister first in importance as an assessor. Ninety per cent felt that she should be one of the principle assessors. A majority felt that she should function <u>alone</u> in this capacity. A further 36 per cent nominated the clinical teacher as another acceptable assessor
84	3.69	A majority of 63 per cent cited 'safety' as the main reason for carrying out ENB staged assessments ( $p < 0.05$ ).
87	3.70	Ninety-seven per cent of assessors carried out ENB staged assessments <u>alone</u>
88	3.71	...and were happy with this arrangement
92	3.73	The great majority of assessors (95 per cent) regarded the ward as the optimal location for ENB staged assessments (see also <u>Paras. 3.28, 3.63, 3.68</u> )
93	3.74	Opinions tended to be equally divided as to whether or not any problems were posed by use of the ward as a venue for staged assessments
95	3.76	More than half of assessors (56 per cent) felt that time was a difficulty in carrying out ENB staged assessments (but cf <u>Para. 3.58</u> above)
97	3.78	The majority of assessors (90 per cent) felt ENB staged assessments to be fair in respect of patients, who generally appeared to enjoy participating (cf <u>Paras. 3.66, 3.67</u> )
98	3.78	A sizeable minority of assessors (one-third) considered that the undue stress and anxiety likely to be felt by students in the 'artificial' setting of ENB staged assessment seriously called into question the validity of the current method
100	3.80	A substantial majority (60 per cent) expressed their unhappiness with current methods, calling into question their <u>efficacy</u> and <u>suitability</u>

SECTION TWO: ON E.N.B. STAGED ASSESSMENT.

NO:	PARA:	FINDING:
	(A)	<u>ORGANISATIONAL ISSUES (continued):</u>
101	3.80	The level of dissatisfaction demonstrated with ENB staged assessment is much greater than that demonstrated in connection with progress assessments; where 60 per cent of assessors either felt it to be 'adequate' or else were 'unsure' (cf Para. 3.49). Fairness on the one hand (cf Para. 3.78) and <u>suitability</u> as perceived by the assessors, must be distinguished here
104	3.83	Ninety-five per cent of assessors considered that more than one attempt to pass each ENB staged assessment should be allowed to each student
105	3.84	A large majority of assessors (80 per cent) stated that no help or support was available to them in dealing with cases of 'borderline' performance in ENB staged assessments
107	3.85	A large majority of assessors (92 per cent) stated that they never got an opportunity to discuss the ENB staged assessment with anyone ( $p < 0.001$ ) (cf also lack of training for assessors, <u>Paras. 3.56, 3.57</u> )
(B)		<u>ASSESSMENT ISSUES:</u>
83	3.68	<u>All</u> assessors put the ward sister first in importance as an assessor. Ninety per cent felt that she should be one of the principle assessors. A majority felt that she should function <u>alone</u> in this capacity. A further 36 per cent nominated the clinical teacher as another acceptable assessor
84	3.69	A majority of 63 per cent cited 'safety' as the main reason for carrying out ENB staged assessments ( $p < 0.05$ )
86	3.69	Some assessors were aware of the <u>cross-sectional</u> , as opposed to <u>longitudinal</u> , character of the ENB staged assessments

SECTION TWO: ON E.N.B. STAGED ASSESSMENT.

NO:	PARA:	FINDING:
	(B)	<u>ASSESSMENT ISSUES (continued):</u>
89	3.72	Forty-three per cent of assessors had referred students in the ENB staged assessment
90	3.72	Only 2 per cent regarded this as a 'frequent' occurrence. Twenty-four per cent regarded it as 'rare'; and 17 per cent as an 'occasional' occurrence
91	3.72	Outright failure in an ENB staged assessment did not appear to occur
92	3.73	The great majority of assessors (95 per cent) regarded the ward as the optimal location for ENB staged assessments (see also <u>Paras. 3.28, 3.63, 3.68</u> )
94	3.75	There was a 95 per cent consensus that the task of carrying out ENB staged assessments is an 'important' or 'necessary' aspect of the ward sister's role
96	3.77	Almost half (46 per cent) of assessors had themselves been assessed in a similar way. Just over one-half (51 per cent) had not
99	3.79	The relative importance of ENB staged assessments as over against progress assessments is subscribed to by only one-quarter of the sample. An equivalent number felt that they were <u>not</u> any more important than progress assessments: and a substantial majority opted for <u>equality</u> of importance as between the two types of assessment
100	3.80	A substantial majority of assessors (60 per cent) expressed unhappiness with the current arrangements for ENB staged assessments, calling into question their <u>efficiency</u> and <u>suitability</u>
101	3.80	The level of dissatisfaction demonstrated with ENB staged assessments is much greater than that demonstrated in connection with progress assessments; where 60 per cent of assessors either felt it to be 'adequate' or else were 'unsure' (cf <u>Para. 3.49</u> ). <u>Fairness</u> on the one hand (cf <u>Para. 3.78</u> ) and <u>suitability</u> must be distinguished here

SECTION TWO: ON E.N.B. STAGED ASSESSMENT.

NO:	PARA:	FINDING:
	(B)	<u>ASSESSMENT ISSUES (continued):</u>
102	3.81	A significantly higher percentage of assessors were happy with the content and format of the ENB staged assessment report form than otherwise ( $p < 0.01$ ). Criticisms included (A) the undesirability of using one form for all four assessments; and (B) the need for a 'comments' section on the form
103	3.82	Just under one-fifth of assessors had been involved in repeated referrals - a significantly smaller number than those who had not been so involved ( $p < 0.001$ )
104	3.83	Ninety-five per cent of assessors considered that more than one attempt should be allowed to a student in each of the four staged assessments
108	3.86	Only one-fifth of assessors (19.5 per cent) were happy with the 'status quo' as regards these assessments. Nearly 70 per cent of respondents had considered possible ways of improving the system: usually by some method of continuous assessment
	(C)	<u>EDUCATIONAL ISSUES:</u>
67	3.56	The great majority (87 per cent) of assessors had only had a two-day course in preparation for carrying out ENB staged assessments
68	3.57	More than sixty per cent felt ill- or partially-prepared for this task: a finding which calls into question the adequacy of current methods of preparation
69	3.57	The content and depth of preparatory two-day courses varied considerably from centre to centre

SECTION TWO: ON E.N.B. STAGED ASSESSMENT.

NO:	PARA:	FINDING:
	(C)	<u>EDUCATIONAL ISSUES (continued):</u>
73	3.61	Almost half of the sample carried out assessments for <u>only one part</u> of the fourfold assessment
74	3.61	The resultant lack of practice in some assessments needs attention in some of the centres studied
75	3.62	Lack of general practice on all four of the assessments leads to a 66 per cent preference for doing specific assessments in the group
77	3.63	The opportunity to practice related skills on the ward made the students' passing the assessment very probable
85	3.69	Just over one-quarter of the assessors felt that a main purpose of the ENB staged assessments was 'to help the students'
86	3.69	Some assessors are aware of the <u>cross-sectional</u> , as opposed to <u>longitudinal</u> , character of the ENB staged assessments
96	3.77	Almost half of the assessors (46 per cent) had themselves been assessed in a similar way. Just over one-half (51 per cent) had not
106	3.84	Assessors indicated that, in the main, they did not <u>need</u> help with ENB staged assessments: a feeling in marked contrast with their feelings regarding progress assessment (cf <u>Para. 3.31</u> )
107	3.85	A large majority of assessors (92 per cent) never got an opportunity to discuss the ENB staged assessment outcomes with anyone ( $p < 0.001$ ) (cf also findings concerning lack of training and education for assessors, Paras. 3.56 and 3.57)

APPENDIX B: GUIDED INTERVIEW SCHEDULES EMPLOYED  
IN THE STUDY.

Interview No:	
Date:	

GUIDED INTERVIEW SCHEDULE:

THE ASSESSMENT OF PRACTICAL SKILLS IN STUDENT NURSES

INTRODUCTORY:

I am trying to find out what the current situation is regarding the practical assessment of student nurses. I am interviewing nurses who are involved in this procedure in order to clarify the particular strength and weaknesses that the system may have. There are no right or wrong answers to the questions, all that is required is as much accuracy according to your own experience as is possible.

Everything you say will be absolutely confidential - no-one else except me will hear this tape and there will be nobody's name mentioned in any reports.



SECTION I: FOR ALL NURSE ASSESSORS

CODING/REMARKS:

SURNAME

FIRST NAMES

AGE GROUP (RING)    21 - 30    31 - 40    41 - 50    51 - 60

Professional Background

Basic Training

Dates

Post Basic

Dates

Assessment Experience

Do you write progress assessment forms for the students on your ward?

a)    Yes .....

b)    No .....

If no - proceed to SECTION II

Do you carry out G.N.C. assessments?

a)    Yes .....

b)    No .....

FOR THOSE COMPLETING PROGRESS ASSESSMENT FORMS

FACTS ABOUT PROGRESS ASSESSMENT FORMS

1.    How long have you been completing these forms?

- |                  |       |
|------------------|-------|
| a) 1 - 6 months  | ..... |
| b) 6 - 12 months | ..... |
| c) 1 year        | ..... |
| d) 2 years       | ..... |
| e) 3 years       | ..... |
| f) 4 years       | ..... |
| g) 5 years       | ..... |
| h) 6 years       | ..... |
| i) 7 years       | ..... |
| j) 8 years       | ..... |
| k) 9 years       | ..... |
| l) 10 years      | ..... |

Cont.... (2)

2. Did you receive any preparation for the task?

a) Yes .....

b) No .....

If yes, was the preparation you received helpful?

a) Yes .....

b) No .....

Can you explain how?

3. How many students can you expect to be allocated to your ward at any given time?

a) 1 .....

b) 2 .....

c) 3 .....

d) 4 .....

e) 5 .....

f) 6 .....

g) 7 .....

h) More.....

4. For assessment purposes, do you feel that these numbers are

a) Too few .....

b) Too many .....

c) About Right .....

5. What stage in training do the students tend to be at?

a) 1st year .....

b) 2nd year .....

c) 3rd year .....

d) Mixture .....

If d, does the mixture follow a particular pattern?

6. Are your students allocated for a set number of weeks?

Yes .....

No .....

If yes

a) 2 - 4 .....

b) 4 - 6 .....

c) 6 - 8 .....

d) 8 - 10 .....

e) 10 - 12 .....

f) More .....

Cont.. (3)

If no, please explain

7. Is there enough time to really get to know the students work in order to assess them in this way?

- a) Yes .....
- b) No .....
- c) Sometimes .....

8. Does a system of internal rotation operate for students on your ward?

- a) Yes .....
- b) No .....

9. How many trained staff including part time staff are usually on your ward for the period

- a) 8.00 a.m. - 4.00 p.m. ....
- b) 1.00 p.m. - 10.00 p.m. ....

10. How satisfied are you with the amount of contact you have with your learners?

- a) Very satisfied - see a great deal of them.....
- b) Satisfied but would prefer more .....
- c) Unsatisfied - limited contact only .....

11. Is your ward a

- Medical .....
- Surgical .....
- Geriatric ..... ward

12. What sort of layout do you have on your ward?

- a) Nightingale .....
- b) Bays .....
- c) Racetrock .....
- d) Other .....

Do you feel that this layout gives enough opportunity for observing the student?

- a) Yes .....
- b) No .....
- c) Other .....

Cont....(4)

13. What average stay do you expect of your patients?

- a) Short .....
- b) Medium .....
- c) Long .....
- d) Mixture .....

14. In your opinion how would you describe the workload on your ward?

- a) Heavy .....
- b) Medium .....
- c) Light .....
- d) Mixture .....

15. Does the pace of work affect student nurse assessments in any way?

- a) Yes .....
- b) No .....

Probe

16. Do you aim to have the forms completed by a certain time?

- a) Yes .....
- b) No .....

17. How long on average do you spend filling in the form?

- a) Under 5 minutes .....
- b) 5 - 10 minutes .....
- c) >10 - 20 minutes .....
- d) >20 - 30 minutes .....
- e) >30 - 60 minutes .....

18. How long do you usually spend discussing the report with the student?

- a) Minutes .....
- b) Up to half an hour .....
- c) Between half and 1 hour .....

19. Do you always manage an initial and final interview?

- a) Yes .....
- b) No .....
- c) Mostly .....

Probe

Cont...(5)

20. Suppose there is a work problem with a student, how do you approach this in respect of the form?

- a) Complete form in pencil and discuss with student as soon as possible. ....
- b) Counsel student and try to help .....
- c) Seek help from others
  - 1. Clinical Teacher .....
  - 2. Nursing Officer .....
  - 3. Tutor .....
- d) Make a point of working with her .....
- e) Other .....

Probe:

At which stage of allocation .....

