The Preceptor's Role in Student Evaluation: An Investigation

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Abstract

The evaluation of nursing students' clinical learning in the preceptorship model of clinical teaching is a shared responsibility between the lecturer and the preceptor in the educational institution where this research took place. The purpose of the study is to explore the preceptor's role in student evaluation.

This thesis uses a comparative descriptive design to investigate the similarities and differences between lecturers' and preceptors' valuing of specific clinical evaluation criteria as set out in the clinical evaluation tool. The lecturers' and preceptors' perceptions of the clarity of the clinical evaluation tool are also explored using a qualitative approach.

A sample of ten lecturers and seventy preceptors who provide clinical teaching to second year undergraduate nursing students in acute care settings, was drawn to compare if the clinical evaluation criteria were valued differently between the groups. A questionnaire was developed using the clinical evaluation tool used by the educational institution. Data analysis demonstrated more similarities than differences between the criteria selected as most critically important by lecturers and preceptors. Differences were demonstrated on four criteria which were rated more highly by lecturers than preceptors. This suggested that preceptors' evaluations of students' clinical practice pertaining to those criteria would differ from lecturers' expectations of students' practice. A quasi-statistical content analysis of open-ended questions explored lecturers' and preceptors' perceptions of the clarity of the clinical evaluation tool.

The influence of preceptors' educational level on the valuing of specific criteria was also explored and was shown to have most influence on preceptors' valuing of cultural safety. Factors which might explain these findings are identified and discussed, namely socialisation of preceptors to work-based values; variability of exposure to the education environment for preceptors; difficulty defining clinical competence and preceptors' level of experience. The study endorses preceptors' involvement in clinical evaluation and highlights future directions for research and development of the preceptor role.

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Glossary

Clinical evaluation	Pertains to both the summative evaluation and the formative evaluation a student receives regarding their practice.
Evaluation	Is both a process and a product. As defined by Scriven (1991) the term refers to the process of systematically determining the merit, worth and value of something and also denotes the products of that process. Therefore both formative and summative evaluation are encompassed in this term.
Formative evaluation	Is the 'process' of evaluation or the ongoing feedback a student receives from both the preceptor and the lecturer to inform them of their progress.
Lecturer	Registered nurse who is employed by the educational institution and provides theoretical teaching in the classroom and facilitates clinical teaching collaboratively with the preceptor.
Nurse clinician	Registered nurse who is employed by a health care agency and whose primary employment is in clinical practice.
Nurse educator	Used generically to include all nurses who work in an educational role. This includes registered nurses who work in health care agencies and educational institutions and who may or may not have a clinical teaching role.
Nurse tutor	Registered nurse who is employed by an educational institution and provides both classroom teaching and clinical teaching in undergraduate diploma programmes.
Preceptor	Registered nurse whose primary employment is in the clinical area where nursing students are placed. Provides one-to-one clinical teaching for a student during their clinical placement.

Summative evaluation	Is the 'product' or end result of achievement the student receives from a lecturer at the completion of a clinical placement.

CHAPTER ONE

INTRODUCTION

This study investigates the similarities and differences between lecturers' and preceptors' evaluation of the clinical performance of second year undergraduate nursing students. In the educational institution where this study was undertaken a preceptorship model of clinical teaching had been introduced in 1996. Preceptorship is a clinical teaching model that is growing in popularity internationally due to its capacity to facilitate role transition and prepare students for the realities of practice (Yonge, Krahn, Trojan, Reid, 1997).

The study was undertaken in an educational institution in a large city in Aotearoa/New Zealand. Following a successful pilot project by Dyson and Thompson in 1996, the educational institution introduced a preceptorship model as a new clinical teaching strategy to enhance the clinical learning for the students in the undergraduate nursing programme. The preceptorship model of clinical teaching was introduced for second and third year nursing students during their clinical placements in medical and surgical wards at a large metropolitan hospital and the surgical wards of a smaller private hospital, where the current study is sited.

There are different models of preceptorship, and the one adopted by the nursing school in the current study is a triumvirate one which is

based on the clinical teaching model utilised in Project 2000[1] (UKCC[2] 1986). This is a collaborative approach to student education and evaluation involving the student, the lecturer and the preceptor. In this model the lecturer participates in clinical teaching and works collaboratively with a clinically experienced preceptor to support the student's learning. The student has supernumerary status and works in a one-to-one relationship with the preceptor in the clinical placement.

In the model used in this study lecturers and preceptors have a shared responsibility for the clinical teaching and evaluation of the students' progress. The preceptors main responsibility is client care. The lecturers main responsibility is clinical teaching which encompasses four aspects: Student teaching, working with preceptors, liaison with clinical staff and evaluation. Different methods are used to facilitate student teaching such as reflection, role modelling, dialogue and working alongside students. Lecturers provide support to preceptors by role modelling teaching strategies and providing assistance with evaluating student progress. The evaluation of students is a continuous process and involves informing students of the expectations of the course using the *Standards for Nursing Practice* (Appendix A) to guide the students' learning. Students are kept informed of their progress and any concerns are addressed by implementing learning strategies to assist the student (AIT, 1997).

The teaching role of the preceptor involves role-modelling everyday practice and demonstrating technical and bedside skills as well

[1] Project 2000 was a governmental review of nursing education in the United Kingdom, which resulted in the transfer of undergraduate nursing education into the tertiary sector in the early 1990s. The aim was to have these changes in place by 2000.

[2] United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

as setting up opportunities for the students to practise. The evaluative role includes providing formative feedback to the students and discussing areas in which they are progressing well or areas that need further development. Preceptors also provide regular feedback to the lecturer about their observations of students' practice (AIT, 1997).

In the preceptorship model assumptions have been made that preceptors who spend the most time at the bedside are in the best position to teach students in the clinical area, and the one-to-one relationship gives them the opportunity to observe and make decisions about students' practice.

However, anecdotal evidence from nursing students suggests there may be inconsistency between the criteria lecturers and preceptors regard as critically important when they make judgements about a student's practice.

Both lecturers and preceptors are expected to evaluate students using the *Standards for Nursing Practice* developed by the educational institution. The current study specifically examines criteria used in the evaluation tool to ascertain if lecturers and preceptors value the criteria differently, as this could influence the final evaluation a student receives.

In 1993 Ferguson and Calder undertook a similar study in Canada, to explore the issue of students' clinical evaluation by their preceptors, an issue not previously explored in the nursing literature. In their study Ferguson and Calder surveyed 19 nurse lecturers and 126 preceptors who worked in a variety of clinical settings; community care, acute care and intensive care, with third and fourth year nursing students. Using a comparative study design Ferguson and Calder compared nurse lecturers' and preceptors' valuing of specific clinical evaluation criteria. The findings of the study demonstrated there were more similarities than differences between the two groups, indicating that nurse lecturers and preceptors agreed on what constituted an acceptable standard of practice.

While these findings are helpful they can only be generalised to the population from which the sample was drawn and not to the Aotearoa/New Zealand context. This led the researcher to consider undertaking a similar study to explore whether Ferguson and Calder's findings can be applied to this particular educational institution in Aotearoa/New Zealand by using two of their research questions. In contrast to Ferguson and Calder's study, the current study will only survey preceptors and lecturers of second year nursing students assigned to medical and surgical wards. The reason being there is a higher lecturer to student ratio with second year students compared to third year students, and first year students are not preceptored. The higher lecturer to student ratio provides a larger sample of lecturers. By only using second year students there was only one level of criteria that participants needed to consider when rating the critical importance of items used in the tool.

Although many studies have examined preceptorship internationally, to date very little research has explored the preceptor model as it is being applied in Aotearoa/New Zealand, and none specifically explores the evaluation of students' clinical practice by their lecturers or preceptors. Previous research within the school exploring the role of the lecturer (Dyson, 1998), found that the final student evaluation was the responsibility of the lecturer and suggested the preceptor's role in clinical evaluation needed further exploration.

As mentioned above, the current study is focused on the *Standards for Nursing Practice* of the nursing school where the study is taking place, because this document provides the criteria on which the students are evaluated. The study is designed to answer the following questions:

1. What are the similarities and differences between nurse lecturers and nurse preceptors in their assessment of the importance of selected performance criteria for the evaluation of clinical performance? (This question was also used by Ferguson and Calder in their 1993 study).

2. How does the level of educational preparation of the nurse preceptor influence the way in which the preceptor assesses the importance of specific performance criteria? (This question was also used by Ferguson and Calder in their 1993 study).
3. What are nurse lecturers' and nurse preceptors' perceptions of the clarity of the Clinical Standards Assessment Tool?

A comparative descriptive design which uses both open and closed questions was chosen for the study. Comparative descriptive designs describe differences in naturally occurring variables between two or more groups, and are particularly suited to providing a picture of the actions of groups in similar situations when little is known about the area of interest (Waltz & Bausell, 1981). As student clinical evaluation in a preceptorship model is an issue which has not been previously explored in the Aotearoa/New Zealand context, the study uses both quantitative and qualitative data gathered from lecturers and preceptors to increase the depth of the data. In comparative studies the variables are not manipulated, as there is no attempt to make causal assertions. Differences between variables can be examined using descriptive and inferential statistics to analyse data. The results from these analyses can provide greater insight into current conditions and practices, and enable informed decision making to contribute to change (Burns & Grove, 1987).

1.1 Background to the Study

In 1976 the first graduates of technical institutes (later some became known as Polytechnics) entered employment. It was envisaged that new graduates from tertiary courses would be independent and autonomous and capable of functioning competently in first level positions within any health care setting, - general hospitals, mental health agencies or the community (Kinross, 1984). However it is recognised that there are gaps between the expectations and the reality of clinical practice of new graduates (Nursing Consensus Conference, 1995).

Many nurses have voiced their concerns regarding the difficulties encountered for students during the transition to registered nurse (Horsburgh, 1987; Perry, 1988) and the lack of preparation for clinical practice demonstrated by new graduates on their entry to the workforce (Stodart, 1992). Evidence of this was presented in a submission to the Ministerial Taskforce on Nursing (1998) by Nurse Executives of New Zealand (NENZ), which represented hospital Directors of Nursing and Nurse Advisors, who maintained there are variations in the standards of clinical competence shown by new graduates. Senior nurses (Hutchins, 1991) also expressed concerns about new graduates' lack of confidence to assume the client loads expected of registered nurses.

Nursing graduates themselves recognise the difficulty they have in making the transition to their new roles. In 1989, Clare, reported that while most new graduates were satisfied with their educational preparation for practice, they also reported being caught between "the individualised nursing care [learned in the educational institution] that they would prefer to give and the care that was given according to the established beliefs and practices of the ward" (p. 3). This could be a traumatic experience for a new graduate who may feel 'disillusioned' from the frustration they have in orientating to their new role (Corwin, Taves & Haas, 1961).

The difficulties encountered in role transition for newly qualified nurses has been described by Kramer (1974, p. 3) as "reality shock". Kramer suggested reality shock arises from a conflict between professional values learned in a nursing school and the more bureaucratic goals of the workplace. However there is a lack of consensus within the nursing profession regarding the basis of the problem (Myrick, 1988; Holly, 1992), though it was believed that immersion in the 'real world' of nursing and exposure to clinically skilled nurses would ease its effects (Chickerella & Lutz, 1981; Benner & Benner, 1979). Preceptorship is being promoted by nurse educators and clinicians internationally as a way to

enhance the role transition from student to graduate. It is gaining momentum as a clinical teaching strategy in undergraduate nursing courses to facilitate the development of critically thinking and reflective new graduates. It is believed that by working alongside their preceptors student nurses will learn about the everyday reality of clinical practice which will better prepare them for their entry to the workforce. The one-to-one teaching relationship which is the foundation of this teaching model is considered the best way for students to learn the practice of nursing. Preceptors promote student learning by acting as role models and facilitating appropriate learning opportunities to extend and reinforce students application of theory to practice. They also help to reduce 'transitional stress' by orientating students to the routine and culture of the health care setting (Beattie, 1998).

1.1.1 Preceptorship and International Trends

Since the 1960s clinical preceptoring has been introduced into undergraduate and graduate nursing programmes internationally. In the United States the model is used to socialise and familiarise new staff to an unfamiliar clinical environment (Holly, 1992). Increasingly in North America staff nurses are acting as preceptors to facilitate student learning in the clinical setting (Myrick, 1988). More recently in the United Kingdom preceptorship has been a pivotal part in project 2000 for providing support to undergraduate and qualified nurses (Burke, 1994). At the University of Canberra in Australia preceptorship is an integral part of undergraduate socialisation in final clinical placements (Grealish & Carroll, 1998). Preceptorship programmes have also been the cornerstone for enhancing the skills and professional development of nurses working in rural areas in South Australia (Dusmohamed & Guscott, 1998) and New Mexico (L'Esperance, DiGregorio, & Wallerstedt, 1996).

1.1.2 Preceptorship in Aotearoa/New Zealand

Although preceptorship was initially implemented by service providers to facilitate the orientation of new graduates (Dixon & Paterson, 1986), it was first introduced into undergraduate nursing education in Aotearoa/New Zealand in 1996, following a trial involving 8 undergraduate students and 8 preceptors over a 7 week period in surgical clinical areas. Dyson and Thompson (1996) evaluated the pilot using a qualitative study to gain insight into preceptorship from the perspective of the preceptor and the student and found that preceptors and students strongly supported the model. Students and preceptors both reported that the preceptored experience enhanced their professional growth and development.

Other schools of nursing in Aotearoa/New Zealand have introduced the model into their courses. The findings of an evaluative study by Kaviani and Stillwell (2000) indicated the preceptorship model was an effective clinical teaching model with senior nursing students.

1.2 Significance of the Study

Prior to the introduction of preceptorship formative and summative evaluation of the student in the clinical area was carried out by the clinical lecturer who worked alongside students on a regular basis. While clinical staff 'buddied' nursing students during clinical placements they had no formal input into student evaluation. With the introduction of preceptorship this role has changed. Clinical staff who are preceptors have a formal clinical teaching role and their observations of students' performances contribute to the evaluation process (Dyson, 1998). However, there is uncertainty regarding the preceptor's role in the process of clinical evaluation as was suggested above, there is a paucity of information in the literature relating to this issue.

1.2.1 The Curriculum Standards for Nursing Practice

Since its introduction in 1990 the *Standards for Nursing Practice* developed by nurse educators within the school has evolved to guide and evaluate student learning in both the traditional model of clinical teaching and the preceptorship model currently being implemented in the Bachelor of Health Science (Nursing) degree programme.

The school's curriculum in which the practice of nursing is given a central place is based on five processes: *Competency, critical thinking, valuing, professionalism,* and *communication,* and has the concept of caring as a core value.

The clinical evaluation tool is criterion-based and the *Standards for Nursing Practice* is comprised of qualitative statements which reflect a progression of clinical practice development over the course of the three-year nursing programme. Specified criteria that underlie professional nursing practice appropriate for each level within the course, formulate the clinical evaluation tool. The criteria specify the values against which a judgement will be made (AIT, 1998).

The *Standards for Nursing Practice* are utilised as an evaluation tool and a learning tool by students, lecturers and preceptors. As an evaluation tool the *Standards for Nursing Practice* is used to provide a comprehensive view of the student's clinical practice. Their practice is evaluated against criteria pertaining to the five curriculum processes. As a learning tool the document clearly informs the student of the expectations for clinical practice. Students are required to achieve in all processes before advancing to the next level and are evaluated on:

- Level of ability in nursing practice;
- application of theoretical knowledge to practice;
- completion of learning activities;
- development in the processes of nursing practice pertaining to the appropriate level of the course (AIT, 1998).

Certain procedures are followed to assure that the clinical evaluation tool is used effectively. They are:

- Pre- and post-clinical meetings between lecturers to establish the expectations of students' practice and promote the reliability and validity of the tool;
- discussions between lecturers, preceptors and students to determine expectations of clinical practice and to familiarise students with the tool;
- processes which address non-achievement, for example examination board.

Decisions on a student's overall achievement are evaluated as: Achieved with merit; achieved; or not achieved (AIT, 1998).

The purpose of this study was to generate some descriptive data which would provide a clearer picture of what lecturers and preceptors value when assessing a student nurse's clinical performance. It was anticipated that providing specific information about the preceptor as evaluator may enable the refinement of the current process of student evaluation within this particular educational institution and, ultimately promote a more collaborative model of student evaluation as suggested by Dyson (1998). It is envisaged that the findings of this study will provide research-based knowledge about clinical evaluation of students' learning in a preceptorship model of clinical teaching. It has the potential to inform and refine current clinical evaluation practices

1.3 Structure of the Thesis

This chapter has introduced the research topic, identified the research goals and provided a background to the study. In Chapter Two a critique of the literature reviewed is presented. The research method and ethical considerations are presented in Chapter Three. Chapter four presents and analyses the findings of the research and in Chapter Five the findings are discussed in relation to the literature and the research questions. Chapter six concludes the research and presents the implications and recommendations for practice.

CHAPTER TWO

LITERATURE REVIEW

Preceptorship is an innovative model of clinical teaching which is gaining popularity with nursing educators worldwide to facilitate students' learning in the clinical setting and to prepare them for the transition to their new professional role as registered nurses. In a preceptorship model, nurses who become preceptors participate in the evaluation of student learning in the clinical setting by providing evaluative feedback to the clinical lecturer. In a preceptorship model the clinical evaluation process, previously conducted by the clinical lecturer, becomes a shared responsibility between a clinical lecturer and a preceptor (Burke, 1994; Dyson, 1998; Ferguson & Calder, 1993).

The literature clearly identifies that most preceptor programmes include preceptor input in the evaluation process, and while the literature on nursing education is replete with discussions pertaining to clinical evaluation in nursing education (Chambers, 1998; Girot, 1993a; Mahara, 1998; Orchard, 1994; Woolley, 1977) and support for the utilisation of preceptorship (Brenner, 1995; Chickerella & Lutz, 1981; Davis & Barnham, 1989; Shamian & Inhaber, 1985), it is noted there is a dearth of literature that is actually researched-based, and a paucity of evidence about clinical evaluation in a preceptored relationship. This study therefore will contribute to the limited empirical knowledge which exists regarding undergraduate clinical evaluation in the preceptorship model of clinical teaching.

In this chapter an exploration is made of the literature pertaining to the evaluation of student nurses' clinical practice, particularly in the

preceptorship model of clinical teaching in nursing education. It will be explored using three broad headings which provide the structure of the literature review: Clinical evaluation of competence, clinical evaluation of competence in the preceptorship model, and the preceptor as evaluator.

2.1 Clinical Evaluation of Competence

Education in an applied discipline such as nursing is about preparing practitioners for, and supporting them in, their practice. Clinical practice provides students with experiential learning opportunities to develop the skills they need for competent practice. The evaluation of the clinical competence of nursing students appears to be the area of clinical teaching that is proving to be the most problematic for the nursing profession. Wood (1982) argues the underlying difficulty is that clinical evaluation is performance-based and relies on direct human observation, which is subjective. Other factors such as a lack of valid and reliable evaluation tools, and an unpredictable learning environment compound the problem (Benner, 1982; Brooke, 1994; Chambers, 1998; Cottrell et al., 1986; Orchard, 1994; Sommerfeld & Accola, 1978). Packer (1994) notes that the reliability and validity of student clinical evaluations have not been reported. According to Krichbaum, Rowan, Duckett, Ryden and Savik, (1994) the complex nature of the problem possibly accounts for the lack of research into this area of clinical teaching.

Mahara (1998, p. 1344) describes clinical evaluation processes as the "quintessence" of clinical learning, yet there is a dearth of research-based literature available. Most of the literature reviewed on clinical evaluation, and preceptorship was found to be descriptive rather than research-based. The actual process of evaluation received little attention. Only two research articles were found that explored clinical evaluation in the preceptorship model (Ferguson & Calder, 1993; Yonge et al., 1997), and both of these studies explored the role of the preceptor as evaluator. It is evident that not only is there a dearth of literature, but especially a

dearth of recent literature available which made it difficult to explore the issue of student evaluation in a preceptored relationship.

2.1.1 The Concept of Clinical Evaluation

Clinical evaluation refers to "the process of obtaining information for making judgements about the learner's performance in the clinical setting" (Reilly & Oermann 1992, p. 380). It is 'interwoven' with the teaching-learning process and in a climate of trust, clinical evaluation promotes students' learning and guides the lecturer in the teaching process. The desired outcome of clinical evaluation is that it is a fair judgement of a student's learning (Hawarink, 2000). Mahara (1998) claims clinical evaluation serves two interrelated functions; an educative one focussed on the teaching learning process, and a gatekeeping one to ensure professional standards are met and to safeguard the public.

During clinical placements students receive formative and summative evaluations. Formative evaluation is ongoing throughout the clinical placement and provides students with the opportunity to refine the understanding of their practice. Loacker, Cromwell and O'Brien (1986) describe formative evaluation as the "teachable moment" (p. 52). It is the time when the student and teacher "sit down beside each other" and focus their attention on the strengths and weaknesses of the student's practice as interpreted from evaluation criteria. The summative evaluation is given at the completion of the learning period and is a judgement about the extent to which the student has met the learning outcomes for the clinical placement.

