# When two worlds collide: a Heideggerian interpretive phenomenological study into the experience of assessing "failing" nursing students within clinical practice

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# Abstract

Clinical nurse educators employed by New Zealand polytechnics experience challenges when assessing Bachelor of Nursing students in clinical practice, particularly students who are considered to be "failing". This phenomenological study sought to explore the experience of clinical assessment and why assessors fail to award "failing" nursing students a fail grade. Fourteen clinical nurse educators, employed within three New Zealand polytechnics were interviewed about their experiences of educating and assessing nursing students' clinical practice. All participants used a preceptorship model of clinical teaching. The interviews were analysed for key themes using Heideggerian Interpretive Phenomenology. The study revealed tensions for participants between *being-in* the w*orld-of-nursing* as well as *being-in* the w*orld-of-education.* Less than half the participants had not failed a nursing student in clinical practice, despite having concerns about their safety to practice. Participants felt ill prepared for their role as educators and assessors. The phenomenon of care was revealed when assessing failing students. Participants acknowledged that some students are *thrown* into the *world-of-nursing;* they wanted to c*are for* students by not failing them and questioned whether assessment should occur in the first year. As students progressed through the programme, participants used the phenomenon of *care for* the health consumer to make a judgement about a students' competence. The responsibility to fail nursing students was frequently *disburdened* to others. The ambiguity of clinical assessment tools, especially the use of competencies, and the lack of progression created challenges for assessors. The threat of students appealing the fail grade inhibited less experienced participants from failing students. Clinical nurse educators lack adequate preparation to educate and assess nursing students. The limitations of this study are its small sample size and lack of generalisability. This study showed that nursing students are passing clinical assessments despite concerns about their competence to practice. Further research is warranted to include a larger sample size and different clinical teaching models, as well as researching the phenomenon of failing from a student perspective.



Key words: Assessment, nurse, failing, phenomenology

# Acknowledgements

This doctoral journey would not have been possible had it not been for Tania asking how she was to deal with a student who was failing in clinical practice. The spark had been ignited for a study into the factors that made it difficult for clinical educators to fail students who were not achieving within the clinical placement. So, thank you Tania for giving me the opportunity to research an area that has not been explored within New Zealand.

I am grateful for the time that I was afforded from the research committee at Southern Institute of Technology.

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Ethical approval was granted by Massey University Human Ethics Committee.

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## LIST OF ABBREVIATIONS

AEI ..... Approved Education Institution

APA ..... American Psychological Association

BN..... Bachelor of Nursing

DEU..... Dedicated Education Unit

DHB ..... District Health Board

ESC..... Essential Skills Cluster

HPCA Act (2003)..... Health Practitioners Competence Assurance Act

GNC..... General Nursing Council

ICN ..... International Council of Nurses

IPA ..... Interpretive Phenomenological Analysis

MoE..... Ministry of Education

MoH……..Ministry of Health

MoJ..... Ministry of Justice

MUGSE..... Massey University Graduate School of Education

NCNZ..... Nursing Council of New Zealand

NMC..... Nursing and Midwifery Council of the United Kingdom

NZ..... New Zealand

NZNO ..... New Zealand Nurses Organisation

NZQA..... New Zealand Qualifications Authority

OSCE..... Objective Structured Clinical Examination

RA..... Regulatory Authority

RCN..... Royal College of Nursing

RN..... Registered Nurse

TEC ..... Tertiary Education Commission

UK..... United Kingdom

USA ..... United States of America

# CHAPTER ONE

## Introduction

I was a newly arrived nurse educator in New Zealand, from England, when I attended a meeting of clinical educators within my school of nursing. During this meeting, one of the experienced clinical educators asked what she should do when working with a "failing student". This question sparked a lively debate about the difficulties of failing a student within the clinical arena. It was this question that started me thinking about the difficulties of clinical assessment. Not long after this meeting, a colleague and I failed four case studies from a recent clinical placement, submitted by year three nursing students. These case studies had been blind second marked and both assessors agreed on the fail grade. The students appealed the grade and the work was sent, by nursing school management, for independent marking to another polytechnic in New Zealand. This resulted in three of the case studies being awarded a pass grade, and one case study retained the fail grade. The re-assessed work was returned to the students without any consultation with the initial markers. This is an extract from my personal journal at the time:

> Since the case study marks were given to the students, a week ago, there has been anxiety, anger and unrest amongst the students and staff. Staff have questioned their marking ability, their clinical credibility, and what they have said to students. The students who failed have been extremely angry, citing "non local tutors" as mitigating factors, conflict over what different tutors have advised, and anger ... I had marked these studies based on NZQA level seven criteria and the fails had clearly not reached this level. It is difficult to remain strong and resolute in the face of possible appeals and bad publicity, but standards must be maintained – this is what is driving my research.

I was an experienced nurse educator in the United Kingdom (UK), with 30 years of nursing experience of which 16 were in education. During this period, I had not experienced a nursing student appeal a fail grade; students may have been upset, but none had contested the assessors' decision. However, within six months of arriving in New Zealand and entering the nurse education system, I continually struggled to understand the difficulties that educators faced when attempting to fail nursing students, particularly within the arena of clinical practice. What became apparent was that students who were not safe in clinical practice were being awarded a pass grade. As a result, these students were able to sit the

state final examination and become registered nurses, despite their unsafe clinical practice. I felt that research was needed to explore the difficulties associated with failing nursing students within the clinical learning environment within New Zealand. Due to my previous experience of nurse education within the UK, I will be making comparisons between UK and New Zealand nurse education systems, as I had come to New Zealand with some preconceived ideas about nurse education and assessment.

I am passionate about my role as a nurse educator to protect the public by ensuring that nursing graduates are safe and competent. A place on the nursing register should assure the general public that the nurse has successfully completed a rigorous scheme of education and is able to provide safe nursing care (Dudek, Marks, & Regehr, 2005; Larocque & Luhanga, 2013; Minarik, 2005; Rutkowski, 2007; Scholes & Albarran, 2005; Tanicala, Schaffer, & Roberts, 2011; Whelan, 2006). The consequence of allowing unsafe students onto the nursing register will have an impact on public safety if inappropriate care is being delivered.

Whilst conducting my research and pondering the importance of public safety and the trust that health consumers[1] place in nurses, I was at the airport hoping to take a flight from the southernmost tip of New Zealand's South Island. The interest of public safety as an airline passenger was highlighted as flights had been disrupted due to snow and ice. We were eventually advised to board the plane after waiting in the airport for a break in the weather. As the plane was taxiing and preparing for take-off, the pilot made a decision to stay on the runway and wait for the spell of bad weather to abate. As a passenger, and knowing nothing about flying, I had placed my life and complete trust in the pilot's judgement, aware that pilot training is extensive and carefully regulated. Whilst watching the downpour of hail striking the runway, I felt that there was an analogy between my circumstances as a passenger on a plane and those of a health consumer lying in a bed with complete trust in the staff who care for them. That trust can only be developed if the public is aware that nurse education is rigorous and maintains that principle of delivering safe care.

Since my appointment as a nurse educator within a polytechnic nursing degree programme, my role has changed to the Head of a School of Nursing, a role that is ratified

[1] The term Health Consumer has been used by the Nursing Council of New Zealand since 2012 and is defined as "An individual who receives nursing care or services. This term represents patient, client, resident or disabled consumer. This term is used in the Health Practitioners Competence Assurance Act (MoH, 2003) (NCNZ, 2012a, p. 33). Health consumer will be used in this thesis when referring to current nursing practice, whilst patient / client will be used when referring to historical perspectives of nursing care.

by the Nursing Council of New Zealand (NCNZ). The principal objective of my role is to ensure public safety by making certain that nursing students receive the best possible education and that they graduate as safe practitioners whom the public can trust. I spend a lot of time dealing with students who appeal assessors' decisions. A lawyer, acting on behalf of a student who had failed a clinical placement for the second time, used sections 27 (1 and 2) of the New Zealand Bill of Rights Act (Ministry of Justice [MoJ],1990) to state that the student had been treated unfairly. In this example, I defended the assessor's decision, using the Health Practitioners Competence Assurance (HPCA) Act (Ministry of Health [MoH], 2003) as the student was unsafe in the clinical placement; my priority was to protect public safety. Despite a comprehensive dossier of evidence supporting the assessor's decision, the lawyer was able to identify a minor breach in process according to the laws of justice. The lawyer was able to claim that the second enrolment within the clinical paper was not lawful and as a result the student was given another opportunity. This example was harrowing for all concerned and took an inordinate amount of time.

Nurse educators have a responsibility to make the correct decision about a student's ability to deliver competent care through assessing their learning – so why does failing a student evoke so many difficulties? By researching this phenomenon, I unearthed some factors that raise awareness about the difficulties of clinical assessment and findings that should be considered for preparing nurses to become nurse educators.

Having explained the scenario that triggered my interest to research the difficulties associated with assessment of nursing students in the clinical environment, I will provide a brief overview of the various definitions of nursing and how it has evolved over the past 150 years. I will introduce how nurse education is delivered in New Zealand and make some comparisons to the UK, as this was a system that I had been familiar with. I will conclude this chapter with the research aim and research questions, and how the thesis will be structured.

**What is Nursing?**

Nursing is a complex interface of a practical art that requires the individual to be clinically competent and possess a sound academic knowledge base upon which to practice. Florence Nightingale, who is considered to be the pioneer for formalising nurse education, defined nursing over 150 years ago as "to put the patient in the best condition for nature to act upon him *(sic)*" (Nightingale, 1860, p. 191). When Nightingale was considering a career in nursing, nurses were considered to be disreputable women who were known for their

drunkenness and immorality (Strachey, 1996, p. 5). When establishing her school of nursing she stated that:

> It must not only teach the mind, but it must form the character. It must be a Home – a place of moral religious and practical training – a place of training of character, habits and intelligence, as well as acquiring knowledge (cited in Woodham Smith, 1951, p. 536).

As nursing evolved over the following years various nurse theorists developed definitions of nursing. During my training we were taught to remember the following definition by the American theorist, Virginia Henderson:

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he *(sic)* would perform unaided if he *(sic)* had the necessary strength, will, or knowledge, and to do this in such a way as to help him *(sic)* gain independence as rapidly as possible (Henderson, 1966, p. 16).

This definition recognises that nurses are not involved solely with sick people, but healthy individuals who require assistance to maintain a healthy status. Henderson also clearly states that the function of a nurse is "unique" and it is this uniqueness that requires nurses to have a special body of knowledge that can be gained through education. More recently the Royal College of Nursing (RCN) in the UK defined nursing as: "The use of clinical judgement in the provision of care to enable people to improve, maintain or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability until death" (RCN, 2003, p. 3).

As nursing is a global profession, the International Council of Nursing (ICN) defines nursing as:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (ICN, 2010).

This comprehensive definition of nursing includes multiple roles for the nurse. This definition goes beyond caring for people, but acknowledges the role of the nurse in policy, education and research. This 21st Century definition of nursing is far more complex than the earlier description of nursing by Nightingale 150 years earlier. This development of the definition of nursing also reflects the development of nursing over time. However, the debates continue about "what is nursing?" It is not the remit of this thesis, but it is important for the reader to consider what is it that a nurse actually does? If we cannot articulate this, then how can we know what we are aiming to achieve through nurse education and assessment? The New Zealand Nurses Organisation (NZNO) has defined nursing within a New Zealand context:

> Nursing is a practice discipline with a unique body of knowledge and skills underpinned by nursing theory and research. Nursing's core focus is people, and the way in which people respond to health, wellbeing, illness, disability, the environment, health care systems, and other people. The discipline of nursing in Aotearoa New Zealand incorporates the uniqueness of our cultural experience, drawing on concepts of whakawhanaungatanga, manaakitanga, rangatiratanga, and aroha in developing effective relationships as an essential tool for improving health outcomes. Nursing assures the human face in healthcare and provides professional, equitable nursing care for individuals, family, whānau, hapū, iwi, and the wider society (2010a, p. 2).

The NZNO definition identifies multiple roles for the nurse and the attainment of these can only be achieved through thorough preparation of an individual to become a nurse. Nurse education programmes are developed in response to changing needs of society and health trends, both nationally and internationally. The preparation of nursing students to become qualified nurses was previously referred to as "nurse training" and was largely undertaken in schools of nursing that were based on hospital sites. Gradually, hospital based training moved into tertiary establishments and the term *training* has been replaced with *education*. At this point it may be useful to clarify the terms *training* and *education*. Schwirian (1998) makes the distinction as follows:

> Training is task-oriented; there is little room for questioning or challenging, activities that are inherent in the research process. In education by contrast, acquisition of knowledge and the development of cognitive skills, fresh ideas, and unique perspectives are encouraged ... the vast majority of nurses were trained in hospital schools (p. 62).

Registered nurses in New Zealand are required to complete a three year degree programme which requires students to study theory and practice at New Zealand Qualifications Authority (NZQA) (2010) level seven (Appendix A). Tertiary institutes offering nursing programmes are audited by the NCNZ against a set of educational standards (NCNZ, 2014) (Appendix B). Whilst there is no national curriculum, there is a national state final examination, which enables successful candidates to become registered nurses. In order to sit the state final examination, students must have successfully completed all elements of their degree programme. Potentially, a person may successfully complete the degree programme, but not pass the state final exam.

Students are required to integrate theory into practice as the NCNZ clearly states: "Nursing practice is using nursing knowledge in a direct relationship with clients or working in nursing management, nursing administration, nursing education, nursing research, nursing professional advice or nursing policy development roles, which impact on public safety" (NCNZ, n.d).

Nurse education providers need to work in collaboration with clinical providers in order to afford students the opportunity to gain appropriate clinical experience. The clinical environment enables students to apply the knowledge learnt in the classroom into the real life world of nursing. Whilst nursing students are in the clinical areas, they are supervised and assessed by registered nurses. NCNZ (2014) educational standards (Appendix B) require that clinical experience demonstrates progression towards meeting the competencies for a registered nurse (2012a) (Appendix C). Within the New Zealand nurse education system, students need to have completed a minimum of 1100 hours of clinical experience and 1100 hours of theory. A student may only have two enrolments in a clinical experience course; failure of a second enrolment means that a student is exited from the programme. In the UK, students are required to have completed 2300 hours of theory and 2300 hours of clinical experience (Nursing and Midwifery Council [NMC], 2010, p. 9). Whilst the numbers of hours differ between New Zealand and UK, the fact that half the programme is clinical, highlights the equal importance given to clinical and theoretical education in both countries.

NCNZ education standard 2.12 (NCNZ, 2014, p. 64) states that nursing programmes must provide:

> ...clinical experience in a range of settings with health consumers across the life span and must include: primary health care and community settings; acute

care including medical and surgical settings; continuing care settings including rehabilitation/disability settings; mental health care including acute and rehabilitation/continuing care settings.

Education standard 2.11 states that "Clinical experiences should be long enough to achieve the competencies identified" (NCNZ, 2014, p. 64). Since 2012, in New Zealand, all education providers of nursing programmes have to include a final, single 360 hours clinical placement where the student must work alongside a nominated preceptor within the clinical environment. In the UK, nurses follow a specialist thread after eighteen months in either adult, sick children, mental health or learning disability nursing (NMC, 2010, p. 7).

Under the Health Practitioners Competence Assurance (HPCA) Act (MoH, 2003), it is the role of the NCNZ to govern the practice of nurses by setting and monitoring standards and competencies for registration, which ensures safe and competent care for the public of New Zealand (NCNZ, 2011). The term "nurse" is a protected title under the HPCA Act (MoH, 2003) and in order to claim the right to call oneself a nurse an individual needs to successfully complete a programme of education that encompasses all the competencies that enable them to carry out the functions as detailed in the definitions above. Successful completion of the education programme, requires that the student is assessed as competent. I will now provide a brief overview of the purpose of clinical assessment.

**Clinical Assessment**

The purpose of assessment allows students to receive feedback on progress, and whether their learning is sufficient to pass; it is also about maintaining standards (Cannon & Newble, 2002; Leach, Neutze, & Zepke, 2003). Assessment can be either norm-referenced, which is concerned with comparing performance of different people, or it can be competency-based which is concerned with assessing against a set of standards, or competencies. Assessment within nurse education is about measuring performance against NCNZ (2012a) competencies in the four NCNZ (2012a) domains of: professional responsibility, management of nursing care, interpersonal relationships, and interprofessional health care and quality improvement. Each domain consists of competencies and specific indicators that are used as a measure for assessment (Appendix C). The NCNZ (2014, p. 48) defines skill or competence assessment as: "A systematic procedure for collecting qualitative and quantitative data to describe progress and ascertain deviations from expected outcomes and achievements". This definition highlights the need to collect evidence to describe progress, yet does not mention whether standards are being measured to achieve competence.

Additionally, the NCNZ (2014) education standard 6.1 requires an assessment process to demonstrate progression throughout the programme, but it is left up to the School of Nursing and auditors to interpret this statement as there are no clear standards indicating how progression is to be achieved throughout the three year programme. NCNZ does not state any specific skills for which a student must demonstrate competence. Assessment should be a continual process where students are regularly receiving feedback about their learning. Some students may not be meeting the required standard to achieve competency and could be considered to be "failing". As this research is about the experience of being with students who may be considered to be "failing", I will now provide a brief overview of the term "failing" student.

**"Failing" student.**

A student who is considered to be "failing" is one who is not meeting performance standards. Therefore, "failing" in this context is a present participle functioning as an adjective to describe a noun, that is, a "student" who is not achieving the required standard. When "failing" is used in this context, it will appear in double quotation marks. This is to differentiate it from failing as a present participle verb when failing is defined as "unsuccessful in an attempt; … judged as being below the officially accepted standard in (a course, examination, etc.)" (Collins English Dictionary, 2002, p. 423). A more comprehensive discussion about clinical assessment, and the "failing" student will follow in chapter two.