21. Would prior knowledge of students in respect of work performance be helpful for assessment purposes?

- a) Yes .....
- b) No .....
- c) Don't know .....

Probe

22. What happens to the forms when they are completed?

23. Do you generally receive feedback from this activity from

- a) Nursing Officer .....
- b) Teaching Staff .....
- c) Students .....

Probe

Belief About Facts of Assessment

24. What do you feel is the overall purpose of assessing students in this way?

25. What do you feel is the value of the completed form in respect of the training of student?

Cont.....(6

26. Which of the following statements would you feel most reflects your feeling - do you feel that progress assessment of students is

- a) The most important part of your job .....
- b) Ranks equally with other important aspects .....
- c) Is less important than some aspects .....
- d) Uncertain .....

Attitudes, feelings and opinions about assessments

27. Given the sort of nursing that you are involved in, what are your feelings about the time that this assessment takes?

Do you have sufficient time for this activity?

- a) Yes.....
- b) No .....

If no

- a) You need a little more time .....
- b) You need a lot more time .....
- c) There could never be sufficient time .....

28. How much time do you feel is spent actually observing the student?

Probe

29. Do you involve other trained nursing staff in your ward when you are preparing reports?

- a) Yes .....
- b) No .....

i) If yes, please specify

- a) Other Sisters .....
- b) Staff Nurses .....
- c) S.E.N.'s .....

ii) Do they write on the form?

- a) Yes .....
- b) No .....

Probe if necessary

30. Apart from the help given by you, is there any other training available for your staff in assessment techniques?

- a) Yes .....
- b) No .....

Cont.... (7)

31. The form itself, do you find this
- a) A useful form
  - b) Of some use
  - c) Of little use
  - d) Of no use
32. Are the comments section a part that you use
- a) Regularly
  - b) Sometimes
  - c) Rarely
- Probe
33. And the columns (show form) do you find the horizontal ones useful?
- a) Yes .....
  - b) No .....
- Can you explain .....
34. Do you feel that the length of the form is
- a) About right .....
  - b) Too long .....
  - c) Too short .....
  - d) Not sure .....
35. Do you complete the form with the learner present?
- a) Always .....
  - b) About 50/50 .....
  - c) Less than half .....
  - d) Hardly ever .....
  - e) Never .....
  - f) Filled in beforehand .....
36. Does the Nursing Officer get involved at any stage eg. interviews, completion of form or observation?
- a) Sometimes .....
  - b) Always .....
  - c) If there is a problem .....
  - d) Never .....
37. Teaching staff, are they involved?
- a) Yes .....
  - b) No .....

Cont....(8)

38. Once the forms are sent on, do you get an opportunity to discuss the completed form.

- a) Yes .....
- b) No .....

Reasons for Attitudes

39. When you were a student, were you assessed in the same way as you currently assess students?

- a) Yes .....
- b) No .....

40. Do you feel that the way in which you were assessed was satisfactory?

- a) Yes .....
- b) No .....

41. The present system in your opinion is

- a) Adequate .....
- b) Not adequate .....
- c) Not sure .....

Level of Knowledge of Assessment

42. What aspects of the students work do you look at in order to carry out this assessment?

43. (Using the form) Are the five categories, (vertical) helpful for the purpose of assessment?

- a) Yes .....
- b) No .....
- c) Not sure .....
- d) Don't know .....

44. What meaning do you give to the words

Satisfactory  
Average  
Progress

45. In your opinion, are the items on the form representative of the usual student activities?

- a) Yes .....
- b) No .....

Cont..... (9)



46. How do you assess the following in a student?

Item 7

Item 9

Item 22

Item 24a & b

47. Do you find some things on the form easier to answer than others?

a) Yes .....

b) No .....

Can you give me an example if yes

Suggestions/ideas about possible improvements

48. Have you ever thought that this system could be improved?

a) Yes .....

b) No .....

If yes, what would you like to see happen?

SECTION II: FOR GNC/ENB ASSESSORS ONLY

1. How long have you been a G.N.C. Assessor?

- a) 6 months .....
- b) 1 year .....
- c) 18 months .....
- d) 2 years .....
- e) 3 years .....
- f) 4 years .....
- g) 5 years .....
- h) 6 years .....
- i) 7 years .....
- j) 8 years .....
- k) More .....

2. How much preparation did you receive?

- a) 2 day course .....
- b) Other .....

If other, please explain

3. Do you feel that you were well prepared?

- a) Yes .....
- b) No .....
- c) Partly .....

Please explain

4. On average, how many assessments do you carry out say

- a) Weekly .....
- b) Monthly .....
- c) Annually .....

5. Have you noticed any particular pattern in the way that assessments occur eg. frequently.

6. Are you happy with your involvement in G.N.C. Assessments?

- a) Yes .....
- b) No .....

Please explain

Cont.....(11)

7. Do you assess for all 4 parts?

- a) Yes .....
- b) No .....

8. Of the 4 parts, do you have any preference for 1 part or another?

- a) Yes .....
- b) No .....

Please indicate which if appropriate

9. Do you assess on your own ward?

- a) Yes .....
- b) No .....

Is there a particular reason for this?

10. Would you say that on average you know the particular students work?

- a) Yes .....
- b) No .....

11. In your opinion, is there an advantage in knowing this?

- a) Yes .....
- b) No .....

Probe

12. When the assessments are in progress do you feel that they influence the ward generally?

- a) Yes .....
- b) No .....

If yes, please explain

13. Do you feel that they affect the patients at all?

- a) Yes .....
- b) No .....

Probe

Cont....(12)

Belief about what the facts are

14. Which of the following ideally in your opinion should be carrying out the assessment of students in this way?

- a) The Sister .....
- b) Nursing Officer .....
- c) Clinical Teacher .....
- d) Tutor .....

15. What do you feel is the overall purpose of assessing students practical ability in this way?

16. Do you assess on your own generally?

- a) Yes .....
- b) No .....
- c) Varies .....

17. Are you happy with this?

- a) Yes .....
- b) No .....
- c) Not sure .....

Probe

18. Have you ever referred a student?

- a) Yes .....
- b) No .....

If yes, would this be

- a) Rarely .....
- b) Often .....
- c) Occasionally .....

19. Which in your view is the best setting for this assessment?

- a) Practical Room .....
- b) Ward .....

Why?

20. Can you mention any problems associated with using the ward as a setting for assessments?

- a) Yes .....
- b) No .....

Probe

Cont... (13

Attitudes, feelings and opinions about assessments

21 Do you feel that this aspect of your job is

- a) Important .....
- b) Necessary .....
- c) Not important .....
- d) Unsure .....

22. What about the time taken to carry out these assessments. Are there any difficulties in this respect in your experience?

- a) Yes .....
- b) No .....

Probe

Reasons for attitudes to G.N.C. Assessments

23. As a student, were you assessed in this way?

- a) Yes .....
- b) No .....

24. Do you feel that the system is fair in respect of

- i) Patients      a) Yes .....
- b) No .....
- ii) Students    a) Yes .....
- b) No .....

If any negatives - probe

25. What is the purpose of assessing nurses in this way in your opinion?

26. Are G.N.C. assessments more important than progress assessments in your opinion?

- a) Yes
- b) No
- c) Not sure
- d) Equally

27. Would you say that you are

- a) happy .....
- b) unhappy .....
- c) neither .....
- d) other .....

with the present arrangement for G.N.C. assessments.

Cont....(12)

Level of knowledge of G.N.C. Assessments

(Have forms readily available)

28. Looking at each form for the 4 stages, are you happy with their content?

- i) Aseptic Technique      a) Yes .....  
   b) No .....

If no, explain

- ii) Medicine Round      a) Yes .....  
   b) No .....

- iii) Total Patient Care      a) Yes .....  
   b) No .....

If no, please explain

- iv) Communication and      a) Yes .....  
    Organisation      b) No .....

If no, please explain

29. Have you been involved in the situation where the student has been referred more than once?

- a) Yes .....  
b) No .....

If yes, what are your feelings about the system for referral?

30. Do you feel that the student should be given more than one chance to pass each stage?

- a) Yes .....  
b) No .....  
c) Don't know .....

31. Are the arrangements for booking assessments satisfactory in your view?

- a) Yes .....  
b) No .....

32. What about borderline performance, is there help available to you to support you in this event?

- a) Yes .....  
b) No .....  
c) Don't know .....

Cont... (1<sup>c</sup>)

33. Do you get an opportunity to discuss the assessments?

- a) formally .....
- b) informally .....
- c) other .....

Probe

Suggestions/Ideas about possible experiments

34. Have you ever thought that the way in which these assessments are carried out could be improved in any way.

- a) Yes .....
- b) No .....

Probe

If no - would you say that you are happy with the way things are in this respect.

- a) Yes .....
- b) No .....

END OF INTERVIEW SCHEDULE

APPENDIX C: THE KING'S FUND STUDY OF STUDENT NURSE  
PROGRESS REPORTS.

(condensed and edited from the report first published  
by the King's Fund Hospital Centre in November, 1968)

THE INITIAL SURVEY:

The initial survey was carried out in 1965-66 with the support of the General Nursing Council for England and Wales (1). This investigation was restricted to the ninety-three hospitals whose schools of nursing had at that time been approved for the adoption of the 1962 revised syllabus of student nurse training. Responses were received from eighty-eight of the ninety-three hospitals. Four other nurse training schools also volunteered to supply information. Copies of progress report forms currently in use were obtained from all ninety-seven hospitals involved. Additional information was also obtained from a conference held late in 1965 attended by matrons, principal tutors and ward sisters from a sample of hospitals taking part in the survey (2).

The interim report concluded that there was an urgent need to reappraise current methods of assessment of student nurses in training, especially in view of the impending introduction of the 1962 revised syllabus, with its emphasis on ward teaching and on patient-centred care, into all nurse training schools. It was felt that the time had not been reached when a standard report form could be designed for use throughout the country: but reference was made to various experimental report systems in use in certain hospitals as part of an investigation into the design and function of report forms. It was suggested that more hospitals should become actively involved in similar experiments. In particular, the following points required further consideration:

- (1) the type(s) of forms and methods of assessment to be used
- (2) the minimum length of placements for which progress reports should be prepared
- (3) the training necessary for nursing personnel responsible for writing reports on student nurses

- 
- (1) KING EDWARD'S HOSPITAL FUND FOR LONDON (1966):  
A Study of Student Nurses' Progress Reports:  
interim report.  
London: The Hospital Centre.



- (4) the extent to which staff nurses should be involved in the preparation of such reports
- (5) the practical participation of the student nurse in the preparation of her reports, and in discussions on her progress
- (6) the number and types of report forms required in order adequately to cover all stages of training
- (7) the need for further experiments in the design and use of assessment forms, taking full advantage of the experience already gained both in hospitals and in industry.

#### OUTCOMES:

This interim report served to arouse interest and to stimulate discussion. The comments from one matron serve to reflect the views of numerous others:

'This report has made us sit up and think again. Although we are groping towards the right ideas, we have a long way to go before we can establish...a constructive and adequate report for the nurses in this hospital. This report has put into words many of the things that we have felt but have not...had the courage to say'.

A number of hospitals have in consequence organised study days for ward and departmental sisters at which the interim report and the report forms in use at the individual hospitals have been discussed. One principal tutor reports:

'The sisters have been very interested in these discussions; and were obviously concerned about their own inadequacies when reporting on nurses'.

Other hospitals have organised working groups of nursing staff to consider in greater detail the purposes and content of the report forms in use in their particular hospitals.

- 
- (2) NURSING TIMES (1965):  
Ward Reports: work of a conference at the Hospital Centre.  
London: Nursing Times, vol 61, pp 1593-1594.

## THE SECOND SURVEY:

Early in 1968 a second questionnaire was sent to all hospitals who had participated in the initial survey. This questionnaire requested information on the following points:

- (1) whether the initial survey had had any influence on assessment methods for student nurses
- (2) whether there had been any changes in methods or in report forms - and if the latter, what had influenced the new design(s)
- (3) what mechanisms had been involved in any changes: e.g. staff consultations; working parties; or external advice
- (4) which grades of staff had been instrumental in bringing about changes: e.g. ward sisters; tutors; staff nurses; psychologists; sociologists
- (5) details of changes involving preparation of ward and departmental sisters to undertake assessments; and in the role played by staff nurses and by the students themselves in their own assessments
- (6) any alterations in minimum length of allocation before a report is prepared, together with factors influencing this change
- (7) current storage of completed assessment forms
- (8) whether any changes made would help the assessors to gain a more unified picture of a student's progress and development
- (9) any further (open-ended) comments.