2.1.2 Definitions of Competence

In their clinical teaching role, lecturers and preceptors are charged with the responsibility of determining if students can integrate their theoretical and practical knowledge to make safe and effective practice decisions. To determine the student's level of achievement requires that competent practice be defined. Herein lies the problem. There is little

consensus of its meaning across the health professions (Butler, 1978; Benner, 1984; Boss, 1985). Manley and Garbett (2000) maintained that the concept is used in different ways which reflects different origins of its meaning and this is confusing. Girot (1993a) argues that the confusion has arisen from the concept being 'overdefined' rather than the 'illdefined'. Girot (1993b) defined competence in terms of attributes. She used a phenomenological approach to explore the determinates of competence and identified four themes: Trust, caring, communication skills, and knowledge/adaptability. Other writers define competence as a developmental process. Maynard (1996) for example, claims competence requires abilities in the cognitive, psychomotor and affective domains and is acquired through theoretical learning and develops within clinical practice. Benner (1984) also describes competence as a developmental process. In her descriptive research carried out in 1984 Benner identified five levels of competency in nursing practice, these are: Novice, advanced beginner, competent, proficient and expert. Yet another definition of competence which is now favoured in the literature is a much broader interpretation and encompasses an integration of behaviours, personal attributes and professional judgement (Gonczi, 1994). The New Zealand Nursing Council's current definition reflects Gonczi's interpretation and defines competence as: "The demonstrated ability to apply the knowledge, skills and attitudes and to exercise the professional judgement which can reasonably be expected of a nurse or midwife in a practice context, commensurate with their qualifications and experience"(Nursing Council, 1998, p. 25).

2.1.3 Measures of Clinical Competence

It is widely argued that the main problem in assessing clinical competence is the shortage of reliable and valid tools to measure it. Consequently a number of evaluation tools have been developed in an attempt to reduce the gap and increase the fairness of the evaluation process (Cottrell et al; 1986; Ross et al., 1988; Sommerfeld, & Accola, 1978).

Traditional clinical evaluation instruments were norm-referenced and they determined the quality of an individual's performance in relation to the performance of other individuals. However, norm-referencing has been critiqued as an unreliable method for evaluating clinical practice. Norm-referencing relies on each evaluator's perception of "average" as the standard of practice required is not defined (Krumme, 1975, p. 765). The result of norm-referencing is inconsistent evaluations between evaluators. Krumme argued that criterion-referenced tools, were a more objective method of evaluating learning, as students, preceptors and lecturers are all informed of pre-determined evaluation criteria.

Hawarink (2000) refers to Coates and Chambers (1992) who reviewed the literature of published clinical competency evaluation instruments to determine whether the development of these instruments was research-based. Only 1 out of eleven articles referred to the reliability and validity of the evaluation tool. One evaluation tool that has been tested extensively for its validity and reliability is the 'Schwirian Six-Dimension Scale of Nursing Performance'. This scale which is used to measure the clinical competence of practising nurses is reported to have a high Cronbach alpha of .844 or above (Bartlett, Simonite, Westcott & Taylor, 2000).

2.1.4 Level of Performance and Competence

In response to concerns about discrepancies with student clinical evaluations Sommerfeld and Accola (1978) developed a single evaluation tool that would be consistent across academic year levels. The criterion-based tool was used to measure students' competency, based on level of performance. Developed from the curriculum of their school in Minneapolis, the tool included all the concepts students were expected to apply throughout their clinical course. A variety of methods of evaluating students' practice were used, such as: Direct observation, written work, and conferences. The researchers believed their student evaluations were more consistent and objective using the tool, than the previous method of

evaluation which consisted of lecturers evaluating achievement of course objectives. A shortcoming with this study is that the reliability and validity of the tool were not reported.

2.1.5 Age, Academic Experience and Competence

Some studies have been carried out to explore the relationship between competence and other variables that were expected to correlate with clinical performance. Krichbaum et al. (1994) developed the criterion-based 'Clinical Evaluation Tool' (CET) to collect data to explore if there was a relationship between age at admission to the course, academic qualifications and competence. The tool they used was reported to have high internal consistency. The researchers found that age at admission to the course and academic experience showed a positive correlation with clinical competence. The researchers identified that the generalisability of these findings is limited by the small sample size (n=48) and lack of representativeness of the student population. The sample was comprised of the final class in a 3-year curriculum.

2.1.6 Educational Level and Competence

In the absence of nationally defined standards for nursing competence in the UK, Bartlett et al., (2000) developed an instrument comprised of 78 items organised into eight constructs to measure competence. The constructs were: Leadership, professional development, assessment, planning, intervention, cognitive ability, social participation and ego strength. The instrument was tested for overall internal consistency between items which produced an alpha coefficient of .95. Using a comparative quantitative study they used a self-completion instrument to measure the competencies of Project 2000 diplomates (n=28) and mentors (n=17), and BA(Hons) adult nursing graduates (n=51) and mentors (n=40) from two UK nursing programmes. The findings from the study showed that on graduation there were no significant differences between diploma and degree graduates' competencies, except in leadership. However a longitudinal analysis showed that differences

between groups were not maintained over time. The researchers identified a limitation to this study was knowing whether the self perceptions were related to actual performance. They recommended that attention to leadership and management be required in the final year of degree courses to promote graduates' confidence in these areas of practice. Preceptorship was proposed as a strategy for assisting the development of confidence.

2.1.7 Critical Thinking and Competence

Developing critical thinking skills is considered to be essential for preparing graduates for competent clinical practice (Bechtel, Davidhizar and Bradshaw, 1999). However a descriptive, exploratory study conducted by May, Edell, Butell, Doughty and Langford (1999) found no statistically significant correlation between critical thinking skills and competence. One hundred and forty three senior nursing students participated in the study. The California Critical Thinking Dispositions Inventory (CCTDI) was used to measure the extent of the participants' characteristics as critical thinkers. The reported Cronbach's alpha reliability is .90. The California Critical Thinking Cognitive Skills Test (CCTCST) measured the nursing students' cognitive skills. The reported Cronbach's alpha reliability is .70. The researchers reported several limitations to the study that may have influenced the results. The clinical evaluation forms had been distributed without clear instructions which may have increased rater bias. Also preceptors in the study had not been orientated regarding the process of student evaluation and there was no incentive for students to take the critical thinking test seriously.

2.1.8 Approaches to Evaluating Clinical Competence

Chambers (1998, p. 206) argues that even though criterion-referenced tools may be more reliable and valid than norm-referenced tools, they do not fit comfortably into a humanistic framework, as they are "task-orientated, didactic, behaviourist and pedagogical in nature". Chambers bases her argument on the premise that nursing is as much an

art as it is a science, and while such a tool may accurately rate competence in terms of technical skills, it fails to identify abstract qualities such as intuition, compassion and empathy, which are fundamental aspects of nursing practice. Benner (1982) emphasised the need to develop evaluation methods that reflect the context of the real world of nursing. Girot (1993a) expressed a similar viewpoint to Benner when she suggested that a combination of approaches would better capture the diverse nature of clinical practice.

Incorporating reflection on practice to develop further learning has been a central value of student-centred learning since the curriculum revolution of the 1980s (Beattie, 1998). According to Burns (1994) reflection and reflective practice are key tools for developing clinical competence, as they foster critical inquiry. The value of reflective learning she suggests is the recognition of the "complex murky reality of clinical practice" (p. 22) in learning experiences. It is suggested that such learning bridges the theory-practice gap by bringing together the science and art of nursing. However it has not been determined in the literature whether experienced nurses incorporate this type of learning in their practice. For many, their educational and work experiences have valued traditional paradigms of knowledge. Beattie suggests further research is needed to understand what factors influence experienced nurses, in their assessment and evaluation of students.

Chambers (1998) argues that if reflective practice is being utilised as a strategy for developing clinical competence then evaluation of reflective practice will demonstrate students' clinical competence. However, the evaluation of reflective practice is problematic, as a formal tool to evaluate reflective skills is yet to be developed.

Inconsistencies in the actual process of evaluation were reported by Neary (2000a) in a study carried out in Cardiff. Neary undertook a quantitative and qualitative approach to explore perceptions of clinical competence evaluations of 300 student nurses and 155 nurse practitioners.

The findings indicated that variation within practice placements concerning evaluation procedures was a common problem. Difficulties with interpreting evaluation criteria were often resolved by students and practitioners negotiating their own objectives, and rejecting the objectives of the educational institution. Similarly in her study carried out in Aotearoa/New Zealand Dyson (1998, p. 63) found lecturers often deviate from the set criteria to determine students' achievement when they used personal unwritten "checklists" to evaluate students. Unlike the participants in Neary's study the participants in Dyson's study formulated their checklists from the practice standards used by the educational institution. The findings from both Dyson's and Neary's study raise the issue of reliability of clinical evaluations, and the need for adequate preparation of evaluators for their role in the evaluation process.

Neary (2000b) found that while students favoured a structured evaluation they wanted teachers to be more flexible to meet their learning needs. Students wanted more time to discuss their progress during the clinical experience and to change the way in which their progress was documented in assessment booklets. The author suggested a new concept of continuous assessment which focuses on the 'worth' and 'merit' of the care given by students. The new model is called "responsive assessment" (p. 34). Merit in the context of patient care can be assessed using predetermined learning objectives and competencies. Worth on the other hand consists of the unpredictable aspects of practice which need to be assessed responsively. The author suggested that the model could assist students to develop the 'know how' and the 'know what' of practice in a more realistic way, through learning contracts, partnership and more effective communication between student and teacher. While the study was useful in identifying students' and practitioners' concerns with evaluation, the model has not been tested and could form the basis of further study.

According to Orchard (1994), evaluation of clinical practice can never be a precise measure, as a student's ability is determined by the clinical evaluator's professional judgement against performance standards. In relation to her afore-mentioned study, Girot (1993b) noted that the notion of intuition and 'gut feelings' as measurement tools seem to equate with the idea of professional judgement. She questions whether a valid independent and objective evaluation of expert performance in the clinical professions is ever possible. Manley and Garbett (2000) consider how expert practice might be made more explicit in practice and how it might be judged. They offer "critical companionship" (p. 355) as a mechanism for recognition of expertise. By this they mean a helping relationship between a facilitator who is an expert or 'critical companion' and a clinician, both of whom are role models to nursing students. The critical companion uses facilitation skills to enable the clinician to demonstrate their expertise and critique their own practice. Evidence of the clinician's expertise is obtained from a critique of practice supported by the 'critical companion'.

Chambers (1998) and Orchard (1994) maintain that without a clear definition of competence, individuals will view the concept based on their own set of values and experiences, and their judgements will reflect their personal perception of what performance constitutes professional nursing practice. Krichbaum et al. (1994, p. 396) agree that evaluation processes are highly subjective as what is valued in clinical performance has not yet been identified, and individual teachers and nursing schools rely on "tacit values" for competent practice. Wong and Wong (1987) make a critical point that irrespective of how well an evaluation instrument is designed, validity and reliability of evaluating clinical competence will depend largely on individual evaluator's understanding and interpretations of the evaluation criteria.

2.2 Clinical Evaluation of Competence in the Preceptorship Model

Ideally formative and summative evaluation in a preceptorship model is a collaborative process between the lecturer, the preceptor, and the student (Davis & Barham, 1989). Stuart-Siddall and Haberlin (1983) maintain that in a preceptored relationship evaluation becomes more objective, as there is an expectation that students are self-directed with their learning needs. This decreases the subjectivity of the evaluation which is further decreased when the preceptor is involved, as three people are making judgements about a student's clinical competence. Students and preceptors participating in a preceptored relationship have reported greater satisfaction with evaluation using a collaborative process (McGregor, 1999).

2.2.1 Measures of Clinical Competence and Preceptees

As mentioned previously the overall goal of the preceptorship relationship is to facilitate the development of a student's clinical competence (Letizia & Jennrich, 1998). Bfrehaut, Turik and Wade (1998) carried out a descriptive correlational study to explore the relationship among perceived self-efficacy, learning experiences, and clinical competence of preceptored and non-preceptored undergraduate students. They used the Perceptions of Public Health Nursing Competence Scale and Perceptions of Self-Efficacy in Public Health Nursing Scale and found no significant difference in the development of clinical competence in public health nursing between preceptored and non-preceptored students. The researchers concluded that the study did not provide evidence that the preceptor model was more effective than a non-preceptored model for developing clinical competence in public health nursing.

Two other studies (Myrick & Awery, 1988; Yonge & Trojan, 1992) which explored the development of nursing students' clinical competence, demonstrated different findings to Bfrehaut et al.'s (1998)

study. Unlike Bfrehaut et al.'s study, the research in the above mentioned studies were carried out in hospital settings and used the Schwirian Six Dimensional Scale of Nursing Performance. Myrick and Awery reported that preceptored students had significant gains in more competence categories. This contrasted with Yonge and Trojan's findings that non-preceptored students had significant gains in more competence categories than preceptored students.

Despite these more recent studies the findings support Myrick and Awery's (1988) claim that the effectiveness of this teaching model has had limited empirical validation despite its broad acceptance by tertiary education institutions.

2.2.2 Values and Professional Socialisation

In any decision making process "values" determine our actions (Steele & Harmon, 1983, p. 4). Values are learned from the role models people have contact with (Wong & Wong, 1987), and socialisation is the process by which values are taken on by individuals. Ewan and White (1984) describe the socialisation process as the "hidden curriculum" (p. 131).

In 1965, Smith carried out a study which found a difference existed between charge nurses and lecturers regarding the behaviours they valued. Charge nurses valued behaviours which contributed to ward efficiency while educators placed a greater emphasis on values that were client focussed. Nearly thirty years later Kelly (1991) found discrepancies still existed between the values students learn in the classroom and the values they observe in the clinical setting.

Clayton, Broome, and Ellis (1989) carried out a quasi-experiment to examine the relationship between a preceptorship and professional socialisation. They used the Schwirian's Six-Dimension Scale of Nursing Performance to measure role socialisation. The tool measured six subscales of nursing performance: Leadership, critical care,

teaching/collaboration, planning/evaluation, interpersonal relations/communication, and professional development. Preceptored students in this study scored higher on: Leadership, teaching/collaboration, interpersonal relations and communications, and planning and evaluation over time, than non-preceptored students. The researchers concluded that senior students who had a preceptored experience, had higher professional socialisation behaviours than students who were not preceptored. These findings support the premise that a preceptored relationship is an effective method for enhancing professional socialisation. Ferguson and Calder (1993) argue that a student's practice will reflect the values role modelled by preceptors, which may differ from the values held by the lecturer, and influence the evaluation a student receives.

2.2.3 Responsibility for Clinical Evaluation

There is a lack of consensus regarding the boundaries of individual responsibilities between lecturers and preceptors, particularly with evaluation which leads to confusion. Nurses who are selected as preceptors share responsibility for clinical teaching, role modelling and the formative and summative evaluation of student learning. However the literature indicates that lecturers' and preceptors' involvement in both types of evaluation is variable. According to O'Malley, Cunliffe, Hunter and Breeze (2000) responsibilities vary from programme to programme and ward to ward.

2.2.4 Lecturer Responsibilities

In her Aotearoa/New Zealand study Dyson (1998) used an exploratory descriptive approach to explore the role of the lecturer in the preceptor model. Twelve lecturers took part in the study. Focus group interviews were used to collect the data. The results of this study showed that lecturers considered student evaluation was their responsibility and that the summative evaluation of student learning was "lecturer driven" (p. 49) with some input from the preceptor.

Other writers (Burke, 1994; Ferguson & Calder, 1993; O'Mara, 1997) concur with Dyson's (1998) findings. Ferguson and Calder who completed their research in Canada, maintained lecturers retain ultimate responsibility for the final evaluation of the student's clinical competence as they have an obligation to assure the profession and the public that nursing graduates are safe to practise nursing. In their study conducted in Wisconsin, Nehls, Rather & Guyette (1997) reported that lecturers conduct the formal evaluation of students as well as providing written feedback, and meeting regularly to discuss student progress and guide their learning. O'Mara emphasised that the responsibility for clinical evaluation is never delegated. However, McGregor (1999) presented a contrasting viewpoint and asserted that certain aspects of the process can be effectively delegated to the preceptor, though she did not clarify what those aspects were.

Chickerella and Lutz (1981) maintained that one of the disadvantages of the preceptor model is that lecturers do not directly observe and supervise students in the clinical area all the time. Myrick (1988) questions the move to place the responsibility of clinical teaching into the hands of those least experienced to teach. Myrick and Barrett (1994) argue that the evaluation process in the preceptorship model is a 'paradox', as lecturers who maintain responsibility for evaluating the student have the least involvement in the actual clinical teaching of students.

2.2.5 Preceptor Responsibilities.

Research conducted by Thompson (1997) in Aotearoa/New Zealand found some preceptors were unsure of their role and responsibilities. In a review of the literature on programmes for preceptors Shamian and Inhaber (1985) reported that in nine out twelve programmes the preceptor was expected to provide some sort of evaluation. Burke (1994) maintains preceptors are facilitators rather than evaluators as they do not have the extensive preparation and support to

enable them to have actual responsibility for conducting the evaluation. In contrast Myrick and Barrett (1994) maintain that it is the preceptor who assumes responsibility for evaluating the student. A more recent study conducted by Yonge et al. (1997) in Canada found that preceptors believed student evaluation should be their responsibility. They reasoned that the one-to-one relationship and close observation of the student's practice supports their participation. Letizia and Jennrich (1998) however, argue that preceptors do not want to be responsible for the summative evaluation of students though they can be 'encouraged' to engage in formative evaluation, and provide regular feedback to the lecturer.

Numerous articles described a plethora of preceptors' responsibilities, however, few included student evaluation in their descriptions, but 'assisting with identified learning goals' was widely supported in the literature (Crancer, Fournier, & Maury-Hess, 1975; Davis & Barnham, 1989; Hayes, 1994; Holly, 1992; Kramer, 1993; Letizia & Jennrich, 1998; Myrick & Barrett, 1994; Parsons, Butcher, McLean, & Sharman, 1985; Piemme, Kramer, Tack & Evans, 1986). While providing feedback was considered by the authors to be an important part of the preceptor's role, the process and content was given little consideration. Holly explained that feedback should be factual and based on actual situations rather than general observations. She contended by asking the right open ended questions the students can be encouraged to critique their own practice which is the most effective form of feedback. Holly suggested feedback from preceptors should be given daily, while other writers were less specific (Kramer, 1993; McGregor, 1999).

2.2.6 Student Responsibilities

In a preceptorship relationship ideally students are participants in the evaluation process. According to Loacker et al. (1986) student input in the evaluation process is important to encourage self-responsibility for learning. Mahara (1998) claims that including students in the summative evaluation eases their anxiety of being evaluated and familiarises them

with self-evaluating their practice against professional standards. However this claim is not supported in an exploratory study conducted by Abbott, Carswell, McGuire and Best (1988) in Canada. Abbott et al. used the Delphi technique to determine lecturers' (n=9) and students' (n=145) perception of self evaluation and found students reported that self-evaluation does not prevent anxiety associated with clinical evaluation, though it does provide direction for learning. Students value the participatory role in clinical evaluation, however contrary to Mahara's claim students do not perceive self-evaluation as a factor in their professional development. Lecturers view self evaluation more positively than students and contend that it helps students understand their progress and it promotes their learning. The researchers concluded that self evaluation is a developmental skill that requires guidance and practice. Further research to explore student self-evaluation in a preceptorship relationship is urgently needed.

2.3 The Preceptor as Evaluator

Even though it is noted that most preceptor programmes include preceptor input in the evaluation process only two studies were found that explored the role of the preceptor as evaluator (Ferguson & Calder, 1993; Yonge et al., 1997). Ferguson and Calder's comparative study compared the valuing of specific student clinical performance criteria by 19 lecturers and 126 preceptors and found both groups valued criteria similarly overall. However there were differences on individual items. They concluded that lecturers' and preceptors' evaluations would be based on similar values, and that the education institution could be confident that preceptors 'acknowledge' both work-based values and client-centred holistic care in their evaluations of students' practice. However the study did not ascertain whether the 'self-reported' valuing of performance criteria was evident in preceptors' actual evaluations.

Yonge et al. (1997) conducted a descriptive exploratory study designed to explore the role and functions of preceptors in the evaluation

process. Their sample included 281 preceptors and 14 management staff from a variety of clinical areas. They found that 98.3% of the preceptors had evaluated students. Some preceptors had difficulties due to "unacceptable evaluation forms; difficulty with objectivity; pressure of time; student weakness; and the need for additional data" (p. 88). The study did not examine the evaluation process or the quality of the evaluations. These two areas need to be studied to give a fuller understanding of student evaluation, particularly in a preceptored relationship.

2.3.1 Preparation of Preceptors

Preceptors need guidance in collecting the information required to provide an appraisal of the students assigned to them as they may have little or no preparation for clinical teaching and the activities involved in student evaluation (Dibert & Goldenberg, 1995; Letizia & Jennrich, 1998;). According to Stuart-Siddall and Haberlin (1983), it can be assumed that most preceptors have not received instruction on evaluation prior to their participation in evaluating students. This assumption is supported by Yonge, et al. (1997) who identified that only 28.8 per cent of preceptors who had evaluated students, had been taught to do evaluations. They found there is a discrepancy between preceptors preparation for their role as clinical evaluator and what is expected of them. Ferguson and Calder (1993) argue that if lecturers who receive preparation in educational theory have difficulty with evaluating clinical practice, then this problem will be even greater for preceptors who have little or no preparation.

The most important feature of any preparation is that it is planned and constructed by, both preceptors and lecturers (Burke, 1994). However the reality for preceptors is that they have little input into the planning of their educational preparation when this is available. Preceptor programmes are designed to prepare the preceptor for their role (Dandrinos-Smith & Bower, 1988; Holly, 1992), however preparation varies from 'extensive' to 'minimal' and depends on how the role is

interpreted (Kramer, 1993; Shamian & Inhaber, 1985). For some preceptors preparation may consist of a brief meeting with lecturers to discuss course objectives and clinical evaluation procedures (Nordgren, Richardson & Laurella, 1998), for others it may be more structured in the form of a workshop. The content of the workshop may include sessions on role definition, responsibilities, problem solving, communication techniques, adult learning theory, teaching/learning techniques and reality shock (Dilbert & Goldenberg, 1995).The duration of workshops may be from a few hours to several days with weekly to monthly follow-ups (Chickerella & Lutz, 1981; Holly, 1992; Shamian & Inaber, 1985). Brenner (1995) suggested that learning about evaluation tools and giving feedback to the student should also be included in the preceptors' preparation.