I have provided the reader with a scenario that triggered my research and highlighted the importance of nurse education to produce safe and competent nurses. A brief overview of the definition of nurse and nursing has been provided to enable the reader to consider the type of person that nurse education is aiming to place on the nursing register. A brief overview of assessment, and the term "failing" have been provided to clarify how these terms will be used throughout the thesis. I now state my research aim and questions, and explain how the thesis will be structured.

**Research Aim**

The overall aim of the research is "To explore the experience of clinical assessment and why clinical nurse educators do not always award "failing" nursing students a fail grade".

**Research questions.**

- How do clinical nurse educators experience the clinical assessment of nursing students?
- What factors influence the grade awarded to a nursing student when a clinical nurse educator is uncertain about whether the student is achieving the standard required to pass a clinical assessment; that is, a "borderline" student?
- How does the clinical teaching model affect the grades awarded by assessors on clinical assessments?
- How do clinical nurse educators experience awarding a grade to a nursing student they do not consider is performing to the standard required to pass a clinical assessment; that is, a "failing" student?

## Thesis Structure

A review of the international literature examining the difficulties of failing nursing students is discussed in chapter two. The literature review also highlights the difficulties of assessing practical components in other professional programmes. Chapter three discusses the research process and the choice of Heideggerian Interpretive Phenomenology as the theoretical perspective that underpinned this research; it also reveals more about me as the researcher. An explanation of the research process used for this thesis is discussed in chapter four. Chapters five and six will present the analysis of findings from the research utilising extracts from participant interviews. Chapter seven will discuss the findings from this research and correlate these with findings from previous studies. Chapter eight will conclude the thesis and make recommendations for nurse education and acknowledge the limitations of the research. American Psychological Association (APA) (2009) conventions will be adopted for the use of single and double quotation marks, and the use of italics. In addition, Heideggerian key terms will be identified throughout this thesis through the use of italics. Appendices provide further information to assist the reader with information and concepts that are referred to in this thesis.

# CHAPTER TWO
# Literature Review

This chapter will discuss research identified from a literature search of previous studies about clinical assessment and "failing" students. A literature review ensures the researcher is aware of other studies within a particular area and facilitates the dissemination of findings (Fraenkel & Wallen, 2006). However, it is also important for the researcher to be able to evaluate the findings of research and determine how previous research may influence a proposed project. With increasing use of the World Wide Web to retrieve information, the credibility of research findings and reports needs to be carefully considered by the reader as not all published material on the internet can be authenticated.

An initial literature search was conducted using Cinahl and Medline databases, with the keywords: "assessment", "nursing", "clinical", "fail", "borderline", "marginal", "competence", and "preceptor". Boolean operators were used to search for English language articles that had been peer reviewed. Initially, articles post-1999 were requested, but it became evident from secondary referencing that there were older key articles. The literature review was an iterative process which developed throughout the writing of this thesis and led to further searches using "profession", "generations", "phenomenology" and "Heidegger". A *nurse* is defined in the Collins English Dictionary (2002, p. 806) as: "a person, often a woman, who is trained to tend the sick and infirm, assist doctors etc." Therefore, throughout this review the nurse will be referred to in the female gender, as this is the general perception of nursing. It is, however, acknowledged that approximately eight per cent of the nursing workforce in New Zealand is male (NCNZ, 2011). Additionally, when searching the literature, the terms *mentor, preceptor, buddy, coach*, and *supervisor* are used interchangeably to refer to a person who is involved in the teaching and assessing of students within a clinical learning environment. *Preceptor* is the term most commonly used in New Zealand for a clinically based registered nurse who supervises students. The term *clinical nurse educator* will be used throughout this thesis when referring to a nurse who is employed by a polytechnic and involved in the education of nursing students, in both clinical practice and within the classroom. In New Zealand, *clinical educator* is generally used for clinical nurses who are primarily responsible for the professional development of qualified nurses working in a clinical environment. However, there are no nationally recognised definitions for these terms.

The literature review commences with an overview of the history of nursing and nursing education in New Zealand as this puts current nurse education into context. The review then considers an analysis of the literature pertaining to the following topics: nursing as a profession, current nurse education, the clinical learning environment, relationships, generational differences, clinical assessment, the competency movement, being with "failing" students, litigation, and identification of gaps in the literature.

**Historical Background of Nursing and Nursing Education in New Zealand**

Prior to the colonisation of New Zealand, indigenous Maori practised rongoā Māori (traditional Maori healing) which involved the spirituality (taha wairua) of plants and herbs. Healing occurred through Maori healers using the power of prayer (karakia), customs (tikanga), and rituals (ritenga) (Jones, 2000; Mark, 2012). During the early arrival of Europeans to New Zealand, activities associated with caring for the sick and assisting at childbirth were mainly performed by women who had some basic knowledge or skills. These women were mostly from the domestic classes and were unqualified. Hospitals staffed by these women were gradually established in New Zealand from the 1840s with locations in Auckland, Wellington, Wanganui and New Plymouth. Hospitals were state funded and provided care for settlers and Māori, but they were unpleasant places that were usually considered a "last resort". Meanwhile, back in the United Kingdom, Florence Nightingale had returned from the Crimean War and in 1860 established the first training school for nurses at St Thomas' Hospital (Strachey, 1996). Nurses who completed their training at St Thomas' were dispersed across the United Kingdom, and overseas, to assist in the development of pan-global nurse training programmes. Nightingale-trained nurses first arrived in New Zealand in the late 1870s where they established apprenticeship programmes to train nurses in Wellington and Auckland hospitals. These programmes brought recognition to the women who had undertaken this training; they demonstrated qualities of trustworthiness, punctuality, cleanliness, and ability to perform specific tasks, such as dressing wounds, and assisting with patients' activities required for daily living. Following an inspection of Wellington Hospital in 1887, Dr Duncan McGregor noted the high personal qualities and intelligence of these nurses and recognised that they were a different type of person to the original nurses of earlier times. It was this recognition of the need for quality nursing that heralded the start of the regulation of nurses in New Zealand (Papps & Kilpatrick, 2002).

The New Zealand Nurses Registration Act of 1901 legally recognised the term "nurse", established a national register of nurses, and gave credibility to nursing as a female occupation. The enactment of this legislation is largely credited to Dr McGregor. However,

Grace Neill, who was a nurse and Assistant Inspector of Hospitals in the Department of Health between 1885 and 1906, proposed that nurse training should be standardised throughout the country; all nurses should sit a state final examination, and she sanctioned the establishment of a register of nurses. Nonetheless, nursing remained largely under the control of medicine, as statutory responsibilities regarding the regulation of nurses was the responsibility of the Registrar, a medical practitioner. It was the Registrar's responsibility to remove a nurse from the Register if found guilty of "grave misconduct" (Papps & Kilpatrick, 2002, p. 3).

Registered nurse training was a three year programme which prepared nurses to work in general and obstetric areas. Nursing students were employed by the hospital board to which the training school belonged and formed the backbone of the workforce. Nursing was hierarchical and entrenched in tradition, a clear link to the previously noted "Nightingale training system". Yet over time the apprenticeship style of nursing, started in the 1870s, was not meeting the changing demands of society, the increased use of technology and changing disease patterns. Nevertheless until the 1970s, registered nurse education had changed little since the initial days of the Nightingale training (Papps & Kilpatrick, 2002).

A revised Nurses Act in 1971 led to the formation of the NCNZ with a statutory role in the approval of nursing courses. The Carpenter Report (1971) (as cited in the Department of Health, 1988), highlighted the need for nurse education programmes to be held in educational establishments with close co-operation of the hospitals in programme development. The first significant change in New Zealand occurred in 1973 with the establishment of nurse education courses at Wellington and Christchurch polytechnics. These courses prepared nurses for work in medical, surgical, psychiatric, psychopaedic, maternal, child and community health. The Report also recommended the establishment of courses leading to an undergraduate diploma or certificate (Department of Health, 1988). This change echoed a similar trend in Canada to move education out of hospitals into community colleges. In the UK, degree courses in nurse education had already started at Manchester University in the early 1960s and polytechnics were also offering degrees in nursing. Both in New Zealand and the UK there was strong resistance from nurses and medical practitioners to the move away from hospital based training. There was a perceived fear of "overeducating" nurses (Cowan, Norman, & Coopamah, 2005; Papps, & Kilpatrick, 2002).

For many years a dual system of polytechnic educated and hospital trained nurses was in operation in New Zealand until hospital training ceased in 1990. A further development in nurse education occurred in 1992 with polytechnic based undergraduate degree programmes being offered in three locations. Two polytechnics were delivering four-year degree programmes until the Ministry of Education made it clear that funding would only be available for three year programmes. During the 1990s, other developments for nursing were also taking place, such as the development of a post registration framework, standards and competencies, and competence-based practising certificates (Papps & Kilpatrick, 2002).

In 2003 the Nurses Act (1971) was replaced with the HPCA Act (MoH, 2003). There are currently 16 Regulatory Authorities (RA) under the HPCA Act (MoH, 2003), of which nursing is one. The number of Regulatory Authorities has recently been under review with a proposal to reduce the number of RAs. Two remits of the HPCA Act (MoH, 2003) are stipulated below:

s. 16 (d) the responsible authority is satisfied that the applicant is unable to perform the functions required for the practice of that profession because of some mental or physical condition

s. 16 (h) the responsible authority has reason to believe that the applicant may endanger the health or safety of members of the public

These two sections form the foundation for protecting the public and ensuring the competence and professional standards of the nursing profession. Nurse education is constantly evolving in response to changing patterns of disease, advances in technology and globalisation of health care. It is worth noting that at the beginning of the twentieth century nursing was described as an occupation, whereas nursing is now described as a profession as reflected within the NCNZ competencies (NCNZ, 2012a). The next section will consider the criteria that are applied to identify an occupation as a profession.

**Nursing as a Profession**

Whilst it is not the primary purpose of this research to explore the nature of nursing and whether it can be classified as a *profession,* a review of the literature in regards to nursing as a profession is warranted because it is pertinent to this research, and also because it is an important measure of competence as a nurse (domain one of the NCNZ (2012a) competencies is "professional responsibility").

As stated earlier, the New Zealand Nurses Registration Act (1901) acknowledged the occupation of nursing - it was not described as a profession. Schwirian (1998) states that "all professions are occupations, but not all occupations are professions" (p. 4). As early as 1915 Abraham Flexner identified that professions had specific characteristics that were "basically intellectual, carrying with it high responsibility; learned in nature, because it is based on a body of knowledge; practical rather than theoretical; technique taught through educational discipline; well organised internally; motivated by altruism" (as cited in Schwirian, 1998, p. 4). Flexner viewed the intellectual element as being at the core of professions and stated that professions belonged to universities, whilst occupations did not. Flexner's strong beliefs that professions belonged to the university sector were reflected in his reforms to medical education in the United States of America at the beginning of the twentieth century. The Flexner report reviewed poor standards and facilities available to medical students and as a result of his recommendations to increase admission criteria, limit the intake size, and close medical schools, the status of medicine was increased and gained respectability as a profession. However, these recommendations continue to challenge nursing today (Schwirian, 1998, p. 20). Recent qualitative research in New Zealand by Walker, Clendon and Walton (2015) highlights the current debate about whether selection of students into a nursing programme "fosters or hinders the ideals of the profession" (p. 12). Their research with 245 registered nurses in New Zealand identified "the strongest disagreement ... about selecting candidates for nursing education.... Others queried the fairness of selecting people to go through the three-year degree programme (with the debt it entailed) only to find at the end they lacked the personal attributes to be nurses" (p. 12). Very few tertiary institutes in New Zealand interview potential students, instead making decisions based around academic criteria (Walker et al., 2015). Whilst it is important to assess whether applicants are able to satisfy the academic criteria required to achieve a Bachelor's degree, nurses also need to be able to show care, compassion and kindness which cannot be determined from an application form. Interviewing potential students goes some way to assessing a person's attitude and their understanding of the competencies required to be a nurse.

In 1964, Harold Wilensky noted that an increasing number of full-time occupations were seeking recognition as professions. He presented a fairly typical sequence in which new institutions would be established along the path to "professionalization *(sic)*": training schools, university schools, local associations, national associations, state licensing laws, and (finally) a code of ethics. He also observed that "the traditional model of professionalism emphasizes *(sic)* ... autonomous expertise and the service ideal" and suggested that

"exclusive jurisdiction and professional authority" are ideally based on "knowledge that is neither too general and vague ... nor too narrow and specific" (p. 137).

Lubell (1978) identified the following criteria for being a professional:

1) Systematic theory - Professionals have a knowledge set that is based on abstract principles, more so than operational procedures, and thus must pursue an extensive formal education.

2) Authority - Professionals have significant control over the nature and extent of the services that they render, because they serve clients who are generally unable to judge the quality of those services.

3) Community sanction - Professionals are subject to licensure or certification that delineates varying degrees of occupational jurisdiction in accordance with criteria over which they have considerable influence.

4) Ethical codes - Professionals adhere to standards of behaviour that are explicit, systematic, binding, and public service oriented; prescribe colleague relations that are cooperative, equalitarian, and supportive; and are enforced by their associations.

5) Culture - Professionals have a career orientation that leads them to high personal involvement in their work and satisfaction with not only monetary rewards, but also symbols such as titles and awards.

When considering the five factors stated above, nursing could be classified as a profession. It has a body of knowledge that is based on underlying applied theory such as psychology, sociology, science and evidence. Nurses are governed by the NCNZ that has a Council of nurses and lay people. Nurses are registered and have to comply with an annual self-certification process demonstrating on-going education and maintenance of competence. A Code of Conduct for nurses states expected standards of behaviour (NCNZ, 2012b). The final factor of culture is possibly more ambiguous in terms of career progression and titles. However, there are opportunities for nurses wishing to enter managerial, research or educational roles or to become independent Nurse Practitioners. In light of these criteria, and the changes that have been implemented for nurse education, nursing can no longer be referred to as an occupation but justifiably as a profession.

Creuss and Cruess (1997) review the concept of *professionalism* within medicine. They state that whilst there are numerous criteria for determining professionalism they summarise by stating that, "at the heart of every profession is a legally sanctioned control over a specialised body of knowledge and a commitment to service ... that professions must be 'moral' or devoted to public good" (p. 1675). Importantly, they state that educators within medicine should teach professionalism as a clearly identified subject within the curriculum; professionalism can be taught. LaSala and Nelson (2005) discuss that within nursing, the appearance of an individual can reflect the knowledge and interest of the professional. As nursing moves towards a professional status they state that nurses are "becoming more cognizant *(sic)* of how their appearance, behaviour and communication influence the first impressions of others" (p. 63). Scholes and Albarran (2005) note the role of clinical assessment and failing to fail that "damages the standards of care and ultimately the reputation of the profession and the public's confidence in us" (p. 114). Their position on failing to fail highlights the importance of maintaining public safety through honest assessment, and acknowledging the importance of awarding a fail to a student who is not performing at the required standard. The phenomenon of "failing to fail" and protecting the public, will be referred to later in the thesis.

Having provided an overview of nursing as a profession, the next section will consider the topic of current nurse education for preparing students to enter the profession of nursing, identified from the literature.

**Current Nurse Education**

New Zealand is a small country with a population of just over 4.5 million people (Statistics New Zealand, 2014). There are currently 50,060 nurses registered with the NCNZ of which 75 have been reported for competency issues (NCNZ, 2013). Within New Zealand there are 17 tertiary institutes (three universities, 13 polytechnics and one other), (MoH, 2011) that offer programmes enabling students to study towards becoming a registered nurse.

The NCNZ (2014, p. 12) state the entry criteria for studying a Bachelor of Nursing degree is: "... in line with university entry criteria for entry to a bachelor degree". Students who do not meet the minimum educational level may undertake pre-nursing/foundation courses, which provide an introduction to the theory and practice of nursing and allow students to develop academic skills such as literacy and numeracy. However, changes to the government funding structure with effect from 2014 means that funding is based on student completion figures (Tertiary Education Commission [TEC], 2013) rather than the

previous system of funding for enrolments into courses, which encouraged high enrolment numbers (Stokes, 2007; TEC, 2010). This change could result in pressure not only to select nursing students very carefully, but also to pass students once enrolled in order to increase numbers within completion statistics. There is a national attrition rate of between 20 – 25% of nursing students who fail to complete their education, with some institutes having an attrition rate as high of 45% (Manchester, 2009). Admission criteria and selection of students are areas that requires further attention, particularly if institutes are required to have high completion rates in order to receive government funding.

Nursing students in New Zealand are not registered with the Nursing Council; they only appear on the Register once qualified. Therefore, as students, they are not formally accountable for their actions. Nursing students in Canada, USA and UK are similarly not registered with the regulatory body. In South Africa, Australia and the Republic of Ireland, nursing students are registered with the Nursing Council (Boak, Mitchell, & Moore, 2012; Zasadny & Bull, 2015). In the UK a consultation process recommended that nursing students should be indexed with the Nursing and Midwifery Council (NMC) to prevent "programme hopping", that is, students transferring from one educational institute to another (Boak et al., 2012, p. 48). Subsequently, the index would:

> Enable approved education institutions (AEI) to identify whether students who have enrolled in a programme at their institution had previously been dismissed from another programme for serious concerns or misconduct. Other benefits identified by the NMC include access to the contact details for every student – enabling the regulator to communicate directly with students on a variety of subjects; enabling the NMC to build a picture of fitness to practise decisions taken by AEIs; and for use in analysing trends in nursing and midwifery education programmes for quality assurance purposes.

However, due to changes within the leadership structure of the NMC, this proposal was not implemented as planned in September 2011 and has been put on hold. The RCN in the UK has expressed its disappointment at this decision, as it believes that indexing of students would provide protection of the public (RCN, 2012). Indexing of nursing students with the regulatory body goes some way to reinforce the students' responsibility to maintain public safety.