Of the seventy hospitals who replied to this questionnaire, thirty reported that changes had occurred since publication of the King's Fund report. In eleven of these hospitals, changes had been brought about by means of consultation with other hospital staff; six had organised working parties; and a similar number had combined consultations with general staff discussions. Five others had augmented their discussions by seeking external advice from experts in industry or education; and six had combined all three methods in the efforts to improve the report system for students.

Twenty-seven said that the King's Fund report had influenced their thinking on the subject: although in seven hospitals no action had yet been taken; and three

hospitals reported that discussions on possible changes were in progress. It appeared that the main reason for actual or anticipated changes was the general realisation of the need for improvement. In twenty of these thirty hospitals it was stated that changes had been made both in methods of reporting and in the report forms themselves. Eight had revised their report forms only: and two had revised their methods of reporting whilst retaining their original forms. Personnel involved had included twenty-seven tutors; twenty-six ward sisters; and eight staff nurses.

#### THE PROCESS OF CHANGE:

The report gives details of an experimental exercise in changing assessment processes carried out at Mile End Hospital, London. Here one of the sisters' regular monthly meetings was devoted to an explanation of the King's Fund study, followed by a general discussion. It was agreed to hold a further meeting to consider revision of the hospital's progress report forms; and to plan further action. A wide selection of report forms in use in hospitals throughout the country, as well as similar forms used for industrial trainees, was made available to aid the discussion.

At the second meeting preference was expressed for a report form featuring detailed headings and making use of a descriptive five-point scale, the descriptive terms being given on the form itself rather than in a separate guide. It was also agreed that a single form should be used for student nurses throughout their training: but that a separate section of the form should apply to third-year nurses only.

A preliminary selection of headings for the five-point system was discussed; and it was left to an elected working party to discuss the items in detail and eventually to produce a draft report for consideration. The working party consisted of two senior nurse administrators; two nurse tutors; one midwifery sister; three ward or departmental sisters; two staff nurses; three student nurses (one from each of the three years of training); and two enrolled nurses. This working party was chaired by the principal tutor; and met on seven separate occasions over a period of six months. The working party was charged with the responsibility to consider in detail the main headings suggested by the sisters' meeting; to reduce them to a workable number; and, having decided on the necessary subsidiary points, to prepare the five-point scale of assessment under each separate heading.

Each member of the working party was responsible for preparing for general discussion her choice of descriptive terms for two or three of the main headings. For example, to one staff nurse were allocated the headings

'awareness of patients' needs' and 'tact and discretion': to the other, 'patience and self-control' and 'alertness, interest and enthusiasm'. One student nurse studied the headings 'resourcefulness' and 'integrity': whilst the enrolled nurse dealt with 'care of equipment' and with 'cheerfulness and sense of humour'. The four sisters between them took responsibility for 'adaptability and self-confidence'; 'learning ability'; 'appearance'; 'communications and reliability'; and 'practical ability and punctuality'. Dictionaries were much in evidence: and a realisation of the need for accuracy of definitions and a new appreciation of the true meaning of words were two side-benefits of the exercise..

A draft report together with a guidance sheet for the new assessment were put into circulation: and the new instrument put into general use for a limited period; following which its value was critically assessed at a sisters' meeting. Additionally a representative group of student nurses discussed very freely with the representative of the King's Fund their reactions not only to the new report form but also to nurse training in general. Some of their very helpful and thoughtful comments were later discussed with the sisters, and related amendments incorporated in the revision of the draft assessment instrument.

Feelings of uncertainty and insecurity in adjusting to a new situation could be observed both with regard to students and to those responsible for assessing them. For this reason, one of the sisters' regular study days was devoted to the subject of reports and reporting. On this occasion the discussion was led by an experienced behavioural scientist, in the hope that this would be a valuable means of deepening both technical appreciation and individual self-knowledge. Further assessment and revision of the new assessment instrument were ongoing at the time of the second King's Fund report.

#### PREPARATION OF SISTERS FOR WRITING PROGRESS REPORTS:

In the initial survey it was found that, although verbal instruction was said to be given to staff in the majority of hospitals, only three of the ninety-seven included this subject in their in-service training programmes. In the second survey, twenty-seven of the seventy hospitals reported that changes had been made in the preparation of ward and departmental sisters for the task of recognising and reporting on the progress of student nurses. Twenty-four said that no changes had been made: and nineteen offered no reply to this question. The usual method of disseminating information on reports for student nurses was by means of general discussions usually on study days; at procedure meetings; or at regular meetings of sisters. Six hospitals stated that instruction

in methods of reporting on students had been included in their induction courses; and in six others the subject had been added to the in-service training syllabus. At one hospital all the sisters had attended a one-week course in management appreciation which had included staff assessment in its programme.

#### INVOLVEMENT OF STAFF NURSES:

In 1965 just over 50 per cent of the ninety-two hospitals stated that ward sisters never delegated responsibility for writing reports on student nurses; and only just under 10 per cent stated that delegation was their normal practice. The remaining 40 per cent stated that delegation of this duty to staff nurses was permitted only in cases of prolonged absence of the ward sister and in other exceptional circumstances. However, three years later in the second survey it was found that only two of the seventy hospitals concerned stated that staff nurses took no part in reporting on the work and progress of student nurses. Six gave no reply to this question: but in the remaining sixty-two, staff nurses were stated to be actively involved. In half of these hospitals staff nurses were accustomed to discuss the progress of students with the ward sisters. In the other half, they were authorised to write the reports when 'acting up' for a ward sister. Thus delegation to staff nurses of responsibility for writing progress reports when required appeared to be common practice in 44 per cent of the hospitals involved in the final survey: and in a similar percentage regular consultation between sister and staff nurse regarding such reports had become normal procedure.

#### THE STUDENT AND HER REPORTS:

Some progress can also be seen in the increased involvement of student nurses in the preparation of their own progress reports. The first survey found that only 34 per cent of the ninety-seven hospitals concerned gave the student an opportunity to sign that she had either seen or discussed her reports: and a further 20 per cent requested the sister to state whether or not the report had been seen by, or discussed with, the student. In the 1968 survey, 60 per cent of hospitals involved reported that student nurses had some knowledge of the content of their reports: the majority being expected to read and sign them. It was also noted that nine of the seventy hospitals expected the students to collect or deliver their own reports: and two placed on the student the responsibility for reminding ward sisters when reports were due.

Eighteen hospitals submitted progress report forms which showed evidence of revision: and of these eleven requested student nurses to sign their own reports; two asked the sister to sign that she had discussed the report with the student; and two omitted any reference to this point. In three cases there was apparently a choice: the sister was asked to state whether or not the report had been discussed with, or seen by, the student - and in one case, 'if not, why not'. Before revision of these report forms, two had given the sisters the opportunity to state whether or not they had discussed the report with the student; only four had asked for the student's signature; and twelve had omitted all reference to any involvement of the student in the preparation of her own progress reports.

#### ANALYSIS OF PROGRESS REPORT FORMS RECEIVED:

A total of twenty-eight progress report forms, including the latest revision of the United Liverpool Hospitals form, was received during the second survey. Three hospitals enclosed their forms merely for interest, although no changes had been made since the original investigation. One hospital supplied a copy of the report form but failed to return the questionnaire: and another reported that changes had been made only in the forms applicable to experience in special departments, such as casualty and theatre. Three further forms showed signs of revision, although this fact was not mentioned in the questionnaire.

Eighteen report forms showed evidence of revision: and these fell into two main groups:

##### (A) THOSE GIVING A CHOICE OF ANSWER:

This type of report consists of a list of attributes for each of which a choice of answer is given: and the person writing the report indicates which specific comment is most nearly applicable to the student concerned. In the original survey twenty-one of the ninety-seven hospitals involved used this type of report form. As a method it can prove somewhat restrictive since it is possible that none of the alternatives are readily applicable to a specific student. Very few of the original twenty-one forms provided additional space for free comment at the end of the report form in an attempt to reduce this disadvantage.

Of the eighteen hospitals with revised forms studied in the follow-up survey, four had originally used forms of this type. As a result of revision one had abandoned this method in-favour of the Liverpool report form: and two had changed to allow free comment on approximately similar attributes to those listed in the original forms.

The fourth had retained the multiple-choice answer but had added a rating scale so that it was possible to give the student an actual mark at the conclusion of each report. For example under the heading of 'relationships with patients', marks could be allocated as follows:

- 5    kind, sympathetic, observant
- 3    fairly kind, fairly sympathetic, fairly observant
- 0    unkind, unsympathetic, unobservant

Follow-up revealed that four of the eighteen hospitals had adopted this multiple-choice method in preference to their original forms. Of these, three had used the grading method; and the fourth had favoured free comment under specific headings.

(B) THOSE EMPLOYING GRADINGS:

The second type of report form is that which lists various characteristics or attributes and gives a grading scale for each one. Thirty-nine samples were obtained in the original survey: and in about half of them additional space was allowed for free comment under each heading. Types and combinations of grading symbols varied widely; and no less than twenty-three variations were found in the initial survey. In the second survey eight hospitals had adopted this method, using seven different methods of grading. The method adopted in two reports combined comments with percentage marking, as follows:

<u>PERCENT:</u>	<u>DESCRIPTION:</u>
0 -30	not up to standard
31-50	passable
51-60	satisfactory
61-75	very good
76-100	outstanding

The other five methods included grading letters only (A to E); comments only (poor; fair; satisfactory; very good; outstanding): and three combinations of comments with letters and of comments with numbers. With one exception, these examples were far more detailed than the original forms which they had superseded: and in some cases the number of headings under which comments were required was doubled or trebled from the original.

### OTHER TYPES OF REPORT:

Only two of the eighteen report forms were less detailed than their predecessors. One had been changed from three gradings plus general comment to a greatly reduced choice of five comments. In the second case (a teaching hospital) a detailed list of questions had been replaced by a blank form with the general request that the report should be '...as full and comprehensive as possible and include comments on the student's conduct; work; general attitude; interest; and appearance'. It was interesting to note that another teaching hospital which had originally used a similar 'essay-type' form, had replaced it with a report form requiring gradings under specific headings plus general comment. Both of these hospitals stated that their changes were influenced by the King's Fund report.

In the original study it was found that the length of time a student was expected to work in a ward or department before a written report was prepared varied from one week to six months. More than half of the replies fell into the four-to-eight-weeks class; but 17 per cent were found to be in the one-to-three-weeks class; and 10 per cent named a placement limit of twelve weeks or more. The follow-up survey showed that fourteen of the seventy hospitals had altered their minimum placement period since the initial survey; and that eleven of these now appeared within the four-to-eight-weeks class. There appeared to be no change in the methods adopted for the filing of completed reports: which were almost exclusively kept in matrons' offices. Both surveys found that only five hospitals kept their reports elsewhere - normally in the school of nursing.

### CONCLUSION:

The original investigation into student nurse progress report forms in 1966 revealed a confused situation. It cannot be said that the follow-up survey held two years later has produced any startling results: neither is it possible to draw any definite conclusions from the evidence provided by the seventy hospitals which participated in both studies. All that can be said is that there would appear to be an increasing realisation of the importance of progress reports; and of the need for further study of this subject.

The General Nursing Council for England and Wales have maintained a keen interest in the two surveys: and as a result of the King's Fund reports have asked the Hospital Centre to join them in setting up a working party to study the possibility of designing a national progress report form for student nurses.