In a small Aoteroa/New Zealand study Kaviani and Stillwell (2000) used focus groups to carry out an evaluation of a preceptor programme and found that formal preparation of preceptors enhanced the teaching and learning opportunities of students. Kramer (1993) discusses the success of a preceptorship policy she introduced into a hospital in the United Kingdom. She suggested the use of a structured approach to preceptor preparation in the form of a preceptorship policy which clearly defines the role and responsibilities of the preceptor.

Burke (1994) suggested that if the preceptor is not adequately prepared for the role students may be disadvantaged, leading to disappointment and even failure. She agrees with Kramer (1993) that what is required is a unified policy for the selection and preparation of preceptors, alongside a well resourced preceptor preparation programme.

In Aotearoa/New Zealand there was no specific policy found for preceptor programmes involving undergraduate students however there was a recommendation for preceptors of new graduates. The Review of the Preparation and Initial Employment of Nurses (RPIEN) National Action Group (Department of Health, 1988) advised that a successful preceptorship programme was dependent on the collaboration between

the charge nurse, preceptor and preceptee as well as sufficient resources and a planned education programme for preceptors. It recommended that the preceptor programme be a collaborative venture between the health care agency and the educational institution and should emphasise:

- The course the graduate has completed;
- the competence and skills of a beginning practitioner;
- the process of giving constructive, regular feedback (p. 10).

The RPIEN recommended that the programme should be flexible enough to allow the preceptor to become a resource person as the preceptee gains confidence. This would require a minimum of six weeks orientation with ongoing support up to six months if needed. A similar programme could be developed for preceptors of undergraduate nursing students.

Since the inception of Project 2000 (UKCC, 1986) the phrase 'knowledgeable doer' has been promoted to describe the competent nurse. The knowledgeable doer can transfer theoretical knowledge to clinical practice and in so doing narrow the gap in nursing between theory and practice (Chambers, 1998). Manuel and Sorensen (1995) maintained that undergraduate nursing curricula should include opportunities for students in both theoretical and clinical learning contexts to develop leadership and organisational skills to prepare them for the demands in their future practice. It is therefore important that nursing education and nursing service are proactive in developing strategies that promote a positive learning environment for the future needs of nurses and their clients. This suggests preceptors need preparation in understanding of the leadership requirements for future nursing graduates.

2.3.2 Selection of Preceptors

It would seem imperative that nurses should be carefully selected for the role of preceptor as they would be participants in the clinical teaching and socialisation of future practitioners. There is conflicting and

confusing information on what basis nurses are selected as preceptors. Most of the literature discussed the selection of preceptors for orientating new employees to the clinical setting, rather than the clinical teaching of student nurses.

In Aotearoa/New Zealand the RPIEN (Department of Health, 1988) recommended that the criteria for selection of preceptors should follow the criteria established by Frieson and Conahan (1980). These are as follows:

- Clinical competence (skilled use of nursing process, deliberate 'thought-based', and sensitive provision of patient care);
- participation in health team activities (active participation in patient education, conferences, and multidisciplinary rounds);
- leadership (ability to set priorities, show sound decision-making and complete performance evaluations);
- communication skills (ability to promote positive interpersonal relationships through the use of tactful, direct and sensitive interaction);
- interest in professional growth (participation in learning activities);
- constructive resolution of professional or bureaucratic conflict (ability to demonstrate successful resolution);
- willingness to work with and provide feedback for the new graduates (p. 10).

In addition to Frieson and Conahan's criteria the RPIEN recommended "that a preceptor demonstrate cultural sensitivity and commitment to the Treaty of Waitangi" (p. 11). The New Zealand Nursing Council (1996) states that cultural sensitivity:

> Alerts students to the legitimacy of difference and begins a process of self-exploration as the powerful bearers of their own life experience and realities and the impact this may have on others (p. 9).
>
> Cultural sensitivity is clearly linked to the concept of cultural safety. According to The New Zealand Nursing Council cultural sensitivity is part of the education process toward achieving cultural safety in nursing

> practice. This process involves a series of steps from awareness, to sensitivity and finally the 'emergence' of safety. Wood and Schwass (1993) concur, they also suggest cultural safety is "one step further than cultural sensitivity" (p. 4).
>
> Cultural safety is defined by the Nursing Council (1996) as:
>
> The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurse's culture on own nursing practice. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (p. 9)

Bain (1996) reports that the only formal requirement by the UKCC for nurses who are selected as preceptors in the UK is that they should be first level nurses with a minimum of one years experience in the clinical area in which they will be precepting. Burke (1994) reports that the English National Board for Nursing, Midwifery and Health Visiting have no set criteria and the responsibility for selection belongs to colleagues.

Cooper, Payette and Porter (1989) maintain that preceptors should be volunteers with experience and with a strong commitment to the role. In contrast Kramer (1993) maintains the responsibility of selection belongs with managers. Other writers report nurses are selected as preceptors because of their clinical expertise, knowledge and skills, and their ability to exhibit professional behaviours (Ferguson and Calder, 1993; Grealish & Carroll, 1998; Myrick & Barrett, 1994; Yonge et al., 1997). According to Letizia and Jennrich (1998) the empirical evidence regarding these criteria and the preceptor selection process is virtually non existent. Myrick and Barrett suggest nurses may be selected as preceptors because of their availability to take a student rather than their experience in the practice area. Davis and Barnham (1989) elude to this view by suggesting that the high turnover of staff within many hospitals may result in there not being suitably qualified and experienced nurses available to appoint as preceptors. Parsons, et al. (1985) maintain that specific criteria are

essential for selection. However, Bain (1996) cautions that rigid criteria, could be restrictive and result in elitism.

2.3.3 Qualifications of Preceptors

There is some controversy regarding the qualifications necessary to be a preceptor. Myrick and Barrett (1994) suggest that ideally preceptors should be nurses with masters degrees, and teaching experience. However the reality is that many preceptors lack formal training in 'educational methods' and 'adult learning' (Bittner & Anderson, 1998), and teaching experience is not considered a priority. Myrick and Barrett express their concern that degree students are frequently preceptored by preceptors who do not have degrees and yet are required to promote the principles and philosophy of a university-based nursing education. Similarly in Aotearoa/New Zealand students learning in a university-based course may be preceptored by preceptors who are diploma-prepared or who have hospital based training as their highest qualification.

Davis and Barnham (1989) report that while some managers insist that preceptors have at least undergraduate degrees, others propose that knowledge is not necessarily acquired through additional qualifications and can be acquired through experience. In Australia, Grealish and Carroll (1998) suggest that preceptors who do not have degrees follow a technical approach to practice which could be a limitation to developing critical thinking skills. Ouellet (1993) agrees with Grealish and Carroll's premise and suggested that preceptors who have degrees provide greater professional socialisation for students than diploma prepared preceptors. In Aotearoa/New Zealand this would apply also to nurses who received hospital-based training.

Bradshaw (1998) raised a contentious issue when she suggested that students cannot be sure that the preceptors they are assigned to are themselves competent. She explored the issue of competence in registered

nurses in the United Kingdom and questioned whether there is any way of ensuring that preceptors, once qualified, are competent. She referred to competence-based practising certificates and the devolvement of responsibility from the regulatory nursing body to the individual nurse for maintaining competent practice. Bradshaw concluded that a void existed directly related to educational ideology and nursing education and that "what counts as competence and expertise is open to question" (p. 104).

2.3.4 Preceptor Difficulties

A consistent theme in the literature pertaining to student evaluation in a preceptorship relationship is the difficulties preceptors experience with it. When it was introduced, assisting in the evaluation of the student was an area that required further development for preceptors (McGregor, 1999; Brenner, 1995). The formal documentation of a student's achievement against standards of practice of the educational institution was problematic for preceptors who had little experience in their teaching role. According to Wong and Wong (1987) inexperienced teachers faced with the ambiguous nature of clinical evaluation resort to using the methods and criteria with which they were evaluated as students. Farley and Hendry (1997) maintain that without appropriately selected criteria there is a tendency to use norm-referenced rather than criterion referenced evaluation which is subjective and invalid. Grealish and Carroll (1998) however, report that a lack of normative evaluation may disadvantage some students, as some preceptors experience difficulties in determining a student's progress when the student they are evaluating is working in isolation from others.

Hill and Lowenstein (1992) recognise the challenge preceptors are presented with, with a failing student. Precepting a weak student is particularly stressful, and providing negative feedback is difficult for preceptors especially in a situation where conflict arises (Hayes, 1994).

Dandrinos-Smith and Bower (1988) emphasised that preceptors require a lot of support if the student fails.

2.3.5 Learning Environment

Learning is multidirectional and a supportive environment based on trust and respect between the lecturer, preceptor and student is essential if evaluation is to be a learning experience (Reilly & Oermann, 1992). An unsupportive learning environment can have negative consequences on a student's confidence and learning (Flagler, Loper-Powers & Spitzer, 1988). Ogier (1982) argues that a positive clinical learning environment for nursing students has a positive correlation with the quality of care patients receive. In a preceptorship relationship the preceptor plays a pivotal role in providing a supportive learning environment, as the foundation of the preceptorship model is the one-to-one relationship between a preceptor and a student (Myrick & Barrett, 1994).

In conclusion, it is evident that nursing preceptorships are gaining momentum internationally, although the research is just emerging about this clinical teaching model. The research literature has focussed primarily on the roles and responsibilities of preceptors and lecturers. It is apparent there is a lack of consensus regarding the boundaries of individual responsibilities and more research is needed to clarify these roles and their benefits for student learning. While it is evident from the literature reviewed that preceptors are already evaluating students' clinical practice, Ferguson and Calder (1993) maintain it is uncertain as to what criteria preceptors base their evaluations on. Very little research has actually explored the issue of evaluation of clinical competence of nursing students by their preceptors.

There is considerable variability in the preparation preceptors receive for their role, especially in relation to clinical evaluation. Preceptors often have difficulty with evaluation because they are

unfamiliar with the evaluation tool used, and find giving negative feedback particularly stressful. The use of formal documentation was also found to be stressful for preceptors.

The literature showed there is some controversy regarding the educational qualifications necessary to be a preceptor and it is clearly an area that needs further exploration. Yonge et al. (1997) maintain a great deal is still unknown about clinical evaluation and particularly in a preceptored relationship.

The aim of this current study is to examine the criteria lecturers and preceptors use to evaluate nursing students' clinical practice to determine if there is variability in their valuing of the criteria they use. It will also explore the influence of preceptors' educational qualifications on the evaluations students receive. The clinical evaluation tool will also be investigated to gain lecturers' and preceptors' perspectives of its clarity. It is crucial these issues are explored to ensure consistency and fairness with student clinical evaluation. The findings of this study have the potential to further inform nursing education about this model of clinical teaching and in particular the contribution preceptors make to evaluation of nursing students.

The following chapter describes the research method used and the ethical considerations of the study.

CHAPTER THREE

METHODOLOGY

This chapter describes the design of the study and the methods used to analyse lecturers' and preceptors' assessment of the importance of individual clinical evaluation criteria, and their perceptions of the clarity of the evaluation tool used by the particular educational institution where the study is based.

The study is a comparative descriptive design which has utilised a three part structured questionnaire to collect data (Appendices B & C). Part one collected demographic data and used closed questions. Part two was The Clinical Standards Rating Scale (CSRS) developed by the researcher from the evaluation tool to measure the relative importance of each evaluation criterion to the overall evaluation of nursing students' performance. Part three consisted of open-ended questions to elicit lecturers' and preceptors' perceptions of the clarity of the evaluation tool. Quantitative data were analysed using descriptive and inferential statistics. Quasi-statistical content analysis was used to analyse the open-ended questions and identify emerging themes and concepts.

3.1 Research Methods

Quantitative and qualitative enquiry are two major approaches to research (Holloway & Wheeler, 1996). For many years it has been debated which approach should be adopted to generate knowledge about phenomena of interest within nursing (Leininger, 1985; Meleis, 1985; Roy, 1980). The debate centres around the competing and conflicting paradigms of positivism and interpretivism, and the method that should

be used for a particular study. Quantitative research follows a positivist approach which seeks to explain the world through the application of formal scientific method. In comparison, qualitative research seeks to understand the nature of human experience through interpretation of that experience (Polit & Hungler, 1997).

More recently the debate has shifted and researchers are now recognising that both quantitative and qualitative approaches have valuable contributions to make to the development of nursing knowledge (Roberts 1995). While there are strengths and limitations to both approaches, Holloway and Wheeler (1996) maintain that a combination of the two is particularly suited to gain an understanding of the many complex phenomena of interest to nursing. Carr (1994, p. 717) contends that combining the strengths of the methods in a study, results in "richer and deeper research findings." However, according to Beanland, Schneider, LoBiondo-Wood and Haber (1998) ultimately it will be the research question that determines which approach is the most appropriate.

3.1.1 Quantitative Research

Quantitative research methods in nursing have their origins in the branch of philosophy known as logical positivism. Logical positivism aims to quantify and explain the world in terms of values and numbers. The thinking underlying this paradigm emerged from the physical sciences, which involves disciplines such as mathematics, physics and chemistry, and was guided by 19th century philosophers such as Comte, Mill, Newton and Locke (Polit & Hungler, 1997). According to Denzin & Lincoln (1994) a paradigm is a set of basic beliefs which shapes our world view. In a quantitative paradigm understanding of the world around us is based on the assumption that reality is external to the individual and governed by laws of nature which remain constant. Some researchers (Carr, 1994; Duffy 1986) claim this method enables phenomena to be studied without influence from their own beliefs and attitude. Carr

argues that the strength of such a detached approach is that it guards against researcher bias and maintains objectivity. However, others argue this quality is incongruous with nursing's holistic focus and regard it as a weakness (Cormack, 1996; Spencer, 1983).

A comparative descriptive design is a non-experimental quantitative research method which is particularly suited to examine and describe the differences in variables between two or more groups as it provides a picture of what others in a similar situation are doing (Waltz & Bausell, 1981). Descriptive studies are designed to discover new facts about a phenomenon and to describe it as it is, not to introduce anything new to the situation. Because descriptive studies are not designed to establish causality, there is no attempt to manipulate the variables (Beanland, Schneider, LoBiondo-Wood, & Haber, 1999; Burns & Grove, 1987). Even though the information gained from descriptive studies can be "diverse" they are a quick and useful method to build up knowledge of a phenomenon of interest (Carter, 1996, p. 108). Comparative descriptive designs have the added advantage of allowing a comparison between groups (LoBiondo-Wood & Haber, 1998; Roberts & Taylor, 1998).

3.1.2 Qualitative Research

Qualitative research methods in nursing have their roots in philosophy and the human sciences, particularly in history and anthropology (Holloway & Wheeler, 1996). This paradigm can be linked to the sociologist Weber (1864-1920) who argued that understanding in the social sciences is inherently different from explanation in the natural sciences. The interpretive paradigm aims mainly to generate knowledge of human experiences. It attempts "to grasp the nature of human experience through words that seek to retell what happened, what it was like, and what it seemed to mean" (Smythe, 2000, p. 18). People's expressions of their personal awareness are valued as being integral to the meaning that comes out of the research.

Reality in a qualitative sense is determined by individual experiences and based on the notion that knowledge is relative to that experience and the context in which it occurred. Because of this notion, reliability is not usually an issue with qualitative research (Roberts & Taylor, 1998). Qualitative researchers often use inductive thinking which enables them to interpret human experience from the perspective of the individual. To ensure validity in qualitative studies, researchers ask participants to confirm that their interpretations are a fair representation of that individual's experience.

Quasi-statistical content analysis is an enumerative approach to analysing qualitative data. This approach is used to assess the content of verbal, visual or written texts and usually measures the frequency of occurrence of units of interest (Grbich, 1999). Text is explored to produce 'objective' accounts of the content, and to describe emergent patterns and themes. The emerging patterns and themes are interpreted in terms of the research question being asked and presented in relevant forms of statistics such as frequencies or percentages.

3.2 Design

The original intent of the present study was to replicate a Canadian study conducted by Ferguson and Calder (1993), and permission was gained from the primary researcher, Ferguson, to do so. While their research was helpful in the design of the current study, a replication of Ferguson and Calder's study was not possible. Their research tool was rejected for use on the following grounds: It was developed from a behaviourist model of thinking and as such, did not fit comfortably with the teaching processes of the educational institution in the current study which utilises a process model approach, to facilitate student learning. The model used by the educational institution utilises reflective thinking and descriptive aims to guide student learning rather than terminal objectives which are the focus of behaviourist models.

The present study is similar in design to the Ferguson and Calder (1993) study except that participants were selected from medical and surgical areas only, and the instrument used was developed by the researcher specifically for use in this study. Unlike Ferguson and Calder's research tool which was adapted from a tool developed by Scheetz (1989), the research tool used in this study was derived from the actual clinical standards used for evaluation of students by the educational institution in the study. The tool was designed to gain accurate information specific to the curriculum processes of that particular educational institution.

A comparative descriptive survey was undertaken, as the aims of this study were:

1. To provide a clearer picture of the clinical evaluation criteria preceptors and lecturers regard as critically important when determining a student's competence in nursing practice.

2. To explore the influence educational level has on the way preceptors assess the importance of specific criteria.

3. To describe the perceptions of the lecturers and preceptors regarding the strengths and weaknesses of the clinical evaluation tool.

Data were collected by survey method. The distinguishing characteristic of the survey method is that the findings from the information collected from sample subjects can be generalised to the population of interest (Wilson & Hutchinson, 1996). According to Roberts and Taylor (1998) survey studies are an efficient and economical means for collecting data from a large number of subjects. Due to the large sample required for the current study a self-administered questionnaire was used to access information.

The main strength of questionnaires lies in their ability to ensure some consistency between measurement situations, as the data is collected

in exactly the same way for each respondent (Polit & Hungler, 1997). This particular characteristic of the questionnaire is important for validity and may also be seen as critical for replication studies (Burns & Grove, 1987). Questionnaires also provide respondents time to consider their replies, rather than requiring an immediate response which may be stressful for some individuals. According to Roberts and Taylor (1998) questionnaires may be particularly suitable for accessing sensitive information as participants can respond anonymously. Another strength is that statistical techniques have been developed which make it easy to test for reliability and validity of questionnaire data.

Questionnaires are designed to gather data from individuals about knowledge, beliefs, attitudes and feelings without asking the respondent directly (LoBiondo-Wood & Haber, 1998). However as suggested by Wilson and Hutchinson (1996) the lack of face-to-face administration may result in a low return rate. Burns and Grove (1987) point out that a response rate less than 50 per cent brings into question the representativeness of the sample. According to Fain (1999, p. 102) a realistic response rate for most studies using questionnaires is from "30% to 60%". Another disadvantage of this method is that data tends to be "relatively superficial" because cause-and-effect relationships are not explored (Wilson and Hutchinson, 1996, p. 58). However, in this study further insight was gained by the use of open-ended questions which enabled participants to provide freer responses about the topic of interest.

3.3 Sample

3.3.1 Target Population

The target population for this study was all lecturers and preceptors working within a preceptorship model of clinical teaching with second year undergraduate students from one particular educational institution in a major city in Aotearoa/New Zealand, and who met the inclusion criteria (see below).

The members of this population worked with second year nursing students in either the medical and surgical wards of a large metropolitan hospital, or the surgical wards of a smaller private hospital. These clinical areas were targeted because they utilised the preceptor model for clinical teaching. Preceptors and lecturers of second year students were targeted because there was a higher lecturer to student ratio with second year students compared to third year students who are more self directed in their learning. It also ensured only characteristics common to second year students were considered. This was important because the clinical standards are formulated to show the expected progression of students' learning over three years, and contain descriptive aims and criteria specific to each year of study. First year students are not preceptored.

The managers of the institutions involved in the study confirmed in writing their approval for the researcher to access the target population.

3.3.2 Inclusion Criteria

The preceptors who were eligible for inclusion in the study were staff nurses who had either previously performed the role of preceptor to second year student nurses or who were in that role and currently employed by the clinical agencies. The lecturers who were eligible for inclusion in the study were faculty members currently employed by the educational institution, and who now, or in the past, had provided clinical teaching to preceptored second year nursing students.

3.3.3 Sample Size

Power calculations based on a chi-square test of association showed that 32 participants were necessary to detect a large effect size (0.5) with $\alpha = 0.05$ and power = 0.8 and 88 participants were necessary to detect a medium effect size (0.3) with the same α and power values. It was anticipated that there would be 150 potential participants. Conservatively, assuming a 30% response rate, a minimum sample size would see 45

respondents. Thus an adequate number of participants to detect a large effect size was expected.

3.3.4 Sampling Approach

Participants were obtained via a convenience sample drawn from the accessible population of lecturers and preceptors. One hundred and forty two preceptors and 12 lecturers were invited to participate. Of these nine lecturers and 58 preceptors responded, giving a response rate of 75% for lecturers and 41% for preceptors. While this was a sufficient sample size to detect a large effect size a second posting was carried out in anticipation of increasing the sample size and minimising the effect of non-response bias.

A second posting of questionnaires increased the response rate by 10% for preceptors (n=14) and 8% for lecturers (n=1). A sample description is provided in the results section.