Nurse education for students wishing to become registered nurses in New Zealand is a three year degree programme: the theory is delivered in polytechnics or universities, and

the practical element is learnt in hospitals, community and primary care settings. Nurse education is regulated by the NCNZ, which conducts regular reviews to ensure that institutions offering nurse education programmes meet prescribed standards laid down by the NCNZ (2014) (Appendix B). Students who successfully complete both theoretical and clinical components of the programme, assessed against NCNZ (2012a) competencies, will gain a Bachelor degree in either Nursing or Health Sciences; however, this alone does not lead to registration as a nurse (Stokes, 2007). At completion of the programme, students sit a national multiple-choice examination that covers all elements of the programme. Students who successfully complete the degree, and pass the state final examination can become registered nurses (RNs). An individual, who successfully completes the degree programme, yet fails to pass the state final examination, cannot be registered as a nurse, but has a Bachelor degree qualification. The initial registration of a nurse requires the signature of the Head of Nursing School stating that the individual has successfully completed all components of the programme and is of "good standing". The student also submits a Ministry of Justice declaration that they agree to a police check to verify good standing/character. These procedures have been implemented to protect public safety in New Zealand (Drake & Stokes, 2004). However, there are no clear guidelines to determine how an individual can be considered as being of good standing or character. Sellman (2011) debates, that being of 'good character' should be much more than a rudimentary check. He uses the example of the practice assessment of a nursing student who was "technically proficient but had an uncertain set of attitudes" (p. 15) which, I would argue, is about being competent as will be discussed later in this chapter. He argues that good character is more than being free of criminal convictions – it is about trustworthiness, honesty, courage, justice and practical wisdom.

Nurse education in New Zealand is a programme of both theoretical and clinical learning. The next section will review the literature that identified how the clinical environment impacts on student learning and assessment.

**The Clinical Learning Environment**

The clinical learning environment has been defined as "the interactive network of forces within the clinical setting that influence the student's clinical learning outcomes" (Dunn & Burnett, 1995, p. 1166). It is within this environment that the student is able to apply the theoretical knowledge gained in the polytechnic/university and apply it to the real life situation of dealing with people (Cederbaum & Klusaritz, 2009; Gaberson & Oermann, 2010; Quinn & Hughes, 2007). Ralph, Walker and Wimmer (2009) state that the clinical

component is possibly the most important phase of undergraduate education and have likened this experience to students in engineering and teacher education courses where theory learnt in the classroom must be applied to professional practice. They surveyed 546 students from engineering, teacher education and nursing programmes upon completion of their practicum experience. Sixty three senior nursing students responded (a response rate of 30%). Data was analysed using both qualitative and quantitative methods. Their Canadian study emphasises that students on clinical placements should be mentored in order to develop professional knowledge, skills and values through optimal learning opportunities available in the clinical arena. Yet whilst more than half the nursing students surveyed acknowledged that clinical placements enabled them to apply theory to practice, only a quarter felt that they were mentored effectively and more than a third felt that the mentorship was inadequate. Other problems revealed in their survey were the unsuitability of tasks that students were expected to accomplish and tasks that did not enhance learning. A quarter of students found that constraints on the amount of time spent in a clinical area were a real barrier to learning.

The type of clinical placement has also been noted as a negative factor, with placements providing insufficient experience for students to achieve clinical learning outcomes. The difficulties of identifying appropriate clinical placements as the nature of nursing evolves and the international shortage of nurses continues was researched in New Zealand by Spence, Vallant, Roud and Aspinall (2012). Their qualitative study that involved two universities and one District Health Board aimed to identify how to provide students with optimum clinical learning experiences. They conclude by suggesting that students are becoming better integrated within clinical teams but that relationships between clinical agencies and education providers, and preceptor preparation require further development. Importantly, Ralph et al. (2009) revealed problems associated with assessment of the student in the clinical environment with just less than ten per cent of students noting that performance appraisals were being conducted by mentors who had not worked with the student. When the researchers compared their findings from the nurses' group to the other two professional groups (engineers and teachers) they found many similarities regarding the positive and negative aspects of practical experience, notably the opportunity to link theory to practice whilst receiving inadequate mentorship. This is an important consideration for the role of the clinical nurse educator working with nursing students in a clinical environment.

Internationally, the preceptorship model is commonly used to support students in clinical practice. Whilst there is no NCNZ definition of preceptor, the New Zealand Nurse Educators Preceptorship Subgroup (2010) have identified that "preceptors should have the following characteristics of patience, flexibility, enthusiasm, caring and understanding, organisational abilities, critical thinking, delegation and direction skill, advocacy skills, and autonomy" (p. 5). Interestingly, there is no mention of educating or assessment skills although these skills are to be incorporated into a 16 hour preceptorship programme. In Sweden, the role of the preceptor has been described as "a nurse who teaches and supports the student and is seen as pivotal to student learning within the clinical setting" (Carlson, Wann-Hansson, & Pilhammer, 2009, p. 522). An experienced RN guides and supports a nursing student in a one-on-one relationship. The RN is responsible for teaching and supervising the student although some preceptors do not actually conduct summative assessments with the students, and may not have received any preparation for their educating and assessing role (Gaberson & Oermann, 2010; MacIntyre, Murray, Teel, & Karshmer, 2009). The preceptorship model is not without its problems as it requires the RN to cope with the competing demands of caring for patients, and varied shift patterns which can impact upon continuity of supervising students (Hallin & Danielson, 2010; O'Connor, Fealy, Kelly, Guiness, & Timmins, 2009; Pulsford, Boit, & Owen, 2002). In the preceptorship model, the educator is supposed to provide educational support to the preceptor which can be described as a "preceptorship triad", involving preceptor, educator and student (Hallin & Danielson, 2010; Paton, 2010).

In the UK, the term *mentor* is preferred when working with nursing students. Guidelines produced by the NMC determine the amount of time a student spends with their mentor, as well as the requirements for an individual nurse being a mentor. A mentor should not be responsible for more than two students at any one time and a student can expect to spend 40% of their clinical experience with their mentor (NMC, 2008; Rutowski, 2007). A mentor is defined as "a registrant who has met the outcomes of stage two and who facilitates learning, and supervises and assesses students in a practice setting" (NMC, 2008, p. 56). This definition highlights the fact that a nurse who is responsible for assessing students has undertaken further training and has a triad of responsibilities. A mentor has also been defined as "someone who enables a person to achieve their potential" (Billings & Halstead, 2005, p. 6) highlighting a nurturing perspective. Additionally, a mentor working with a nursing student in their final third year placement must have successfully completed an extra two day educational programme and have their name recorded on the nursing register as a *sign-off mentor*. This acknowledges the importance of assessment in the final

period of students' education (Shakespeare & Webb, 2008). Prior to the implementation of these controls for clinical assessment, Duffy (2003) found that mentors were reluctant to fail students, citing limited time working with students, poor documentation, lack of clear assessment criteria, and emotional difficulties. Inadequate preparation for the role of assessor has also been identified in international qualitative studies from Canada, UK and Ireland respectively, as a reason for not failing students (Dudek et al., 2005; Duffy, 2003; O'Connor et al., 2009;). The multiple roles of assessor, educator and supervisor have also been identified as possible reasons for nurse educators not having the courage to fail students in practice (Duffy, 2003; Wilkinson & Wade, 2007). The reasons for not having the courage to fail nursing students needs further study to ensure that clinical nurse educators are well prepared for their role as assessors, and have the confidence to fail nursing students when necessary.

Some regions of New Zealand are adopting the Dedicated Education Unit (DEU), an Australian model of improved nursing student learning (Edgecombe, Wotton, Gonda, & Mason, 1999; Jamieson et al., 2008; Watson et al., 2012). The concept of the DEU is to enhance support to students in the clinical learning environment by establishing close links between faculty and the clinical area. Students form the core of the model; supporting students is a collaboration of clinical nurses and academics who develop effective communication channels with each other to provide a positive learning environment. Key personnel are identified who support the students with both learning and assessment needs. The major differences between the DEU and the preceptorship models are the appointment of dedicated clinical support staff, collaborative partnerships for assessment, dedicated time for liaison educators, and increased student numbers in the clinical environment. Two mixed-methods research studies in the United States of America (USA) have highlighted the effectiveness of collaboration and strong relationships between educators and clinical staff, which ultimately benefit the student learning experience (Galuska, 2015; Mulready-Shick & Flanagan, 2014). Another topic that was identified from the analysis of literature was the importance of positive relationships between nurse educators, clinical staff and students for effective learning to occur. This topic will be discussed in the next section.

**Relationships.**

Nursing students require the supervision and support of registered nurses whilst in the clinical environment. The impact of student/educator relationships on learning is well researched. MacIntyre et al. (2009), in a discussion article addressing RN shortages in the

United States of America, suggest that insufficient clinical placements and inadequate numbers of educators are important factors that contribute to the nursing shortage. They recommend that relationships between student, staff nurse, faculty and institution are central to the socialisation of the student and improvement of the quality of clinical education for nursing students. Two Swedish studies, one ethnographic (Carlson et al., 2009) and another cross sectional design (Hallin & Danielson, 2010), highlight how preceptors' positive perceptions of students enhance the relationship between student and preceptor, positively influencing students' clinical learning. However, Cederbaum and Klusaritz (2009) report from an American study that clinical instructors may experience problems in their relationships with students. Relationship problems could include personality conflicts, different values, limited skill levels, and lack of interest on the part of the student. They also state that clinical instructors have different styles of teaching and they note the lack of research on effective teaching in the clinical environment. It is important to note here that students also have different learning styles and nurse educators should be aware of the impact of different teaching and learning styles for the student.

In a New Zealand qualitative study with third year nursing students, Vallant and Neville (2006) identified five categories of relationship that existed between nursing students and nurse clinicians. Whilst this was focus group research with only eleven third year students, the results show a basic inequity within the relationship. Terms such as "not stepping on toes", "being invisible", and "lost opportunities for learning" were being used by students regarding their relationships in the clinical environment, which hindered learning. Positive aspects to the relationship were seen in terms of "nurturing" and "reciprocity" which enhanced student learning and reduced student anxiety. They also explored the language that is used amongst staff when referring to students and found that students are commonly referred to as "the student", not by their names. The relevance of this study is that reduction in student anxiety is a pre-requisite for student learning. Whilst the research does not focus on clinical assessment, the role of the relationship between the clinical nurse and student is an important influence on learning to meet clinical competence.

If there are problems with student/educator relationships it would be no surprise to learn that problems spill onto the student/assessor relationship. Research has highlighted that there are problems with who conducts assessments in clinical practice. A personal observational study with medical students in New Zealand and the UK identified that there was role conflict when the supervisor was also conducting clinical assessments (Wilkinson & Wade, 2007). They also observed that when there are reduced numbers of assessors, which is frequently the case, the amount of time spent with the student is limited which may

affect the validity of the assessment. These findings are supported in a Canadian quantitative survey of 546 engineering, nursing and teacher students, following a practicum experience, (Ralph et al., 2009), which noted that only 27% of surveyed nursing students found their mentorship effective and only 21% worked with their supervisors. A limitation of Ralph et al.'s (2011) study was that only 30% of nursing students completed the survey, compared to 52% of engineering students and 98% teacher education students. However, the researchers do not identify the actual numbers of students from each group.

Another challenge faced by assessors is being with a friendly student who appears to get on with patients and staff, leading to positive assumptions about their clinical practice which can affect an assessment decision; this phenomenon is known as the "halo effect" and was observed by Wilkinson and Wade (2007). The impact of this phenomenon was also noted in a quantitative study of 42 pharmacy students in the USA (Ried & Douglas, 2015). Therefore, a "failing" student who is perceived as being likeable is more likely to pass an assessment than a student who is not perceived as being likeable. Wilkinson and Wade (2007) acknowledge that assessors have their own particular idiosyncrasies about what attributes they specifically observe. This phenomenon has also been acknowledged by Tiwari et al. (2005) in a qualitative study of 38 nursing students and teachers, in Hong Kong, which showed that nursing students would select assessors according to the assessor's reputation to fail (or not fail) and their particular idiosyncrasies. So, in conclusion, these international studies highlight the importance of good relationships between students and clinical staff to enhance student learning. However, there are concerns about the subjectivity of assessments created by the relationship that exists between educators/assessors and students.

**Generational differences.**

It is worth noting some relevant research that identifies how generational differences can impact upon relationships within nursing. The average age of the registered nurse in New Zealand is 45.6 years (NCNZ, 2011) and nursing students can be any age from eighteen to their sixties. Data collected from my own institution would suggest that the average age of a nursing student is 27 years. The average age of the nurse educator is between 50 – 55 years (NCNZ, 2011); therefore an educator is generally from the baby boomer era, whilst a student could be a baby boomer or generation X or Y, and this may have a significant impact on the relationship between clinical nurse, educator and student (Suplee, Lachman, Siebert & Anselmi, 2008). However, it should also be remembered that nursing students may also be older than the nurse educator, which can present different challenges. Baby boomers are

generally considered to be those people born between 1943 and 1964; generation X born between 1965 and 1980, and generation Y (or millennial generation) born between 1981 to the present (Altimier, 2006; Hill, 2004).

A brief understanding of the characteristics of the different generations may well help understand some of the potential difficulties of teaching and assessing when there are generational differences. In general, baby boomers were taught to think independently and fought for rights and the freedom to speak out. Generation X was brought up to be independent, observing their parents working long, hard hours. This generation also witnessed the start of the age of technology and increasing media presence. Generation Y developed self-confidence through a high value being placed on education; they were encouraged to be involved in decision making, to express their opinions and were consequently viewed as equals with parents and teachers. Additionally, they are technologically competent having being brought up with the Internet and mobile communications (Chambers, 2010; Hill, 2004). Altimier (2006) states that this latter generation is also known as Generation *WHY*? This is an important concept when considering this generation as they have been raised to question and not to accept, which can pose challenges for older generations who were not raised to question their elders. Additionally, Walker et al. (2015) identified that younger nurses felt that knowledge and technical competence were important attributes for nurses to be considered professional, whilst older nurses considered empathy, smart appearance and work ethic were more important attributes. The implications of differing opinions and values for the relationship between registered nurses and students of different generations should be considered when teaching and assessing nursing students.

This section has highlighted how relationships between students and educators may impact upon the assessment process. A positive relationship between educators and students may have a positive effect upon the students' learning, but it may also create challenges when assessing students, especially for those students who are considered to be "failing", that is, the halo effect, described earlier in this chapter. In addition, the differing values, attitudes and skills associated with generational differences may also create challenges for the clinical nurse educator. The next section will review the literature relating to the experiences of clinical assessment.

## Clinical Assessment

The term "clinical assessment" was briefly introduced in chapter one. This section will provide a deeper, more critical review of the concepts of assessment, including an overview of the development of clinical assessment. The analysis of the literature identified the challenges associated with clinical assessment and the development of competency assessment as a significant topic which will be presented below.

### Defining key assessment terms.

Assessment can be defined as "a professional obligation … a systematic process requiring data collection, evaluation of the data, decision making and drawing a conclusion" (Karayurt, Mert, & Beser, 2008, p. 1124). An American review of educational assessment, stated that "Education assessment seeks to determine how well students are learning…. It provides feedback to students, educators … the public about the effectiveness of educational services" (Pellegrino, Chudowsky, & Glaser, 2001, p. 1). They conclude the review by acknowledging that assessments can differ depending upon the context and purpose, but that assessment is "always a process of reasoning from evidence" (p. 2). They also state that "Every assessment, regardless of its purpose rests on three pillars" (p. 2) which are: how students demonstrate knowledge and competence; the task or situation being observed, and the interpretation of the performance. These three pillars can apply to this thesis as clinical assessment is concerned with how a nursing student applies knowledge to the care of health consumers and how clinical nurse educators interpret the students' clinical practice as meeting NCNZ (2012a) competencies. Assessment can be either formative (continuous) or summative. There is extensive debate in the literature about the terms "formative" and "summative". I have selected a few definitions to provide the reader with an overview of the two concepts associated with assessment, which will be presented in the next section.

The purpose of formative assessment, which should not be graded, is about determining what has already been learnt and what further learning/education is required by students and teachers (Karayurt et al., 2008: Quinn & Hughes, 2007). Formative assessment enables students to receive feedback on their performance, highlighting strengths and weaknesses, and identifying future learning outcomes to improve performance (Cleary & Walter, 2010). More recently, formative assessment has been identified as providing feedback during the learning process, a move termed as "assessment *for* learning" (Leach, Zepke, & Neutze, 2011, p. 199). Formative assessment could be considered as a form of continuous assessment enabling students to receive constant

feedback to assist with goal setting. Formative assessment highlights the connection between learning and assessing.

The purpose of summative assessment is to determine whether students have achieved either professional standards or academic requirements, and students will therefore receive a grade which may ultimately determine fitness to practise (Karayurt et al., 2008; Norton, 2003; Quinn & Hughes, 2007). Students should be aware of the criteria that are being used for assessment (Cannon & Newble, 2002; Leach, Neutze, & Zepke, 2003).

Assessment should meet the tenets of reliability and validity. Reliability denotes the consistency of an assessment's results when the assessment procedure is repeated on a population of individuals or groups. Validity refers to the degree to which evidence and theory support the interpretations of assessment scores (Pellegrino, Chudowsky, & Glaser, 2001). The importance of these elements in reflected in the NCNZ (2014) education standards, which states that: assessments should be reliable in that "a tool functions consistently in the same way with repeated use" (p. 49) and be valid in that the "measurement tool measures that which it purports to measure" (p. 50). Thus a clinical assessment tool should not be ambiguous for either the student or assessor, and it should not be open to interpretation depending upon who is conducting the assessment. However, the development of reliable and valid clinical assessment tools has presented challenges over the years, and will be discussed in more depth in the next section.