# APPENDIX D: PROGRESS ASSESSMENT FORMS EMPLOYED IN THE VARIOUS CENTRES.

## FIRST FORMAT (as used in Centre A):

X	Z applies	Tendency to Z	Y applies	Tendency to Y	Y
<b>PROFESSIONAL BEHAVIOUR/ ATTITUDE</b>					
1. Always punctual in coming on duty.					Often unpunctual in coming on duty
2. Takes care to appear neat and tidy; wears uniform correctly.					Often untidy; uniform sometimes worn incorrectly.
3. Shows appreciation of the need for politeness in speech and manner.					Appears unaware of the need for politeness in speech and manner
4. Responds effectively to all situations.					Early refusal; acts impulsively
Comments					

APPLICATION TO AND QUALITY OF WORK	Z applies	Tendency to Z	Y applies	Tendency to Y	Y
5. Industrious and a willing worker					Lazy, unwilling worker. Does no more than he/she has to.
6. Very quick in grasping essentials					Often fails to grasp essentials
7. Carries out the daily routine reliably without supervision					Cannot be relied upon to carry out the routine unless closely supervised
8. Carries out nursing procedures very reliably and with a minimum of length of service and experience					Gives poor performance of nursing procedures; lacks depth of knowledge of service and experience
9. Carries out instructions reliably with a minimum of supervision.					Cannot be relied upon to carry out instructions unless closely supervised
10. Work is done thoroughly with attention to detail.					Work is not done thoroughly; very little attention to detail
11. Very observant; reports signs, symptoms and relevant information					Unobservant; sometimes omits to communicate relevant information
12. Can always be relied upon to keep clinical records up to date					Unavailable in keeping clinical records up to date
13. His/her written records and reports are complete, accurate and clearly expressed.					His/her written records and reports are inadequate
14. Confident and resourceful; capable of planning his/her own work.					Lacks confidence; does not organize his/her own work effectively
15. Always applies his/her theoretical knowledge intelligently in the practical situation					Generally fails to apply his/her theoretical knowledge intelligently in the practical situation
16. Eager to extend his/her knowledge and skill.					Appears to lack interest in learning

FIRST FORMAT (continued):

X	1 tendency to X	2 tendency to Y	3 tendency to Z	4 tendency to W
APPLICATION TO AND QUALITY OF WORK				
17. Can be relied upon to initiate action when appropriate				
Comments				
ATTITUDE TO PATIENTS				
18. Shows understanding of patients as individual persons				
19. Is tactful and considerate towards patients				
20. Shows skill in gaining the confidence and co-operation of patients				
21. Tries to understand the patients' psychological needs				
22. Deals sympathetically and courteously with patients, relatives and visitors				
Comments				
ATTITUDE TO CO-WORKERS				
23. Polite and helpful in his/her approach to other members of the hospital staff				
24. Works well as a member of the nursing team				
25. Responds readily to guidance and instruction				
26. His/her instruction and supervision of others is effective and well accepted				
27. Gives alert and efficient professional assistance to medical staff in the clinical situation				
Comments				

FIRST FORMAT: Summary Sheet.

DISTRICT SCHOOL OF NURSING									
SUMMARY SHEET FOR PRACTICAL ASSESSMENTS									
1. NAME (in full)					WARD				
SET:					DATE:				
2. Please tick type of Assessment:									
PUPIL			STUDENT						
MEDICAL			A			C			
SURGICAL			B			D			
GERIATRIC									
3. Please outline work given									
4. Please tick or comment as appropriate: S = Satisfactory									
			S	If unsatisfactory please give reason					
A. General preparation for Assessment									
B. Awareness of patient(s) physical condition									
C. Awareness of patient(s) emotional needs									
D. Understanding of patient(s) diagnosis(es) and treatment prescribed.									
E. Knowledge and performance of specified work.									
F. Communication with patient(s)									
G. Approach to colleagues.									
H. Overall performance									
5. Other comments:									

Form 1288

FIRST FORMAT: Summary Sheet (continued).

5. RESULT  
(please tick)

PASS

REFER

FAIL

6. If student/pupil referred/failed give exact reasons why below:

.....  
Signature of Assessor(s)

.....  
Signature of Student/Pupil

Date. ....

Date.....

PLEASE RETURN THIS FORM TO THE EXAMINATIONS OFFICER, SCHOOL OF NURSING, .. IMMEDIATELY.

7. Interview note by Senior Tutor in case of referral:

.....  
Signature of Senior Tutor

.....  
Signature of Student/Pupil

Date.....

Date.....

# SECOND FORMAT (as used in Centre C):

X		Y	
1. APPLICATION TO WORK			
1. Exceptionally industrious: a very keen and willing worker.			Does little more than she/he has to; appears half-hearted and indifferent.
2. More active than most in using opportunities to extend knowledge and skill.			Shows little active interest in using opportunities to increase knowledge and skill.
3. Outstandingly quick in grasping essentials.			Sometimes has difficulty in grasping essentials.
4. Always punctual in arriving for duty.			Not always punctual in arriving for duty.
5. Consistently prompt in carrying out duties. Timing excellent.			Does not yet keep to time very well; tends to hold up work.

COMMENTS:

X		Y	
II. QUALITY OF WORK			
6. Maintains a very high standard when carrying out nursing procedures.			Does not show a good enough standard in carrying out nursing procedures.
7. Makes excellent application of theoretical knowledge to practical work.			Often appears not to apply her/his theoretical knowledge to the practical situation.
8. Work shows a consistently high standard of attention to detail and finish.			Work does not always show sufficient attention to detail and finish.
9. Irreproachably carries out instructions reliably without supervision.			Needs more supervision than most; cannot always be relied upon to carry out instructions completely.
10. Unusually observant. Always reports signs, symptoms and other relevant information.			Not yet sufficiently observant; sometimes omits to observe/pass on relevant information.
11. (a) Exceptionally self-reliant and resourceful.			(a) Needs more than the usual amount of support to cope with routine work.
(b) Shows excellent ability to plan and complete own work/organize work of others.			(b) Has not yet learnt to organize/own work effectively/work of others.
12. Can always be relied upon to record promptly all necessary clinical data.			Inclined to be dilatory in recording necessary clinical data.
13. Regularly produces excellent reports which are written, complete and clearly expressed.			Written reports and records are not always complete and clear; more practice needed.

COMMENTS:

## STUDENT NURSE PROGRESS ASSESSMENT FORM

Confidential to individual named and to assessors

### HOSPITAL SCHOOL OF NURSING

Surname \_\_\_\_\_ Forename \_\_\_\_\_  
 Date of entry \_\_\_\_\_ Anticipated date of final examination \_\_\_\_\_  
 Previous nursing or other relevant qualifications \_\_\_\_\_  
 Ward/Dept. \_\_\_\_\_ Specialty \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_  
 Absence \_\_\_\_\_

### PRELIMINARY INTERVIEW

Date \_\_\_\_\_  
 Note special abilities requested by student, and any comments made on particular weaknesses and difficulties: it may also be helpful to note any omissions revealed in record of practical instruction.

### FINAL INTERVIEW

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 1. Any further comments by assessor \_\_\_\_\_

2. OVERALL GRADING: Review your assessments and decide appropriate overall grading (tick in box)

outstandingly good	very good	good-satisfactory	just good enough	not good enough

Signature \_\_\_\_\_ Post held \_\_\_\_\_

### WHEN YOU COMPLETE THIS FORM

Try to remember that you are assessing a student over a PERIOD OF TIME. It is all too easy to allow particular incidents to influence both your assessment of a particular quality and also your general impression of overall merit.

Under each item in turn put a tick in the box which best fits the nurse's usual performance. If you cannot assess an individual on any particular item, write N/A for 'not applicable', and give your reasons under 'Comments'. Do not hesitate to give X (very high) or Y (low) gradings where deserved. Try not to let the nurse's strength or weakness in one quality cloud your judgment of her/his standing in another. Grades should be given where it is deserved.

It is quite normal for an individual to be above average in some respects and to fall short in others. Comments are always helpful particularly to explain an unusual grading or when an unqualified tick might not present a true picture.

FOR FURTHER HELP AND GUIDANCE REFER TO THE KING'S FUND GUIDANCE BOOKLET.

# SECOND FORMAT (continued):

If there are any relevant matters concerning the conditions in the ward or department or any current personal problem which might have affected the student's progress, please note below.

If the student has any special skills, ability, limitations or training needs, please note these below.

Signature \_\_\_\_\_

## STATEMENT BY STUDENT

I have read this assessment and have had an opportunity to discuss it

Signature \_\_\_\_\_

## COMMENTS BY STUDENT IF DESIRED

Signature \_\_\_\_\_

## COMMENTS BY UNIT NURSING OFFICER

Signature \_\_\_\_\_

Post held \_\_\_\_\_

## COMMENTS BY PERSONAL TUTOR

Signature \_\_\_\_\_

Post held \_\_\_\_\_

CV/3

Y

X

III. ATTITUDE TO PATIENTS	2	3	4	5	6	7	8	9	10
14. Successfully anticipates and meets the physical needs of patients.									
15. Shows exceptional understanding of patients as individual persons.									
16. Shows outstanding skill in gaining the confidence and co-operation of patients, tactful and considerate.									
17. Shows better ability than most in dealing tactfully and courteously with patients' relatives and visitors.									

COMMENTS:

IV. ATTITUDE TO CO-WORKERS	2	3	4	5	6	7	8	9	10
18. Very well accepted by nurse colleagues; works well as member of a team.									
19. Close, alert and very efficient professional assistance to doctors in the clinical situation.									
20. Distinguished by courtesy and helpfulness towards other members of the hospital staff.									
21. Responds with good grace to instructions/advice. Makes the most of constructive criticism.									
22. Highly successful in the instruction and supervision of others.									

COMMENTS:

V. PROFESSIONAL BEHAVIOUR	2	3	4	5	6	7	8	9	10
23. Always very neat and well groomed—wears uniform correctly.									
24. (a) Demonstrates understanding of the need for quietness in speech and manner.									
(b) Protects patients from undue noise at all times.									
25. Neatly poised and effective even in situations of stress.									

COMMENTS:

THIRD FORMAT (as employed in Centres B and D - not  
discussed in the present study).

<u>DISTRICT - SCHOOL OF NURSING</u>		
<u>ASSESSMENT OF LEARNERS PROGRESS</u>		
<u>STUDENT/PUPIL</u>	<u>INTAKE</u>	<u>HOSPITAL</u>
<u>NAME OF WARD/DEPARTMENT</u>	<u>TYPE OF EXPERIENCE</u>	
	<u>FROM:</u>	<u>TO:</u>
<u>INTRODUCTION TO WARD/DEPARTMENT DURING FIRST WEEK OF EXPERIENCE</u>		
<u>CHECK LIST</u>	<u>LEARNER</u>	<u>TRAINED NURSE</u>
<u>PROCEDURE IN CASE OF FIRE</u>		
<u>PROCEDURE FOR CARDIAC ARREST</u>		
<u>LOCATION OF SPECIAL EQUIPMENT</u>		
<u>POLICY CONCERNING VISITORS</u>		
<u>PROCEDURE FOR ACCIDENTS TO PATIENTS, VISITORS AND STAFF</u>		
<u>POLICY CONCERNING HEALTH &amp; SAFETY</u>		
<u>GENERAL &amp; SPECIAL WARD AIMS/ OBJECTIVES</u>		
<p><u>INFORMATION</u></p> <p>These Assessment Forms will be issued by the respective Allocation Officers to all Learners in the Introductory Course and study blocks/weeks. They must be completed by the Sister/Charge Nurse by placing the appropriate response (tick) in the boxes in either column A, B or C, during the middle week of the allocated experience - (first assessment). At the beginning of the last week of the allocated experience, the Sister/Charge Nurse must complete the form by placing the appropriate response (tick) in the boxes in either column A, B or C (Final Assessment).</p> <p>Comments should be made by the Learner and Sister/Charge Nurse.</p> <p>The overall grading must be completed by referring to the grading criteria below.</p> <p>The duly completed form must be brought back by the Learner on the first day of his/her next study block/week.</p> <p><u>GRADINGS</u></p> <p><u>First Assessment</u> (Middle of Experience) ✓ the boxes in either column A, B or C.</p> <p><u>Final Assessment</u> (Last week of Experience) ✓ the boxes in either column A, B or C.</p> <p><u>Overall Gradings:</u> Exceptional - All column A boxes ✓</p> <p>Very Good - All column A and B boxes ✓</p> <p>Satisfactory - Column A and B boxes ✓ and less than 50% Column C boxes</p> <p>Requires greater effort - More than 50% column C boxes.</p>		

THIRD FORMAT (continued):

<u>SCHOOL OF NURSING</u>		<u>FIRST ASSESSMENT</u>			<u>FINAL ASSESSMENT</u>		
		<u>A</u> Always	<u>B</u> Most Occasions	<u>C</u> Seldom	<u>A</u> Always	<u>B</u> Most Occasions	<u>C</u> Seldom
<u>ASSESSMENT OF CLINICAL EXPERIENCE</u>							
Identifies and fulfills the total needs of the Patient under supervision.							
Anticipates and prepares to meet the total needs of the Patient with minimal supervision.							
Attempts to obtain all the relevant information concerning the Patient and His/Her condition.							
Organises, plans and completes the day's work efficiently and methodically with minimum supervision.							
Interprets, records and reports observations and clinical data reliably.							
Recalls the location and uses of equipment and how to retain articles in good order.							
Tends to be prompt and efficient in carrying out the nursing procedures.							
Attempts to gain Patient's confidence and co-operation effectively.							
Endeavours to be tactful and supportive in dealing with patients and relatives.							
Assists and guides junior colleagues to plan and organise their work.							
Tends to act upon advice and constructive criticism.							
Identifies learning opportunities for the purposes of increasing knowledge and expertise.							
Applies the relevant theoretical knowledge to the practical situation.							
Adapts nursing care effectively to overcome difficult or changing situations.							
Carries out instructions willingly and reliably.							
Co-operates with colleagues and participates effectively as a useful member of the ward team.							
Recalls information and communicates reliably at all times.							
Organises his/her time so that promptness and punctuality is observed at all times.							
Maintains a neat and tidy appearance and wears correct uniform.							
Remains calm and behaves responsibly in dealing with patients, staff and visitors in stress situations.							
Date .....		Date .....			Date .....		
Signatures .....		Signatures .....			Signatures .....		