3.4 Procedure

The research project and its purpose was discussed with each unit manager or charge nurse from the clinical areas and the unit co-ordinator from the educational institution. Any questions that arose at that time were answered by the researcher. A contact number was also made available to answer any further queries regarding the research study.

The unit co-ordinator from the educational institution and the unit mangers and charge nurses from the clinical areas acted as a conduit between the researcher and the participants by identifying the lecturers and preceptors who met the eligibility criteria for the study and by distributing the questionnaires.

Preceptors in the clinical areas and lecturers in the educational setting were given a letter of information (Appendices D & E) introducing the researcher, along with an in depth explanation of the aim and purpose of the study. They were also informed of the risks and benefits of being

involved in the study and were invited to participate. Included in this posting was the questionnaire and a fact sheet to inform participants of their human rights pertaining to this study. Participants were invited to return completed questionnaires to the researcher via the internal mail in the pre-addressed envelopes provided.

3.5 Ethical Considerations

When research involves human participants ethical approval must be gained from an ethics committee of the institutions involved and informed consent must be gained from the participants involved (Polit & Hungler, 1997). Prior to the commencement of the current study ethical approval was granted by the Massey University Human Ethics Committee and participants' informed consent was implied by the return of the questionnaires.

3.5.1 Informed Consent

In light of being a potential participant in a research study, individuals require sufficient information to enable them to make an informed decision on whether or not to participate.

Potential participants were treated as autonomous agents and their right to self-determination was protected by inviting them to participate in the current study. They were provided with an information sheet (Appendix F) which thoroughly briefed them about their human rights as research participants in accordance with The Privacy Act (1993). The information sheet clearly stated that participants had the right to decline the invitation to take part and, once involved in the study, they had the right to refuse to answer any of the questions, or withdraw from the study without negative consequences. The return of the completed questionnaire therefore implied voluntary consent to participate in the study had been given by the respondent.

3.5.2 Anonymity

According to Roberts and Taylor (1998) the researcher should build appropriate procedures to protect the anonymity of the participants. Participants in the current study were assured their anonymity would be preserved. The unit managers and charge nurses from the hospital, and the unit co-ordinator from the educational institution acted as a conduit for distributing questionnaires so there was no direct contact between the researcher and the participants. Participants were informed once the researcher received the questionnaire information could not be withdrawn, as it would not be traceable to them. Any anxiety regarding disclosure of information made by the participants was addressed by assuring them that questionnaires did not contain unique codes or identifiers.

3.5.3 Confidentiality

Researchers are obliged to protect data from unauthorised access so that individuals are not compromised (Roberts & Taylor, 1998). Participants were informed that only the researcher and a bio-statistician would have access to their individual contributions. Assurance was given that questionnaires would be destroyed at the end of a 5-year period, and would be kept in a confidential location until that time.

3.5.4 Potential Harm to Participants

Participants have the right to be protected from harm through their involvement in research studies (Roberts & Taylor, 1998). Harm to participants is likely to be minimal but a potential risk of psychological distress brought about by the issues exposed in the process of participation in the study was addressed by offering participants a contact point for counselling services should they require it.

3.6 Data Collection

3.6.1 Method and Rationale

In this study a structured questionnaire was the preferred research tool as it was an efficient means for delivering and receiving of information from a large number of participants working in different geographical locations as well as generating objective data which could be statistically analysed.

3.6.2 The Instrument

A three-part questionnaire was constructed. Using Ferguson and Calder's (1993) tool as a guide, a likert scale was used to measure participants' perception of performance criteria. Each criterion was derived from the Nursing School's clinical evaluation tool.

Part 1 was designed to collect demographic information including experience with preceptorship, educational background and experience in nursing.

Part 2 was developed from the School's *Standards for Nursing Practice* for Year 2 nursing students. It comprised 64 criteria grouped into five curriculum processes: Communication, competency, valuing, critical thinking and professionalism. A six-point likert scale from *(1) less important* to *(5) critically important* was used by respondents to rate their perceptions of the relative importance of each criterion pertaining to a student's overall achievement. An *undecided (6)* category was also offered so respondents were not forced to make a choice if they were uncertain of individual items.

Part 3 consisted of open-ended questions designed to collect data regarding the participants' perceptions of the *Standards for Nursing Practice* used by the nursing school. Participants were invited to comment on the following: Clarity, helpfulness, improvements needed and any other comments they wanted to make.

3.6.2.1 Piloting the instrument

The questionnaire was pre-tested for clarity of instructions, and its suitability and relevance, by three lecturers and three clinicians who did not participate in the study. The questionnaire was found to be appropriate and relevant. The criteria and language used in the rating scale was relevant and appropriate as it was formulated from the evaluation tool both lecturers and preceptors use with the students. Minor modification was required to one question seeking demographic information.

3.7 Data Analysis

Quantitative data from this study were analysed using descriptive and inferential statistics. Descriptive statistics were used to describe and synthesise data. Inferential statistics which are based on the laws of probability (Polit & Hungler, 1997) provided a means to draw conclusions about the population from which the sample was drawn. Chi-square tests of association were used to see if any differences in the distribution of responses by lecturers and preceptors existed on any of the 64 criteria on the CSRS. Fisher's Exact Test is a useful calculation when sample sizes and expected frequencies are small. It is a one tailed test which tests the significance of the association between two categorical variables. Wilcoxon signed-ranks test, a bivariate statistical test, was used to test the difference in ranks of scores of the two groups.

Open-ended questions were analysed using quasi-statistical content analysis to identify emerging themes and concepts. This analysis is appropriate for qualitative data when an analytic induction approach is not used (Polit & Hungler, 1997).

Data were entered by the researcher and the assistance of a bio-statistician was sought to analyse the data and with use of the SPSS computer package.

In order to address each of the present study's objectives, the data collected were analysed in the following ways using the SPSS version 10 software:

1. Demographic data were analysed using descriptive statistical methods.

2. Fisher's Exact Test was computed to see if any differences exist in the distribution of responses by lecturers and preceptors on any of the clinical performance criteria in the five curriculum processes of the CSRS. An alpha level of .05 was adopted for all statistical tests.

3. Fisher's Exact Test was computed to see if any differences exist in the distribution of responses by preceptors with different educational levels on any of the clinical performance criteria in the five curriculum processes of the CSRS. An alpha level of .05 was adopted for all statistical tests.

4. Subsequently the items of the CSRS which were identified as critically important by each group were ranked according to frequency and percentage. Tied ranks were assigned by averaging the ranks that would have been assigned if the percentage rating the item as critically important were unique.

5. The rankings were carried out separately for lecturers and preceptors and then compared using Wilcoxon signed-ranked tests to see if differences exist in the rankings of the five curriculum processes for the two professional groups. An alpha level of 0.05 was adopted to establish significance.

6. Quasi-statistical content analysis of open-ended questions was used to identify prominent themes and patterns relating to the respondents' perception of the Standards for Nursing Practice.

The following steps were taken and adapted from Grbich (1999):

a) Data were collected as an entire entity before analysis

b) Data were entered in SPSS to facilitate the content analysis

c) Words and phrases were identified as the units to be analysed

d) The content was explored and dominant words and phrases noted

e) The patterns, themes and concepts which emerged were described and interpreted in terms of the research question

f) Frequencies and percentages were used to present the results.

3.7.1 Initial Screening of Data

When the last of the questionnaires had been returned, all of the data were entered into a spreadsheet. Invalid and missing data were identified. There was very little data missing. Respondents could elect an undecided category. These responses were treated as missing in subsequent analyses. This decision was made because the categorical responses were recoded to *critically important* and *less than critically important* and *undecided* did not fit in this schema. Furthermore, the undecided option was included to facilitate complete data as respondents could make a choice even if uncertainty about individual items existed.

3.7.2 Summary

This chapter has described the rationale for the research design and the methods used to collect and analyse the data. It has also discussed the ethical requirements for the involvement of human participants.

In the next chapter the findings of the research are presented. Quantitative data are summarised in tables. Qualitative data are presented according to the themes that emerged.

CHAPTER FOUR

RESULTS

This chapter presents and analyses the data generated by the questionnaire. Descriptive statistical methods, Fisher's Exact Test and Wilcoxon signed-ranked tests were computed to analyse the quantitative data, and quasi-statistical content analysis was performed to analyse the open-ended questions.

The respondents of each group sampled will be described according to professional and educational characteristics thought to be relevant to their clinical teaching role. This chapter will also present results of Fisher's Exact Test performed on the association between the type of the respondent (lecturer or preceptor) and each item from the CSRS. It will also present results of Wilcoxon signed-ranked tests which compared rankings between the groups. Amongst the preceptors, Fisher's Exact Tests were also conducted to assess the relationship between educational level and responses to each item in the CSRS. In addition this chapter will present the results of the quasi-statistical content analysis performed on the data collected from the open-ended questions.

All associations between lecturers and preceptors for each of the five standards of the CSRS are shown in Appendix G.

4.1 Quantitative Data

A large difference in response rates exists between the lecturers and preceptors. The response rate for the 12 nurse lecturers who fulfilled the criteria was 83 percent (n = 10). Of the 142 questionnaires distributed to preceptors, 72 were returned, a response rate of 51 percent. However of

these 72, two were invalidated because they did not meet the inclusion criteria, representing a response rate of 49 percent (n=70). The study, then, is based on 80 valid questionnaires, representing a true response of 53 percent. While preceptors constituted the largest proportion of the sample (87.5%) compared to lecturers (12.5%), the findings from the lecturers will more likely be representative of that group, than the findings from the preceptor group because of the high response rate from lecturers (83%) compared to 49 percent for preceptors.

4.1.1 Preceptors' Professional and Educational Characteristics

A registered nurse is a first level nurse who has graduated from a three year nursing programme or course, "who provides professional nursing services in fields appropriate to the registration" (Department of Health, 1986, p. 97). That is, nurses who graduated from a three year hospital based programme have registration as a general and obstetric, psychiatric or psychopaedic nurse. Nurses graduating from a three-year tertiary undergraduate nursing course are registered as a comprehensive nurse.

An enrolled nurse is a second level nurse who has graduated from at least, a one year hospital-based programme, "who provides basic nursing care under the supervision of a registered nurse or medical practitioner" (Department of Health, 1986, p. 97).

Table 1 presents the professional and educational characteristics of the preceptors. As shown, the sample included 70 preceptors with *nursing experience* ranging from less than one year to over 20 years, with one to three years the most frequently reported length of experience. One to three years was also the most frequent response for *time employed on the specific ward, and specialty experience.* As shown the *number of students* preceptored was variable. The majority of preceptors however, preceptored 1 - 3 students.

Table 1
Professional and Educational Characteristics of Preceptors

Characteristics	N	%
Time Employed on Ward (n =70)		
Less than 1 year	15	21
1 - 3 years	34	49
3 - 5 years	12	17
5 – 10 years	7	10
10 - 15 years	0	0
15 - 20 years	2	3
More than 20 years	0	0
Specialty Experience (n=70)		
Less than 1 year	9	13
1 - 3 years	33	47
3 - 5 years	13	18
5 – 10 years	9	13
10 - 15 years	2	3
15 - 20 years	4	6
More than 20 years		
Nursing Experience (n=70)		
Less than 1 year	8	12
1 - 3 years	19	27
3 - 5 years	12	17
5 – 10 years	13	19
10 - 15 years	5	7
15 - 20 years	1	1
More than 20 years	12	17
Students Preceptored (n=70)		
Not sure	4	6
One	15	21.5
Two	16	23
Three	14	20
Four	5	7
Five	1	1
More than five	15	21.5
Nursing Qualifications (n=70)[1]		
Registered Nurse	43	61
Enrolled Nurse	5	7
Diploma in Nursing	18	26
Bachelors Degree	42	60
Post Graduate Certificate	6	9
Masters Degree	0	0
Other	8	11
Basic Education (n=70)		
Registered Nurse with Bachelors degree	42	60
Registered Nurse with Diploma in Nursing	13	19
Registered Nurse without Tertiary Qualification	14	20
Enrolled Nurse	1	1.5

Note. [1] Multiple responses permitted.

4.1.1.1 Time employed in ward

Preceptors were asked to identify how long they had been employed on the ward they were currently working in. Of the total number of preceptors (n=70), 15 (21%) respondents identified less than 1 year, 34 (49%) identified 1 - 3 years, 12 (17%) identified 3 - 5 years, seven (10%) identified 5 - 10 years, and two (3%) identified between 15 - 20 years employment on that specific ward.

4.1.1.2 Specialty experience

Preceptors were asked to identify how much experience they had in this specific speciality of nursing. Of the total number of preceptors (n=70), nine (13%) identified less than 1 year, 33 (47%) identified between 1 - 3 years, 13 (18%) identified 3 - 5 years, nine (13%) identified 5 - 10 years, two (3%) identified 10 - 15 years and four (6%) identified they had more than twenty years specialty experience.

4.1.1.3 Nursing experience

Preceptors were asked how much total experience they had in nursing. Of the total number of preceptors (n=70), eight (12%) identified they had less than 1 year, 19 (27%) identified 1 - 3 years nursing experience, 12 (17%) identified 3 - 5 years, 13 (19%) identified 5 - 10 years, five (7%) identified 10 - 15 years, one (1%) identified 15 - 20 years and 12 (17%) identified more than twenty years total nursing experience.

4.1.1.4 Students preceptored

Preceptors were asked to identify how many second year nursing students they had preceptored. Of the total number of preceptors (n=70), 15 (21.5%) had preceptored one student, 16 (23%) had preceptored two students, 14 (20%) had preceptored three students, five (7%) had preceptored four students, one (1%) had preceptored five students, 15 (21.5%) had preceptored more than five students, and four (6%) identified they were not sure how many students they had preceptored

4.1.1.5 Nursing qualifications

Preceptors were asked to identify the nursing qualifications they had attained. The question enabled multiple responses to be given. Of the total number of preceptors (n=70), 43 (61%) identified registered nurse, 42 (60%) identified bachelors degree, 18 (26%) identified diploma in nursing, eight (11%) identified 'other', six (9%) identified postgraduate certificates, and five (7%) identified enrolled nurse.

Responses recorded as 'other' listed such qualifications as *diploma in psychiatric nursing, diploma in midwifery, certificate in emergency nursing, urology specialty paper, residential care certificate, graduate certificate and neurological services special topic paper.* Diplomas and graduate certificates are tertiary qualifications awarded to registered nurses or midwives. Certificates are post-registration hospital-based qualifications awarded to registered nurses.

The nursing qualifications were summarised and further categorised as 'Basic Education' to identify the highest basic nursing qualification held by the preceptors. The majority of preceptors (n=42, 60%) were registered nurses with a bachelors degree in nursing as their highest basic nursing qualification. Fourteen (20%) identified they were registered nurses who gained their qualification in hospital based training, 13 (19%) held a diploma in nursing. Diplomas preceded degrees.

4.1.2 Lecturers' Professional and Educational Characteristics

Table 2 presents the professional and educational characteristics of the lecturers. As illustrated the sample included ten lecturers with nursing experience ranging from ten to more than 20 years. The majority of lecturers have acted in the role of clinical teacher more than five times.

Table 2

Professional and Educational Characteristics of Lecturers

Characteristics	n	%
Nursing Experience (n =10)		
Less than 1 year	0	0
1 - 3 years	0	0
3 - 5 years	0	0
5 - 10 years	0	0
10 - 15 years	1	10
15 - 20 years	6	60
More than 20 years	3	30
Times Acted As Clinical Lecturer (n=10)		
None	0	0
Once	0	0
Twice	1	10
Three	0	0
Four	1	10
Five	1	10
More than five	7	70
Nursing Qualifications (n=10)[1]		
Registered Nurse	10	100
Enrolled Nurse	0	0
Diploma in Nursing	0	0
Bachelors Degree	9	90
Post Graduate Certificate	3	30
Masters Degree	1	10
Other	2	20
Basic Education (n=10)		
Registered Nurse with Bachelors Degree	9	90
Registered Nurse	1	10

Note. [1] Multiple responses permitted.

4.1.2.1 Nursing experience

Lecturers were asked to identify how much experience in total they had in nursing. Of the total number of lecturers (n=10), one (10%) identified 10 - 15 years, six (60%) identified 15 - 20 years and three (30%) identified over twenty years total experience in nursing.

4.1.2.2 Times acted as clinical lecturer

Lecturers were asked how many times they had acted as a clinical lecturer in the preceptor model to a second year nursing student. Of the total number of lecturers (n=10) one (10%) identified twice, one (10%) identified four times, one (10%) identified five times, and the majority, seven (70%) identified they had acted in the role of clinical lecturer more than five times.

4.1.2.3 Nursing qualifications

Lecturers were asked to identify the nursing qualifications they had attained. The question enabled multiple responses to be given. All lecturers (n=10) identified they were registered nurses, nine (90%) held a bachelors degree, three (30%) had attained post graduate certificates, two (20%) identified 'other' and one (10%) held a masters degree. Responses recorded as 'other' listed such qualifications as certificate in cardio-thoracic and vascular nursing and certificate in coronary care nursing. A 'certificate' is a hospital-based post registration qualification awarded in a specific nursing specialty

The responses were re-coded and further categorised as 'Basic Education' to identify the highest basic nursing qualification held by lecturers (n=10). Nine (90%) lecturers had completed a bachelors degree, one of whom had also completed a masters degree and one (10%) identified registered nurse without a tertiary nursing qualification as their highest basic nursing qualification.

As shown in Tables 1 and 2 the highest basic nursing qualification for nine out of ten (90%) nursing lecturers was a bachelors degree, whereas 42 out of 70 (60%) of preceptors had a bachelors degree. Thirteen out of 70 (19%) preceptors held a diploma in nursing whereas none of the lecturers held this qualification, though one out of ten (10%) lecturers was identified as a registered nurse without a tertiary nursing qualification compared to 14 out of 70 (20%) preceptors. One out of 70 (1.5%) preceptors was an enrolled nurse.

In summary of the descriptive characteristics of the groups, lecturers and preceptors were similar in that the highest basic nursing qualifications for the majority of lecturers and preceptors was a bachelors degree. However the two groups differed in that lecturers had more years nursing experience overall when compared to preceptors.

4.2 Clinical Standards Rating Scale (CSRS)

The CSRS provides data on how importantly lecturers and preceptors rate specific assessment criteria. The standards measured by the CSRS are *competency, critical thinking, valuing, professionalism* and *communication*. Lecturers and preceptors were asked to select an item as critically important if they considered satisfactory performance of that item was critically important for a student to achieve overall acceptable clinical performance.

4.2.1 CSRS Reliability

To assess reliability of the CSRS, Cronbach's alpha was calculated for each of the five standards as shown in Table 3. A Cronbach's alpha of .50 is considered acceptable for instruments to be used for comparisons between different groups (Cockburn & De Luise, 1992). With the exception of *critical thinking*, the standards all showed a high Cronbach's alpha suggesting good reliability. While Cronbach's alpha for *critical thinking* was somewhat lower, it nonetheless provides evidence of moderate reliability for this standard. This indicated that participants

tended to rate the criteria in the same way, and that ratings within the scale were internally consistent. Therefore it can be reasonably assured that any significant associations found between lecturers and preceptors would be real differences and not errors in measurement.

4.2.2 CSRS Validity

Validity is the degree to which an instrument measures what it is intended to measure. The CSRS was developed from the *Standards for Nursing Practice* used by the nursing school to determine students' level of clinical performance. Therefore it is a valid instrument for providing answers to the research questions.

4.2.2.1 Face validity

Face validity of the CSRS which measured lecturers' and preceptors' responses regarding the critical importance of individual assessment criteria, was ensured by piloting the questionnaire.

4.2.2.2 Content validity

To ensure all relevant dimensions were covered in the questionnaire, expert educators were consulted on the content of the questionnaire before finalising the instrument.

Table 3

Cronbach's Alpha for Five Standards in CSRS

Standard	Cronbach's alpha
Competency	0.93
Critical Thinking	0.56
Professionalism	0.81
Valuing	0.93
Communication	0.94

To address the question: *What are the similarities and differences between nurse lecturers and nurse preceptors in their assessment of the importance of selected criteria for the evaluation of clinical performance?*, the

data were re-coded. Individual items were collapsed into *critically important* or *not critically important* categories, since there were sparse data in some of the *not critically important* categories. The *not critically important* category comprised responses rated from 1 - 4 on the likert scale. The *critical important* category comprised responses rated as 5 on the likert scale. Fisher's Exact Test was used to assess the association between respondent type (lecturer or preceptor) and the importance of each item.

The significant results that emerged are illustrated in Table 4.

Table 4

Summary of Lecturers and Preceptors Criteria Rated as Critically Important

Criteria	Lecturers (n=10)		Preceptors (n=70)		
	n	%	n	%	p value
Client care is based on ongoing assessment *(competency)*	10	100	41	59	0.011
Demonstrates caring while implementing nursing practice *(competency)*	8	80	31	45	0.047
Shows awareness of cultural, spiritual and moral influences that affect client's health *(valuing)*	8	80	30	43	0.041
Nursing practice reflects sensitivity for cultural needs of client *(valuing)*	8	80	24	34	0.012

As shown in Table 4, significant associations were demonstrated by Fisher's exact test on four items of the CSRS. A difference exists between lecturers and preceptors in their perceptions of the critical

importance of the four items, with more lecturers rating the criteria as critically important than preceptors do.

Items that were rated more highly by lecturers than preceptors included items pertaining to *client care i.e. ongoing assessment, caring in nursing practice,* and *cultural safety.* These items are specific to two processes of professional nursing practice: *Competency* and *valuing.*

Subsequently, the five sections of CSRS were considered separately. In each section, the responses were ranked by number of critically important responses. This was carried out separately for lecturers and preceptors.