**Development of clinical assessment strategies.**

This section will provide an overview of the development of clinical assessment in New Zealand and the UK over the previous 35 years. Historically, clinical assessment has presented challenges for regulatory bodies.

In 1980 the NCNZ was concerned about how nursing schools were implementing clinical assessment, and commissioned a project to investigate methods of assessing clinical competence of nursing students (Mark, 1980). "Many students were being assessed for worker performance and employment potential, to the detriment and, sometimes, even the exclusion of their nursing practice" (Mark, 1980, p. 1). Interestingly, one could argue that worker performance is about nursing practice. Clinical assessment appeared to be chaotic and open to interpretation by schools of nursing. There was uncertainty about who should assess, when the assessor conducts the assessment in relation to their other job requirements, and at what stage in their programme a student should be assessed (Mark,

1980, p. 2). At the time of Mark's research, nursing students were assessed in three areas: a theoretical state final examination; a hospital practical examination; and ward reports usually written by the charge nurse, based on observations of the student's performance (Mark, 1980, p. 9). At the time of the study, some students were training under the Hospital Board system, whilst other students were being educated through the Comprehensive School of Nursing tertiary education system. Another difficulty identified by Mark (1980) was the use of a suitable assessment tool. Students had "skills books", although these were not assessment tools, but workbooks to guide learning; highlighting the importance placed on nursing skills. The ward reports formed the basis of clinical assessment, but varied depending upon whether the student was under the tertiary system or the hospital board. A dual system of nurse education would have most certainly created confusion for registered nurses in the clinical setting, due to different expectations from the tertiary institute, or the Hospital Board.

Similarly, the UK was reviewing clinical assessment with a move away from mock ward scenarios to assess clinical tasks and procedures within the School of Nursing. Four ward-based assessments were introduced by the General Nursing Council (GNC) in the early 1970s. The assessments were intended to assess skills that were critical to patient safety – aseptic technique, drug administration, total care of one patient, and finally the management of a group of patients. Criticisms of the four assessments came from both students and assessors as it was felt that the situation was "artificial" because assessors had different standards and the assessment time was too short (Chambers, 1998; Clifford, 1994; Nicol & Freeth, 1998). The four assessments were eventually replaced in the mid-1980s by a process of continuous practical assessment, which enabled the student to be observed and assessed on a daily basis by clinical staff. Currently, the NMC (2007) has five essential skills clusters (ESC) that support the achievement of learning outcomes for all nursing students. ESCs for pre-registration nursing programmes were introduced in 2008 (NMC Circular 07/2007). They include: care, compassion and communication; organisational aspects of care; infection prevention and control; nutrition and fluid management; and medicines management. These skills have progression points, which clearly articulate the requirements of nursing students throughout their programme of study. They have been amended and form guidance within the standards for pre-registration nursing education (NMC, 2010) (Appendix D). Having clearly identified national progression points enables both students and educators to be aware of the required expectations of students at specific points in their nursing programme. The progression points go some way to address the different level of skill required from nursing students throughout the three year

programme. Indeed, Benner, Tanner and Chesla (2009) refer to nurses' skill and knowledge acquisition and understanding as moving from "novice" to "expert". To clarify, a novice is defined by Benner et al. (2009), as "a beginner who is given rules for determining actions" and an advanced beginner is able to apply these rules to specific situations (p. 10). Nursing students could never really be considered more than a novice.

The preceding two paragraphs have highlighted the development of clinical assessment in the UK and New Zealand since the 1970s. Additionally, the 1970s saw the introduction of the Objective Structured Clinical Examination (OSCE), in Scotland, as a method of assessing clinical skills and practice in medical education. OSCEs were designed to reduce long clinical examinations and improve assessment reliability (Lauder et al., 2008; Pell & Roberts, 2006, Traynor & Galanouli, 2015). Within an OSCE assessment, the student moves around various skill testing clinical stations and is assessed against criteria on a marking sheet. Lauder et al.'s (2008) research in the UK identified that competency assessment is complex as satisfactory performance within one skill does not imply competence within a variety of skills. They urge caution when using OSCEs for clinical assessment due to the multiple dimensions that should be assessed. However, when developing the assessment tool, consideration should be given to the dimensions that should be assessed and these can be incorporated into the marking criteria. Tan and Prosser (2004) also discuss the limitations of criterion-based assessment that determines whether a student has passed or failed – they have either met the criteria or not. They argue that a more generic standards-based assessment measures overall performance and enables students to be aware of what needs to be learnt.

The use of clear assessment criteria in conjunction with a standard error of measurement (SEM) statistical tool has been advocated as a means of assisting with making clinical assessment decisions, especially with borderline students in medicine and nursing (Hays, Gupta, & Veitch, 2008; Traynor & Galanouli, 2015). A quantitative study of the OSCE assessment with 1571 medical students in UK and Australia, identified 132 borderline students (Hays et al., 2008). They recommended that borderline students should not be offered a resit, but should repeat the year to enable further learning. This acknowledges the importance of students having more time to facilitate learning and achieve a clear pass in an assessment, a point that will be referred to later in this chapter. The next section will discuss how assessment influences learning.

Assessments can also determine the learning that the student undertakes (Leung, Mok, & Wong, 2008; Tiwari et al., 2005). Students who are concerned about passing a

summative assessment for wound dressing technique may well forego the opportunity to care for a dying patient, because passing of the wound dressing technique is a requirement of the clinical placement, whereas there may not be an assessment concerned with the dying patient. This influence on assessment to guide learning has been termed the "backwash effect" and will direct the learner into either a surface or deep approach to learning (Biggs, 1996; Tiwari et al., 2005). The surface approach to learning means that the student will learn the material that is required for an assessment. Utilising focus groups to investigate the perceptions of 38 students and teachers about clinical learning in Hong Kong, Tiwari et al. (2005) identified a strong correlation between assessment and learning. They state that "the need to meet the assessment requirements was so strong that it inhibited students from gaining a holistic clinical learning experience" (p. 305). They recommend a process of continuous assessment and the use of portfolios containing a selection of evidence to develop a deep approach to learning.

Assessment of nursing students in clinical practice is fraught with problems and has led to assessors "failing to fail" (Boley & Whitney, 2003; Duffy, 2003; Larocque & Luhanga, 2013; Luhanga, Yonge, & Myrick, 2008a; O'Connor et al., 2009). This failing to fail phenomenon has also been identified in medical schools, occupational therapy and teacher education with assessors being reluctant to award a fail grade for poor practical performance (Dudek et al., 2005; Hawe, 2003; Ilott & Murphy, 1997; Rees, Knight, & Cleland, 2009). Assessors from all these professions have an obligation to protect the public as they are identifying the practitioners of the future; assessors have been termed "gatekeepers" (Anderson, 2008; Parrott, 1993; Scholes & Albarran, 2005; Shakespeare & Webb, 2008). The general public expect nursing care that is safe and unlikely to do harm and Dolan (2003) states the "ultimate aim of producing competent nurses is to ensure that patients receive a high level of care" (p. 133). The NCNZ was established to protect the public but as nursing students are not registered with the Nursing Council, students are not regulated. Therefore, the actions of nursing students are the responsibility of the nurse educators and the registered nurses who work alongside them in clinical areas. The student has a responsibility to acknowledge their limitations and seek help when necessary and nurse educators have a professional and ethical responsibility to protect the public from harm and maintain patient safety (Black, Curzio, & Terry, 2014; Dolan, 2003; Drake & Stokes, 2004; Gregory, Guse, Dick, & Russell, 2007; Parrott, 1993; Scholes & Albarran, 2005; Tee & Jowett, 2009). This particular aspect of clinical nursing education will be revisited extensively later in this thesis because it is a salient and highly relevant point.

International researchers have highlighted subjectivity and inconsistency in clinical assessment. This is caused by the lack of valid and reliable instruments, with inconsistent criteria (Boley & Whitney, 2003; Lankshear, 1993; O'Connor et al., 2009; Scholes & Albarran, 2005; Watson, 2002). Poor documentation, the use of educational jargon and lack of specific criteria also add to the difficulties faced by assessors (Pulsford, Boit, & Owen, 2002; Skingley, Arnott, Greaves, & Nabb, 2007; Tan & Prosser, 2004). Pell and Roberts (2006) argue that within medical education where students have different patient scenarios, with different assessors, in different hospitals and at different times, reliability is compromised to ensure validity of assessments. They identify ten factors that can affect clinical assessment reliability including "assessor subjectivity" and "assessor fatigue" (p. 92). The factors stated by Pell and Roberts (2006) can also be applied to the clinical assessment of nursing students. However, they stress that assessment decisions must be "fair and defensible" (p. 93) through valid and reliable assessment procedures.

In conclusion, an appropriate means of clinical assessment has presented challenges for many years. This phenomenon is not unique to New Zealand or nursing. Assessment of nursing students is designed to protect the public and ensure that nursing graduates are competent to enter the profession of nursing. However, it is also acknowledged that there is reluctance by assessors to fail nursing students. The next topic, synthesised from the review of literature, relates to how the competency movement has been incorporated into nursing curricula and utilised a means of assessing nursing students. This topic will be presented in the next section.

## The competency movement.

The competency movement for both curricula development and assessment is well established in Australia, Canada, Ireland, New Zealand, UK and the USA (Butler et al., 2011; Nelson & Purkis, 2004; Ordonez, 2014). Competency assessment is used in many countries, including New Zealand, to measure individual's practical performance in professions as diverse as health, architecture, engineering, education, and law (Gonczi, 2013; Leggett, 2015). However, there is a lack of consistency in the definition and understanding of the terms competent and competence (Wilkinson, 2013).

### *Defining competent.*

The origin of the term competent comes from the Latin competēns, meaning to be "fit, proper, or qualified" (Hoad, 1992, p. 88). The origins of the word would suggest that being competent equates to being suitable for a qualification. Prior to the introduction of the

HPCA Act (2003), nurses were regulated for their "fitness" and "properness" under the Nurses Act (1977); competent to practice was introduced with the enactment of the HPCA Act (2003) in 2004 (NCNZ, 2010). The NCNZ (2012a, p. 32) define competence as: "the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse", thus highlighting "fit" and "proper" through attitudes, skills, knowledge and values. An interesting point to note with the New Zealand definition is that it relates to being a nurse, that is, a registered nurse and not a nursing student. The Canadian Nurses Association (2010, p. 15) define competence as "The integrated knowledge, skills, judgement *(sic)* and attributes required of a registered nurse to practise safely and ethically in a designated role and setting". This definition clearly articulates competence of a registered nurse, but also explicitly states the role of the nurse in a specific setting. The Canadian definition also states "attributes" as a component of competence, which concurs with definitions by Cassidy (2009) and Gonzi (2013). In the UK, the NMC (2010, p. 145) defines competence as: "the skills and ability to practice safely and effectively without need for being supervised directly." The UK definition requires that the competent nurse should be able to perform without direct supervision. However, when assessing students to be competent in clinical practice, it could be considered unreasonable to expect them to perform without direct supervision. None of these three definitions articulates how competent can be related to a nursing student; indeed Benner et al. (2009) states that in the five stage continuum of "novice to expert", a competent nurse is the third stage, after novice and advanced beginner. This is an important factor to consider when nursing students are being assessed for their competence. Indeed international literature from Canada, the United States, the UK, Ireland and Australia would acknowledge that defining competent is complex and it is more than a set of skills, attitudes and knowledge (Butler et al., 2011; Cassidy, 2009; Clinton, Murrells, & Robinson, 2005; Cowan et al., 2005; Lurie, 2012; Watson, 2002). The next section will discuss how competencies are assessed.

**Competency assessment.**

The previous section highlighted the difficulties associated with defining competent and competency, yet nursing students are assessed for their competency to practise. It could be argued that competency assessment determines whether an individual has the abilities to perform in a specific job (Cassidy, 2009; Gonczi, 2013; Watson, 2002; Wilkinson, 2013). However, if there is an inconsistent interpretation of the term "competency", then the validity and reliability of competency assessment should be questioned (Cassidy, 2009; Leggett, 2015; Minarik, 2005). Competency assessment should be an ongoing process of observation of practice, which assesses more than just knowledge, but ability to provide

safe care to health consumers (Gonczi, 2013; Lauder et al., 2008; Levett-Jones, Lathlean, Higgins, & McMillan, 2011; Watson, 2002; Whelan, 2006). Gonczi (2013) challenges that competency can be assessed through observation alone; competency assessment should be a composite of assessments including diaries, portfolios and observation.

In New Zealand, students are assessed against 20 competencies (NCNZ, 2012a). Anderson's (2008) New Zealand grounded theory study found that "experienced" assessors had difficulty performing a valid and reliable assessment of competence with third year nursing students. She identified that assessors went through four different stages to formulate a professional judgement about competence. Initially assessors would gather information to inform the decision making process; secondly, the assessor would "weigh up" the evidence using benchmarking and comparative analysis; thirdly, the assessor would judge the information; and finally the assessor would moderate the process before making a final decision to ensure that professional responsibilities and public safety were protected. Anderson's (2008) thesis highlights some key elements in the assessment of nursing students in clinical practice. However, one of the challenges she faced was that many assessors could not define the term "competence". The lack of a definitive interpretation of competence may fundamentally undermine the whole assessment process.

In Ireland, a nurse is required to be competent in five domains (Butler et al., 2011; O'Connor et al., 2009): professional/ethical practice; approach to care and the integration of knowledge; interpersonal relationships; organisation and management of care; and personal and professional development. The concept of being competent in ethics is also evident in Canada where ethical attributes are an essential requirement for the professional role of being a nurse (Nelson & Purkis, 2004). Nelson and Purkis (2004) believe that the emphasis on ethical competence is diluting the importance of the knowledge and skills required by nursing. However, it could be argued that this appreciation of right and wrong should be reflected in the assessment of students' clinical performance – is it "right" to pass a "failing" student? It is this ambiguity with determining and measuring competence that makes its assessment and measurement difficult (Cowan et al., 2005). With the global nature of nursing and international transfer of nurses across the world to seek employment, the validation of what constitutes a "competent" nurse is challenging.

The assessment of nursing skills within the clinical environment presents challenges to determine whether a student is competent. Lauder et al. (2008) conducted a quantitative survey of 99 nursing and midwifery students in the UK to determine the effectiveness of

assessing students' skills in simulated scenarios, using clear assessment criteria and preparation of assessors. Their study demonstrated that competent performance in one skill did not necessarily imply that the student was competent in a variety of skills, highlighting the complex nature of the variety of skills required by nurses. They conclude by stressing the importance of "conceptualising skills as a series of competencies rather than a single overarching notion of competence" (p. 42). Cowan et al. (2005) also state that "because nursing requires complex combinations of knowledge, performance, skills and attitudes, a holistic definition of competence needs to be agreed upon and operationalised" (p. 355). Indeed, both the UK and New Zealand have definitions of competence, but these relate to the competence of a registered nurse and not a nursing student. Interestingly, a competent nurse is defined by Benner et al. (2009, p. 61) as a nurse who is about two years into practice and has "gained the ability to anticipate certain typical progressions in the patient's recovery and likewise begins to perceive discomfort when the patient's progression violates experientially gained expectations."

A common theme that emerged in the literature was that clinical skills are a component of competence and can form part of a student's assessment portfolio (Cassidy, 2009; Dolan, 2003; Fotheringham, 2010). However, Cassidy (2009) notes that whilst assessment of tasks can be considered to be fairly straightforward, that is, either the nurse can or cannot perform a dressing; nursing is about more than just tasks. The assessment of a task can be broken down into clearly identified criteria and the bottom line would be "safety". However, the privacy, dignity and anxiety of the patient also need to be acknowledged. Nursing involves abstract concepts such as attitude, professionalism and communication and therefore assessment of these attributes tends to be more subjective. He therefore explores three domains of competence for consideration in the UK: "behavioural competence", pertaining to psychomotor skills and performance that can be cross checked against a check list; "attributive competence" is concerned with personal qualities required for nursing such as critical thinking, adaptability and self-confidence, and "holistic competence", explores the "interrelatedness of knowledge, skills and attitudes necessary for emotionally intelligent nursing." Therefore, assessors are faced with a complex array of qualities and skills when determining competence (Cassidy, 2009, p. 41). He highlights the degree of subjectivity that is present when assessing all the components of competence and recommends the use of reflection and holistic assessment to integrate knowledge, skills, and attitudes required for competent nursing. Researchers in Australia have investigated the challenges presented by assessing the complexities of competence.

As a result of their research, the researchers have developed assessment models which will be discussed below.

In Tasmania, an assessment tool using multiple forms of assessment has been developed which recognises that nursing students are registered with the Australian Health Professional Regulatory Authority (Zasadny & Bull, 2015). In response to the ambiguity and complexity which centred on assessment of competency, failing students, and determining progression, the authors developed the Amalgamated Student Assessment in Practice (ASAP) tool. The acronym ASAP was also chosen to reflect the need to identify students who needed remedial support in order to achieve competence. The model reflects attitudes, skills and knowledge as elements of competence. The authors have considered that measurement of safety is a measure of progression, a considerationwhich could be ambiguous due to the diverse interpretations of safety within nursing practice. The latter will be discussed later in the chapter.

Another model, developed and evaluated in New South Wales, is the Structured Observation and Assessment of Practice (SOAP) (Levett-Jones, Gerbasch, Arthur, & Roche, 2011). Holistic assessment takes place over a full day using trained assessors who use observation, an oral examination, and a mapping of students' behaviours against competencies As a result of both qualitative and quantitative methodologies with 1031 third year undergraduate nursing students, the authors conclude that clinical assessment of nursing students requires observation of nursing students by registered nurses with strong educational and clinical experience, and have been trained as assessors. This model seems to offer an alternative, more reliable form of clinical assessment to portfolio submission though a triangulation of data collection.