THIRD FORMAT (continued):

Comments by Sister/Charge-Nurse - Middle of Experience.

DATE ..... SIGNATURE .....

Comments by Learner - Middle of Experience

DATE ..... SIGNATURE .....

Comments by Sister/Charge-Nurse - End of Experience

Comments by Learner - End of Experience

DATE ..... SIGNATURE .....

Overall Assessment Grading (Tick appropriate box).

☐

Excellent

☐

Very Good

☐

Satisfactory

☐

Requires greater effort - please specify and state clearly below in which areas effort is required.

DATE ..... SISTER/CHARGE-NURSE .....  
LEARNER .....

APPENDIX E: DOCUMENTATION FOR E.N.B. STAGED ASSESSMENTS.

(1) E.N.B. SCORING GUIDE FOR THE FOUR ASSESSMENTS.

ASSESSMENT OF PRACTICAL NURSING FOR THE GENERAL NURSING COUNCIL						ERN A
PART A - ASEPTIC TECHNIQUE						
(Specify Procedure _____)						
* 1st 2nd 3rd Attempt	Name of Candidate _____					
Ward _____	Date _____					
	Organisation	Care of patient (Physical and Psychological)	Procedural Technique	Teamwork	Theoretical Understanding	
Maximum Score	5	10	25	5	5	
Candidates Score						
Remarks: (State reason/s for refer or fail)						
Total _____						
Grade _____						
Result * Pass Refer Fail						
Assessors _____						
Candidate I have been shown this result and have been informed of any shortcomings						
_____						
Read notes overleaf      *Delete as applicable						

ASSESSMENT OF PRACTICAL NURSING FOR THE GENERAL NURSING COUNCIL						ERN B
PART E - ADMINISTRATION OF DRUGS: THE CARRYING OUT OF A MEDICINE ROUND						
(Specify Procedure _____)						
* 1st 2nd 3rd Attempt	Name of Candidate _____					
Ward _____	Date _____					
	Organisation	Care of Patient (Physical and Psychological)	Procedural Technique	Teamwork	Theoretical Understanding	
Maximum Score	5	10	15	10	10	
Candidates Score						
Remarks (State reason/s for refer or fail)						
Total _____						
Grade _____						
Result * Pass Refer Fail						
Assessors _____						
Candidate I have been shown this result and have been informed of any shortcomings						
_____						
Read notes overleaf      *Delete as applicable.						

# E.N.B. SCORING GUIDE (continued):

## ASSESSMENT OF PRACTICAL NURSING FOR THE GENERAL NURSING COUNCIL SRN C PART C - PLANNING AND CARRYING OUT NURSING CARE REQUIRED BY A PATIENT DURING A SPAN OF DUTY AND OBSERVATION OF PART OF THAT CARE

\* 1st 2nd 3rd Attempt

Name of Candidate \_\_\_\_\_

Ward \_\_\_\_\_

Date \_\_\_\_\_

	Theoretical Understanding, Planning and Organisation	Care of Patient, Procedural Technique	Teamwork (including reporting)
Maximum Score	20	25	5
Candidate Score			

Remarks: (State reason/s for refer or fail)

Total \_\_\_\_\_

Grade \_\_\_\_\_

Result \*Pass Refer Fail

Assessors \_\_\_\_\_

Candidate I have been shown this result and have been informed of any shortcomings

Read notes overleaf

\*Delete as applicable

SRN D

## ASSESSMENT OF PRACTICAL NURSING FOR THE GENERAL NURSING COUNCIL

### PART D - ORGANISATION AND COMMUNICATION:

1. Organisation of the ward staff for a span of duty
2. Writing the ward report and Kardex progress reports and giving this report on hand-over at the end of a span of duty
3. Giving a verbal report to the Assessors (as if to a Medical Officer) on a group of 10-12 patients.

Name of Candidate \_\_\_\_\_

Date \_\_\_\_\_

\* 1st 2nd 3rd Attempt

Ward \_\_\_\_\_

	ORGANISATION		COMMUNICATION		
	Appreciation of Task	Delegation of Duties to Staff	Written Reports	Verbal hand-over to Nurses	Report to "Medical Officer"
Maximum Score	10	10	10	10	10
Candidates Score					

Remarks: (State reason/s for refer or fail)

Total \_\_\_\_\_

Grade \_\_\_\_\_

Result \* Pass Refer Fail

Assessors \_\_\_\_\_

Candidate I have been shown this result and have been informed of any shortcomings

Read notes overleaf

\*Delete as applicable

(2) E.N.B. NOTES FOR GUIDANCE ON CONDUCT OF THE ASSESSMENTS.

ASSESSMENT OF PRACTICAL NURSING FOR THE GENERAL NURSING COUNCIL

PART A - ASEPTIC TECHNIQUE

NOTES FOR GUIDANCE

1. In this assessment the performance of a safe aseptic technique is of paramount importance. If the aseptic "barrier" is breached the candidate must fail this assessment. NIL marks are given for Procedural Technique. If this occurs the assessor should stop the candidate and take appropriate measures to ensure that the treatment is safely and efficiently concluded.

2. SCORING. Some of the aspects of an Aseptic Technique could be considered arbitrarily to fall under more than one heading. In order to achieve uniformity the various aspects should be scored under the main heading as below:

a. ORGANISATION (5 marks)

Preparation of trolley and equipment (except for "aseptic" area which is included under Procedural Technique)  
Preparation of bed space/dressing station  
Clearing away equipment

b. CARE OF PATIENT (10 marks)

Explanation of treatment  
Patient's comfort  
Nurse-patient relationship

c. PROCEDURAL TECHNIQUE (25 marks) (All Aseptic aspects are included in this section).

Nurse - hands, uniform etc.  
Trolley or other "aseptic" working surface  
Handling of pack and equipment  
Actual dressing management  
Care in disposal/clearing of equipment

d. TEAMWORK (5 marks)

Instructions to assistant  
Utilisation of assistant  
Report state of wound, etc to nurse in charge  
(if candidate works alone and assessors think that this section could not be assessed adequately the other 4 sections' marks are totalled and one tenth of this sub-total is added to it to make a "standardised" total).

e. THEORETICAL UNDERSTANDING (5 marks)

Knowledge of principles of asepsis (obtained by questioning candidate)

3. QUESTIONING AND TEACHING. Unless it is essential during the performance of the procedure, it is suggested that questions and teaching should be left until the candidate has completed the actual procedure. The candidates must be told of any shortcomings. Criticism should be constructive and should be used as a "teaching situation".

4. RESULT. The result and grade is obtained by comparison of the Candidates score with the table below. The candidate is to be informed by the Assessors after completing the Assessment.

<u>SCORE</u>	<u>GRADE</u>
44 - 50	A)
36 - 43	B) Pass
26 - 35	C)
25 and below	Fail (Recorded as "Refer" when 1st or 2nd attempt)

## E.N.B. NOTES FOR GUIDANCE (continued):

### ASSESSMENT OF PRACTICAL NURSING FOR THE GENERAL NURSING COUNCIL

#### PART B - ADMINISTRATION OF DRUGS: THE CARRYING OUT OF A MEDICINE ROUND

##### NOTES FOR GUIDANCE

1. In this assessment the safe administration of drugs to each patient is of paramount importance: is the correct dose of the right drug being given to the right patient at the right time? If found unsafe by these criteria the candidate must fail this assessment, NIL marks are given for Care of Patient and Procedural Technique.
2. For this assessment the candidate will act as the "Senior" nurse working with a "Junior" nurse. If the assessor wishes, he/she may act as the "Junior".
3. SCORING. Some of the aspects of the administration of drugs could be considered arbitrarily to fall under more than one heading. In order to achieve uniformity the various aspects should be scored under the main heading as below:
  - a. ORGANISATION (5 marks)  
Preparation of trolley: Prescription sheets, medicines, measures etc.  
Record book
  - b. CARE OF PATIENT (10 marks)  
Positive identification of patient  
Explanation of treatment/answering patient's questions  
Patient's comfort/method of presentation of medicine  
Nurse-patient relationship  
Observation of patient
  - c. PROCEDURAL TECHNIQUE (15 marks)  
Checks: Patient-prescription, for drug, dosage, time, method of administration  
Special considerations eg Digoxin - pulse check, Anticoagulants - prothombin times  
Measuring accurate dose  
Ensure patient takes medicine  
Records: Patient's record, Controlled Drug or poison stock books  
Maintaining drug security
  - d. TEAMWORK (10 marks)  
Working with checker  
Teaching "Junior"  
Reporting any findings/problems to nurse in charge
  - e. THEORETICAL UNDERSTANDING (10 marks)  
Knowledge of drugs: Therapeutic effects  
Side effects  
Features of overdosage  
Principles underlying correct procedure:  
Safety precautions in administration  
Controlled Drugs and Poisons regulations
3. QUESTIONING AND TEACHING. Unless it is essential during the performance of the procedure questions and teaching should be left until the candidate has completed the actual procedure. The candidate must be told of any shortcomings. Criticism should be constructive and should be used as a "teaching situation".
4. RESULT. The result and grade is obtained by comparison of the candidate's score with the table below. The candidate is to be informed by the assessor after completing the assessment.

<u>SCORE</u>	<u>GRADE</u>
44 - 50	A)
36 - 43	B) Pass
26 - 35	C)
25 and below	Fail (Recorded as "Refer when 1st or 2nd Attempt")

## E.N.B. NOTES FOR GUIDANCE (continued):

### ASSESSMENT OF PRACTICAL NURSING FOR THE GENERAL NURSING COUNCIL

SRN C

#### **PART C — PLANNING AND CARRYING OUT NURSING CARE REQUIRED BY A PATIENT DURING A SPAN OF DUTY AND OBSERVATION OF PART OF THAT CARE**

##### **NOTES FOR GUIDANCE**

1. It is desirable for one assessor to be a member of the ward staff. The nurse in charge of the ward should be asked to select 2 or 3 patients who require sufficient nursing care to allow an adequate assessment of the candidate. When the assessors have selected a patient the candidate should be asked if he/she is agreeable to the assessment being carried out on the nursing care of that particular patient. If the candidate does object the assessors should satisfy themselves that the objections are reasonable and an alternative patient may be offered.

2. **SCORING.** Candidates should fail if they are particularly weak in: Knowledge of the patient's condition, the nursing care, and the organisation of the "patient's day". These aspects will be assessed under, *Theoretical Understanding, Organisation and Care of the Patient.*

##### **a. THEORETICAL UNDERSTANDING, PLANNING & ORGANISATION (20 marks)**

Appreciation of patient's total condition and requirements

Planning of the nursing care, having regard of the following: Regime (e.g. strict rest, up for periods, ambulant); Observations/Investigations and recording data; Personal Toilet; Pressure Areas; Diet; Drugs; Bowel/Bladder; Care of Mind/Sleep/Visiting; Special Procedures (eg physiotherapy, dressings. etc). The student should provide a written "programme" of nursing care objectives.

Candidate's response to incidents/instructions requiring modification to patient-care plan.

##### **b. CARE OF PATIENT & PROCEDURAL TECHNIQUE (25 marks)**

Physical comfort, mental well-being, rapport (nurse-patient relationship)

Procedural technique will be assessed on any part of the nursing care that is observed

##### **c. TEAMWORK (5 marks)**

Communications with others in ward team: eg intended plan of treatment giving instructions/requesting advice or assistance, reporting progress/findings

3. **QUESTIONING AND TEACHING.** Questions will be required to clarify certain points and to explore the candidate's knowledge at several stages during the assessment. The candidate must be told of any shortcomings. Criticism should be constructive, used as a "teaching situation" and wherever possible not given until the end of the assessment.

4. **RESULT.** The result and grade is obtained by comparison of the candidate's score with the table below. The candidate is to be informed by the assessor after completing the assessment.

4. **RESULT** The result and grade obtained by comparison of the candidate's score with the table below. The candidate is to be informed by the assessor after completing the assessment.