Wilcoxon signed-rank tests were used to test for significant differences between the groups

4.2.3 Competency

In ranking the items which were identified as critically important by both groups from highest to lowest according to percentage, the following results emerged as illustrated in Table 5.

Table 5

Ranking of Critical Importance of Competency Criteria by Lecturers and Preceptors

Criteria	Lecturers (n=10)			Preceptors (n=70)		
	Rank	n	%	Rank	n	%
Client care is based on ongoing assessment	**1.0**	10	100	**2.0**	40	59
Responds rapidly and appropriately to factors that effect client safety	**2.0**	9	90	**1.0**	46	67
Demonstrates caring while implementing nursing practice	**3.0**	8	80	**6.5**	30	45
Determines and carries out a plan of care that is safe and competent, in partnership with the client when possible and appropriate	**4.5**	7	70	**3.0**	39	56
Utilises clinical staff/nurse lecturers to evaluate/validate client care	**4.5**	7	70	**4.0**	35	51
Can use nursing knowledge as a basis for practice	**6.0**	6	60	**9.0**	26	39
Plans appropriate nursing care requirements with client, when appropriate	**7.5**	5	50	**12.0**	22	32
Identifies individual client's needs from data	**7.5**	5	50	**15.0**	18	26
Collects sufficient information to formulate client's needs/problems	**10.0**	4	40	**5.0**	32	46
Evaluates and reviews client status in response to care given	**10.0**	4	40	**10.0**	23	34
Is aware of own emotions and their effect on self and on client's care	**10.0**	4	40	**11.0**	22	33
Prioritises care according to known information	**13.0**	3	30	**6.5**	31	45
Nursing care and decisions are based on sound rationale using knowledge and experience	**13.0**	3	30	**8.0**	30	44
Applies holistic concepts to client care	**13.0**	3	30	**13.0**	21	31
Begins to adapt nursing practice according to situations/clients	**15.0**	2	20	**17.0**	25	15
Performs technical skills competently recognising contextual influences	**17.0**	1	10	**14.0**	19	28
Incorporates all appropriate data in assessment, e.g. clinical tests	**17.0**	1	10	**17.0**	25	15
Able to determine appropriate criteria to measure the effectiveness of client care	**17.0**	1	10	**17.0**	25	15
Organises nursing care within an appropriate time frame	**19.0**	0	0	**19.0**	22	16

As shown in Table 5 ratings are similar on many items, although more lecturers thought *client care based on ongoing assessment* to be more important, while, *responds rapidly and appropriately to factors that effect client safety* was rated most highly by preceptors. Both groups rated *organises nursing care within an appropriate time frame* as the least critically important item. No significant difference was found between the lecturers' and preceptors' rankings of the items ($p = 1.00$).

4.2.4 Critical Thinking

In ranking the items which were identified as critically important by both groups from highest to lowest according to percentage, the following results emerged as illustrated in Table 6.

Table 6

Ranking of Critical Importance of Critical Thinking Criteria by Lecturers and Preceptors

Criteria	Lecturers (n=10)			Preceptors (n=70)		
	Rank	n	%	Rank	n	%
Critiques own practice using criteria	**1.0**	5	50	**3.0**	20	30
Uses reflective skills to enhance nursing practice.	**2.5**	4	40	**1.0**	25	37
Can identify changes in own practice	**2.5**	4	40	**2.0**	22	32
Shows an ability to think in an autonomous manner	**5.5**	1	10	**4.0**	19	26
Recognises sociopolitical factors that impact on the practice of nursing	**5.5**	1	10	**5.5**	10	15
Uses nursing and other theories to enhance practice	**5.5**	1	10	**7.0**	10	14 [1]
Begins to show creativity within nursing care	**5.5**	1	10	**8.0**	6	9
Uses theoretical frameworks that are appropriate for different clients	**8.0**	0	0	**5.5**	10	15

Note. [1] 1 respondent did not answer, therefore n=69 for this item

As shown in Table 6, responses were variable. Lecturers thought *critiques own practice using criteria* to be more important, while, *uses*

reflective skills to enhance nursing practice was rated most highly by preceptors. The difference between rankings by lecturers and preceptors was not significant ($p = 0.932$).

4.2.5 Professionalism

In ranking the items, which were identified as critically important by both groups from highest to lowest according to frequency, the following results emerged as illustrated in Table 7.

Table 7

Ranking of Critical Importance of Professionalism Criteria by Lecturers and Preceptors

Criteria	Lecturers (n=10)			Preceptors (n=70)		
	Rank	n	%	Rank	n	%
Maintains professional behaviour and attitudes in nursing	**1.5**	7	70	**1.0**	51	74
Promotes the partnership philosophy in caring with clients and family	**1.5**	7	70	**5.0**	29	42
Accepts responsibility for practising within professional codes	**3.5**	6	60	**2.0**	44	64
Practices in accordance with relevant legislation and health agency policies	**3.5**	6	60	**4.0**	39	56
Shows a commitment to developing practice knowledge	**5.0**	5	50	**3.0**	42	60
Shows awareness of legislation that impacts on his/her practice	**6.0**	4	40	**6.0**	26	38
Is aware of issues which impact on health and health care	**7.0**	1	10	**7.0**	15	22

As shown in Table 7, both groups agreed *maintains professional behaviour and attitudes in nursing* to be most critically important. *Shows awareness of legislation that impacts on practice,* and *is aware of issues which impact on health care,* were indicated to be least critically important by both groups. The difference between rankings by lecturers and preceptors was not significant ($p = 0.76$).

4.2.6 Valuing

In ranking the items, which were identified as critically important by both groups from highest to lowest according to percentage, the following results emerged as illustrated in Table 8.

Table 8

Ranking of Critical Importance of Valuing Criteria by Lecturers and Preceptors

Criteria	Lecturers (n=10)			Preceptors (n=70)		
	Rank	n	%	Rank	n	%
Respects client's culture, values and beliefs without inflicting own values on client	**1.0**	9	90	**1.0**	48	70
Demonstrates a caring attitude	**3.0**	8	80	**2.0**	45	66
Shows awareness of the cultural, spiritual and moral influences that affects client's health	**3.0**	8	80	**6.5**	29	43
Nursing practice reflects sensitivity for cultural needs of client	**3.0**	8	80	**8.5**	23	34
Negotiates with client their involvement in own care	**6.0**	6	60	**4.0**	34	50
Promotes client individuality	**6.0**	6	60	**5.0**	30	44
Promotes client's awareness of rights	**6.0**	6	60	**6.5**	29	43
Nursing care responds to how client perceives his/her problem(s) and treatment	**8.0**	5	56[1]	**8.5**	23	34
Values the worth of input of other health professionals	**9.0**	5	50	**3.0**	40	59
Begins to recognise the reality of client's experience	**10.0**	4	40	**10.0**	22	32
Shows awareness of value dilemmas in the use of technology	**11.0**	2	22[1]	**13.0**	13	20
Recognises the differing values and beliefs involves in ethical issues	**12.5**	2	20	**11.0**	21	31
Recognises the impact institutional values have on client's care	**12.5**	2	20	**12.0**	16	24

Note. [1] 1 respondent did not answer, therefore n=9 for this item

As shown in Table 8, both groups agreed, respects clients culture, values and beliefs without inflicting own values on client to be most important. The difference between rankings by lecturers and preceptors was not significant ($p = 0.824$).

4.2.7 Communication

In ranking the items, which were identified as critically important by both groups from highest to lowest according to percentage, the following results emerged as illustrated in Table 9.

Table 9

Ranking of Critical Importance of Communication Criteria by Lecturers and Preceptors

Criteria	Lecturers (n=10)			Preceptors (n=70)		
	Rank	n	%	Rank	n	%
Documents and records the care planned for clients	**1.0**	8	80	**6.0**	32	47
Shows congruence between communication and action	**2.0**	7	78	**7.0**	28	43
Communicates relevant information to health care team	**4.0**	7	70	**1.0**	44	65
Maintains records of client's progress	**4.0**	7	70	**4.0**	35	52
Discusses own practice appropriately with lecturer	**4.0**	7	70	**5.0**	31	48
Develops a trusting relationship with most clients	**6.0**	6	60	**3.0**	38	56
Articulates own learning needs to clinical staff and lecturers	**7.5**	5	50	**2.0**	40	60
Identifies strategies to develop personal therapeutic communication	**7.5**	5	50	**16.0**	20	29
Developing fluency of communication skills within own personal style	**9.5**	4	40	**10.5**	25	37
Use communication in a proactive manner	**9.5**	4	40	**10.5**	25	37
Using appropriate communication skills acknowledging different therapeutic client needs and changing environment	**11.0**	3	33	**17.0**	15	22
Shows an ability to communicate therapeutically with clients	**13.5**	3	30	**8.5**	25	38
Negotiates own clinical experiences	**13.5**	3	30	**8.5**	25	38
Use a range of communication modes to ensure effective nurse/client communication	**13.5**	3	30	**12.5**	23	34
Recognises and responds to less obvious client cues	**13.5**	3	30	**14.0**	22	33
Interacts effectively with health care team	**16.0**	2	20	**12.5**	23	34
Contributes to team discussions on client's care when appropriate	**17.0**	1	10	**15.0**	21	31

As shown in Table 9, responses were more variable and lecturers thought *documents and records the care planned for clients* to be most critically important while *communicates relevant information to the health care team* was rated most highly by preceptors. No significant difference was found between the lecturers' and preceptors' rankings of the items ($p = 0.897$).

To address the second question: *How does the level of educational preparation of the nurse preceptor influence the way in which the preceptor assesses the importance of specific performance criteria?*, the responses were re-coded. They were further categorised as 'education level' to identify preceptors with a bachelors degree and preceptors without a bachelors degree. Fisher's Exact Test was used to assess the association between education level of preceptors and the importance of each item. A significant association was demonstrated on one item; nursing practice reflects sensitivity for cultural needs of client (p value = .034) The respondents with a bachelors degree were more likely to rate this as critically important than those without a bachelors degree (46 % vs. 19%) as illustrated in table 10.

Table 10

Association Between Preceptors' Education Level and Cultural Safety

Preceptors Education Level	Critically Important	Not Critically Important	Total
With bachelors degree	18	21	39
Without bachelors degree	5	22	27
Total	23	43	66

It can be seen that preceptors with a bachelors degree rated cultural safety similarly to preceptors without a bachelors degree when compared to lecturers

4.3 Qualitative Data

To ascertain the clarity of the clinical assessment tool an answer was sought to the third research question: *What are lecturers' and preceptors' perceptions of the clarity of the Clinical Standards Assessment Tool?*, participants were asked if they had seen the *Standards for Nursing Practice* utilised by the educational institution in the current study. The response rate indicated that 100% of the lecturers and 39% of the preceptors had seen the assessment tool.

Participants who had seen the tool were then invited to respond to four open ended questions which asked:

- *What are your views on the clarity of the standards?*
- *What features do you consider helpful?*
- *What features do you consider could be improved?*
- *Do you have any other comments?*

Quasi-statistical content analysis was performed to analyse the qualitative data from the open-ended questions. Several key concepts pertaining to the clarity of *Standards for Nursing Practice*, which is a criterion-referenced tool became evident throughout the analysis. They are identified below.

4.3.1 Clarity of the Standards for Nursing Practice

Some respondents made more than one comment. Of the 37 respondents to this section, 31 (84%) answered the question: *What are your views on the clarity of the standards?*

The majority of the respondents perceived the assessment tool in positive terms, as *clear and concise* (16, 52%) *easy to understand* (5, 19%) and *appropriate* (2, 6%). In contrast to this, some respondents found the tool was *difficult to use* (7, 23%), and *difficult to interpret* (5, 16%).

Several key concepts pertaining to clarity emerged from the data, these included: Language and interpretation, detail of the document, guiding student learning, student clinical evaluation, and availability of the evaluation tool.

4.3.1.1 Language and interpretation

Eleven (35%) of the respondents commented that they were dissatisfied with the clarity of the language. The main reason was maintaining consistency when interpreting the criteria. For example statements were made such as: *Results in a variety of interpretations or misinterpretations; could lead to inconsistency with assessments; could be interpreted in different ways.* Two (6%) respondents suggested lack of clarity was also confusing for the students. The first pointed out a *second year student would have difficulty interpreting some criteria such as shows awareness of value dilemmas in the use of technology;* the second respondent commented that *professionalism*, one of the competencies, *is a grey area for students to grasp which needs clarifying with students by the clinical lecturer.* Three (10%) respondents suggested a *more user-friendly language* would enhance clarity especially for students with English as a second language. Two (6%) respondents commented that a lack of familiarity with the assessment tool created difficulty with interpretation.

4.3.1.2 Detail of the document

Respondents commented that the detail of the document also impacted on its clarity. Five (16%) respondents stated it was *too long and wordy.* This could affect the tool's reliability as one respondent pointed out: *There is a danger that there are so many* [criteria] *that you flick through them quickly.* Only one respondent (3%) commented positively about the detail of the document describing it as *very clear, detailed and holistic in approach.*

4.3.1.3 Guiding student learning

The clarity of the tool for guiding student learning was apparent from the many comments describing it as *appropriate* for this purpose (6, 19%). Three respondents suggested that the tool provides a reference point for setting learning goals. They commented that [the clinical standards] *clearly differentiate the expectations for each level* (1, 3%); *enable effective learning strategies to be set* (1, 3%) and *assists students with their journalling of clinical practice* (1, 3%).

4.3.1.4 Student clinical evaluation

For the summative evaluation of professional practice a student will receive one of three possible grades: *merit, achieve* or *non-achieve.* While there were no specific data on clarity of the tool pertaining to an *achieve* grade, some comments were made suggesting a *merit* grade be made more explicit (3,10%). In contrast to this, using the tool to determine a *non-achieve* grade was not perceived as a problem. One respondent (3%) stated tend *to use them more effectively with non-achieving students to set concrete learning strategies that can be monitored through the evaluation process.* Three (10%) respondents suggested there was a lack of clarity about the level of practice required to meet the criteria. It was suggested that the criteria exceeded the abilities expected of a second year student nurse. The first respondent commented that *some aspects* [of the standards] *are unrealistic and very difficult to achieve.* The second respondent suggested that [the criteria] *need to be more realistic and practice focused.* The third respondent asked: *Are students meant to do everything under each standard for each clinical?*

4.3.1.5 Availability of the clinical evaluation tool

Two (6%) respondents commented that the *Standards for Nursing Practice* are not always accessible in clinical areas, which may account for the lack of familiarity and thus clarity of the document as has already

been pointed out. This may also account for the low number of preceptors who have seen the assessment tool.

4.3.2 Helpful Features

Of the 37 respondents to this section, 27 (73%) answered the question: *What features do you consider most helpful?*

Some respondents made more than one comment. The vast majority of comments were positive regarding the helpfulness of the tool. Generally the comments indicated that the assessment tool was easily adapted to practice. The specific features identified as helpful pertain to: The design of tool, evaluation of nursing practice, student learning and clinical teaching.

4.3.2.1 Design of the tool

The helpful features in the design of the tool identified by respondents were: The *specific criteria* (9, 33%); *divisions into five areas* (3, 11%); *progression from year one to year three* (2, 7%); *clear headings* (1, 4%); *bullet points* (1, 4%).

4.3.2.2 Evaluation of nursing practice

Many respondents made specific comments about helpfulness with evaluation. Some examples are: *Explanations given on how to achieve each standard* (3, 11%); *specific areas of focus for each year were highlighted in the criteria* (1, 4%); *expectations are clear cut* (1, 4%); and *identify crucial areas to be scrutinised* (1, 4%); *reduces any bias or unfairness* (1, 4%).

Two (7%) respondents commented on evaluation of non-achieving students. Their comments were: *Good to have this document to support a non-achieving assessment decision* and *effective to work with, with non-achieving students.*

4.3.2.3 *Student learning and clinical teaching*

Several respondents commented on the tool's effectiveness for guiding student learning and clinical teaching. Some examples were: *Ensure that students get the best learning from their ward experience* (1, 4%); *...the standards are there to either aspire to in practice or create individual goals* (1, 4%); *offers guidance ... and explains how to achieve each standard* (1, 4%).

4.3.2.4 *Availability and time to read*

One preceptor commented that the tool was helpful *when available* and another stated the criteria were helpful when *time allows for them to be read.*

4.3.3 Features Needing Improvement

Of the 37 respondents to this section 22 (59%) answered the question: *What features do you consider could be improved?*

Some respondents made more than one comment. While three (14%) respondents to this question indicated no improvement was needed, the most common suggestion for improving the tool was to simplify, and thus clarify the language. Fourteen (64%) respondents recommended this. Some of their comments were: *Simplification of terminology to make meaning clearer, fewer repetitive statements*; *clearer, more user-friendly standards*; *not so technical*; *shorter format and more concise statements.* The respondents also wanted to see: *More clarity on the merit grade* (2, 9%); *an instruction sheet identifying critical points that indicate achievement* (1, 4.5%) and one respondent (4.5%) suggested: *Some examples from clinical logs on how lecturers could write to standards.*

Other suggestions for improvement made by two respondents were: *More room to write* is necessary on the assessment sheet (1, 4.5%); and the standards for practice *should be upgraded yearly* (1, 4.5%).

4.3.4 Comments

Of the 37 respondents to this section 19 (51%) answered the question: *Do you have any other comments?*

Some respondents indicated more than one comment. Most respondents (12, 63%) commented about the problems they perceived with using the tool while others made comments expressing their satisfaction with it (7, 37%).

4.3.4.1 Preparation

A lack of preparation for using the evaluation tool was commented on by 5 (26%) respondents. The responses suggest that a specific preparation time is needed for preceptors and lecturers to dialogue about the assessment process prior to students commencing their clinical placements. This is particularly necessary for those who are new to the assessment process. One respondent suggested *a teaching session* [assessment focussed] *should be given* [to those who are unfamiliar with the assessment process] *prior to each clinical placement for clarification* [of the clinical standards]. Another respondent suggested ongoing dialogue between lecturers and preceptors is required *to ensure the nurses' perception matches the expectation of the institute.* It was suggested by one respondent that a copy of the standards should be available for preceptors to read, prior to commencing their preceptor role.

4.3.4.2 Measurement of clinical competence

There were three (16%) comments indicating satisfaction with the tool, suggesting it was a fair measure of students' clinical competence. One respondent stated: *Useful criteria to measure clinical practice.* Another respondent indicated that it was a fair measure as students were aware of the expectations of their clinical practice before they received their summative evaluations and commented: [The tool] *provides a very firm guideline for the student.* Part of the clinical evaluation process is the expectation that students self evaluate. One respondent indicated that the

tool was: An *effective measure for students' self-evaluation* and another commented it was: *Helpful for* [student] *self-evaluation.*

The following chapter presents a discussion and interpretation of the overall findings in relation to the research questions and the literature reviewed.

CHAPTER FIVE

DISCUSSION

The research objectives of this study were to explore the issue of evaluation of student nurses' clinical practice by their preceptors and to examine lecturers' and preceptors' perceptions of the clarity of the clinical evaluation tool used by the educational institution where the current study is sited. This chapter will summarise the research findings and discuss them in relation to the research questions, and to the literature reviewed in Chapter Two.

5.1 Lecturers' and Preceptors' Rating of Clinical Performance Criteria.

The first research question asked: What are the similarities and differences between nurse lecturers and nurse preceptors in their assessment of the importance of selected performance criteria for the evaluation of clinical performance? (This question was also used by Ferguson and Calder in their 1993 study).

Fisher's exact test showed a difference exists between lecturers and preceptors in their perceptions of the critical importance of four CSRS items. The findings of the current study demonstrate that the lecturers and preceptors have more similarities than differences in their ratings of the critical importance of clinical performance criteria. The findings are consistent with Ferguson and Calder's (1993) findings which demonstrated that lecturers and preceptors in their Canadian study had more similarities than differences in their stated valuing of clinical performance criteria. As stated earlier Ferguson and Calder used a

different tool to that used in the current study, therefore direct comparisons cannot be made.

5.1.1 Differences Between Lecturers' and Preceptors' Valuing of Evaluation Criteria

In the current study all criteria showing significant associations were rated more highly by lecturers than preceptors. Ferguson and Calder suggested criteria rated more highly by lecturers than preceptors indicate that in clinical teaching these aspects of nursing care are emphasised more by lecturers than by preceptors. Consequently, lecturers may have higher expectations of students' competencies in these areas of clinical practice than preceptors do. Lecturers perceived *client care is based on ongoing assessment* ($p=.011$); *demonstrates caring while implementing nursing practice* ($p=.047$); *shows awareness of cultural, spiritual and moral influences that affects client's health* ($p=.041$); *nursing practice reflects sensitivity for cultural needs of client* ($p=.012$) to be more critically important than preceptors did (Table 4). The significant associations suggest that evaluations of students' competence by preceptors, pertaining to these criteria, would differ in comparison with lecturers' expectations. This creates problems in the accurate and fair assessment of students abilities in these areas of practice. This raises issues for the student especially when discrepancies between evaluators' expectations lead to the student receiving inconsistent feedback about their level of practice. Students have a right to expect consistency in evaluation procedures and have a right to complain if discrepancies exist, as they may be wrongly failed. If expectations of evaluators differ, the quality of the evaluations must be questioned, as evaluators may 'fail to fail' incompetent learners. This also raises issues for the profession and society as a whole as evaluators have a moral obligation to ensure their evaluations are trustworthy to ensure that clients receive safe nursing care.