This section has highlighted the lack of a consistent interpretation of competency assessment from an international perspective that presents challenges when assessing nursing students for competent performance. However, the incorporation of skills assessment has been acknowledged as being one component of competency assessment, yet nursing is more than a series of skills and tasks. The next section will discuss the analysis of the literature concerned with the topic of the "failing" student.

**Being with "Failing" Students**

My research is specifically concerned with the difficulties of awarding a fail grade to a nursing student. The term "failing student" was briefly described in chapter one. This section will provide a more critical review of studies concerned with determining how a "failing" student is identified and the challenges of being with these students in nursing as well as other professions.

A "failing" nursing student was identified by Hrobsky and Kerbergen (2002) as one who did not ask questions, exhibited an unenthusiastic attitude for nursing and demonstrated unsatisfactory skill performance. Peelo and Wareham (2002, p. 2) state that a "failing" student is one who "fails to meet acceptable academic standards". This simplistic definition does not identify what "acceptable" is and refers only to academic standards. Possibly this lack of clarity about "acceptable" confuses the assessor when confronted with a "failing" student due to the subjective nature of acceptable. Failing nursing students in their theoretical components does not seem to raise the same issues about awarding a fail grade, although it is well acknowledged that failing an essay can invoke feelings of poor self-esteem, shattered dreams, anger, frustration and resentment for the student (McSherry & Marland, 1999). An Iranian randomised control trial (Peyrovi, Parvizy, & Haghani, 2009) with 42 "failing" nursing students over a 12 month period explored the need to identify struggling students early and provide counselling interventions to support those students. Interestingly, the authors identify the concept of "caring" for nurse educators to support students holistically as they will be entering a caring profession. Nursing is viewed as a caring profession and failing a student could be viewed as the antithesis of caring (Kevin, 2006; Luhanga et al., 2008a), which may provide some explanation as to why clinical nurse educators have difficulty awarding a fail grade to a nursing student.

Unsafe practice has been cited by some authors as a reason for failing students and being the bottom line in clinical assessment – would we want this person in our nursing team or caring for ourselves or family? (Scholes & Albarran, 2005; Whelan, 2006). Whilst safety, such as the maintenance of asepsis, or the correct administration of drugs according to the five rights[2] (Lim & Honey, 2015; NZNO, 2012), can easily be measured against specific criteria, attitudes, professionalism and behaviour are not so simply quantified. Ilott and Murphy (1997) refer to the Allitt Enquiry (1994) which concerned an enrolled nurse in the UK who killed four children and harmed a further nine by administering large doses of

[2] Right patient, right dose, right medication, right route, and right time (NZNO, 2012).

insulin whilst they were patients on a paediatric ward in England. The report from the enquiry highlighted a number of issues that could have prevented such a tragedy, including the fact that ward staff were reluctant to voice concerns about this nurse as they were "soft" issues which fell outside her measurable performance. Staff had subjective concerns about her practice, but could not quantify their concerns as they related to her personality and behaviour within the team. Clinical staff had similar concerns about this nurse when she was a student. Despite the concerns, she was allowed to complete her training and become a qualified nurse, with devastating consequences. This highlights the importance of recognising students of concern and taking appropriate action to protect public safety.

An integrative literature review by Killam, Luhanga and Bakker (2011) found that there were three major themes for unsafe practice: "ineffective personal interactions, knowledge and skill incompetence, and unprofessional image" (p. 437). They linked these three themes to students' inability to provide safe care for clients. These three characteristics were also identified by Walker et al. (2015) from their research about professionalism in nursing, thus highlighting the importance of safety as a component of professionalism. A study to identify what was interpreted as an unsafe clinical practice was conducted in Canada by Mossey, Montgomery, Raymond and Killam (2012) who classified unsafe students into five identifiable groups: displaced student, vulnerable student, unprepared student, unknowing student, and the distanced student. This interesting piece of research highlighted a diversity of behaviours that could be classified as being unsafe, such as falsifying records, repeated errors, not demonstrating critical thinking, not considering the guidance of the clinical educator and working outside their scope of practice. This final aspect of unsafe practice is an interesting concept in New Zealand as there is no clearly identified scope of practice for a nursing student. This makes it difficult to assess whether a student is acting within their scope.

Ilott and Murphy (1997) investigated the feelings of assessors when dealing with "failing" students in occupational therapy courses. In a qualitative study of 30 practice and academic staff, they noted a commonality about the feelings of dealing with "failing students". It was frustrating, a reflection of personal failure and guilt, emotionally taxing and involved much personal soul searching. Whilst assessors frequently felt anxious about awarding a fail grade, there was often a feeling of relief about meeting a "professional obligation" (p. 310). However, as with Duffy's study, Ilott and Murphy (1997) found that assessors frequently gave the "benefit of the doubt" (p. 308) with borderline students. The reluctance to award a fail grade for the borderline student requires more research and

clarification. Ilott and Murphy (1997) studied affective responses and how these influenced the decision-making process when assessing students within an occupational therapy programme. They concluded that feelings such as anxiety, guilt, and a sense of failure, contributed to the process of assessment and that awarding a fail grade was a "troublesome responsibility" (p. 314). Many researchers, from a variety of professions, have found that assessors have a lack of confidence about awarding a failing grade (Duffy, 2003; Hawe, 2003; Rees et al., 2009; Rutkowski, 2007; Wilkinson & Wade, 2007). The lack of confidence to award a failing grade within professional courses, where there is a responsibility to maintain public safety, is a cause for concern and warrants further study.

To fail a student has been viewed as a reflection on the educator; failing a student could be a consequence of poor teaching and providing insufficient feedback to the student (Hawe, 2003; Rees et al., 2009; Rutkowski, 2007). The term failure is described as "an emotive term due to the destructive association between failure on a prescribed task and failure as a person" (Ilott & Murphy, 1997, p. 308). Hawe (2003) cites Shephard and Smith (1989) who found that the "f" word was not used by classroom teachers in teacher education courses. The negative connotations associated with the term "failure" means that it is not commonly used in assessments, and has been replaced with more acceptable terms such as "refer", "not achieved" and "not yet competent" (Peelo & Wareham, 2002).

The reluctance to fail students is not confined to nursing. A New Zealand study of teacher education institutes found that student teachers were given alternative opportunities and marking criteria were changed to justify awarding a pass grade rather than a fail. The rationale being that the "person will make a good teacher" (Hawe, 2003, p. 376). A similar sentiment is shared within the nursing profession – the belief that given time, the person will make a good nurse (Duffy, 2003; O'Connor et al., 2009). Failing students in professional courses has dual consequences: not only is the failed student denied an academic qualification but they also lose the opportunity to follow their chosen career (Cleary & Horsfall, 2010; Hawe, 2003; Ilot & Murphy, 1997). This may also have financial implications for the student (Boley & Whitney, 2003; Pell, Boursicot, & Roberts, 2009). Suplee et al. (2008) refer to this as "property interest – an entitlement to or vested interest in gaining a qualification" (p. 73). Whilst this dilemma for the assessor is concerned with the needs of the student, the rights of the public to receive competent care must also be considered.

Reasons for not awarding a fail grade have been cited as fear of litigation, lack of support from faculty, and ruining someone's future career; students have therefore been given the "benefit of the doubt" (Duffy, 2003; Luhanga, Yonge & Myrick, 2008a; Stokes, 2007; Wakefield et al., 2005). Duffy's (2003) qualitative research, conducted in three institutes of higher education in Scotland, had a very clear focus, which was to identify "why some student nurses were allowed to pass clinical assessments without having demonstrated sufficient competence" (p. 10). Interviews with 14 lecturers and 26 mentors highlighted major problems with actually failing students in clinical practice. It emerged that many mentors did not feel that it was their responsibility to award a fail grade. It should be noted here that this study was completed prior to the implementation of the sign off mentor. The complexity of assessing failing students and reluctance to award a fail certainly warrants further study from a New Zealand nursing perspective.

Whilst awarding a fail grade may be perceived as difficult by assessors, it may also be seen as a motivating factor by students who may not want to lose face and may fear the consequences of failing (Pell et al., 2009). Pell et al. (2009) identified in a quantitative analysis of OSCE results with UK medical students, that whilst the fear of failure may motivate students not to fail, the implementation of a robust re-sit policy enabled students to have a second opportunity at passing their summative assessment. Students who were permitted to re-sit an assessment generally learnt from this process although the report was limited, as it did not provide information about the student's performance in the resit. These findings would not support the study mentioned earlier by Hays et al. (2008), who did not advocate for resits. This conflict with research findings would justify the need for further research about the role of resits in learning and assessment. A New Zealand quantitative study with 125 third year nursing students (Bland & Gallagher, 2009) acknowledged that allowing nursing students multiple re-assessments for written assignments may result in a student exceeding the five year maximum time limit to complete the BN programme (NCNZ, 2014). Whilst NCNZ has a limit for the number of enrolments in a clinical paper, there are no guidelines for enrolments into theoretical courses as this is determined by individual educational institutes. The lack of research pertaining to the subject of resubmissions/resits warrants further study.

**Lack of support and litigation.**

By advocating for students, colleagues place pressure on assessors to change a fail grade to a pass (Dudek et al., 2005; Hawe, 2003). Students are also aware of this reluctance to award a fail grade. This was noted by Māori and Pacific Island student teachers who

recognised that they were able to "get away with so much more" (Hawe, 2003, p. 376). When faculty support preceptors through regular meetings between preceptors, staff and students in the clinical environment, preceptors are more likely to assign a fail grade to a student (Luhanga, Yonge, & Myrick, 2008b).

The lack of support from faculty to fail a student in various professional education programmes, has been cited by many authors (Boley & Whitney, 2003; Dudek et al., 2005; Hawe, 2003; Rees et al., 2009; Scholes & Albarran, 2005). The fear of having decisions overturned by faculty has led to reluctance to award a fail grade. Dudek et al. (2005) cite an example in their research of a supervisor failing a medical student. Because the supervisor's decision was overturned by faculty, he said that he would never fail a student again as his professional integrity and credibility had been challenged. It is, therefore, questionable whether he should be responsible for student assessment if he is not prepared to fail a student who is not meeting the required passing criteria.

A study of 15 Schools of Nursing in New Zealand by Drake and Stokes (2004), found that many nurse educators were being faced with "moral dilemmas" (p. 16) to allow nursing students to continue with their education under their rights as students, despite being assessed as unsafe in practice. Students are increasingly aware of their rights which Drake and Stokes (2004) state has led to a rise in student litigation, citing examples of students "unfit for the nursing profession [who] completed programmes on grounds of procedural justice within education provider organisations" (p. 19). Reports from the United States demonstrate that if faculty have robust, fair and consistent policies and procedures then courts are reluctant to overturn faculty decisions (Billings & Halstead, 2005; Boley & Whitney, 2003; Goclowski, 1985; Parrott, 1993). Hawe (2003) acknowledges that awarding a pass grade creates fewer problems for staff than failing students. However, it could be argued that problems may be created in the future when a student has been incorrectly passed and creates issues as a qualified professional practitioner, as evidenced in the Allitt enquiry mentioned earlier in this chapter.

**Gaps in the Literature**

Within this international literature review, there have only been 12 New Zealand references to clinical learning and assessment (Anderson, 2008; Bland & Gallagher, 2009; Drake & Stokes, 2004; Edgecombe et al., 1999; Jamieson et al., 2008; Lim & Honey, 2015; Mark, 1980; Spence et al. 2012; Stokes, 2007; Vallant & Neville, 2006; Walker et al., 2015; Wilkinson & Wade, 2007). There is inadequate New Zealand research into the experiences

of clinical nurse educators assessing and failing nursing students. I was unable to identify any New Zealand research which highlights the factors that are considered when making a judgement about a student's clinical practice, particularly when a student is considered to be "failing". The preparation of nurses to become clinical nurse educators and their subsequent experiences have also not been researched. The preparation of mentors in the UK has been discussed, but by contrast, there is little written on the optimum training and support for assessors both internationally and in New Zealand. Furthermore, anecdotal evidence suggests that there is a reluctance to fail students due to the small community within New Zealand and how social relationships may be affected by awarding a fail to a person whom they may know. Scholes and Albarran (2005) acknowledge that it takes courage to fail a student: an important attribute that is required to protect the public and retain professional pride.

**Conclusion**

A synthesis of the research that has been discussed in this chapter would highlight that there are challenges associated with the assessment of a practical component within a professional programme. The challenges are particularly evident when making assessment decisions about a student who is not performing at the required standard, that is, a "failing" student. The chapter commenced with a historical overview of nurse education in New Zealand, and the move from classifying nursing as an occupation, to that of being a profession. The recognition of nursing being a profession requires that nursing has a unique body of knowledge, which is regulated, and has a code of conduct which outlines the expected attributes of nurses. This chapter has also highlighted how professionalism is reflected in the competencies for assessing nursing student, yet professionalism is poorly defined.

The theoretical components of a nurse education programme are delivered in universities and polytechnics in New Zealand, whilst the practical application of the theory is learnt in a variety of settings away from the university/polytechnic. The importance of the clinical learning environment was highlighted from international research. The clinical learning environment should enable students to apply theory to practice, yet some of the literature would question the value of some of the clinical learning environments. Of particular note was the importance of the relationship that the students had with the clinical staff and their mentors. Whilst the term preceptor is predominantly used in New Zealand for the clinical nurse who works alongside the student, the interpretation of this role is ambiguous and may influence the students' learning experience. International research

concerning the role of clinical staff has highlighted the importance of good relationships between the clinical staff, academic staff and the student for effective teaching and assessing to occur. These relationships may also be influenced by the generational differences that exist between student and the registered nurses who are responsible for educating and assessing.

The chapter developed by focussing on research pertaining to clinical assessment and the challenges associated with competency assessment. A historical review of the literature highlighted the challenges for nurse education to identify a reliable and valid form of clinical assessment. Competencies now form the basis upon which clinical assessment is conducted in many countries, including Australia, Canada, Ireland, United Kingdom, United States of America, as well as New Zealand. However, the complexity pertaining to a consistent definition of competency has identified difficulties of knowing how, and what, to assess in clinical practice. The term competency is predominantly used to refer to registered nurses' fitness for being a nurse and not for nursing students in a nursing programme. Not only has this review identified difficulties associated with clinical assessment, international research has also identified the difficulties that assessors experience when assessing students who are not meeting the required assessment criteria. This phenomenon is not isolated to nursing, but exists in programmes where there is a professional application of theory, such as medicine, occupational therapy and teacher education.

The literature review continues with research that explores the difficulties associated with the "failing" student. The research from international studies in nursing as well as other professional programmes identifies that assessors have difficulty awarding a fail grade to a student who is not performing at the required standard. The reasons for this apparent difficulty would suggest that assessors are ill prepared for assessment and being with a "failing" student; unclear documentation and inconsistent interpretation of required standards, such as safety and professionalism; the multifaceted approach to the assessment of nurses as individuals; the relationship that exists between assessor and student; ambiguity about competency assessment, and the impact that a failing grade will have on an individual student. Increasingly the fear of being unsupported and possible litigation hovers over the final judgement. Assessors who failed students had mixed emotions, including anxiety, but ultimately relief. This literature review has at least highlighted the importance of robust policies and procedures for the assessment process.

The need to protect public safety, the rights of students to an education, and the funding arrangements for higher education all impact upon the decision making process. The practice and education of nurses changed slowly throughout the last century with nurses often being seen as secondary to the role of medicine. Over the last twenty years an increase in public knowledge and medical developments has led to a change in the practice of nursing which education has had to address. This change has been rapid and nursing is evolving in response to the demands of the public and medical professions, possibly with limited time for evaluation. It is the complex nature of competency that needs to be addressed to enable valid and reliable assessment.

The next chapter will explain the research process that was followed to investigate the research questions highlighted in chapter one.

# CHAPTER THREE
# The Research Process

So far, I have explained the rationale for the research topic and have presented a literature review, which highlights research about assessment within a workplace environment, especially the assessment of nursing students in the clinical setting. The review demonstrates that the difficulty of awarding a "fail" grade to a student is not limited to nursing, but occurs in other professions with a practical component, such as teacher education, medicine, and occupational therapy.

In this chapter I will describe my nursing experience in more detail and explain how my chosen methodology of Heideggerian Interpretive Phenomenology provides a desirable approach to the research and also utilises my subjective experiences. I will discuss the research process that was implemented for this study using the framework suggested by Crotty (1998). Crotty was a moral theologian, who lectured in a South Australian school of nursing. Because Crotty made a significant contribution to the role of Heideggerian phenomenology within nursing research (Crotty, 1995) and challenged the "new" phenomenology of North American nurse theorists, such as Benner and Wrubel (Darbyshire, Diekelmann, & Diekelmann, 1999; Garrett, 1998), it is Crotty's (1998) research framework that will inform this chapter. Crotty (1998) recognises that there is often confusion and lack of clarity around the terminology that is used within research literature. He states that the same term "can be used in a number of different, sometimes even contradictory, ways" (p. 1). Because of Crotty's careful examination and clarification of such research literature, and his antipodean background within nurse education, I found Crotty's framework to describe the research process in this study to be the most useful. It provides a logical framework that moves from knowledge through to data collection methods and is appropriate for a study of nurse education in New Zealand.

Crotty (1998) acknowledges that researchers frequently refer to paradigms of qualitative and quantitative research. A paradigm has been defined as a "position or view of understanding the world (world-view or view-of-the-world) which covers philosophical assumptions that are shared by a community of scholars or scientists" and is usually identified as either qualitative or quantitative (Schneider, Whitehead, LoBionda-Wood, & Haber, 2013, p. 22). However, Crotty (1998) would disagree with the terms qualitative and quantitative being used to describe the epistemology and theoretical perspectives; he believes that the terms belong to the methods that are used for collecting the information

(p.15). Giddings and Grant (2009) state that the paradigm reflects the researcher's "beliefs about what reality is (ontology), what counts as knowledge (epistemology), how we gain the knowledge (methodology) and the values we hold (axiology)" (p. 120). However, they do not refer to theoretical perspectives, but use the following terms to describe four main paradigms: positivist/post positivist, interpretivist/constructivist, radical/critical and post structural/postmodern. Crotty (1998) would describe these terms as the theoretical perspectives and I will refer to these in more detail when discussing how I have employed his framework.