SCORE	GRADE
44 — 50	A)
36 — 43	B) — Pass
26 — 35	C)

25 and below

Fail (Recorded as "Refer" when 1st or 2nd attempt)

## E.N.B. NOTES FOR GUIDANCE (continued):

### ASSESSMENT OF PRACTICAL NURSING FOR THE GENERAL NURSING COUNCIL

#### PART D - ORGANISATION AND COMMUNICATION

- (1) Organisation of the ward for a span of duty
- (2) Writing the ward report and "Kardex" progress reports and giving this report on hand-over at the end of a span of duty
- (3) Giving a verbal report to the assessors (as if to a Medical Officer) on a group of 10-12 patients

#### NOTES FOR GUIDANCE

1. It is desirable for one of the assessors to be a member of the ward staff. If the nurse in charge is not on the GNC "Panel of Examiners" he/she will be needed for guidance and advice. The candidate must have been working on the ward for at least 2 weeks.

2. SCORING. Various aspects of this assessment should be considered under the main headings as below:

a. APPRECIATION OF TASK (10 marks)

"bed state"

Ward task for the day (ie whether theatre list, admitting etc.)

General assessment of patients (nursing demands)

Ward services (collections, deliveries etc.)

b. DELEGATION OF DUTIES (10 marks)

Instructions to each staff member, having regard to experience and seniority of each member. Ascertaining that delegated tasks are understood.

Adequate supervision of staff

Teaching as applicable

Response to new situations

c. WRITTEN REPORTS (10 marks)

Clarity, Brevity, Accuracy, Inclusion of all important details

d. VERBAL REPORTS (10 marks)

Accurate and relevant information to ward staff about patients, including their: Diagnosis, Present Condition, Nursing Requirements: Observations/Investigations

Toilet

Drugs

Diet

Special: medical treatment/  
operations/  
investigations

e. "REPORT TO MEDICAL OFFICER" (10 marks)

Accurate information on patients including:

Name, age, occupation, diagnosis, present condition, observations

Results of significant observations/investigations

Results of drug therapy

3. QUESTIONING AND TEACHING. Questions will probably be required to clarify certain points and to explore that candidate's knowledge at several stages during the assessment. The candidate must be told of any shortcomings. Criticism should be constructive, used as a "teaching situation", and wherever possible not given until the end of the assessment.

4. RESULT. The result and grade is obtained by comparison of the candidate's score with the table below. The candidate is to be informed by the assessors after completing the assessment.

<u>SCORE</u>	<u>GRADE</u>
44 - 50	A)
36 - 43	B) Pass
26 - 35	C)
25 and below	Fail (Recorded as "Refer" when 1st or 2nd Attempt)

(3) SCORING GUIDE (as employed in Centres B and D):

SCHOOL OF NURSING

STUDENT NURSE WARD BASED PRACTICAL ASSESSMENT

A. ASEPTIC TECHNIQUE

\*DAY/NIGHT DUTY

NAME ..... WARD .....

INTAKE ..... HOSPITAL .....

+SATISFACTORY

UNSATISFACTORY

- i) Personal appearance and professional attitudes
- ii) Preparation of equipment
- iii) Preparation of patient
- iv) Nurse/Patient relationships
- \*\*v) Safety and performance
- vi) Understanding and knowledge of asepsis

\* Delete as appropriate

+ Tick as appropriate

\*\* A satisfactory tick is obligatory in this section in order to pass

1. Comments and Counselling

2. Refer or Fail - (reasons in detail)

RESULT (TICK AS APPROPRIATE)

PASS

REFER

FAIL

ASSESSORS SIGNATURE .....

DATE .....

THE RESULT OF THE ASSESSMENT HAS BEEN DISCUSSED WITH ME.

LEARNERS SIGNATURE .....

DATE .....

PLEASE RETURN COMPLETED FORM TO ..... SENIOR TUTOR

ISSUED BY ..... ALLOCATION OFFICER.



SCORING GUIDE (Centres B and D) (continued):

SCHOOL OF NURSING

STUDENT NURSE PRACTICAL EXAMINATION

B. MEDICINE ROUND

\*DAY/NIGHT DUTY

NAME .....

WARD .....

INTAKE .....

HOSPITAL .....

+SATISFACTORY    UNSATISFACTORY

- i) Personal appearance and professional attitudes
- ii) Preparation of equipment
- iii) Nurse/Patient relationships
- \*\*iv) Technique - safety and expertise
- v) Understanding and knowledge of administration, storage and safe keeping of:
  - (a) Prescribed drugs
  - (b) Controlled drugs

\*Delete as appropriate

+Tick as appropriate

\*\*A satisfactory tick is obligatory in this section in order to pass.

1. Comments and Counselling:

2. Refer or Fail - (Reasons in detail)

RESULT (TICK AS APPROPRIATE)

PASS

REFER

FAIL

ASSESSORS SIGNATURE .....

DATE .....

THE RESULT OF THE ASSESSMENT HAS BEEN DISCUSSED WITH ME.

LEARNERS SIGNATURE ... ..

DATE .....

PLEASE RETURN COMPLETED FORM TO .....

SENIOR TUTOR.

ISSUED BY .....

ALLOCATION OFFICER.

## SCORING GUIDE (Centres B and D) (continued):

### SCHOOL OF NURSING

#### STUDENT NURSE PRACTICAL EXAMINATION

##### C. TOTAL NURSING CARE

\*DAY/NIGHT DUTY

NAME .....

WARD .....

INTAKE .....

HOSPITAL .....

The planning and carrying out of the nursing care required by a patient during a span of duty; a suitable part of this care to be observed by the Examiner. (At least a minimum of two hours during the span of duty.)

+SATISFACTORY    UNSATISFACTORY

- i) Personal appearance and professional attitudes
- ii) Knowledge of the patient:    (a) Medical  
  (b) Social
- iii) Planning the Patient's day
- \*\*iv) Practical skills:    Nursing expertise
- v) Relationships:    (a) Patients  
                              (b) Others

- \* Delete as appropriate
- + Tick as appropriate
- \*\* A satisfactory tick is obligatory in this section in order to pass

#### 1. Comments and Counselling

#### 2. Refer or Fail

RESULT: (TICK AS APPROPRIATE)

PASS

REFER

FAIL

ASSESSORS SIGNATURE .....

DATE .....

THE RESULT OF THE ASSESSMENT HAS BEEN DISCUSSED WITH ME.

CANDIDATE'S SIGNATURE .....

DATE .....

PLEASE RETURN COMPLETED FORM TO .....

SENIOR TUTOR

ISSUED BY ..... ALLOCATION OFFICER.

SCORING GUIDE (Centres B and D) (continued):

SCHOOL OF NURSING

STUDENT NURSE WARD BASED PRACTICAL ASSESSMENT

\*DAY/NIGHT DUTY

D. ORGANISATION AND COMMUNICATIONS

NAME .....

WARD .....

INTAKE .....

HOSPITAL .....

For a Ward or Group of 10/12 patients, involving:

- (a) Writing of Ward Reports  
Progress or Kardex Reports
- (b) Verbal reports as given to  
member of medical staff.
- (c) Organisation of duties of ward  
staff - (at least a minimum of  
two hours during this examination.

\*SATISFACTORY

UNSATISFACTORY

- i) Organisation/delegation of the ward staff
- ii) Professional/social skills
- \*\*iii) Nursing reports: (a) Verbal  
(b) Written
- iv) Reports as given to Medical staff
- \*\*v) Supervision and teaching.

- \* Delete as appropriate
- + Tick as appropriate
- \*\* If applicable, a satisfactory tick is obligatory in this section in order to pass.

1. Comments and Counselling

2. Refer or Fail - Reasons in detail

RESULT: (TICK AS APPROPRIATE)

PASS

REFER

FAIL

ASSESSORS SIGNATURE .....

DATE .....

THE RESULT OF THE ASSESSMENT HAS BEEN DISCUSSED WITH ME

LEARNER'S SIGNATURE .....

DATE .....

PLEASE RETURN COMPLETED FORM TO .....

SENIOR TUTOR.

ISSUED BY ..... ALLOCATION OFFICER.

(4) POLICY CONCERNING WARD-BASED ASSESSMENTS (Centres B and D).

SCHOOL OF NURSING

POLICY CONCERNING WARD BASED ASSESSMENTS - 1982

THIS CANCELS ANY PREVIOUS POLICY

LEARNERS: - STUDENTS AND PUPILS. SISTERS/CHARGE NURSES ASSESSORS.

Learners must pass all four assessments (students) or three assessments (pupils) before entry to the Consolidation Block and taking the State Final Examination/Assessment.

The programme of training details the allocated areas for the complete period of training, and this information must be used by the learner to plan and organise the assessments with the Sister/Charge Nurse Assessor for each allocated area. The learners must therefore ensure that the programme of training is kept safely throughout their training period. Loss of these documents, or failure to use them to plan assessments, will necessitate action being taken which could result in discontinuation of training and termination of employment.

The learner must be on the ward for at least one week prior to the assessment. In the event of referral, a different Assessor will assess the second attempt; and for the final attempt there will be two Assessors, one being from the School of Nursing. The second and final assessment will both be organised by the Senior Tutor.

STUDENTS:

Should have attempted Part A - Aseptic Technique and Part B - Medicine Round by the end of the first year or no later than the third study block.

Should have attempted Part C - Total Nursing Care before the fifth study block; also Part A and/or Part B if previously referred.

Should have attempted Part D - Management/Organisation - (and any others if previously referred), between the seventh study block and commencement of the consolidation block, or earlier.

PUPILS:

Should have attempted their Geriatric Assessment during their geriatric experience before the third study block.

Should have attempted either Medical or Surgical Assessment, at least in the respective experience; or if necessary either one of these assessments during their Childrens Experience.

Should have attempted the remaining Assessment (and any others if previously referred), between the sixth study block and the commencement of the Consolidation Block.

The necessary forms are attached - (four for students) - (three for pupils), for the appropriate assessments. The Assessor will complete the form whilst the learner is present, immediately the assessment is finished; and return it to the appropriate Senior Tutor. Only if the learner is referred will the Senior Tutor arrange for a further assessment(s) and issue another form to the learner for this purpose.

All Sisters/Charge Nurses in allocated areas are required to be Assessors and will help and give guidance to achieve the required standard. Meanwhile, the Senior Tutor and the District Allocation Officer will monitor progress and inform the learner if it is not satisfactory; but the final responsibility rests with the learner.

POLICY FOR WARD-BASED ASSESSMENTS (Centres B and D)  
(continued):

GUIDE TO ASSESSORS OF STUDENT NURSES

CRITERIA FOR WARD BASED ASSESSMENTS

A. ASEPTIC TECHNIQUE

- i) Personal appearance and professional attitudes
- ii) Preparation of equipment
- iii) Preparation of Patient
- iv) Nurse/Patient relationships
- v) Safety and performance
- vi) Understanding and knowledge of asepsis.

B. MEDICINE ROUND

- i) Personal appearance and professional attitudes
- ii) Preparation of equipment
- iii) Nurse/Patient relationships
- iv) Technique - safety and expertise
- v) Understanding and knowledge of administration
- vi) Storage and safe keeping of:
  - (a) Prescribed drugs
  - (b) Controlled drugs.

C. TOTAL PATIENT CARE

The planning and carrying out of the nursing care required by a patient during a span of duty, a suitable part of this care to be observed by an Assessor. (A minimum of two hours during the span of duty.) The Assessor will choose one of three patients. Where the Assessor is not the Ward Sister, the choice of patient must be made, following consultation with the person in charge of the ward.

- i) Personal appearance and professional attitudes
- ii) Knowledge of the patient: a (Medical) b (Social).
- iii) Planning the patient's day
- iv) Practical skills: Nursing expertise
- v) Relationships: a (Patients) b (Others)

D. ORGANISATION/COMMUNICATIONS - For a Ward or a Group of 10/12 patients involving:

- i) Writing of ward reports, Progress or Kardex reports
- ii) Verbal reports as given to member of medical staff
- iii) Organisation of duties of ward staff

This must not be the first occasion during which a candidate has managed the ward for a span of duty. Night duty may be used unless Part C above has already been undertaken on night duty.

- i) Organisation/delegation of the ward staff
- ii) Professional/Social skills
- iii) Nursing reports: a (Verbal) b (Written)
- iv) Reports as given to medical staff
- v) Supervision and teaching.

POLICY FOR WARD-BASED ASSESSMENTS (Centres B and D)  
(continued):

FAILURE TO PASS ANY OF THE ASSESSMENTS AT THE FIRST ATTEMPT	-	REFER
FAILURE TO PASS ANY OF THE ASSESSMENTS AT THE SECOND ATTEMPT	-	REFER
FAILURE TO PASS ANY OF THE ASSESSMENTS AT THE THIRD AND FINAL ATTEMPT	-	FAIL

RESULTING IN THE FOLLOWING ACTION BEING TAKEN:

APPEAL PROCEDURE (EDUCATIONAL)

1ST REFERRAL All students and pupils must be reminded of the General Nursing Council's regulations by the Assessor, immediately following the result.