5.1.1.1 Values and professional socialisation

One possible explanation for these findings may be related to different value systems held by lecturers employed by the educational institution, and preceptors employed by the hospitals. Previous research by Corwin et al. (1961), Kelly (1991) and Kramer (1974) suggests that nurse educators internalise a 'professional role conception' whereas nurses working in hospitals internalise a 'bureaucratic role conception'. The criteria rated more highly by lecturers than preceptors emphasise client centred care, perhaps reflecting a more professional role conception by lecturers than preceptors. Therefore a student engaging in client-centred care may receive a more favourable evaluation from a lecturer than from a preceptor.

Both Steele and Harmon (1983) and Wong and Wong (1987) claimed that values are learned from the role models people have contact with. Their claims suggest that preceptors educated in a tertiary institution would demonstrate ratings congruent with lecturers' ratings. However, the findings of the current study do not demonstrate this and may be partially explained by "professional-bureaucratic role conflict theory" (Kramer, 1974, p. 32). This theoretical perspective suggests that new graduates in the workplace experience conflict between professional and bureaucratic values and on seeing other staff nurses being appraised for their 'work-oriented values' discard their 'school-bred' values and conform to, and adopt, the value system of the work organisation. It may be that preceptors educated in tertiary institutions in the current study have experienced this conflict and have adopted some values considered more important in their particular workplace. This may be confusing for students, as both lecturers and preceptors act as role models for students.

A lack of exposure to the education environment by preceptors, and therefore the values and expectations of lecturers, may also explain why preceptors rated some criteria significantly lower than lecturers did. Smith (1965) noted that nurses at the bedside demonstrate values learned

in the workplace more than values espoused by lecturers. Research by Smith has shown differences exist in the values held by lecturers and the values held by charge nurses. If the significant associations in the current study reflect preceptors' socialisation of workplace values, then a further consideration when analysing these findings is the impact of the charge nurse on the education of student nurses, as charge nurses are role models for staff nurses.

5.1.1.2 Competence in nursing practice

Another reason for the significant associations may have arisen from a difficulty nursing has in defining competent clinical practice. There is a large body of literature which attests to a lack of consensus of what constitutes competence in nursing practice (Bradshaw, 1998; Girot, 1993a; Wood, 1992; Woolley, 1977). Without a clear definition, individuals will view competence, based on their own set of values and experiences of evaluation (Chambers, 1998; Orchard, 1994). It may be that what is critically important in a student's practice has not been clearly defined so, preceptors rely on their personal perceptions to determine this. Their own view may differ from the expectations of the educational institution.

Wong and Wong (1987) contended that inexperienced clinical teachers have difficulty with defining competent clinical practice because of the ambiguous nature of clinical evaluation and the complexity of the clinical environment. The demographic variables (Table 1) show that most preceptors have had little experience in the preceptor role. The findings suggest that preceptors' inexperience, combined with their unfamiliarity with the educational institution's evaluative processes and expectations of students' practice, may lead to uncertainty in their evaluations of students. Evaluators have an obligation to evaluate accurately and objectively to ensure that nurses who carry out client care are competent to do so. However, uncertainty may lead preceptors to rely on their personal experiences and this would place at jeopardy the validity of such evaluations. It may also result in the reluctance of preceptors to

participate in student evaluation and suggests the need for adequate preparation and support to ensure that preceptors evaluations reflect the expectations of the curriculum.

5.1.2 Similarities in Lecturers' and Preceptors' Valuing of Evaluation Criteria

As Ferguson and Calder (1993) noted, the similarities in the valuing of individual criterion demonstrated by lecturers and preceptors shows that, for the most part, both groups value aspects of nursing care that reflect differing values. The findings of the current study concur that lecturers and preceptors consider both professional and bureaucratic values to be important when they evaluate students' clinical practice.

There was a common perception with lecturers and preceptors that respect for human dignity was the most critically important requirement of a student nurse's practice. This is shown in Table 8 where the criterion *respects client's culture, values and beliefs without inflicting own values on client* was ranked as equally most critically important by lecturers and preceptors. There were no other criteria valued as equally *most* critically important by the groups.

There were two criteria ranked as equally *least* critically important by lecturers and preceptors. The criteria were: *Organises nursing care within an appropriate time frame* and, *is aware of issues which impact on health and health care.* When considering an acceptable standard of *competency* (Table 5) these findings show that lecturers and preceptors focus more towards a student's ability with learning the practical knowledge associated with client care and client safety than their ability with time management skills. Similarly, lecturers and preceptors regard an awareness of broader health care issues as less critically important than maintaining professional nursing behaviours and attitudes, when determining an acceptable standard of professionalism for second year nursing students (Table 7). These findings do not suggest that time

management and health care issues are not important aspects of a student's practice. They indicate that lecturers and preceptors consider them less critically important than other criteria when evaluating a student's level of *competency* and *professionalism.*

The nursing literature is replete with reports on the gap between nursing education and nursing service (Corwin et al. 1961; Holly, 1992; Kelly, 1991; Kramer, 1974; Myrick, 1988; The Ministerial Taskforce on Nursing, 1998). However, the findings of the current study strongly suggest concurrence between the two in their expectations of second year nursing students' practice. Therefore, when determining the *overall* acceptability of a student's practice, lecturers' and preceptors' evaluations should be similar.

This research shows that the differences between lecturers and preceptors in their assessment of the importance of selected criteria are: *Client care is based on ongoing assessment; demonstrates caring while implementing nursing practice; shows awareness of cultural, spiritual and moral influences that affects client's health;* and *nursing practice reflects sensitivity for cultural needs of client.* This suggests that evaluations of students' clinical practice by preceptors and lecturers pertaining to these criteria would differ. As discussed previously this may lead to incongruent evaluations of students' practice.

5.2 The Influence of Educational Level on Preceptors' Rating of Clinical Evaluation Criteria

The second research question which guided this study was: How does the level of educational preparation of the nurse preceptor influence the way in which the preceptor assesses the importance of specific performance criteria? (This question was also used by Ferguson and Calder in their 1993 study).

When the educational level of preceptors was explored, Fisher's exact test showed a significant association existed in one criterion, demonstrating that preceptors with bachelors degrees are more likely to rate the criterion *nursing practice reflects sensitivity for cultural needs of client* (p value .034) as critically important, than preceptors without bachelors degrees (Table 10). In Table 4 it can be seen that preceptors with bachelors degree (60%) rated this criterion similarly to preceptors without bachelors degree (40%) when compared to lecturers. This finding indicates that while there is a difference between preceptors and lecturers there is also a difference within the group of preceptors. Preceptors with bachelors degrees place more emphasis on the critical importance of cultural sensitivity in nursing practice in comparison to preceptors without bachelors degrees. However, when preceptors with bachelors degrees are compared with lecturers there is a difference which may be explained by the preceptors' socialisation within the workplace where 'getting the job done' is given priority.

5.2.1 Cultural Safety

A possible explanation for the difference within the group of preceptors is the variability of exposure to cultural safety in preceptors' basic nursing education. This finding is not surprising when changes to the Education Amendment Act (1990) and changes to the New Zealand Nursing Council Standards for Registration (1990, cited in Nursing Council, 1995) are considered. In 1990 a change to the Education Amendment Act gave polytechnics the authority to confer degrees. In the same year there was a change to the Nursing Council Standards for Registration requiring cultural safety to be incorporated as an outcome of nursing education.

The demographic variables in this study indicate that some preceptors' basic education occurred before 1990 and, consequently they may not have received instruction relating to cultural safety throughout their nursing career. This contrasts to preceptors with bachelors degrees

who, throughout their basic nursing education have been required to demonstrate competence in cultural safety to become a registered nurse. It could be argued that student nurses' perceptions of cultural safety in nursing practice may be confused if they are learning alongside preceptors with an educational level that differs from that pursued by the student.

In light of the changes to the Nursing Council Standards for Registration (1990) and the changes to the Education Amendment Act (1990), the results of this study suggest that a lack of exposure to formal education processes pertaining to cultural safety in nursing practice, is a reality for some preceptors. This points to a need for instructional strategies emphasising cultural safety for potential preceptors who have not received cultural safety education. This initiative would promote the criterion for selection of preceptors recommended by the RPIEN (Department of Health, 1988) "that a preceptor demonstrate cultural sensitivity and commitment to the Treaty of Waitangi"(p. 11). Nurse educators may need to consider the inclusion of cultural safety education as a component of preceptor workshops to ensure consistency between preceptors' knowledge and teaching of the curriculum requirement for cultural safety.

Myrick and Barrett (1994) maintain that ideally preceptors should hold masters degrees and have teaching experience. However the current study shows that many preceptors have not attained the academic qualifications the student is studying for and that they have had little clinical teaching experience. Myrick and Barrett argue that lecturers perpetuate the status quo when they do not ensure that the nurses who preceptor students studying in undergraduate degrees adhere to the principles and philosophy of a degree education. It is apparent this is an area that needs further consideration.

The results of this study show there is a relationship between preceptors' educational level and their perception of the critical

importance of cultural safety in nursing practice. Consequently, lecturers' and preceptors' evaluations of culturally unsafe practice may differ.

5.3 The Clinical Evaluation Tool

The third research question asked was: *What are nurse lecturers' and nurse preceptors' perceptions of the clarity of the Clinical Standards Assessment Tool?*

In the triumvirate model of preceptorship in which the current study is based the preceptor participates in the evaluation process by providing formative evaluations to the student and the lecturer. The type of evaluation process used by the nursing school in this study is criterion-referenced which informs lecturers, preceptors and students of the criteria to be met in advance of any evaluation.

The results of this study show that only 39% of preceptors compared to 100% of lecturers had seen the tool used to evaluate student learning in the clinical setting. This raises questions of consistency and subjectivity in the evaluation process and begs the question: What method of assessment do preceptors use to evaluate the clinical practice of student nurses when stated evaluation criteria are not utilised? As suggested by Farley and Hendry (1997), without criterion-referenced tools there would be a tendency for evaluators to use norm-referencing in which they use value judgements rather than the predetermined criteria to ascertain the quality of students' professional practice. Krumme (1975) argued that norm-referenced evaluations were inconsistent and unreliable because they relied on each evaluators perception of 'average' which may vary from individual to individual and result in different interpretations of the same performance. The finding that many preceptors who participated in this study were not familiar with the evaluation tool suggests a weakness in the evaluative procedure and a deficit in the preparation of preceptors.

The preceptor provides consistent feedback to the lecturer about a student's performance, which contributes to the summative evaluation a student receives from the lecturer. If the feedback from preceptors is norm-referenced, it could be strongly argued that there is a lack of reliability and validity in the evaluation process which will lead to inconsistent student evaluations.

The subjective nature of evaluation is an issue which continues to be widely discussed. Reilly and Oermann (1992) maintain that clinical evaluation cannot be objective, however it can be fair if it is carried out in a climate denoting trust. Previous research by Dyson (1998) in the same school of nursing as the current study, found that lecturers were consistently "filtering preceptor feedback" (p. 49) which demonstrated a mistrust of the information provided by preceptors. According to Dyson the reasons for this were unclear, however the findings of this study suggest that preceptors' use of norm-referencing, provides lecturers with feedback which is inconsistent with the lecturers' criterion-referenced interpretations. It is possible therefore, that the use of different types of reference tools for the evaluation of students' clinical competence, results in lecturers filtering the feedback given to them by preceptors. This has important implications for the student who may be achieving according to set criteria but may be penalised because they are in a group of above average achievers and not meeting their level of practice.

Flager et al. (1988) and Reilly and Oermann (1992) maintain that trust between the student and the teacher is a requirement for fairness in the evaluation process, however, it might equally be said that a trusting relationship between lecturers and preceptors is a critical determinate of a fair evaluation. Davis and Barnham (1989) contend that ideally formative and summative evaluation in a preceptorship model is a collaborative process between the lecturer and the preceptor and the student. The results of this study suggest there is a need for more collaboration between lecturers and preceptors. This is necessary to maintain

consistency with evaluation processes and to increase fairness for the students.

The findings of this study have identified a 'shortfall' in preceptors' preparation. It is well documented in the literature that preceptors require guidance in the activities involved in student evaluation (Brenner, 1995; Dibert & Goldenberg, 1995; Letizia & Jennrich, 1998; Stuart-Siddall & Haberlin, 1983). Holly (1992) suggests preceptors' preparation should be provided by a formalised preceptor programme which includes sessions about evaluation tools and giving feedback to students, as well as teaching and learning strategies and, adult learning principles. Consideration needs to be given to the preparation of preceptors for their participation in student clinical evaluation.

5.3.1 Lecturers' and Preceptors' Perceptions of the Clarity of the Clinical Evaluation Tool

The findings discussed in this section were drawn from the open-ended questions in the study. These responses more accurately reflect the perceptions of lecturers than preceptors as all of the lecturers compared to only 39% of preceptors had seen the tool and therefore responded to the open-ended questions. A quasi-statistical content analysis of the data pertaining to the clarity of the *Standards for Nursing Practice* showed that the majority of respondents expressed satisfaction with the clarity of the evaluation tool. According to Reilly and Oermann (1992) and Hawranik (2000) clarity of the learning objectives for clinical practice is a requirement for fair clinical evaluation, and is dependent on the consistent application of a valid and reliable tool.

Although criterion-referenced tools are said to be more valid and reliable than norm referenced tools the main obstacle with them is that they rely on the subjective decision of the evaluator (Chambers, 1998). This raises the issue of interrater reliability which depends on consistent interpretation amongst assessors. While it is apparent from the comments

made by most respondents that the clinical evaluation tool has face validity - *appropriate criteria to measure clinical practice; clear detailed and holistic; enables effective learning strategies* - it was also apparent there were differences in interpretation of the tool suggesting the need for further research to ascertain the tool's overall validity and reliability.

5.3.1.1 Problems perceived by lecturers and preceptors pertaining to the clinical evaluation tool

Many respondents in the current study commented they had difficulty using the *Standards for Nursing Practice.* Respondents identified two main problems. Firstly, difficulty understanding and interpreting the clinical evaluation criteria - *difficult to interpret; results in a variety of interpretations or misinterpretations; could lead to inconsistency with assessments*, and, secondly, insufficient preparation for using the tool - *a teaching session should be given.* Respondents indicated they needed guidance with - *writing to standards; determining merit achievement* and, *the expectations of the institute.*

The detail and length of the tool was also problematic. The findings show that some evaluators' expectations of students' practice varies from the school's expectations. Clearly the problems identified need to be addressed to improve consistency with the use of the tool as the desired outcome of evaluation is that it is a fair measure of the student's learning.

It was also apparent that the clinical evaluation tool is not always available in clinical areas. This may account for the low number of preceptors who had seen the tool. It is imperative that this be addressed if students are to receive valid and fair evaluations of their learning in clinical areas.

The shortcomings of the tool that were identified by lecturers and preceptors will influence the reliability of the clinical evaluations students receive. In light of these difficulties, it follows that the tool's reliability is

an issue that needs to be addressed and could provide the basis for further study. Test – retest reliability of the tool has not been established, and warrants attention. There is also a need for further exploration of the overall validity of the clinical evaluation tool described in this study.

The issue of reliability, validity and objectivity related to clinical evaluation is a constant theme in the literature (Cottrell et al., 1986; Ross, et al., 1988; Sommerfeld & Accola, 1978). However, there is a lack of research studies available that actually investigate the accuracy or the adequacy of clinical evaluation tools (Hawranik, 2000). Wong and Wong (1987) point out that validity and reliability in clinical evaluation are dependent on the evaluators' understanding and interpretation of the evaluation criteria. The respondents in this study identified that a *more user-friendly language* was a much-needed improvement to the tool. Other suggestions for improvement were: *Simplification of terminology; fewer repetitive statements; shorter format and more concise statements; more clarity with merit grade; an instruction sheet to identify critical points; more room to write on the evaluation form;* and, *examples for documenting progress.*

The findings indicated that respondents wanted specific preparation time prior to students commencing their clinical placements, to familiarise themselves with the clinical evaluation tool.

5.4 Conclusion

This study has identified that the lecturers and preceptors have more similarities than differences in their 'self-reported' valuing of specific clinical competencies of second year student nurses. While there were similarities between lecturers and preceptors in their valuing of *most* criteria, there were also differences in four criteria overall.

Several factors contributed to the differences: The professional socialisation of preceptors to a work-based value system; a lack of

exposure to the education environment for preceptors; difficulty with defining competent clinical practice and preceptors level of experience.

This study also explored the influence of preceptors' educational level on the valuing of specific criteria. The level of educational preparation of the preceptor was shown to have most influence on preceptors' valuing of cultural safety.

The clarity of the clinical evaluation tool was also investigated. It was found, that while most respondents' comments expressed satisfaction with the tool's clarity some respondents identified areas for improvement.

Both this study and Ferguson and Calder's (1993) study used simulated clinical evaluations. Neither study explored whether the 'self reported' valuing of specific criteria by preceptors was actually evident in feedback given to students. Therefore, further research is needed to specifically explore preceptors' real evaluations of student practice in the clinical setting.

The findings of both studies provide support for preceptors' participation in the clinical evaluation of preceptored nursing students. However, strategies need to be developed which prepare and support preceptors for their role in the clinical evaluation of nursing students. The criteria for selection of preceptors also needs further consideration.

The findings of this study have highlighted the need for closer collaboration between lecturers and preceptors to enhance student learning and maintain fairness of clinical evaluations.

It is concluded that the variability with lecturers' and preceptors' clinical evaluations reported by nursing students, has arisen from the different reference systems (norm vs. criterion-based) being used to evaluate students' clinical practice. This is compounded with clinical evaluation criteria which some evaluators find difficult to interpret.

Different valuing of the critical importance of some clinical evaluation criteria by lecturers and preceptors is also a contributing factor.

While the current study endorses preceptor participation in the evaluation process, its relevance to clinical teaching needs to be considered in context of the other roles of the preceptor. The evaluation process is linked to the teaching role of the preceptor as they work alongside the student and observe their practice. An important part of that role is to give feedback to the student to inform students of their progress. It is critical that students receive regular feedback that is consistent with the school's expectations and that their progress is recorded accurately. It is also important for preceptors to learn the students capabilities and understand their learning needs to guide safe practice. The preceptor has regular contact with the lecturer and the preceptors observations and judgements of students' practice contribute to the overall evaluation a student receives. The preceptor is also a socialisation agent for students' transition into the clinical environment. In this role the preceptor role-models clinical practice and determines the learning opportunities that are available to the student to consolidate their practice.

CHAPTER SIX

CONCLUSION

While the information gathered has provided evidence to refine current evaluation procedures in the preceptorship model, there are some limitations that need to be considered when interpreting the data in this study.

In the present study data were gathered from a small and relatively homogeneous sample which limits generalisation of the findings outside this particular nursing school.

While the overall response rate of 53% was not ideal, it was acceptable. Fain (1999, p. 102) suggests that a realistic response rate for questionnaires is "30% to 60%".

The study did not determine whether preceptors' stated valuing of specific clinical evaluation criteria was evident in their actual evaluations. Evaluations in clinical practice, result from a student's performance on a variety of criteria, rather than on single items. Therefore, it is possible that the outcome of this study may not reflect the actual evaluation process as experienced by students in the real setting. Future research on preceptorship could specifically explore preceptors' actual evaluations of student nurses' practice to help develop the role of the preceptor in this area of clinical teaching.

This study used a self-developed data collection tool as there was no existing tool that would serve the purpose of the current study. The specific nature of the tool precludes its use in other settings. However, there is potential for the CSRS to further refine clinical evaluation

procedures within the school. The tool may offer opportunities for exploring what educators and clinicians consider to be the most critically important aspects of student nurses' practice. It may also assist in seeking evaluators' perceptions of the clinical evaluation tool with the purpose of further modifying it to increase interrater reliability.

Reliability of the CSRS was established by the moderate to high Cronbach's alpha (0.56 - 0.94) indicating that it could be reasonably assured that the significant associations in this study were real differences and not errors of measurement (Cockburn & De Luise, 1992). The CSRS was developed from the school's Standards for Nursing Practice therefore it was a valid instrument for providing answers to the research questions. Piloting the tool also assisted in establishing its validity.

In order to gain more in-depth and richer data from this descriptive design, the questionnaire included open-ended questions. This enabled respondents to express their views more freely. Using a combination of objective and subjective data strengthens the research findings.

6.1 Implications

The purpose of the present research was to explore the evaluation of student nurses' clinical competence by their preceptors and, to establish the clarity of the clinical evaluation tool used by the nursing school in which the study is sited. The aim of this study was to provide a research-based approach to improve the process of clinical evaluation in the preceptorship model. The present study provides support for preceptors' involvement in clinical evaluation and highlights future directions for research and development of the preceptor role. It also suggests modifications to the design and accessibility for use of the clinical evaluation tool in order to increase its overall reliability.

The question of reliability and validity when evaluating clinical competence has important implications for nursing education, the

profession and society as a whole. Evaluators need to be aware of their accountability when evaluating students. Inconsistent evaluations impact on the safety and well being of the client and the quality of the care they receive. Ultimately this may result in incompetent nurses gaining registration. This has serious implications for the profession and, as mentioned, for those cared for by members of the profession.

New Zealand's current health care reforms are challenging nursing's role in the contribution of health care and placing new demands on nurses professional responsibilities. Such reforms demand that nursing education must adapt to meet the changes required to produce new graduates who are safe and competent to practice in a changing and complex environment. This requires closer collaboration between nursing education and nursing service. This collaboration is being promoted in the preceptorship model of clinical teaching.

This research study contributes empirically based knowledge to the developing literature related to the preceptorship model and preceptors' role in students' clinical evaluation in particular.

The following recommendations suggest possible areas for further research and changes in the process for preparation of preceptors to enhance students' learning in clinical practice. This is imperative if we are to produce educationally and clinically competent graduates.