Before discussing the research process, I present an overview of myself as the researcher, how my own experiences of clinical assessment have influenced this research and how this information can be utilised within a Heideggerian research methodology. Giddings and Grant (2009) state that the trustworthiness of the research lies in the self-reflexivity of the researcher, therefore, I believe that it is important for the reader to understand how I have positioned myself within this research study. This will become apparent when I discuss the use of Heideggerian phenomenology. I then discuss the epistemological foundations which underpinned the theoretical framework. Having identified the framework, I discuss differences in Husserlian and Heideggerian phenomenology, and explain why I opted for the latter as a research methodology. Finally, I discuss research methods and why I opted for interviews as the tool for collecting data and explain how the data was analysed.

**Being-a Researcher – Who I am**

When conducting research using a Heideggerian approach, Draucker (1999) explains that the researcher is an active participant within the research process and comes to the research participants with preconceived notions based on his or her own experiences. Draucker (1999) believes that the researcher's ability to self-reflect on their own experiences contributes to the interpretive process of Heideggerian phenomenology and that the researcher's experiences can be woven into the participants' experiences. Conversely, McNamara (2005) states the importance of *bracketing* when using phenomenological research, although what McNamara (2005) fails to make explicit in his discussion paper on phenomenological research is that bracketing is a Husserlian concept and not one that is associated with Heideggerian methodology. While the differences between these two methodologies will be explored later in this chapter, it is important here to acknowledge the relevance of "self" to my research. Walters (1995, p. 796) states that:

> The implication of the Heideggerian perspective of the person for the involvement of the researchers is that the researchers and their beliefs will be an important part of the research process. The notion of being-in-the-world enables the researchers to legitimately bring their experiences and understanding to the research. Indeed, it is not something that can be left out of the research process.

Heidegger (1953/2010, p. 150) notes that each individual brings something into a relationship and cannot be truly divorced from that encounter – none of us is truly an outsider. He uses the term *fore-having* [*Vorhabe*] to describe the importance of coming into a situation having already placed meaning and interpretation from previous experience. He explains, that when we are trying to interpret an experience we use information that has previously been used to understand and make sense of items; it is an integral part of *Being*. Making sense of a situation requires it to be *unveiled* and this is performed by an

> act of appropriation that is always done under the guidance of a perspective which fixes that with regard to which what has been understood is to be interpreted.... interpretation is grounded in a *foresight* [*Vorsicht*] that "approaches" ["anschneidet"] what has been taken with a definite interpretation in view (p. 145).

Interpretations that belong to beings are already decided because interpretation is therefore always based upon something that is already known and is, therefore, not without presuppositions (Converse, 2012; Mackey, 2005); Heidegger called this *fore-conception* [*Vorgriff*]. Consequently, in light of the fact that I am using a Heideggerian perspective, I recognise that it is important to acknowledge my own role within this research and how my own experiences may influence the findings and interpretation of the relationships I have encountered in the course of this research.

In the late 1970s I *trained* to become a nurse in a very traditional London based teaching hospital where patients truly formed the core of nursing and the ward sister was the ultimate authority on all nursing matters – she was highly respected and her knowledge was never questioned. As a nursing student, I learnt from other students, obeyed the ward sister and lived in fear of the clinical teacher coming to the ward. Christian names between staff members were not permitted and all patients were treated with absolute respect – as if they were members of my own family. Nursing was a series of tasks with more menial tasks being undertaken by more junior students. As a first year nursing student, I would be

asked to do the "back round" which was conducted every two hours to check for pressure sores; or the "temperature round", taking everyone's temperature, pulse, blood pressure and checking that their bowels had opened that day. Patients were treated as a series of tasks, where nurses of differing levels attended to a task relevant to the patient. As my training progressed, the tasks became more complicated and patients were viewed more holistically as the nursing process and research based care were gradually being introduced. By my third year, it was not uncommon to be in charge of a 32-bed ward, especially on night shift, managing patients, staff and the multidisciplinary team.

Theory lessons were conducted as blocks within the school of nursing, sandwiched between periods of usually eight weeks in clinical placements. The ward sister would assess clinical practice by writing a report at the end of the placement. Additionally, I recall the four ward-based assessments as laid down by the General Nursing Council (GNC) of the UK, which were conducted at certain stages throughout the three year programme. The first two assessments, which could be undertaken after six months training, were an aseptic technique, and a drug administration round. After eighteen months the third assessment was total patient care, and in the third year I was assessed in the management of at least half the ward for a full shift. Each assessment was formal and a GNC certified assessor would come to the ward and upon the presentation of an examination card, I entered a formal exam in the clinical area. Failure to pass on a second attempt resulted in the termination of nurse training. Even after more than thirty years, I can vividly recount each of the four assessments – being filled with dread the night before and studying diligently, as I certainly did not want to fail. Entering an examination which would determine my future as a qualified nurse had a huge impact on my motivation to succeed.

Five years after qualifying as a State Registered Nurse (as it was then), I attended a two day assessors' course to become a GNC assessor. It was my turn to become an assessor of those pre-determined clinical skills. By this time, I had studied for six months full-time to become a registered clinical nurse teacher. This course had three elements – educational psychology, the theory and practice of clinical teaching, and applied physiology. As a registered clinical teacher, my name was placed on the nursing register and my qualification was recorded by the GNC. I worked as a clinical teacher in a military school of nursing, to provide clinical education and assessment within the school and link this to clinical learning experiences within designated wards. Students were able to choose their assessor, but choice was often dictated by the availability of assessors. As an assessor, I still felt anxious for a student and, deep down, always dreaded the possibility of having to fail a student, but as the criteria were so clearly stated for each assessment, it certainly made it easier to fail a

student who had not met the criteria. I did fail students and I cannot recall any appeals made against my decisions, but I do recall that after failing a student, I had a reputation as an assessor who failed students, and I would not be approached to conduct assessments for a while afterwards.

This process of clinical assessment was eventually replaced in the late 1980s by a form of continuous assessment, where ward sisters would complete written reports against clearly identified criteria. A mid placement report would be completed, to enable the student to receive a progress report and identify areas for concern. The ward staff would inform the school of nursing if they were concerned about a nursing student and a member of the school staff would provide remedial support for the student.

I was a clinical teacher for four years and then undertook a further full-time one year course of study to become a registered nurse tutor. This was also a Nursing Council approved programme, with specific elements to address nurse education. Upon successful completion of this course my name was recorded on the register as a nurse tutor. Having been a ward sister, clinical teacher, nurse tutor, and programme manager within the British Army, and now Head of a School of Nursing in New Zealand, I have been extensively involved with the clinical assessment of nursing students. I believe that each assessment is a unique experience for the student and the assessor. Each assessment has a meaning for the student – not only does it determine their future within a nursing programme, it also ratifies their ability to become a nurse. As a result of the Nursing Council approved courses that I studied in the UK, I believe that being a nurse educator is a clearly identified scope of practice which involves responsibility for upholding rigorous educational principles for the protection of health consumers. I have been surprised by the liberal use of the term *educator* within New Zealand. The educator has the responsibility to determine the future of the nursing student.

More recently, in my current role I have been increasingly involved with students who have appealed a fail grade and ultimately sought legal advice and support. I was very aware of my own experiences of failing students and the subsequent litigation that was occurring at the same time as I was conducting interviews for this research. Draucker (1999) believes that the researcher's experience and perspective forms an important part of the analysis and cites an example of a military researcher who failed to acknowledge how this may have influenced the interpretation of data (p. 369). My own experience within the military has enabled me to consider the importance of following correct processes, but also being aware that the military have clear and transparent processes that are well documented. As a Head of School, I was empathetic to participants when they were re-counting stories about the

level of support that they received from the managers within their nursing school and I asked questions about how the NCNZ (2014) standards for education were being implemented for "failing" students. My personal values about nursing and what nurse education should be achieving are to ensure that health consumers can trust the nurse who is caring for them. I believe that it is a privilege to be a nurse, and not a right. I believe that health consumers have the right to safe and competent care. I am from the baby boomer generation and probably have some old fashioned ideas about nursing which stemmed from my very traditional training and my role within the military. Nevertheless, I believe that the health consumers' safety and welfare should be at the core of all decisions that are made about a student's future to become a nurse. I will reflect on these values in the final chapter of this thesis.

I will now explain how Crotty's (1998) framework was used to inform my research design and process. This starts with the epistemological approaches to research that are discussed in the next section.

**Epistemological Stances**

What is research? "Research is a systematic and logical process and exists as a mechanism or tool through which knowledge is generated and tested" (Schneider et al., 2013, p. 21). When considering the research process, Crotty (1998) urges the researcher to consider the type of knowledge to be generated from the inquiry. Knowing oneself and being aware of how knowledge is developed should enable the researcher to identify the research process. How the outcomes are presented results from the epistemological stance taken by the researcher. How the epistemological questions guide the research process is illustrated in Figure 3.1:

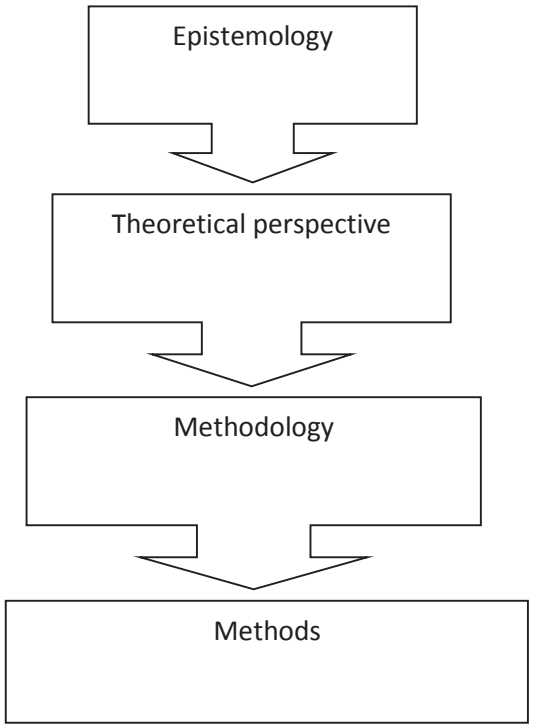


Figure 3.1: Four elements of the research process (Adapted from Crotty, 1998, p. 4).

Epistemology has been defined by Maynard (1994, cited in Crotty, 1998, p. 8) as "concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate." Crotty (1998) summarises this as being "about how we know what we know" (p. 8). Gray (2004) similarly defines epistemology as "a philosophical background for deciding what kinds of knowledge are legitimate and adequate" (p. 16). Crotty (1998) concedes that research usually starts with an issue that is to be investigated and not the epistemology. However, as both definitions highlight, it is the epistemological stance that informs the research process, and enables the researcher and reader to consider how the conclusions have been developed. Crotty (1998) identifies three main categories of epistemology: objectivism, subjectivism, and constructionism, but also acknowledges that these cannot be compartmentalised. I will now briefly describe objectivism and subjectivism and then concentrate on discussing how constructionism informed my research.

Objectivism is described as a view that meaningful reality exists without the need for any conscious awareness. Objectivism is linked to positivism and post positivism and the search for objective truth using scientific methods. Using objectivist knowledge, a tree in a forest, for instance, is always a tree. When a human being comes across a tree in a forest, they will recognise it as such, because they have discovered its meaning as it has been "lying in wait for them all along" (Crotty, 1998, p. 8). Adopting an objectivist approach to the

existence of trees, Crotty (1998) explains that trees in a forest exist, whether we are aware of them or not.

Subjectivism is concerned with meaning that is "imposed on the object by the subject ... the object makes no contribution to the generation of meaning" (Crotty, 1998, p. 9). However, he goes on to say that meanings are usually made from something, whether they are dreams, beliefs, or our collective unconsciousness, but that they are not made from nothing. Subjectivism is considered to be linked to post-modernism and the use of language (Crotty, 1998; Gray, 2004).

Constructionism rejects the notion that objective truth is waiting to be discovered. It is concerned with constructing meaning through our interaction with the world, rather than discovering it. Meanings are constructed within our minds and therefore, each phenomenon will be constructed differently between individuals. Whilst we can presume that most individuals would describe a tree as having a trunk with leaves, the description of the tree could differ from an evergreen pine tree, a deciduous sycamore or a palm tree with bananas. Constructionism is "the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty, 1998, p. 42). Therefore, a tree will have a different interpretation for human beings depending upon how we construct a meaning for that tree in our minds. For instance, a tree could be interpreted as a source of income for someone living in a logging town, or an item of beauty for an artist's settlement or something to desire for an inhabitant of a slum that has no trees (Crotty, 1998, p. 43). Human beings construct meanings of objects as an interpretation of the world they are living in and therefore they cannot be entirely objective.

The concept of *intentionality* is also reflected in constructionism. Brentano (1977) developed the concept of intentionality from medieval philosophy stating that we are always "conscious of something" (cited in Crotty, 1998, p. 44). Crotty (1998) simplifies this by stating "when the mind becomes conscious of something, when it knows something, it reaches out to and into, that object" (p. 44). Intentionality recognises that there is inter-dependence between a subject and their world. The use of the word intentionality in this context is not about "having a purpose", but means "referentiality, relatedness, directedness, aboutness" (Crotty, 1998, p. 44), derived from its Latin root *tendere*, meaning "to tend". The concept of intentionality was taken by Edmund Husserl, considered to be the founding father of phenomenology, to become an essential component of phenomenology

(Crotty, 1998, p. 44) and was later developed by Heidegger. Phenomenologists state that intentionality forms the bridge between object and subject as it describes a relationship that exists between a person's experience of an object and their subjective consciousness of that experience. Therefore, the subject and the object co-exist, which challenges Descartes' binary separation between mind and body (Crotty, 1998, p. 45). Constructionism therefore rejects a wholly objectivist, or wholly subjectivist approach to interpreting how we interact within our world.

The role of culture has been well explained by Crotty (1998) with regards to how it guides human thought and behaviour. Culture is defined as "a set of control mechanisms-plans, recipes, rules, instructions ... for the governing of behaviour" (Geertz, 1973, p. 44, cited in Crotty, 1998, p. 53). Crotty (1998, p. 62) draws on theory proposed by George Mead which claims that we are constructed from the social attitudes and behaviours within our communities, or the worlds in which we live – the "Me" is constructed from the society in which we interact. Therefore, Crotty (1998) would claim that we see the world from the culture to which we belong; enabling human beings to make sense of the world to which they belong. For the researcher, cultural influences may either restrict or enrich the interpretation of experiences. The researcher needs to be aware of differing perspectives that may impact upon the significance of experiences (Crotty, 1998, p. 70).

Crotty (1998) acknowledges that within his framework, ontology, the study of being, is not identified as a separate entity although some theorists would differentiate the study of being, the nature of existence, from study of knowing or epistemology (Gray, 2004). Crotty (1998) believes that ontology emerges from epistemology to inform all the theoretical perspectives, that "being" is inherent in all theory. As the theory of being is central to Heidegger's philosophy, I am content to agree with Crotty at this stage and will follow up the theory of being as proposed by Heidegger within the theoretical perspective of the research process.

When considering the three epistemological approaches, I felt that a constructionist approach would be the most appropriate. I wanted to know how assessors made sense of the experience of assessing nursing students and the factors that were considered when making a final judgement. I aimed to explore how assessors felt about failing a nursing student and what that meant to the assessor. The purpose of this research was not to identify correlations, prove or disprove theories; it was about seeking understanding of a phenomenon. I was not taking an objectivist approach to find an objective truth about assessing nursing students. Neither was I trying to create a subjectivist approach by

presuming or imposing meaning from the participants' experiences. I wanted to interpret their experiences of clinical assessment of failing students and what that experience meant for them; to quote Nietzsche "there are no facts only 'interpretations'" (Grondin, 1994, p. 13). Grondin (1994) continues to say that experiences are subject to historical, cultural and individual perspectives that may account for our actions which I believe are critical components to consider when understanding the experience of assessing clinical practice with nursing students.

My research is very clearly about people and their experiences, namely clinical assessment. When considering my own epistemological viewpoint, I considered the original question that had sparked this piece of research. I could not understand why experienced clinical nurse educators found it difficult to award a fail to a nursing student when they had accepted that the student was failing to achieve. I questioned whether my own military background and military culture influenced my own interpretation of assessment. I questioned whether it was because I was new to the culture of New Zealand nursing and whether it differed from my own British education. Clinical assessment of nursing students has occurred for as long as there has been a system of nurse training/education. I therefore wanted to construct meaning based around the phenomenon of "failing to fail" from the experiences of assessors in the clinical area. Did their own student experiences of being assessed influence their own behaviour? What criteria guided their decision-making and how did they feel about their final decision? A constructionist approach seemed to be the most appropriate, as I was not observing the assessment or attempting to make scientific observations.

A constructionist stance was congruent with my own views of the world and my past experiences; therefore this was the epistemological stance that I adopted. I will now explore how this epistemological stance informed the theoretical perspective adopted for this study.

**Theoretical Perspectives**

The second element of Crotty's (1998) research process is the theoretical perspective - "the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria" (1998, p. 3). Positivism, interpretivism, critical inquiry, feminism and post-modernism are all considered theoretical perspectives (Crotty, 1998, p. 5). A brief overview of these main perspectives will now follow, although Gray (2004) suggests the theoretical perspectives of positivism and interpretivism have had the greatest influence on research (p. 17).