- i) That all ward based assessments must be passed before taking the State Final written examination.
- ii) Three attempts at each assessment are allowed. Full details must be entered on the Assessment Criteria sheet.

2ND REFERRAL A VERBAL WARNING - (This is an Education Procedure, not a Disciplinary Procedure) stating as above, but reminding the Candidate that this is the second referral for this particular Assessment, and that they have only one more attempt at this particular Assessment. (This should be recorded in writing). Full details must be entered on the Assessment Criteria sheet.

3RD ATTEMPT Before undertaking any Assessment for the THIRD and FINAL attempt, the Director of Nurse Education must be informed. The Candidate must also be informed well in advance, in the presence of a friend or representative, of the significance of the outcome of the third and final attempt. This must then be confirmed in writing.

FAILURE AT THE THIRD ATTEMPT

Both Assessors will counsel the Candidate, enter full details on the Assessment Criteria result sheet and return it to the Director of Nurse Education immediately.

THE CANDIDATE MUST NOT BE ALLOWED TO UNDERTAKE ANY DUTIES IN ANY WARD/ DEPARTMENT FOR HIS/HER REMAINING TIME IN TRAINING, CONCERNED DIRECTLY OR INDIRECTLY WITH THE ASSESSMENT HE/SHE HAS NOW FAILED, AND THE SENIOR NURSING OFFICER (GENERAL) SHOULD BE INFORMED IMMEDIATELY AS WELL AS THE CANDIDATE.

The Candidate should also be informed immediately of his/her right of appeal to the Director, which must be made to him within two weeks of the date of failure. Within one week, the Director will see the candidate and explain the procedure.

- i) One month's notice plus annual leave outstanding.
- ii) Discontinuation of training form to the General Nursing Council.
- iii) No transfer of training can take place under that particular registration.
- iv) No recommencement of further training under that particular registration.
- v) That application for different training under another registration could be made.

POLICY FOR WARD-BASED ASSESSMENTS (Centres B and D)  
(continued):

GUIDE TO ASSESSORS OF PUPIL NURSES

Where considered suitable, one of the three Assessments can be taken on night duty.

Criteria for Ward Based Assessments

Medical.

Surgical.

Geriatric.

Criteria for all three Assessments.

- i) Personal appearance and professional attitudes
- ii) Knowledge of the patient
- iii) Relationships: (a) Patients (b) Relatives (c) Others
- iv) Basic Nursing Care (a) Immediate (b) Short term (c) Long term
- v) Concept of total patient care:
  - (a) Observations/Recording.
  - (b) Drug Administration, Reasons and Safe-Keeping.
  - (c) Practical Performance.

APPENDIX F: METHOD OF STATISTICAL ANALYSIS AND TABULAR  
SUMMARY OF FREQUENCY DATA.

Frequency data derived from the audiotaped interviews were analysed using the chi-squared model for 'goodness of fit' in cases where the expected frequencies may be obtained from theoretical considerations. For these purposes, data from the following tables was partitioned to yield interesting and potentially relevant comparisons, in cases where expected frequencies could be predicted by virtue of the logical constraints upon the data ( 72 ).

Example 1: In the responses to Question 2, Section 1 (cf Pages 68, A64) replies to the question, 'Did you receive any preparation for the task (of assessment)' occur in a straightforward 'Yes'/'No' distribution. The total N of 44 gives a theoretical expected frequency of 22 for each of these cells. In the event, the observed frequencies were 'Yes' = 14, 'No' = 30. When analysed using chi-squared with Yates' correction:

$$\text{chi-squared} = \sum \frac{(O - E - 0.5)^2}{E}$$

this gives chi-squared = 5.114, df 1,  $p < 0.05$  as reported in the text - i.e. a beyond-chance frequency of negative responses to this question.

Example 2: In the responses to Question 4, Section 1 (cf Pages 69-70, A65), it is reasonably argued that the responses are partitionable into two main groups: that is, those who feel the numbers of students allocated to a ward to be about right for assessment purposes; and those who do not, for whatever reasons. The total N of 43 gives a theoretical expected frequency of 21.5 in each case. In the event, the observed frequencies were 'about right' = 32, other = 11, giving chi-squared = 9.302, df 1,  $p < 0.01$  as reported in the text - i.e. a beyond-chance frequency of positive responses in this case.

Thus in order to carry out the statistical analysis, data in the accompanying tabular summary were grouped or partitioned according to the logical constraints operative and to the nature of the questions for which answers were being sought, according to the above basic procedures. In order to facilitate mechanical aspects of computation, the resultant cells were analysed using a specially-written chi-squared program on the Sharp MZ80K microcomputer. These analyses can be replicated by referring to the data contained in the accompanying tabular summary.

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(72) SIEGEL, S. (1956):  
Nonparametric Statistics for the Behavioral Sciences,  
especially pp. 42-47, 104-111, 175-179.  
New York: McGraw-Hill Book Company.



TABULAR SUMMARY OF FREQUENCY DATA:

		FREQUENCY:			
Q:	SUBJECT:	A	B	C	D
<u>SECTION I:</u>					
Age groups of respondents:	21-30	10	4	4	2
	31-40	4	3	5	3
	41-50	0	0	3	5
Date of basic training:	1969-	2	1	6	5
	70-79	11	7	6	5
	1980+	1	0	0	0
Undertook post-basic training:	YES	11	5	10	8
	NO	3	3	2	2
Involved in completing progress assessment forms:	YES	13	8	12	10
	NO	0	0	0	0
Involved in ENB staged assessments:	YES	13	7	12	10
	NO	1	1	0	0
<u>FOR THOSE COMPLETING PROGRESS ASSESSMENTS:</u>					
1. Length of time involved:	6-12mths	2	2	0	0
	2 years	5	0	1	4
	3 years	6	2	2	0
	4 years	0	2	2	0
	5 years	0	1	3	0
	6 years	1	1	0	0
	7 years	0	0	2	1
	8 years	0	0	1	1
	10 years+	0	0	1	4
2. Any preparation for task:	YES	2	0	8	4
	NO	12	8	4	6
2a. Was this helpful?:	YES	2	0	7	3
	NO	0	2	2	1

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
3.	Expected student allocation at any given time:	3: 3	2	0	0
		4: 3	0	3	5
		5: 1	2	7	4
		6: 3	0	1	1
		7: 0	2	0	0
		More: 4	2	0	0
4.	For assessment purposes, are these numbers	Too few: 1	1	0	1
		Too many: 4	2	1	1
		About right: 8	5	11	8
5.	Stages in training	First Year: 4	4	8	2
		Second Year: 3	1	1	1
		Third Year: 7	5	10	0
		'Mixed': 3	1	1	8
6.	Set allocation in weeks:	YES: 14	7	11	9
		NO: 0	1	1	0
6a.	Number of weeks:	6- 8: 5	3	4	6
		8-10: 1	3	5	4
		10-12: 6	2	3	0
		More : 2	1	0	0
7.	Enough time to get to know students?:	YES: 8	7	9	8
		NO: 4	1	2	1
		Sometimes: 2	0	1	1
8.	Internal rotation for students on your ward?:	YES: 12	4	5	6
		NO: 2	4	7	4
9.	Trained staff on morning shift (0800-1600)?:	1 : 0	0	0	2
		2 : 1	2	1	7
		3 : 5	4	8	0
		4 : 4	2	1	0
		5 : 4	0	2	0

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
9a.	Trained staff on evening shift (1300-1000)?:	1: 1 2: 8 3: 1 4: 4	0 4 1 3	0 10 1 2	0 10 0 0
10.	Satisfaction with learner contact:           Very satisfied:	0	2	2	0
	Satisfied:	7	4	6	6
	Unsatisfied:	7	2	4	4
11.	Type of Ward: Medical	5	3	6	5
	Surgical:	3	3	2	5
	Geriatric:	1	2	0	0
12.	Ward Layout: Nightingale:	8	6	1	4
	Bays:	2	1	9	4
	L-shaped:	2	1	0	2
	Cubicles:	2	0	2	0
13..	Layout suitable for observing the student?:           YES:	11	7	3	5
	NO:	3	1	9	4
	Unsure:	0	0	0	1
14.	Average length of patient stay?:                   Short:	2	0	4	2
	Medium:	1	2	0	4
	Long:	1	0	0	1
	Mixed:	10	6	8	3
15.	Workload on ward?:    Heavy:	4	1	6	7
	Medium:	0	1	2	0
	Mixed:	10	5	5	3
16.	Pace of work affects student assessments?:           YES:	12	6	9	7
	NO:	2	2	3	3

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
17.	Deadline for completion of progress assessment forms?:	YES: 13	6	12	10
		NO: 1	2	0	0
18.	Length of time spent in completing the form?:				
	Less than 5 minutes:	1	0	0	2
	5-10 minutes:	2	2	3	3
	10-20 minutes:	7	5	5	0
	20-30 minutes:	4	1	3	3
	30-60 minutes:	0	0	1	2
19.	Length of time discusses form with student?:				
	Minutes only:	5	5	5	3
	Up to half-an-hour:	7	2	5	4
	Between half and one hour:	2	1	2	3
20.	Conducts both initial and final interview?:	YES: 5	6	7	10
		NO: 6	2	2	0
		Mostly: 3	0	3	0
21.	Approach to work problem with a student?:				
	Counsel student and try to help:	14	6	11	9
	Seek help from clinical teacher:	8	6	3	6
	Work with the student:	1	1	4	3
22.	Would prior knowledge of student help this assessment?:	YES: 5	2	3	1
		NO: 9	6	6	6
		Unsure: 0	0	3	3
23.	Disposal of form:	To student: 0	0	4	10
		To school: 10	7	5	0
		To N.O.: 10	3	1	0

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
24.	Feedback received about the assessment?:	YES: 0	0	0	0
		NO: 14	8	12	10
25.	Purposes of Assessment?:				
	Benefits the student:	12	7	7	8
	Benefits the school:	4	2	3	2
	For records:	2	1	0	0
	Serves no purpose:	1	0	2	0
26.	Does the completed form have training value?:	YES: 5	6	5	8
		NO: 9	2	7	2
27.	Assessment:				
	ranked equally with other important parts of your job:	10	6	10	9
	is less important than some aspects:	4	1	2	1
	Uncertain:	0	1	0	0
28.	Sufficient time for assessment?	YES: 4	6	5	7
		NO: 9	2	7	3
29.	Time spent in observing the student?:				
	'A lot':	4	2	3	3
	A reasonable amount:	2	3	0	3
	Not enough:	3	0	2	0
	Uncertain:	4	2	7	4
30.	Involvement of other trained nurses in writing report?:	YES: 13	7	12	10
		NO: 1	1	0	0
30a.	Do they write on the form?:	YES: 2	0	3	0
		NO: 12	8	9	10

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
31.	Any training other than yours for staff in assessment?: YES:	1	0	2	0
	NO:	13	8	10	10
32.	The assessment form is useful:	2	2	2	5
	of some use:	8	6	7	4
	of little use:	2	0	3	1
	of no use:	2	0	0	0
33.	You use the comments section regularly:	8	5	11	10
	sometimes:	6	2	1	0
	rarely:	0	1	0	0
34.	Do you find the assessment categories useful?: YES:	2	4	6	10
	NO:	12	4	6	0
35.	The length of the form is about right:	9	6	9	9
	too long:	2	0	2	0
	too short:	1	1	1	0
	uncertain:	2	1	0	1
36.	Do you complete the form with the learner present?: YES:	1	0	0	1
	NO:	13	8	12	9
37.	Involvement of nursing officer in the process of assessment?: YES:	0	0	0	0
	NO:	14	7	12	10
38.	Involvement of teaching staff in the process of assessment?: YES:	3	0	2	0
	NO:	11	8	10	10

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
39.	Opportunity to discuss the completed form?:	YES:	2	0	0
			12	8	10
		NO:	12	8	10
40.	Were you assessed in a similar way?:	YES:	6	4	2
			8	4	9
		NO:	8	4	9
41.	Was the way in which you were assessed satisfactory?	YES:	7	5	5
			4	3	7
		NO:	4	3	7
42.	The present system is	adequate:	1	5	6
			9	1	4
			4	2	2
		uncertain:	4	2	0
43.	Aspects of student's work which are looked at are	interpersonal skills:	10	3	6
			7	5	7
			6	2	5
			1	0	0
		interest in work:	1	0	0
44.	Are the five vertical categories helpful?:	YES:	11	7	8
			1	1	2
			2	0	2
		Uncertain:	2	0	0
45.	Are items representative of the usual student activities?	YES:	8	7	4
			6	1	8
		NO:	6	1	8