6.2 Recommendations

As a result of the findings of this research I recommend that:

- The preparation of preceptors for their role in student evaluation should be addressed. Preceptor workshops should include teaching sessions to familiarise preceptors with the *Standards for Nursing Practice,* and the curriculum requirements of student's practice.

- Cultural safety training should be provided for preceptors who have not received formal instruction on the concept.

- Greater collaboration is needed between lecturers and preceptors to provide a more supportive learning environment for students.

- There should be regular formal meetings between lecturers and charge nurses to plan strategies to promote the clinical learning of student nurses.

- The educational institution's Standards for Nursing Practice should be rewritten using a more user-friendly language, and with input from preceptors.

- Ensure preceptors have access to the clinical evaluation tool when working with students.

- Further research should be carried out to explore the preceptors involvement in clinical evaluation.

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APPENDIX A

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : COMMUNICATION		
YEAR ONE	**YEAR TWO**	**YEAR THREE**
Identifies own strengths and limitations as a communicator. ***Begins to explore professional methods of communication with clients in various contexts.*** ***Articulates own feelings, thoughts and ideas clearly and logically.***	***Continues to develop therapeutic communication with clients.*** ***Communicates appropriately within the context of nursing practice.***	***Communicates effectively and professionally with individuals and groups.***
****Communicates Effectively and Therapeutically with Clients****		
STANDARDS FOR NURSING PRACTICE		
• Communicates effectively with older client using a variety of modalities • Identifies strengths and limitations of own communication • Begins to recognise the effect his/her own behaviour and communication has on the nurse/client relationship • Differentiates between the content and process of communication	• Demonstrates that using communication skills acknowledges different therapeutic client needs and changing environment.	• Is able to recognise and respond appropriately to the lived experience of clients and families.
• Initiates interactions appropriately • Uses attending skills when interacting with clients • Begins to use facilitation skills • Checks own perception with that of clients • Uses appropriate touch to facilitate communication • Recognises the appropriate communication skills for the client's situation • Recognises and responds to obvious client cues	• Identifies strategies to develop professional therapeutic communication • Uses a range of communication modes to ensure effective nurse/client communication • Shows congruence between communication and action • Recognises and responds to less obvious client cues • Shows an ability to communicate therapeutically with clients	• Actively develops therapeutic communication • Works with the client to create a therapeutic environment • Uses therapeutic communication skills in a professional manner without direct supervision • Communicates in a manner that respects the partnership role with clients and families • Communicates effectively and therapeutically with groups/families and children
• Terminates interaction/relationship appropriately		

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : COMMUNICATION		
YEAR ONE	**YEAR TWO**	**YEAR THREE**
Identifies own strengths and limitations as a communicator. ***Begins to explore professional methods of communication with clients in various contexts.*** ***Articulates own feelings, thoughts and ideas clearly and logically.***	***Continues to develop therapeutic communication with clients.*** ***Communicates appropriately within the context of nursing practice.***	***Communicates effectively and professionally with individuals and groups.***
"Interacts and Communicates Effectively in a Health Care Setting"		
STANDARDS FOR NURSING PRACTICE		
• Keeps current, accurate and legible records • Demonstrates a development in the use of clinical language • Gives accurate information to members of health care team	• Documents and records the care planned for clients • Maintains records of client's progress.	• Maintains essential written records and communication • Written plans are consistent with client needs and care given • Written documentation reflects comprehensive nature of interaction with clients.
• Interacts appropriately with clinical staff and colleagues • Meets contracted arrangements with client, clinical staff and lecturer	• Contributes to team discussions on client's care when appropriate • Communicates relevant information to health care team • Interacts with health care team	• Communicates planned client's care to other members of the health care team • Communicates effectively in an interdisciplinary team • Uses correct clinical language when appropriate • Shows an ability to use informatic technology appropriate to clinical setting • Communicates with individuals and groups in a professional manner
• Begins to negotiate own clinical experience • Responds appropriately to guidance from lecturer and registered nurse	• Negotiates own clinical experiences • Articulates own learning needs to clinical staff and lecturers • Discusses own practice appropriately with lecturer/clinical staff	• Assumes responsibility for communicating learning needs to clinical staff • Able to discuss own practice with clinical staff and peers

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : COMPETENCY		
YEAR ONE	**YEAR TWO**	**YEAR THREE**
Begins to assess clients effectively using nursing knowledge *Implements appropriate nursing interventions safely* *Beginning to understand the interdependence of knowledge and practice* *Recognises own strengths and limitations*	*Prioritises nursing care in a safe and effective way, demonstrating effective problem solving methods* *Developing ways to integrate knowledge and practice* *Assesses own and peers' performance against a given criteria*	*Demonstrates a professional nursing practice base which recognises the interdependence of theoretical knowledge, practice wisdom and established practice standards*
STANDARDS FOR NURSING PRACTICE		
• Begins to base the implementation of appropriate interventions on assessment • Participates in and recognises the need for ongoing assessment of clients • Uses a problem solving format as a basis for nursing practice • Recognises relevant sources of data collection, eg. Client appearance, notes, information from relatives • Draws conclusions about client's health status from assessment data, eg. Nursing diagnoses	• Client care is based on ongoing assessment • Can use a nursing knowledge as a basis for practice • Collects sufficient information to formulate client's needs/problems • Incorporates all appropriate data in assessment, eg. Clinical tests • Identifies individual client need from data.	• Undertakes specified detailed assessments when appropriate • Can use nursing knowledge to guide your nursing practice and problem solving in a deliberate manner, that is dynamic rather than linear • Rapidly assesses clinical safety needs • Analyses, prioritises and acts on all data using multiple ways of knowing • Proposes nursing diagnosis consistent with assessment and individual client
• Identifies appropriate nursing care requirements with assistance from an experienced clinician/lecturer and plans care accordingly	• Begins to prioritise care according to known information • Plans appropriate nursing care requirements with clients, when appropriate	• In partnership with client, develops realistic outcomes of client care • Plans client care within an appropriate time frame

• Implements nursing care in collaboration with the client when possible or appropriate • Nursing practice demonstrates the expected knowledge for level of programme, eg. Application of bioscience • Performs technical skills safely recognising underlying principles of practice • Nursing care effectively assists client to maintain comfort, dignity and well-being • Understands rationale for decisions/actions taken in implementation of care • Recognises the elements of caring within nursing practice, eg. Knowledge base, skill development • Nursing care reflects the whole client situation – social, emotional, physical, spiritual and cultural • Performs nursing care within an appropriate time frame • Aware of the link between own emotional well-being and caring	• Determines and carries out a plan of care that is safe and competent, in partnership with the client when possible and with staff supervision • Nursing care and decisions are based on rationale using knowledge and experience • Performs skills competently • Organises nursing care within an appropriate time frame • Begins to adapt nursing practice according to situations/clients • Is aware of own emotions and their effect on self • Responds appropriately to factors that effect client safety • Demonstrates caring while implementing nursing practice	• Nursing care is developing adequately to be at the expected level of a newly registered nurse by the end of the third year • Effectively manages situations which call for non-collaborative decision making • Nursing care and decisions are based on sound clinical judgement • Uses knowledge and skill to empower client • Able to nurse safely within a dynamic and complex client environment • Manages nursing care within an appropriate time frame • Consistently demonstrates caring in nursing practice • Responds effectively and safely in an emergency or time constrained situation
• Utilises nurse lecturers to validate client care • Evaluates effectiveness of care implemented	• Utilises clinical staff/nurse lecturers to evaluate/validate client care • Evaluates and reviews client status in response to care given	• Checks the validity of own evaluations • Utilises valid criteria to measure nursing actions and decisions, utilising other health care professionals and the client

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS: THINKS CRITICALLY WITHIN NURSING PRACTICE

YEAR ONE	YEAR TWO	YEAR THREE
Uses information to support arguments on issues and statements, presents ideas in a logical and clear way *Uncovers assumptions inherent in own ideas*	*Analyses information gained from the use of criteria and appropriate frameworks* *Analyses discrepancies between ideas from self, others and societal norms*	*Uses critical thinking abilities to continually develop, refine, enhance and validate nursing practice* *Demonstrates appropriate reflection on, and reasoned judgement about, nursing practice*

STANDARDS FOR NURSING PRACTICE

• Developing reflective skills, eg. – Can provide a comprehensive description of selected nursing activities – Begins to tell insightful stories about experiences and uses outcome of analysis within own practice – Begins to recognise the difference between own and client's reality in nursing situations – Begins to identify alternative nursing actions following reflection	• Uses reflective skills to enhance nursing practice, eg. – Identifies values and beliefs that underly practice – explores own practice through dialoguing, journalling, drawing etc. • Begins to show creativity, eg. – Lateral thinking in planning and delivery of care – Shows initiative in nursing practice	• Engages in praxis and reflective practice, eg. – demonstrates insights into own performance – acknowledges different nursing approaches – analyses the culture of nursing – appreciates the complexity of practice – critically analyses the impact of own practice on client and families • Utilises reflection to enhance practice
• Uses a problem solving format as a foundation for nursing practice • Begins to use nursing and other frameworks as the basis for nursing practice • Recognises contextual determinants in understanding client and nurse behaviour	• Begins to use theoretical frameworks that are appropriate for different clients • Uses nursing and other theories to enhance practice	• Articulates nursing and other theoretical concepts/knowledge which guide nursing practice • Recognises the contribution different nursing theories make to practice • Practice reflects an understanding of multiple ways of knowing • Critically analyses the impact of own practice on client and families

• Recognises own development in practice	• Can identify changes in own practice • Critiques own practice	• Refines own practice in recognition of developing knowledge • Critically evaluates the quality of nursing care within the social/political context • Recognises sociopolitical factors that impact on the practice of nursing • Assumes responsibility for own clinical judgement and action • Shows an ability to think in an autonomous manner

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : PROFESSIONALISM IN NURSING PRACTICE

YEAR ONE	YEAR TWO	YEAR THREE
Begins to identify influences in New Zealand society that affect health care and nursing practice *Explores and accepts responsibility for own actions and learning*	*Practises nursing reflecting a value of the worth of individuals* *Interacts appropriately with other health professionals* *Reflects on the concept of power in nursing practice and health care and begins to develop the role of client advocate*	*Assumes professional accountability for practice in contemporary society*
STANDARDS FOR NURSING PRACTICE		
• Begins to understand the role and scope of professional nursing practice within the specific clinical context • Practices in accordance with relevant legislation and protocols within the clinical agency, eg. – Privacy Act – Medicines Act – Health and Disabilities Act – Health Commissioner Act – Code of Clients Rights	• Shows awareness of legislation that impacts on his/her practice, eg. – Mental Health Act • Practices in accordance with relevant legislation and health agency policies, eg. – Informed consent – IV policy	• Practices in accordance with relevant legislation, eg. – Nurses Act
• Practises nursing within codes and standards of practice with guidance, eg. – Begins to recognise the complexities related to maintaining client confidentiality	• Accepts responsibility for practising within professional codes, eg. – Discusses issues of client confidentiality with others	• Practises nursing complying with professional codes of practice, eg. – Uses professional judgement within issues of confidentiality
• Demonstrates an understanding of the role and practice of nursing within a specific setting • Is aware of the impact of funding of services for clients, service providers and on nursing practice	• Is aware of issues which impact on health and health care, eg. – Shows awareness of factors which may cause conflict in a nursing context – Recognises the scope of own nursing practice	• Actively engages in issues in relation to own professional practice, eg. – Shows an ability to deal appropriately with conflict in a nursing context – Able to fulfil responsibilities when there is a risk of incurring the disapproval of others – Is aware of how to effect change within a nursing context – Takes action to effect change when and as appropriate (client centred)

• Shows a commitment to developing practice knowledge, eg. – Shows a commitment to learning by seeking opportunities for learning and for practising skills – Shows an awareness of own learning needs and develops learning objectives in practice	• Shows a commitment to developing practice knowledge, eg. – Shows a commitment to improving own knowledge, skills and nursing practice – Utilises data to substantiate a realistic self-evaluation of practice	• Shows a commitment to developing practice knowledge, eg. – Able to articulate personal values and beliefs about nursing – Consistently monitors own performance against quality assurance criteria – Utilises research as a basis to his/her nursing practice – Alters practice in response to self-evaluation • Demonstrates accountability for own practice
• Shows awareness of power within the nurse client relationship • Begins to incorporate the philosophy of partnership in caring for clients	• Promotes the partnership philosophy in caring with clients and family, eg. – Encourages and supports client's ability to self-care when appropriate	• Promotes the partnership philosophy in care with the client and or family, eg. – Promotes the value of client/family centred care within the health care system – Develops the ability to empower the client – Practises nursing in a way that empowers the client
• Maintains professional behaviour and attitudes in nursing, eg. – Meets contracted time arrangements – Enthusiasm and commitment to practice – Takes responsibility for personal health as a nurse – Punctuality within practice	• Maintains professional behaviour and attitudes in nursing, eg. – Punctuality within practice	• Maintains professional behaviour and attitudes in nursing, eg. – Meets all contractual arrangements

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : VALUING IN NURSING PRACTICE

YEAR ONE	YEAR TWO	YEAR THREE
Identify own values and beliefs, how they relate to own judgements and behaviour and how these differ from others' judgements and behaviour. *Practices in a way that demonstrates valuing of clients, staff and family.*	*Identify, respect and develop ethical reasoning in relation to the differing values and beliefs of individuals and groups within the moral and ethical conflicts that arise from nursing practice.*	*Respect, be aware and be able to act on recognised and understood value systems of self, individuals and groups and the moral and ethical conflicts that arise from nursing practice.*
STANDARDS FOR NURSING PRACTICE		
• Recognises how own values and beliefs impact on client care • Identifies the dominant values within their clinical setting • Recognises obvious moral/ethical dilemmas in nursing	• Respects client's culture, values and beliefs without inflicting own values on client • Nursing care responds to how client perceives his/her problem(s) and treatment • Shows awareness of value dilemmas in the use of technology • Recognises the impact institutional values have on client's care • Begins to recognise the differing values and beliefs involved in ethical issues • Promotes client individuality	• Uses an ethical framework to address ethical dilemmas • Advocates appropriately for client when client's values/wishes conflict with the practice setting • Maintains client/family as centre of practice • Nursing practice reflects respect for differing values, when in conflict with own values and beliefs
• Demonstrates genuine respect for clients and maintains their dignity • Recognises the ability of client and appropriately involves in decision making and nursing care • Plans care taking into account client's wishes where possible • Facilitates family's participation in decision making and nursing care when appropriate and possible • Nursing action reflects an awareness of client's rights	• Shows awareness of the cultural, spiritual and moral influences that affects client's health • Negotiates with client their involvement in own care • Promotes client's awareness of rights	• Practises nursing in a manner that is culturally safe for clients and their families • Works with client to create an environment that is culturally safe • Involves client in the decision making process and supports his/her decision • Nursing practice promotes partnership with client and family • Makes informed value judgements and ethical decisions when faced with dilemmas or conflicts • Recognises ethical decisions may involve a multi-disciplinary approach • Nursing practice demonstrates humanistic issues related to client's rights

• Recognises specific cultural needs of clients • Recognises individual differences and takes these into account when caring for clients	– Nursing practice reflects sensitivity for cultural needs of client	• Recognises ethical decisions for clients are based on their cultural values • Advocates for client to facilitate cultural needs
• Shows a willingness to care • Aware of link between own emotional wellbeing and caring	• Begins to recognise the reality of client's experience • Demonstrates a caring attitude	• Cares effectively for client without relying on a positive response • Values the family's involvement in individual care • Nursing care reflects the reality of client's experience • Nurses clients holistically • Maintains a caring focus in nursing, including complex and challenging situations • Practice consistently reflects a genuine caring attitude
• Demonstrates respect for colleagues and peers	• Values the worth of input of other health professionals	• Actively supports colleagues in practice

APPENDIX B

INSTRUCTION SHEET

QUESTIONNAIRE

Please complete all parts of the questionnaire and answer all questions based on your own beliefs.

Specific instructions for each part of the questionnaire precede the questions.

When you have completed the form, please seal it in the accompanying envelope and return via internal mail by 22nd November 1999

THANK YOU FOR YOUR PARTICIPATION IN THIS RESEARCH PROJECT

PART 1

This part of the questionnaire will collect data concerning your professional experience as a nurse.

Please circle the number(s) beside your choice of answer.

1. How much experience in total do you have in nursing?
   1. Less than 1 year
   2. 1 year to less than 3 years
   3. 3 years to less than 5 years
   4. 5 years to less than 10 years
   5. 10 years to less than 15 years
   6. 15 years to less than 20 years
   7. over 20 years

2. How many times have you acted in the role of clinical lecturer in the preceptor model to a second year nursing student?
   1. none
   2. once
   3. twice
   4. three
   5. four
   6. five
   7. more than five

3. What nursing qualification(s) have you attained?
   1. Registered Nurse
   2. Enrolled Nurse
   3. Diploma in Nursing
   4. Bachelors Degree
   5. Post Graduate Certificate
   6. Masters Degree
   7. Other - please specify _____

PART 2

RATING SCALE FOR
AUCKLAND INSTITUTE OF TECHNOLOGY
Bachelor Of Health Science (Nursing)
STANDARDS FOR CLINICAL PRACTICE
Year Two

This part of the questionnaire explores your beliefs about the importance of selected criteria to your evaluation of the clinical performance of second year nursing students. All of these criteria are important aspects of clinical practice but some may be more important to you than others, when you evaluate a student's overall performance.

Please indicate the relative importance you attach to each criterion using the scale provided. Any point on the scale is your judgement of the relative importance of this criteria in the overall evaluation of the student's performance. A critically important criterion is defined as one that you consider the student must perform satisfactorily to achieve OVERALL acceptable clinical performance.

Please circle the number between 1 to 6 which best indicates the importance you attach to each criterion.

less important 1 2 3 4 5 **crititically important** **undecided** 6

COMPETENCY

1.	Client care is based on ongoing assessment	1	2	3	4	5	6
2.	Can use a nursing knowledge as a basis for practice	1	2	3	4	5	6
3.	Collects sufficient information to formulate client's needs/problems	1	2	3	4	5	6
4.	Incorporates all appropriate data in assessment, e.g. clinical tests	1	2	3	4	5	6
5.	Identifies individual clients needs from data	1	2	3	4	5	6
6.	Prioritises care accordingly to known information	1	2	3	4	5	6
7.	Plans appropriate nursing care requirements with client, when appropriate	1	2	3	4	5	6
8.	Determines and carries out a plan of care that is safe and competent, in partnership with the client when possible and appropriate	1	2	3	4	5	6
9.	Nursing care and decisions are based on sound rationale using knowledge and experience	1	2	3	4	5	6
10.	Performs technical skills competently recognising contextual influences	1	2	3	4	5	6
11.	Applies holistic concepts to client care	1	2	3	4	5	6
12.	Organises nursing care within an appropriate time frame	1	2	3	4	5	6
13.	Begins to adapt nursing practice according to situations/clients	1	2	3	4	5	6
14.	Is aware of own emotions and their effect on self and on client's care	1	2	3	4	5	6
15.	Responds rapidly and appropriately to factors that effect client safety	1	2	3	4	5	6

16.	Demonstrates caring while implementing nursing practice	1	2	3	4	5	6
17.	Utilises clinical staff/nurse lecturers to evaluate/validate client care	1	2	3	4	5	6
18.	Evaluates and reviews client status in response to care given	1	2	3	4	5	6
19.	Able to determine appropriate criteria to measure the effectiveness of client care	1	2	3	4	5	6

CRITICAL THINKING

1.	Uses reflective skills to enhance nursing practice.	1	2	3	4	5	6
2.	Begins to show creativity within nursing care	1	2	3	4	5	6
3.	Uses theoretical frameworks that are appropriate for different clients	1	2	3	4	5	6
4.	Uses nursing and other theories to enhance practice	1	2	3	4	5	6
5.	Can identify changes in own practice	1	2	3	4	5	6
6.	Critiques own practice using criteria	1	2	3	4	5	6
7.	Recognises sociopolitical factors that impact on the practice of nursing	1	2	3	4	5	6
8.	Shows an ability to think in an autonomous manner	1	2	3	4	5	6

PROFESSIONALISM

1.	Shows awareness of legislation that impacts on his/her practice	1	2	3	4	5	6
2.	Practices in accordance with relevant legislation and health agency policies	1	2	3	4	5	6
3.	Accepts responsibility for practising within professional codes	1	2	3	4	5	6
4.	Is aware of issues which impact on health and health care	1	2	3	4	5	6
5.	Shows a commitment to developing practice knowledge	1	2	3	4	5	6
6.	Promotes the partnership philosophy in caring with clients and family	1	2	3	4	5	6
7.	Maintains professional behaviour and attitudes in nursing	1	2	3	4	5	6

VALUING

1.	Respects client's culture, values and beliefs without inflicting own values on client	1	2	3	4	5	6
2.	Nursing care responds to how client perceives his/her problem(s) and treatment	1	2	3	4	5	6
3.	Shows awareness of value dilemmas in the use of technology	1	2	3	4	5	6
4.	Recognises the impact institutional values have on client's care	1	2	3	4	5	6
5.	Recognises the differing values and beliefs involves in ethical issues	1	2	3	4	5	6
6.	Promotes client individuality	1	2	3	4	5	6
7.	Shows awareness of the cultural, spiritual and moral influences that affects client's health	1	2	3	4	5	6
8.	Negotiates with client their involvement in own care	1	2	3	4	5	6
9.	Promotes client's awareness of rights	1	2	3	4	5	6

10.	Nursing practice reflects sensitivity for cultural needs of client	1	2	3	4	5	6
11.	Begins to recognise the reality of client's experience	1	2	3	4	5	6
12.	Demonstrates a caring attitude	1	2	3	4	5	6
13.	Values the worth of input of other health professionals	1	2	3	4	5	6

COMMUNICATION

1.	Identifies strategies to develop personal therapeutic communication	1	2	3	4	5	6
2.	Develops a trusting relationship with most clients	1	2	3	4	5	6
3.	Developing fluency of communication skills within own personal style	1	2	3	4	5	6
4.	Use a range of communication modes to ensure effective nurse/client communication	1	2	3	4	5	6
5.	Shows congruence between communication and action	1	2	3	4	5	6
6.	Use communication in a proactive manner	1	2	3	4	5	6
7.	Recognises and responds to less obvious client cues	1	2	3	4	5	6
8.	Shows an ability to communicate therapeutically with clients	1	2	3	4	5	6
9.	Using appropriate communication skills acknowledging different therapeutic client needs and changing environment	1	2	3	4	5	6
10.	Documents and records the care planned for clients	1	2	3	4	5	6
11.	Maintains records of client's progress	1	2	3	4	5	6
12.	Contributes to team discussions on client's care when appropriate	1	2	3	4	5	6
13.	Communicates relevant information to health care team	1	2	3	4	5	6
14.	Interacts effectively with health care team	1	2	3	4	5	6
15.	Negotiates own clinical experiences	1	2	3	4	5	6
16.	Articulates own learning needs to clinical staff and lecturers	1	2	3	4	5	6
17.	Discusses own practice appropriately with lecturer	1	2	3	4	5	6

PART 3

This part of the questionnaire asks for your views of the Auckland Institute of Technology, Bachelor of Health Science (Nursing) "Standards for Nursing Practice".