Positivism comes out of the Cartesian inspired objectivist epistemology and argues that the social world is external to the researcher and that measurements can be taken from observation. It is concerned with "objectivity, systematic and detailed observation, testing hypotheses through experimentation and verification" (Grant & Giddings, 2002, p. 13). Within this perspective, researchers are seeking to discover knowledge to explain, predict and control events (Grant & Giddings, 2002, p.14). My research was not concerned with testing a theory or scientific certainty; it was about searching for meaning. Therefore, a positivist theoretical perspective was not suitable for this study.

Critical inquiry stands apart from the understanding of interpretivism as it challenges theory rather than tries to understand and make sense of information. It is research that challenges; it is concerned with conflict and aims to produce change (Crotty, 1998, p. 113). Karl Marx is considered to have laid the foundations for critical inquiry and modern thought (Crotty, 1998, p. 115). He fought to apply his philosophical beliefs into action by challenging social reality. Critical inquiry examines how knowledge is used to create power and control. Crotty (1998, p. 142) explains that critical inquiry used by Habermas comes from the epistemological stance that "human beings constitute their reality and organise their experience in terms of cognitive (or 'knowledge-guiding') *interests*". Therefore this perspective is concerned with "predicting and controlling objectified processes. This is the realm of instrumental action" (Crotty, 1998, p. 142). There are elements of critical inquiry that could have been utilised such as Habermas' discussion about the use of language, as the word "fail" certainly evokes discussion. However, my research was embedded in the lived experience of clinical assessment. Whilst the findings from my research may challenge current practices, which may result in change to the current system of clinical learning and assessment, I do not wish to create conflict.

Feminism views the world as patriarchal and its culture as masculine (Crotty, 1998, p. 161). Whilst there are many categories of feminism such as Marxist feminism, radical feminism, liberal feminism, and psychoanalytical feminism, Crotty (1998) explains that feminism is not about women "knowing" differently from men, rather feminists "theorise the act of knowing differently from men" (p. 174). As nursing is predominantly a female occupation, a feminist theoretical perspective could have been used in my research. However, I did not think that it was appropriate for my research as it is not a perspective that either fits comfortably with the central aim of the study, nor my own interpretation of the world.

Interpretivism is closely linked with the epistemological stance of constructionist epistemology and is a major anti-positivist stance (Gray, 2004, p. 20). Interpretivism seeks to "understand what it is to be human and what meanings people attach to their lives" (Grant & Giddings, 2002, p. 16). Interpretive research involves the researcher gathering information from participants and interpreting the information for analysis. It requires that the researcher is able to listen, observe and reflect on the information, as well as being aware of their own position within the research. This type of research is more common in nursing than the positivist research described above (Grant & Giddings, 2002). The interpretivist approach "looks for culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67). Interpretivism is about searching for understandings and is inextricably linked with hermeneutics.

Hermeneutics comes from the Greek "*hermeneuein",* which means "to interpret" or "to understand". Its background is in exegenesis, which is concerned with study into interpretation of the Bible. Hermeneutics is about making sense of an object, or an experience. How we make sense of objects can be influenced by our own history, culture and experiences. The role of "self" is an important consideration when conducting research using a hermeneutic approach. The use of the "hermeneutic circle" is well described by Crotty (1998) and Heidegger (1953/2010) as a means of achieving meanings from experience. An event occurs and meaning is made through interpretation shared between persons in their interactions through a process of reflection. Heidegger suggests that, following an interpretive process, we can return to the starting point in a circular fashion. However, Conroy (2003) suggests that hermeneutics is not circular, but spirals as information is interpreted and re-interpreted, which demonstrates that life is not static, but constantly evolving as our inter-dependence with others changes.

Hermeneutic principles are important for the research process, as each individual experience is valuable and significant. Conroy (2003) uses the metaphor of footprints to explore how information is collected and reviewed by the researcher. She explains that each participant places themselves in the world through their footprints, with each footprint being unique, but footprints "blend with the earth's contours or with others' tracks and fade or stray from a pathway in the woods" (p. 5). Conroy likens footprints to individual contributions to the hermeneutic spiral, which can be interpreted to enhance understanding. These footprints follow pathways to eventually reach Heidegger's metaphorical "clearing in the woods". Interpretive phenomenology may be said to be about a continual oscillation between footprint collection and footprint interpretation.

Van Manen (1990), a hermeneutic phenomenologist, believes that the researcher must have a serious interest in a phenomenon. This commits the researcher to the world and enables them to use reflections on experience to explore meanings. I believe that assessing a nursing student in the clinical environment is an "experience" for the assessor. It is an experience for which most assessors prepare. The awarding of the final grade will have meaning for the student and the assessor. Ultimately the awarding of the appropriate grade will impact upon health consumer care; a pass grade which is awarded to a "failing" student means that the student, despite not being competent, will become accountable for health consumers when admitted to the nursing register. Interpretive phenomenology allowed for that experience to be studied in detail – to probe the assessor about whether previous experiences, both as a student and as an assessor, affected how they judged a student. The assessment of a student is interplay of many factors such as the relationship with faculty, the impact on health consumers, the dynamics of the clinical environment, the characteristics of the student and their stage in training, the relationship between the student and the assessor and the effects of the actual assessment on the student. Gathering information about those experiences from clinical assessors and interpreting their experiences would enable me to construct meaning regarding the difficulties associated with failing nursing students. Therefore, interpretivism was an appropriate theoretical perspective to adopt for this research.

Having discussed the theoretical perspectives that informed the research process, I now move onto Crotty's third element of the process to explore the methodology that informed my research project.

**Methodology**

Methodology is defined as "the research design that shapes our choice and use of particular methods and links them to the desired outcomes" (Crotty, 1998, p. 7). Giddings and Grant (2009, p. 121) simplify this as "the thinking tool." As outlined above, I have taken an interpretivist theoretical perspective in this research. There are many different methodologies within the interpretivist perspective, such as ethnography, grounded theory and phenomenology (Crotty, 1998; Grant & Giddings, 2002). I have chosen phenomenology which I now discuss in more detail, including my rationale for this choice.

**Phenomenology.**

This section starts with an overview of the development of phenomenology as a research methodology. Although there are multiple philosophical contributions to phenomenology, I will eventually discuss the ideas of just two popular phenomenologists

who have made major contributions to the field of research - Husserl, as the founding father of phenomenology, and Heidegger, whose philosophy has informed this research. Later, I will explain my rationale for choosing Heideggerian phenomenology.

Phenomenology comes from the Greek term φαίνόμενον which means "what shows itself, the self-showing, the manifest" (Walters, 1995, p. 791). It is a compound of two Greek words: *Phainomenon*, meaning that which appears; and *logos* – to reason (Sokolowski, 2000, p. 13). In this original Pre-Socratic form, phenomenology was primarily about the experience of being and how the world could be understood from within that experience (Korab-Karpowicz, n.d.). Yet, in its development as a major philosophical and ontological concept over the centuries, this basic idea gave way to a considerable variety of reinterpretations, remodelling, and repositioning. Subsequently, in the present age, there is still no consensus amongst phenomenologists about the exact meaning of phenomenology (Cohen, Manion, & Morrison, 2007; Johnson, 2000).

Nevertheless, there is some common ground between the different notions of phenomenology. For instance it is generally accepted that:

> Phenomenology is the study of structures of consciousness *as experienced from the first-person point of view.* The central structure of an experience is its intentionality, its being directed toward something, as it is an experience of or about some object. An experience is directed toward an object by virtue of its content or meaning (which represents the object) together with appropriate enabling conditions (Stanford Encyclopedia of Philosophy, n.d., italics added).

Thus, whilst arguments remain about the exact meaning of phenomenology, the "core doctrine of phenomenology is the teaching that every act of consciousness that we perform, every experience that we have, is intentional: it is essentially 'consciousness of' or an 'experience of something or other'" (Sokolowski, p. 8). In this, there is little argument at least, and it remains to note that the most successful interpretations reflect this central position. These include Husserl's transcendental phenomenology and Heideggerian interpretive phenomenology.

Hence, due to the diversity of phenomenological approaches, there is no single way to approach phenomenological research (Todres & Wheeler, 2001), and as Draucker (1999) and McNamara (2005) acknowledge, there is no definitive text which outlines how to conduct phenomenological research. Johnson (2000) claims that nurse researchers have

traditionally used Husserlian phenomenology to explore participants' lived experiences, but more recently they have started to embrace Heideggerian philosophy. However, some criticise the use of Heideggerian philosophy within nursing research due to a lack of interpretation of Heideggerian philosophy and an understanding of some of Heidegger's key concepts (Johnson, 2000; McNamara, 2005; Stoller, 2009). The philosophers of phenomenology do not dictate how research should be conducted; they present a theory for understanding an experience.

I will now discuss two key phenomenological philosophers and their roles in informing the methodological framework used in my research.

**Husserlian philosophy.**

The German philosopher and mathematician, Edmund Husserl (1859 – 1938) is considered to be the founding father of phenomenology, as he sought to move away from traditional Cartesian dualism of "mind and body" and adopt a more scientific approach to interpreting philosophy (Draucker, 1999; McNamara, 2005; Walters, 1995). Husserl developed Brentano's concept of intentionality as a means of understanding conscious acts (Dowling, 2007). Husserl challenged the traditional objectivist theories that dominated from Ancient Greek times until the late 19th century. He argued that there was a personal, more subjective element that could be used in modern philosophy. He believed that it was one's consciousness that structured experience. Husserl believed that, since the time of Descartes, all philosophy had adopted a scientific stance, and this was a problem in modern philosophy. How individuals interpret the same object, for example a tree, will differ from person to person. So whilst a tree is perceived by many as an object, the subjective interpretation of its use and appearance will be different according to individuals' perception of its structures (Smith, Flowers, & Larkin, 2009, p. 14).

Husserl used the term *lifeworld* as "that stratum of lived experience which is prior to and logically independent from those conceptions of the world developed through applications of scientific methods" (Russell, 2011, p. 43). He believed that most individuals take their world for granted and attempted to find a systematic description for the structure of the life world. He believed that, to examine an everyday experience we need to be able to "step out of it" and reflect inwardly on that experience, referred to as *bracketing*. Bracketing involves removing any preconceived ideas about a phenomenon. As McNamara (2005) states, it "entails abandoning the culturally and socially derived understandings with which we operate in the natural attitude" (p. 697). In order to reflect on an experience we need to distance ourselves from it. Husserl intended phenomenology to be a science

without any presuppositions, so judgements need to be bracketed to remove subjectivity. Husserl used the term *epochē* to describe the procedure of bracketing. He wanted a means of ensuring that knowledge that was gained through phenomenological study was not contaminated with previous knowledge, experience or bias. It therefore allows the researcher to thematise entities without interference from other theories (Overgaard, 2003; Sokolowski, 2000). Husserl's phenomenology is therefore meant to be *a priori*, free of contamination from individual or related properties in order to concentrate on perception of the world. He believed that individual personal experience informed second order science (Smith et al., 2009).

Husserl was keen to investigate the ideas underlying a subjective experience, a process known as *eidetic reduction*. Husserl described a procedure that goes through a series of reductions which allows for different means of viewing a given phenomenon. The reductions allow for the researcher to move away from their own preconceptions and back to the "essence" of the experience. This technique involves reflecting on past experiences and then imagining new experiences, to establish the essence of a lived experience (Smith et al., 2009; Sokolowski, 2000). However, Husserl wanted to go beyond eidetic reduction and look further into the nature of consciousness, a process he called "transcendental reduction". He wanted to identify the content of conscious experience to identify particular features of an experience. It is this early desire to study the features of an experience that influenced phenomenological philosophy (Luft, 2005; Smith et al., 2009; Sokolowski, 2000).

I have introduced Husserl as the founding father of phenomenology and outlined his contributions to a philosophical stance that broke away from traditional scientific methodologies in the late 19th century. Many other scholars developed Husserl's philosophy, but it is the work of Heidegger that I now wish to pursue. Heidegger, a pupil of Husserl, took a different approach to phenomenology which I now discuss in further detail.

**Heideggerian phenomenology.**

Martin Heidegger (1889 – 1976) was the son of a craftsman in a staunchly Roman Catholic district of Germany. Theology and religious studies formed the basis of his educational studies and he started studying theology at Freiburg University in 1909 before moving into philosophy. He started to reject Catholicism, but never left his beliefs in Christianity. His early studies in theology enabled him to consider the role of hermeneutics within philosophy – being able to interpret experiences. His early lectures at Freiburg were concerned with medieval thought and logic. In 1916, Husserl arrived at Freiberg University and Heidegger believed that this was his opportunity to develop phenomenological

research. He became Husserl's assistant until he started to develop his own lectures on phenomenology and moved from Freiberg to Marburg University to take a professorial appointment in 1923. Once Heidegger moved to Marburg there is evidence from his early lectures that he started to criticise Husserl and challenge his status as a philosopher (Overgaard, 2003).

The relationship between Heidegger and Husserl is well documented but what appears to have created a major debate between the two was the writing of a definition of phenomenology for the *Encyclopaedia Britannica* in 1927 (Luft, 2005, p. 142). Husserl and Heidegger disagreed about the role of consciousness within a definition of phenomenology. Heidegger defined phenomenology as "a formal method of letting things be seen in the way they show themselves – and in so doing severs an immediate link to consciousness" (Luft, 2005, p. 142). This was a departure from Husserl's definition that "the topic for phenomenology, namely, consciousness or subjectivity conceived as transcendental, i.e., as distinct from worldly subjectivity" (Luft, 2005, p. 142). Furthermore, Heidegger challenged Husserl's concept of bracketing by stating that all philosophies have presuppositions:

> There is no pure phenomenology ... according to its essence, it is laden with presuppositions, as is all human activity. And the task of philosophy is not something like doing away with presuppositions at any cost, but rather admitting them and gearing the investigation to them positively and in a manner based in its matters (Boedeker, 2005, as cited in Dreyfuss & Wrathall, 2005, p. 164).

Heidegger's beliefs lay in the understanding of *Being*, which he termed *Dasein*. He thought that Husserl had not defined being (Luft, 2005). Heidegger was obsessed with language, the meaning of words and had a tendency to develop new words in German which means they cannot easily be translated into English (Davis, 2010). Heidegger (1953/2010, p. 53) also used hyphens to make compound expressions to signify "a *unified* phenomenon". Therefore hyphens are used for phrases such as *being-in-the-world,* or *Being-a nurse*[3]*.* I offer some of his key concepts to describe and enhance his theory of *Being* in the following sections.

[3] A small *b* will be used when *being* is with a prepositional or adverbial phrase attached, such as *being-with*; a capital *B* will be used when hyphenated with a noun such as *Being-a* nurse.

***Dasein: the meaning of Being.***

Heidegger explored the meaning of *Being* which he published in his Magnum Opus, *Being and Time* (*Zeit und Seit*) which in 1927 (Heidegger, 1953/2010), he curiously dedicated to Husserl in "admiration and friendship". Heidegger investigated an ontological approach to human beings which is concerned with what makes it possible for us to be human. He believed that it is our way of existing within the world that made us human – which he called Dasein. In colloquial German, it means existence, but Heidegger uses it to refer to the human way of existing. Dasein is one of Heidegger's key concepts and literally translates to "being there" taken from the German verb – Sein, to be. In some of Heidegger's later works this is written as two words Da-Sein signifying *existence;* the capitalisation of German words signifies a noun (Colony, 2009). Stambaugh (1995) explains that the capitalisation of Da-Sein would lead readers to believe that Heidegger is referring to 'a being', but this was not Heidegger's intention (p. xxiv). Perhaps this goes some way to explain why a translation of Heidegger's work is sometimes confusing.

Heidegger believed that our way of *being-in-the-world* is about how we exist within the world, and that worldly things cannot be reduced to physical properties, but that everything co-exists. Unlike Husserl's term *lifeworld*, Heidegger used *being-in-the-world* to explain how we exist. To understand how we exist requires a hermeneutic approach to life (Dreyfus & Wrathall, 2005). How we understand ourselves requires that one should go back to a concrete situation within our historical lives, a process he referred to as *facticity*. This process needs to be hermeneutic as well as phenomenological, in order to return to the "historical embeddedness of human beings" (Davis, 2010, p. 2). As we are part of a world made up of different entities, we can start to question the structures that make up our world.

He states that people are rational beings and actions are performed for a reason. Haugeland (1992, pp. 36-38) explains Heidegger's theory of Dasein with an analogy to playing a game of chess. The game of chess is about being within a situation, such as *being-in-the-world*. Rules dictate how pieces are to be moved and the player will conform to those rules when moving the pieces. The player assesses the various possibilities available to him and eventually will decide on the least threatening move; each move is made for a reason. This is likened to *being-in-the world* and our actions are based on norms and have a rationale.

***Temporality.***

*Temporality* and the concept of *Time* is an important consideration for Heidegger's explanation of Dasein as there is a connection between *Time* and *Being*. He states that

*temporality* is a dynamic state and that the present is always about the future, and is determined by the past. *Historicity* and *temporality* are core components of Dasein. He argued that we were born into this world and *thrown* into our historical world (Davis, 2010, p. 26). *Throwness* is about being born into a world that one did not make and a life that was not asked for. Our very being can be attributed to our historical past and associated heritage. The future gives meaning to events and death, or demise *(Ableben)* is the ultimate future event (Heidegger, 1953/2010, p. 247).

Blattner (2005) describes Dasein's being as "projecting forward into some way of life" (p. 312). To illustrate this, Blattner (2005) describes someone wanting to become a musician and that projecting forward into a musician's way of life involves setting about "doing what musicians do" (p. 313). As such, being a musician may be argued as a possibility for the future, but does not exist in the present. When the requirements to become a musician do not exist in the present, then the possibility of being a musician cannot be fulfilled despite "pressing ahead into being one ... *the Unattainability Thesis"* (p. 34). Using this example it is possible to compare the desire to become a musician with the desire of a nursing student to become a nurse.