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
<u>SECTION II: FOR E.N.B. ASSESSORS.</u>					
1.	Period of time spent as E.N.B. assessor:				
	1 year:	5	0	2	1
	2 years	3	2	2	1
	3 years	0	2	0	2
	4 years	2	0	3	2
	5 years	0	2	1	1
	6 years	2	1	3	1
	7 years	0	0	0	2
	9 years	0	0	1	0
2.	Preparation received:				
	Two-day course:	12	6	12	6
	Other preparation:	0	1	0	4
3.	Were you well-prepared?: YES:	6	4	5	5
	NO:	4	3	5	4
	Partly:	2	0	2	1
4.	Assessments are carried out on the following basis:				
	Weekly:	4	0	0	0
	Monthly:	7	6	11	7
	Annually:	1	1	1	3
5.	Any pattern in which assessments occur?: YES:	2	2	1	3
	NO:	8	5	11	5
6.	Happy with involvement in E.N.B. assessments?: YES:	10	5	11	7
	NO:	1	2	1	3
7.	Assess for all four parts of the staged assessment?: YES:	6	3	6	7
	NO:	6	4	6	3
8.	Preference for any part?: YES:	8	4	7	8
	NO:	2	3	5	2



Tabular Summary of Frequency Data (continued):

			FREQUENCY:			
Q:	SUBJECT:		A	B	C	D
9.	Assess on own ward?:	YES:	12	7	11	10
		NO:	0	0	1	0
10.	Do you usually know the student's work?:	YES:	12	7	11	10
		NO:	0	0	1	0
11.	Is this an advantage?:	YES:	8	7	10	10
		NO:	4	0	2	0
12.	Do assessments influence the ward?:	YES:	7	5	9	7
		NO:	4	2	3	3
13.	Do they affect patients?	YES:	8	7	9	7
		NO:	4	0	3	3
14.	Who should carry out assessments?:					
	Ward Sister:		10	6	11	10
	Nursing Officer:		0	0	2	0
	Clinical Teacher:		6	3	5	1
	Tutor:		1	1	1	0
	'Any combination':		0	0	1	0
15.	Purpose of practical assessment?:					
	To ensure safety:		7	4	10	5
	'To help the student':		5	1	1	4
	For record-keeping:		1	1	0	0
	No purpose!		0	1	1	1
16.	Do you assess on your own?:	YES:	12	7	11	10
		NO:	0	0	1	0
17.	Are you happy with this?:	YES:	12	7	12	9
		NO:	0	0	0	1

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
18.	Ever referred a student?: YES:	5	0	9	4
	NO:	7	7	3	6
18a.	Would this be rarely?	4	1	3	3
	often?	1	0	0	0
	occasionally?	1	0	5	1
19.	Best setting for assessment?				
	Practical Room:	2	0	0	0
	Ward:	10	7	12	10
20.	Any problems with using the ward for assessments? YES:	6	4	7	2
	NO:	6	3	5	8
21.	This aspect of your job is important:	7	2	8	7
	necessary:	5	4	3	3
	not important:	0	1	0	0
	uncertain:	0	0	1	0
22.	Difficulties in finding time for assessments : YES:	7	4	10	2
	NO:	5	3	2	8
23.	Were you assessed in this way?: YES:	8	4	5	2
	NO:	4	2	7	8
24.	System fair to patients?: YES:	11	6	10	10
	NO:	0	1	2	0
	System fair to students?: YES:	6	5	8	8
	NO:	6	2	4	2
	Unsure regarding patients:	1	0	0	0

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
25.	Are E.N.B. staged assessments more important than progress assessments?				
	YES:	4	1	4	1
	NO:	2	2	4	3
	Equally important:	5	3	3	7
	Unsure:	1	1	1	1
26.	With regard to present arrangements for E.N.B. staged assessments, you are:				
	Happy:	9	4	3	7
	Unhappy:	3	2	11	9
	Neither:	0	1	1	1
27.	For each of the four staged assessments, are you happy with their content?				
	Aseptic technique: YES:	6	4	11	7
	NO:	2	2	1	3
	Medicine round: YES:	4	5	11	7
	NO:	3	2	1	3
	Total patient care: YES:	6	4	11	7
	NO:	2	2	1	3
	Ward management: YES:	5	4	11	7
	NO:	1	2	1	3
28.	Ever involved in repeated referral?:				
	YES:	1	1	4	2
	NO:	11	6	8	8
29.	Should student be given more than one chance to pass each stage?:				
	YES:	12	7	11	9
	NO:	0	0	0	1
	Uncertain:	0	0	1	0

Tabular Summary of Frequency Data (continued):

Q:	SUBJECT:	FREQUENCY:			
		A	B	C	D
30.	In cases of borderline performance, do you have help/support?:				
	YES:	5	1	1	1
	NO:	7	6	11	9
31.	Opportunity to discuss the staged assessments?:				
	YES:	2	1	0	1
	NO:	10	6	12	9
32.	Any thoughts on improving the system of staged assessment?				
	YES:	6	3	11	8
	NO:	6	4	1	2
	If not, are you happy with the present situation?				
	YES:	2	3	1	2
	NO:	4	1	0	0

NB: The letters 'A, B, C, D' above the frequency columns in the accompanying tabular summary refer to the centres in which the study was carried out and from which data were obtained. For purposes of reference, the numbers of assessors working in each centre are as follows:

TYPE OF ASSESSMENT:	CENTRE A:	CENTRE B:	CENTRE C:	CENTRE D:
Progress assessments:	14	8	12	10
E.N.B. staged assessments:	12	7	12	10

i.e. out of the total number of respondents (N = 44), two in Centre A and one in Centre B were not as yet qualified to act as assessors in E.N.B. staged assessments.

## APPENDIX G: OVERVIEW OF IMPLICATIONS OF THE STUDY.

NB: Whilst it should be borne in mind that this study is based on a relatively small sample of assessors (N = 44) based in four centres in the London area, with all the limitations contingent upon such small sample studies, the following implications emerge logically from the existing data; and are offered, together with the findings in Appendix A, as possible indicators for further study.

### IMPLICATIONS RELATING TO PROGRESS ASSESSMENTS:

#### A. Organisational Issues:

1. There is a need in some assessment centres to look at the workload of progress assessment as it affects individual wards and individual assessors.
2. Similarly, in training areas where progress assessments regularly take place, the ratio of trained to untrained nursing staff should be agreed by consensus involving managers, teachers and assessors; and should be kept under review regarding its suitability for the specific assessment area.
3. The modal duration of learner allocations should be reappraised in the light of what can realistically be achieved by the student, bearing in mind the need for a 'settling-in' phase.
4. Student nurses should become more centrally involved in the process of monitoring and administering their own assessments; especially with regard to responsibility for disposal of relevant forms, and greater involvement in discussion with assessors during the actual completion of the progress assessment form.
5. In place of the present rather piecemeal arrangements, full participation in the assessment process by other senior trained nursing staff should be encouraged. Thus the existing team approach to progress assessment should become more formalised, with recognition of senior staff contributions to assessment discussions and actual writing of the assessment form.
6. Assessors should be given an opportunity to discuss the completed assessment with nurse managers as a part of this more formal structure.

B. Assessment Issues:

1. There is a need to reconsider the format and categories of the progress assessment form.
2. These should be amended to specify performance criteria; and to include genuinely developmental and progressive (i.e. formative features).
3. Categories in the progress assessment form should also be reconsidered in relation to representativeness of student nurse activities on the ward: and due weight should be given to the items relating to the acquisition of interpersonal and basic care skills.
4. Reliability should be investigated using synchronous dual assessment studies involving assessors from more than one centre: possibly employing use of video playback techniques to help overcome attendant difficulties (cf, e.g., S30). Studies are also needed into improving the properties of the instrument as a diagnostic and monitorial device of more direct relevance to the progress of individual students, based on considerations in (1), (2) and (3) above.
5. The format and process of progress assessment should maintain continuity and indicate students' developmental progress throughout their education, whilst allowing for the specialist experience which they gain during the second year of the course.
6. All preliminary interviews with students should be regarded as essential baseline data for developmental assessment, and completed accordingly.
7. Discussions of the assessment with each student should be longer and in rather greater depth concerning her gains and current needs; and the areas requiring her special attention in future placements.
8. For similar reasons, the student nurse should preferably always be present when the assessor is completing her progress assessment form.

C. Educational Issues:

1. All assessors should receive a preparatory course.
2. Where appropriate, the content of such courses should be reviewed to include (e.g.) a discussion of the psychological and educational processes underlying progress assessment.

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(S20). LANGE, C.M. (1978):  
Using media in evaluation.  
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3. These courses should be offered to all senior nursing staff collaborating in the process of progress assessment (e.g. RGNs and SENs).
4. Further research is required into educational methods of achieving higher levels of inter-assessor reliability: and a discussion of such reliability should become part of the focal content of preparatory courses.
5. Attention needs to be drawn to the requirement to improve the validity of an assessment which relies heavily on observations undertaken by non-assessing members of the ward team.
6. Attention should be drawn to the need to provide some qualitative indication of the student's progress during a specific allocation; since at present the instrument is used largely retrospectively and summatively.
7. Where appropriate, preparatory courses should include some discussion of the logic of 'average' grades, to reduce their pejorative use as a minimal criterion of acceptability.
8. Attention of assessors should be drawn to potential problems of assessor subjectivity and (in certain cases) lack of sensitivity of the assessment instrument, as potential hazards in the use of the present progress assessment forms.
9. Shared completion of the progress assessment form by current assessors and senior qualified staff might be considered with regard to its potential benefits.
10. Other discussions which might with advantage be introduced into preparatory courses include: The possible value of looking outside the ward ambience for help and advice in connection with specific assessments; of longer discussion with each student regarding her assessment; and of the potential benefits accruing from full participation in assessments by other qualified members of the ward team.
11. The validity of ward-based assessments might be further improved by encouraging a 'partnership' in validation by discussion between assessors, educational and management staff.

12. Dearth of creative ideas regarding methods of improving progress assessment techniques may be partially overcome by inviting constructive suggestions from assessors and holding regular discussions of issues in progress assessment, such as those outlined in (1) above.

#### IMPLICATIONS RELATING TO E.N.B. STAGED ASSESSMENTS:

##### A. Organisational Issues:

1. Consideration should be given to diversifying the experience of E.N.B. assessors who currently assess for one 'stage' only, in the interests of assessor versatility.
2. Ways should be sought of formally recognising the positive role played in E.N.B. staged assessments by the assessor's prior knowledge of a student's work.
3. Student knowledge that this recognition is occurring, together with appropriate social skills awareness on the part of assessors, should go some way towards reducing the 'charged' atmosphere which appears to be common during staged assessments.
4. Establishment of a semi-formal or formal support group is desirable in order to offer advice and help to assessors during routine discussion of current E.N.B. staged assessments. Such a support group could also offer advice and help in connection with 'borderline' student performance; and could consider, and offer suggestions to minimise, any ward problems emergent during or as a result of, E.N.B. staged assessments.
5. Such a support group could also form the nucleus of an assessment policy group which would include also management and education staff; and which would consider needs and resources for assessment; and make recommendations on these issues and on issues relating to the preparation and versatility of assessors.



B. Assessment Issues:

1. There is a need to reconsider the format in which the results of individual 'stages' of the assessment are recorded. There is a consensus that each 'stage' requires its own specially-designed form. Reappraisal of formats should recognise the need for a comments section in which the assessor can amplify qualitative aspects of the student nurse's performance during staged assessments.
2. There is a widespread view that an instrument which is totally summative is possibly missing-out on the formative properties which are inherent in these assessment situations. The longitudinal or developmental aspects of the assessment should be increased, possibly by means of periodic appraisal against 'baseline' data obtained during the early stages of each ward placement. Such a system could be of particular value to 'borderliners' in helping them to pace themselves; and to achieve improvement through an increased awareness of personal progress.

C. Educational Issues:

1. All E.N.B. assessors should receive an adequate preparatory course, inclusive of materials on the psychological processes involved in assessment, such as the value of 'social skills' techniques in reducing tension in fraught assessment situations.
2. There is a need to consider diversifying the experience of assessors who currently assess for one stage of the assessments only: e.g. by arranging for them to have the opportunity to observe appropriate role-models during assessment for other stages; followed by participation in dual assessment and individual practice (cf also Organisational Issues, implication (1), Page A79, above).
3. All E.N.B. assessors should be recognised members of the assessors' support group (see Paras. 4.19, 4.20, above); which should meet regularly to discuss relevant issues in assessment. In addition to clinical assessors, the group should include education and management resource members to help overcome the difficulties outlined in Para. 4.31, above.

4. Opportunities should be provided for student liaison with members of the support group. Student members could be invited to discuss with the group methods for overcoming the tensions of assessment, and for ensuring that students gain maximum benefit from the assessment situation.