1. Have you ever seen the A.I.T "Standards for Nursing Practice" for Bachelor of Health Science (Nursing) ?

   yes ☐ no ☐

If you have seen the "Standards for Nursing Practice" please answer the following questions:

2. What are your views on the clarity of the Standards?

3. What features do you consider most helpful?

4. What features do you consider could be improved?

5. Do you have any other comments?

APPENDIX C

INSTRUCTION SHEET

QUESTIONNAIRE

Please complete all parts of the questionnaire and answer all questions based on your own beliefs.

Specific instructions for each part of the questionnaire precede the questions.

When you have completed the form, please seal it in the accompanying envelope and return via internal mail by 22nd November 1999

THANK YOU FOR YOUR PARTICIPATION IN THIS RESEARCH PROJECT

preceptor

PART 1

This part of the questionnaire will collect data concerning your professional experience as a nurse.

Please circle the number(s) beside your choice of answer.

1. How long have you been employed on this specific ward ?
   1. Less than 1 year
   2. 1 year to less than 3 years
   3. 3 years to less than 5 years
   4. 5 years to less than 10 years
   5. 10 years to less than 15 years
   6. 15 years to less than 20 years
   7. over 20 years

2. How much experience do you have in this specific speciality of nursing?
   1. Less than 1 year
   2. 1 year to less than 3 years
   3. 3 years to less than 5 years
   4. 5 years to less than 10 years
   5. 10 years to less than 15 years
   6. 15 years to less than 20 years
   7. over 20 years

3. How much experience in total do you have in nursing?
   1. Less than 1 year
   2. 1 year to less than 3 years
   3. 3 years to less than 5 years
   4. 5 years to less than 10 years
   5. 10 years to less than 15 years
   6. 15 years to less than 20 years
   7. over 20 years

preceptor

4. How many second year nursing students have you preceptored?

1. not sure
2. one
3. two
4. three
5. four
6. five
7. more than five

5. What nursing qualification(s) have you attained?

1. Registered Nurse
2. Enrolled Nurse
3. Diploma in Nursing
4. Bachelors Degree
5. Post Graduate Certificate
6. Masters Degree
7. Other - please specify _____

PART 2

RATING SCALE FOR AUCKLAND INSTITUTE OF TECHNOLOGY
Bachelor Of Health Science (Nursing)
STANDARDS FOR CLINICAL PRACTICE
Year Two

This part of the questionnaire explores your beliefs about the importance of selected criteria to your evaluation of the clinical performance of second year nursing students. All of these criteria are important aspects of clinical practice but some may be more important to you than others, when you evaluate a student's overall performance.

Please indicate the relative importance you attach to each criterion using the scale provided. Any point on the scale is your judgement of the relative importance of this criteria in the overall evaluation of the student's performance. A critically important criterion is defined as one that you consider the student must perform satisfactorily to achieve OVERALL acceptable clinical performance.

Please circle the number between 1 to 6 which best indicates the importance you attach to each criterion.

less important 1 2 3 4 crititically important 5 undecided 6

COMPETENCY

1.	Client care is based on ongoing assessment	1	2	3	4	5	6
2.	Can use a nursing knowledge as a basis for practice	1	2	3	4	5	6
3.	Collects sufficient information to formulate client's needs/problems	1	2	3	4	5	6
4.	Incorporates all appropriate data in assessment, e.g. clinical tests	1	2	3	4	5	6
5.	Identifies individual clients needs from data	1	2	3	4	5	6
6.	Prioritises care accordingly to known information	1	2	3	4	5	6
7.	Plans appropriate nursing care requirements with client, when appropriate	1	2	3	4	5	6
8.	Determines and carries out a plan of care that is safe and competent, in partnership with the client when possible and appropriate	1	2	3	4	5	6
9.	Nursing care and decisions are based on sound rationale using knowledge and experience	1	2	3	4	5	6
10.	Performs technical skills competently recognising contextual influences	1	2	3	4	5	6
11.	Applies holistic concepts to client care	1	2	3	4	5	6
12.	Organises nursing care within an appropriate time frame	1	2	3	4	5	6
13.	Begins to adapt nursing practice according to situations/clients	1	2	3	4	5	6
14.	Is aware of own emotions and their effect on self and on client's care	1	2	3	4	5	6
15.	Responds rapidly and appropriately to factors that effect client safety	1	2	3	4	5	6

16.	Demonstrates caring while implementing nursing practice	1	2	3	4	5	6
17.	Utilises clinical staff/nurse lecturers to evaluate/validate client care	1	2	3	4	5	6
18.	Evaluates and reviews client status in response to care given	1	2	3	4	5	6
19.	Able to determine appropriate criteria to measure the effectiveness of client care	1	2	3	4	5	6

CRITICAL THINKING

1.	Uses reflective skills to enhance nursing practice.	1	2	3	4	5	6
2.	Begins to show creativity within nursing care	1	2	3	4	5	6
3.	Uses theoretical frameworks that are appropriate for different clients	1	2	3	4	5	6
4.	Uses nursing and other theories to enhance practice	1	2	3	4	5	6
5.	Can identify changes in own practice	1	2	3	4	5	6
6.	Critiques own practice using criteria	1	2	3	4	5	6
7.	Recognises sociopolitical factors that impact on the practice of nursing	1	2	3	4	5	6
8.	Shows an ability to think in an autonomous manner	1	2	3	4	5	6

PROFESSIONALISM

1.	Shows awareness of legislation that impacts on his/her practice	1	2	3	4	5	6
2.	Practices in accordance with relevant legislation and health agency policies	1	2	3	4	5	6
3.	Accepts responsibility for practising within professional codes	1	2	3	4	5	6
4.	Is aware of issues which impact on health and health care	1	2	3	4	5	6
5.	Shows a commitment to developing practice knowledge	1	2	3	4	5	6
6.	Promotes the partnership philosophy in caring with clients and family	1	2	3	4	5	6
7.	Maintains professional behaviour and attitudes in nursing	1	2	3	4	5	6

VALUING

1.	Respects client's culture, values and beliefs without inflicting own values on client	1	2	3	4	5	6
2.	Nursing care responds to how client perceives his/her problem(s) and treatment	1	2	3	4	5	6
3.	Shows awareness of value dilemmas in the use of technology	1	2	3	4	5	6
4.	Recognises the impact institutional values have on client's care	1	2	3	4	5	6
5.	Recognises the differing values and beliefs involves in ethical issues	1	2	3	4	5	6
6.	Promotes client individuality	1	2	3	4	5	6
7.	Shows awareness of the cultural, spiritual and moral influences that affects client's health	1	2	3	4	5	6
8.	Negotiates with client their involvement in own care	1	2	3	4	5	6
9.	Promotes client's awareness of rights	1	2	3	4	5	6

10.	Nursing practice reflects sensitivity for cultural needs of client	1	2	3	4	5	6
11.	Begins to recognise the reality of client's experience	1	2	3	4	5	6
12.	Demonstrates a caring attitude	1	2	3	4	5	6
13.	Values the worth of input of other health professionals	1	2	3	4	5	6

COMMUNICATION

1.	Identifies strategies to develop personal therapeutic communication	1	2	3	4	5	6
2.	Develops a trusting relationship with most clients	1	2	3	4	5	6
3.	Developing fluency of communication skills within own personal style	1	2	3	4	5	6
4.	Use a range of communication modes to ensure effective nurse/client communication	1	2	3	4	5	6
5.	Shows congruence between communication and action	1	2	3	4	5	6
6.	Use communication in a proactive manner	1	2	3	4	5	6
7.	Recognises and responds to less obvious client cues	1	2	3	4	5	6
8.	Shows an ability to communicate therapeutically with clients	1	2	3	4	5	6
9.	Using appropriate communication skills acknowledging different therapeutic client needs and changing environment	1	2	3	4	5	6
10.	Documents and records the care planned for clients	1	2	3	4	5	6
11.	Maintains records of client's progress	1	2	3	4	5	6
12.	Contributes to team discussions on client's care when appropriate	1	2	3	4	5	6
13.	Communicates relevant information to health care team	1	2	3	4	5	6
14.	Interacts effectively with health care team	1	2	3	4	5	6
15.	Negotiates own clinical experiences	1	2	3	4	5	6
16.	Articulates own learning needs to clinical staff and lecturers	1	2	3	4	5	6
17.	Discusses own practice appropriately with lecturer	1	2	3	4	5	6

PART 3

This part of the questionnaire asks for your views of the Auckland Institute of Technology, Bachelor of Health Science (Nursing) "Standards for Nursing Practice".

1. Have you ever seen the A.I.T "Standards for Nursing Practice" for Bachelor of Health Science (Nursing) ?

   yes ☐ no ☐

If you have seen the "Standards for Nursing Practice" please answer the following questions:

2. What are your views on the clarity of the Standards?

3. What features do you consider most helpful?

4. What features do you consider could be improved?

5. Do you have any other comments?

APPENDIX D

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences - Albany
Private Bag 102 904,
North Shore Mail Centre,
Auckland, New Zealand
Telephone: 64 9 443 9700
Facsimile: 64 9 443 9372

Preceptor And Lecturer Valuing Of Clinical Performance Criteria

INFORMATION SHEET

Dear Lecturer

I am a Graduate Student of the School of Health Sciences, Massey University and carrying out a research study for a Masters of Arts (Nursing) degree. The Massey University Human Ethics Committee has approved this study and given me permission to invite you to participate because you have been a clinical lecturer to second year students.

The aim of the study is to explore how lecturers and preceptors rate the importance of the criteria used to determine the acceptability of student nurses' clinical performance. The study comprises of a questionnaire based on the criteria for the Auckland Institute of Technology, School of Nursing and Midwifery, "Standards for Nursing Practice". Responses to the questionnaire are very important because the number of clinical lecturers is limited.

The decision to participate is entirely voluntary. You can be become involved in this study by completing and returning the enclosed questionnaire. You have the right to refuse to answer any particular question. You may benefit as a participant by knowing that you will have contributed to our knowledge relating to the evaluation of student clinical performance. Harm to you as a participant in the study is likely to be minimal, but there may be a small increase in workload as the questionnaire will take approximately fifteen minutes to complete.

If you decide to participate in this study, any information provided and any publications resulting from it will be kept confidential. Anonymity is guaranteed, as no information is traceable to individuals taking part in the study. Collection, use and storage of information are in accordance with the Privacy Act 1993. Questionnaires will be destroyed after a 5 year period.

My supervisor for this project is Michelle Adams, R.N., M.A. Associate Teacher, School of Health Sciences, Massey University, who can be contacted by phone on (09) 4439700. I will be available to discuss any questions you may have concerning this study. I can be contacted on (09)3079999 ext.7266 (Please leave a message. AIT). I would be pleased to provide a report of the findings of this study upon request at the number above.

Thank you for taking the time to read about this research project.

Sincerely,

Dianne Marshall, R.N., B.A.
Graduate Student, School of Health Sciences
Massey University

APPENDIX E

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences - Albany
Private Bag 102 904,
North Shore Mail Centre,
Auckland, New Zealand
Telephone: 64 9 443 9700
Facsimile: 64 9 443 9372

Preceptor And Lecturer Valuing Of Clinical Performance Criteria

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Dear Preceptor

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The aim of the study is to explore how lecturers and preceptors rate the importance of the criteria used to determine the acceptability of student nurses' clinical performance. The study comprises of a questionnaire based on the criteria for the Auckland Institute of Technology, School of Nursing and Midwifery, "Standards for Nursing Practice". Responses to the questionnaire are very important because the number of clinical lecturers is limited.

The decision to participate is entirely voluntary. You can be become involved in this study by completing and returning the enclosed questionnaire. You have the right to refuse to answer any particular question. You may benefit as a participant by knowing that you will have contributed to our knowledge relating to the evaluation of student clinical performance. Harm to you as a participant in the study is likely to be minimal, but there may be a small increase in workload as the questionnaire will take approximately fifteen minutes to complete.

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Thank you for taking the time to read about this research project.

Sincerely,

Dianne Marshall, R.N., B.A.
Graduate Student, School of Health Sciences
Massey University

APPENDIX F

PRECEPTOR AND LECTURER VALUING OF CLINICAL PERFORMANCE CRITERIA

Consent to Participate in Research.

Researcher: Dianne Marshall (R.N., B.A.) Graduate Student

Supervisors: Dr Mary Finlayson
Michelle Adams (R.N., M.A.) Associate Teacher

Aim: The purpose of this study is to explore preceptors and lecturers beliefs about the **criteria** for evaluation of clinical performance rather than with the specific evaluation of the student. The questionnaire will also collect data about your professional experience and your views of the clarity of the "Standards for Nursing Practice" for the Bachelor of Health Science (Nursing) A.I.T. The researcher carrying out this study supports the principles governing both ethical conduct of research and the protection at all times of the interests, comfort and safety of participants.

Your return of the completed questionnaire implies you have consented to participate in the study and indicates eight things:

1. You have had an opportunity to ask questions and have them answered to your satisfaction. You have received sufficient information to understand the purpose of the study.

2. You understand that you have the right to decline to answer any particular question

3. You understand that once a completed questionnaire is received by the researcher your information cannot be withdrawn from the study as any information will not be traceable to you.

4. You understand that participation in the study will be kept confidential and anonymous, and is entirely voluntary.

5. You agree to complete all parts of the questionnaire without consulting your colleagues.

6. You have had time to consider whether to take part in this research project.

7. You know whom to contact if you have any concerns as a result of participation in this study.

8. You understand that questionnaires used will be destroyed following a period of 5 years and that the information from the study may be published.

APPENDIX G

All Associations Between Lecturers and Preceptors for Each of the Five Standards of the CSRS

Criteria	Lecturers			Preceptors			
	N	n	%	N	n	%	p value
Competency							
1. Client care is based on ongoing assessment	10	10	100	68	40	59	0.011
2. Can use a nursing knowledge as a basis for practice	10	6	60	67	26	39	0.304
3. Collects sufficient information to formulate client's needs/problems	10	4	40	69	32	46	0.748
4. Incorporates all appropriate data in assessment, e.g. clinical tests	10	1	10	69	17	25	0.440
5. Identifies individual clients needs from data	10	5	50	69	18	26	0.145
6. Prioritises care accordingly to known information	10	3	30	69	31	45	0.502
7. Plans appropriate nursing care requirements with client, when appropriate	10	5	50	69	22	32	0.297
8. Determines and carries out a plan of care that is safe and competent, in partnership with the client when possible and appropriate	10	7	70	69	39	56	0.508
9. Nursing care and decisions are based on sound rationale using knowledge and experience	10	3	30	68	30	44	0.505
10. Performs technical skills competently recognising contextual influences	10	1	10	69	19	28	0.438
11. Applies holistic concepts to client care	10	3	30	68	21	31	1.000
12. Organises nursing care within an appropriate time frame	10	0	0	69	15	22	0.194

Criteria (continued)	Lecturers			Preceptors			
	N	n	%	N	n	%	p value
Competency (continued)							
13. Begins to adapt nursing practice according to situations/clients	9	1	11	68	17	25	0.676
14. Is aware of own emotions and their effect on self and on client's care	10	4	40	66	22	33	0.728
15. Responds rapidly and appropriately to factors that effect client safety	10	9	90	69	46	67	0.268
16. Demonstrates caring while implementing nursing practice	10	8	80	67	30	45	0.047
17. Utilises clinical staff/nurse lecturers to evaluate/validate client care	10	7	70	68	35	51	0.326
18. Evaluates and reviews client status in response to care given	10	4	40	68	23	34	0.731
19. Able to determine appropriate criteria to measure the effectiveness of client care	10	1	10	67	17	25	0.437
Critical Thinking							
1. Uses reflective skills to enhance nursing practice.	10	4	40	67	25	37	1.000
2. Begins to show creativity within nursing care	10	1	10	69	6	9	1.000
3. Uses theoretical frameworks that are appropriate for different clients	9	0	0	68	10	15	0.596
4. Uses nursing and other theories to enhance practice	10	1	10	69	10	14	1.000
5. Can identify changes in own practice	10	4	40	69	22	32	0.722
6. Critiques own practice using criteria	10	5	50	67	20	30	0.279
7. Recognises sociopolitical factors that impact on the practice of nursing	10	1	10	66	10	15	0.292
8. Shows an ability to think in an autonomous manner	9	1	11	68	18	26	0.438

Criteria (continued)		Lecturers			Preceptors			
		N	n	%	N	n	%	p value
Professionalism								
1.	Shows awareness of legislation that impacts on his/her practice	10	4	40	68	26	38	1.000
2.	Practices in accordance with relevant legislation and health agency policies	10	6	60	69	39	56	1.000
3.	Accepts responsibility for practising within professional codes	10	6	60	69	44	64	1.000
4.	Is aware of issues which impact on health and health care	10	1	10	69	15	22	0.677
5.	Shows a commitment to developing practice knowledge	10	5	50	69	42	60	0.515
6.	Promotes the partnership philosophy in caring with clients and family	10	7	70	69	29	42	0.172
7.	Maintains professional behaviour and attitudes in nursing	10	7	70	69	51	74	0.721
Valuing								
1.	Respects client's culture, values and beliefs without inflicting own values on client	10	9	90	69	48	70	0.268
2.	Nursing care responds to how client perceives his/her problem(s) and treatment	9	5	56	68	23	34	0.273
3.	Shows awareness of value dilemmas in the use of technology	9	2	22	62	13	20	1.000
4.	Recognises the impact institutional values have on client's care	10	2	20	68	16	24	1.000
5.	Recognises the differing values and beliefs involves in ethical issues	10	2	20	67	21	31	0.714
8.	Promotes client individuality	10	6	60	68	30	44	0.500
9.	Shows awareness of the cultural, spiritual and moral influences that affects client's health	10	8	80	68	29	43	0.041
10.	Negotiates with client their involvement in own care	10	6	60	68	34	50	0.738
11.	Promotes client's awareness of rights	10	6	60	68	29	43	0.330

Criteria (continued)		Lecturers			Preceptors			
		N	n	%	N	n	%	p value
Valuing (continued)								
12.	Nursing practice reflects sensitivity for cultural needs of client	10	8	80	67	23	34	0.012
13.	Begins to recognise the reality of client's experience	10	4	40	68	22	32	0.724
14.	Demonstrates a caring attitude	10	8	80	68	45	66	0.487
15.	Values the worth of input of other health professionals	10	5	50	68	40	59	0.735
Communication								
1.	Identifies strategies to develop personal therapeutic communication	10	5	50	68	20	29	0.276
2.	Develops a trusting relationship with most clients	10	6	60	68	38	56	0.543
3.	Developing fluency of communication skills within own personal style	10	4	40	68	25	37	1.000
4.	Use a range of communication modes to ensure effective nurse/client communication	10	3	30	68	23	34	1.000
5.	Shows congruence between communication and action	9	7	78	65	28	43	0.075
6.	Use communication in a proactive manner	10	4	40	67	25	37	1.000
7.	Recognises and responds to less obvious client cues	10	3	30	66	22	33	1.000
8.	Shows an ability to communicate therapeutically with clients	10	3	30	66	25	38	0.737
9.	Using appropriate communication skills acknowledging different therapeutic client needs and changing environment	9		33	67	15	22	0.435
10.	Documents and records the care planned for clients	10	8	80	68	32	47	0.088
11.	Maintains records of client's progress	10	7	70	67	35	52	0.332
12.	Contributes to team discussions on client's care when appropriate	10	1	10	68	21	31	0.267
13.	Communicates relevant information to health care team	10	7	70	68	44	65	1.000

Criteria (continued)		Lecturers			Preceptors			
		N	n	%	N	n	%	p value
Communication (continued.)								
14.	Interacts effectively with health care team	10	2	20	68	23	34	0.487
15.	Negotiates own clinical experiences	10	3	30	66	25	38	0.737
16.	Articulates own learning needs to clinical staff and lectures	10	5	50	67	40	60	0.733
17.	Discusses own practice appropriately with lecturer	10	7	70	65	31	48	0.309