***Attunement.***

Heidegger also stresses the importance of moods and the impact that our moods can have on our experience and interpretation of the world. Moods can determine how things matter to us – they can make a situation meaningful. Our *being-in-the-world* means that we have a way to be there, how to act and exist and how we are tuned into the world. Heidegger referred to this as *attunement*. As individuals, we need to know how the world acts, how all the different components within our world work together. Having understood our *being-in-the-world*, we develop coping mechanisms in order to exist. Heidegger recognises that we all differ, and he uses the term *distantiality* which means that "Dasein stands in *subservience* to others" (Heidegger, 1953/2010, p. 122). That is, "we simply accept unthinkingly the ways in which one does things. But the 'one' who decides how things ought to be done is no definite person or group: the 'who' is not this one, not oneself, not some people, and not the sum of them all. The 'who' is the neuter, the 'one'" (Heidegger, 1927, as cited by Dreyfus & Wrathall, 2005, p. 7). This links to the concept of *inauthenticity* discussed in the next section.

***Authenticity/inauthenticity.***

Within *Being and Time*, Heidegger (1953/2010) states that Dasein always exists within one of two modes of *Being*; *authentic (Eigentlichkeit)* or *inauthentic*

*(Uneigentlichkeit)* (p. 53). The root of these two words is *eigen,* the German for "to own". This was important for Heidegger as "I can be my own self or not be my own self" (Davis, 2010, p. 54). "An authentic way of existing is one that requires individuals to take responsibility for their attitudes and actions. They individualise themselves as distinct from yielding the authority for their lives to others" (Davis, 2010, p. 63). Heidegger (1953/2010) explains that being authentic requires a "voice of conscience" (p. 258) and that "being-a-self which we are looking for" is termed *resoluteness* (p. 260).

> Authentic people renounce overwhelming instrumentalism, and they practise a careful respect before other beings; they let beings show themselves in their own events. Authenticity means that people check their impulses to control and define their worlds by invasive actions. The differences of others thus often interrupt unconsidered inclinations to do what we are supposed to do under the banner of normal morality (Davis, 2010, p. 65).

The term *inauthentic* describes how we exist in everyday living. From early childhood we observe how others behave and seek acceptance from the people around us. Davis (2010) describes this inauthentic way of living as "I see myself the way others see me, if I go along to get along, I make choices as though I were not my own life. I intend what they intend for me" (p. 59). Heidegger (1953/2010) terms this the *everydayness* of Dasein which defines our existence (p. 17). He accepts that we might not always wish to conform, as it means that we would never take a stand for what we believe in as ourselves, and therefore calls this conformity *inauthenticity* and refers to other people as the *they* (p. 123). Dreyfus and Wrathall (2005, p. 7) state that as a result of constantly being aware of conforming to others "there is a tendency that things will be levelled to the lowest common denominator, or the average". The norms that govern events are available to everyone, meaning that it is the same for everybody. This leads to a tendency to *disburden*, which enables us to free ourselves of responsibility and decision making as we do what everyone else would do. However, an *authentic* way of being is about taking responsibility for attitudes and action.

***Truth.***

Heidegger took the Greek word, *alêtheia*, which literally translated means *truth*. However, Heidegger thought that truth was more than *correctness*; it was the *unhiddenness* of something. "Truth defines human existence and human beings define themselves by the way they conceive the truth" (Davis, 2010 p. 117). Heidegger investigated the search for truth using three stages: "*correctness* of thoughts and assertions, the *unhiddenness* of beings

and the *clearing* for beyng's [*sic*] self concealment" (Davis, 2010, p. 117). Heidegger uses the analogy of a clearing in a forest to explain the search for openness and truth. The clearing is that area of forest which is devoid of trees and allows the light to get through. Davis (2010, p. 120) cites Heidegger's explanation:

> Light can stream into the clearing, into its openness, and let brightness play with darkness in it. But light never first creates the clearing. Rather light presupposes it.... The clearing is the open region for everything that becomes present and absent.

Therefore, when utilising Heideggerian phenomenology, it is necessary to uncover meanings that may not present themselves initially and to return to the past of the research participants; this will be discussed in greater detail in later chapters.

***Use of tools.***

Another important facet of Heidegger's *being-in-the-world* is how we use tools to achieve an objective. He states, that "there is no such thing as a useful thing.... A useful thing is essentially in 'order to'.... The different kinds of 'in order to' such as serviceability, helpfulness, usability, handiness, constitute a totality of useful things" (Heidegger, 1953/2010, p. 68). Heidegger (1953/2010) illustrates the use of tools by explaining how a hammer is used. Each individual will hold a hammer differently; will use different amounts of force to strike an object. A hammer has a primary purpose, but can be adapted for other purposes; a hammer needs someone to hold it and an object for it to strike in order to achieve its primary purpose. A hammer may be used to place a nail into a piece of wood, which is being used to construct a table, so that a family can place it in their home in order to dine from. The hammer therefore has a purpose that ultimately enables a family to eat. He also states (pp. 83-4) that there is never just one tool to perform a task. The analogy of the hammer as a tool will be applied to the use of assessment tools for assessing nursing students.

***Caring.***

The concept of Care (*Sorge)* is important for Heidegger (1953/2010) as he states "our human being is shaped by Care. The ways we care and what we care for govern our lives to a considerable degree" (p. 58). "To live is to care.... What we care for and about, what caring adheres to, can be defined as meaningfulness" (Davis, 2010, p. 58). I believe that this aspect of caring is important within my own research for understanding the assessment of nursing students and the role of caring within nursing and education. Caring is an integral part of

interpreting the world and Heidegger defines three specific worlds of care: "the environing world, the shared world and one's own world" (Davis, 2010, p. 21).

However, his *being-in-the-world* means that we are never alone; we co-exist with other people, with objects around us. Our experiences of the world are influenced by interpretations of the world we exist in. Heidegger refers to approaching a clearing in the woods as a means of interpretation of the world and that involves interpreting the twists and turns of the terrain (Conroy, 2003). For Heidegger, hermeneutics is about understanding human beings – what it is to be human. For this study I needed to understand what it means to be a clinical nurse educator with a duty to protect the public. Heidegger (1953/2010) posits that the understanding of human beings is to understand that humans are self-interpreting beings. In Heidegger's attempt to move away from Cartesian duality, he aimed to explain the meaningfulness of human life's experiences.

**Justification for utilising Heideggerian phenomenology.**

I am passionate about maintaining the health and safety of members of the public as health consumers through the honest assessment of nursing students which allows them to become accountable practitioners. My interest is deeply rooted in the experience of assessing students and how assessors feel about their role and their ultimate decisions. Van Manen (1990) strongly supports the role of reflection within Hermeneutic Phenomenology and nurses are strongly socialised to reflect on actions for the development of professional portfolios as measures of competency assessment. Because nurses are aware of reflection, I believed that this would help with the investigative process that I pursued in my interviews. Each account must be considered unique. Smith et al. (2009) stress the importance of not making assumptions and allowing the interviewee to tell their story, using probes to obtain further information.

My research was about people and their experiences of clinical assessment. As I was not observing the assessment, not attempting to make scientific observations, not seeking correlations, or testing a theory, an objectivist approach was not appropriate. When considering my own epistemological viewpoint I wanted to construct meaning from the experiences of assessors in the clinical area and how the assessment of a "failing" student affected them. Heideggerian phenomenology enabled me to enter the world of the assessors and interpret their experiences to seek meanings associated with failing students.

The clinical assessment of a nursing student is a unique experience for both student and assessor. The clinical environment is dynamic, with many interactive forces (Dunn &

Burnett, 1995, p. 1166) impacting upon that environment, which ultimately influences the assessment experience. Multiple factors impact upon the assessment of nursing students within the *world-of-nursing*: health consumers are individuals with their own personalities, health issues, and concerns; the health care team has multiple dimensions; each nursing student possesses unique individual qualities; and the assessor is a professional with an obligation to the nursing profession. The meaning of the final assessment decision has consequences for the nursing student. A student who passes the assessment will be permitted to continue with their nursing programme. A student who fails an assessment will either require extra clinical time, or may have to exit the programme and not qualify as a nurse. The uniqueness of each clinical assessment and the consequences of the final decision for both the student and the assessor, means that the interpretive perspective of Heideggerian phenomenology is appropriate for constructing meanings associated with the experiences of clinical assessment.

Having discussed Heideggerian phenomenology as the methodology for my research, I now move to Crotty's (1998) fourth element within the research process, that of data gathering methods.

**Data Gathering Methods**

The fourth element of Crotty's framework is about the activities that are used to collect the data or, as Giddings and Grant (2009) described, "the doing tools for collecting the information" (p. 121). As I have already identified the research methodology as Heideggerian phenomenology, I outline why some research methods were discounted, such as questionnaires, observation and written records, in favour of interviews. I discuss in more detail the rationale for interviews as the chosen data collection method.

**Questionnaires.**

Questionnaires can collect information pertaining to knowledge, values, preferences, attitudes, beliefs and feelings. They do not allow for personal interactions between the researcher and the participant. Questionnaires allow for a larger sample size and reduce researcher bias, as the researcher is not usually present during the completion of the questionnaire, although the questions may contain researcher bias. They can also be administered on-line, as well as the more conventional means of personal distribution or post (Cohen et al., 2007; Schneider et al., 2013). However, the development of a questionnaire demands careful planning and preparation to ensure the respondent is able to understand and respond accurately to the questions asked. They do not allow for the researcher to probe or clarify meanings. As questionnaires would not allow me to gain

deeper meanings of the experiences of the assessor, I did not consider them to be a suitable data gathering tool.

**Observation.**

Observational methods rely on the researcher observing subjects within their normal environment and taking notes about behaviour and attitudes. The researcher may be a participant within the group and can either conceal their role as a researcher or make participants aware of it. Alternatively, the researcher may be an observer who does not participate with the subjects (Cresswell, 2002). The advantages of this method are that the researcher is able to witness, and contextualise, behaviours and attitudes within the natural setting. Although an assessment may be observed, the feelings and meanings about the assessment decision could not be identified without a dialogue: it is this dialogue which enables access to meanings held by the participants.

**Journals.**

Another possibility is to analyse written records such as reflective diaries and journals, or comments made on assessment sheets. The advantage of using journals is that the researcher can access the material at any time providing the subjects agree to the release of the material. The information is already written, so the researcher does not need to do any transcription. However, written notes will require the honesty of the respondent and the information may not be complete. Confidentiality of written records and the context of the information need to be considered as students may also be identified. The personal nature of journals and the accuracy of their content meant that this method was discounted.

**Interviews.**

Interviews are the most commonly used method for collecting information from participants within phenomenological research (Converse, 2012; Mackey, 2005; Smith et al. 2009). In-depth interviews enable participants to "tell their story, in their own words" (Conroy, 2003; Smith et al. 2009, p. 57) whilst the researcher is able to encourage the participant to reflect on those experiences. I chose to interview participants because I believed that I would be able to explore their experiences and in using their recollections, I would be able to probe deeper into their accounts to create meaning. Within a Heideggerian methodology, Johnson (2000, p. 141) explains that an interview must be an engagement between two people – "the interviewer should place themselves in the other person's situation to understand their perspective". She explains that interviews should try to elicit stories and continually make sense of the words and what they mean. The interviewer must constantly remain open and maintain that sense of curiosity and try to make sense of the

participants' world. Interviews allow the researcher to explore events and enable the participant to reflect, clarify and illuminate experiences (Wimpenny & Gass, 2000).

Interviews can be conducted in various ways: telephone, face-to-face, and as a group process. They may be unstructured, structured or semi-structured. Ideally they should be recorded to enable the researcher to give full attention to the participant and enable them to enter the participants' world. The interviewer needs to be confident and skilled in collecting consistent information in a respectful manner. During the interview it is important to ensure that the researcher does not allow the interview to deviate from the primary purpose. Difficulties include: identifying suitable interviewees, and identifying a mutually convenient time and location for the interview. Prior to any interview, the participant should be made aware of the purpose of the interview and know who the interviewer is. The advantages of using interviews are that participants generally find it easier to talk than write about themselves, and the researcher can acquire a greater depth of information than that acquired through questionnaires (Cohen et al. 2007; Fraenkel & Wallen, 2006; Schneider et al. 2013; Smith et al. 2009).

Interviews can be time consuming: the time to conduct the interview, as well as time to transcribe and analyse the content. The presence of a researcher may result in a bias and limit what a participant may say with honesty. I needed to be aware that my presence could influence a participant's response. A participant may have answered according to what they thought I might wish to hear for fear of being portrayed negatively or socially and professionally unacceptable. The questions may be searching for information that the respondents may not be able to provide, or are uncertain about (Schneider et al., 2013; Tuckman, 1978).

Group interviews and focus groups were not used as they have limitations, in that dominant members of the group may take over and quieter members may feel inhibited. The use of focus groups is also not advised for phenomenological research as it is harder to make inferences from the data, due to the multiple numbers of people involved (Smith et al., 2009; Webb & Kevern, 2001). They also warn against unstructured interviews as they can be unfocused and may result in superfluous information being obtained (Miles & Huberman, 1994). Conversely, a structured interview would not have allowed for the individuality of each participant and their personal experiences.

I chose to use a semi-structured individual interview to facilitate a comfortable interaction that enabled a detailed account of participants' experiences. A semi-structured

interview allowed for some consistency yet provided a flexible framework. Carspecken (1996) suggests that the interviewer should encourage participants to use case studies to talk about experiences within the interview to illustrate and expand the information being requested.

An interview schedule was developed using nine key open-ended questions (Appendix E). The questions used "why", "how", "describe", "explain", and "what" to collect sufficient information and allow the participant to describe, in detail, their experience of assessing a nursing student within a clinical environment. Open questions removed much of the control from myself, and enabled participants to answer from their own experience. Developing a schedule ensured that the skeleton of the interview was consistent amongst all participants to allow for ease of analysis. Whilst the key questions formed the backbone of the schedule, participants were encouraged to elaborate on issues and I provided prompts to enable the participant to expand on specific issues. A semi-structured individual interview enabled me to enter the world of each participant allowing me to encourage them to recount their experiences of assessing nursing students. The schedule was flexible enough to adapt to each participant, yet had a series of core questions to allow for some consistency in all interviews.

Having outlined various methods for obtaining data and justifying the use of face-to-face interviews using a semi-structured interview schedule, I now outline the framework used for analysing the data.

**Analysing the Data**

Denscombe (2007) outlines four guiding principles for the analysis of data. Firstly, the analysis, and conclusions drawn, must be based firmly in the data. Secondly, any explanations of the data should come from careful and meticulous reading of the data. Thirdly, the researcher needs to be aware of preconceived ideas, prejudices and bias when conducting data analysis; this is especially true of Heideggerian phenomenological research. Finally, data analysis is an iterative process which moves back and forth between the interview, the comments, and emergent themes; this is likened to Conroy's (2003) footprint metaphor of continual oscillation between collection and interpretation.

Analysis of the data was conducted using interpretive phenomenological analysis (IPA) suggested by Smith et al. (2009). Heideggerian interpretive phenomenological principles inform the theoretical underpinnings of the process. They describe an approach which explores how lived experiences have significance for people. Their method for

analysing data within an interpretive phenomenological methodology employs six stages. They state that analysis is "an iterative process of fluid description and engagement with the transcript. It involves flexible thinking, processes of reduction, expansion, revision, creativity and innovation" (Smith et al., 2009, p. 81).

**Stage one** is concerned with immersing oneself in the data by reading and re-reading the transcript, including reading the transcript in conjunction with the audio recording.

**Stage two** is about examining the transcript for semantic content and language use, and making notes and comments about anything of interest. Conroy (2003) adds another point here that when making comments the researcher should make some interpretations.

**Stage three** starts to develop the emergent themes and this should be checked with a second reader to reduce the element of subjectivity.

**Stage four** searches for connections across the emergent themes. Smith et al. (2009) suggest that themes are adjusted to look for patterns and connections. They also note that there may be opposing connections; looking for differences as well as similarities. Smith et al. (2009) also suggest identifying the number of times a particular theme emerges.

**Stage five** starts to repeat the process for the next and following transcripts. Smith et al. (2009) state the importance of reviewing each transcript on its own merits and separating the analysis from previous transcripts. However, they acknowledge that it is difficult not to be influenced by previous analyses; in Heideggerian terms the *fore-structure* has changed.

In **stage six** patterns are sought across all the interviews and tabulated to identify the common themes. However, an absence of commonality across the interviews is also important, as the analysis is about a "whole" picture. A male perspective or participant from a different clinical environment may have a different experience. Their contributions are just as valid and must be incorporated into the overall analysis.

Using the IPA framework, Smith et al. (2009) stress the importance of looking for interpretation from the participants' words. Using relevant extracts from interviews can demonstrate how interpretations have been made from the participants' experiences.

**Research Validity**

The term validity, usually associated with positivist research, will be used to encompass terms of "generalizability [*sic*], replicability and controllability" (Cohen et al., 2007, p. 134). Smith et al. (2009) refer to Yardley's (2000a) principles for assessing validity and quality of interpretive phenomenological research. Yardley (2000b) argues that determining the validity of a qualitative piece of research is quite different to that of validity of a quantitative piece of research due to differences in sample size, the focus on both yielding objective findings and replicability of findings. In particular, Yardley (2000b) suggests that when the research involves the interpretation of a phenomenon, it may be inappropriate to consider reliability and replicability. Yardley (2000b) acknowledges that whilst two researchers can be trained to code interview texts for common themes in the same way, the influence of subjectivity may just result in two people who agree to an interpretation of data rather than objectivity. She also argues that defining rules for coding themes inhibits creative interpretations. Therefore, Yardley (2000b) recommends assessing the quality of qualitative research using four main characteristics which will be outlined below. I believe that these four characteristics provide a good platform from which the research can be assessed for validity as the importance of participants' experiences is acknowledged.

The first characteristic, which Yardley (2000b) considers, is that of "sensitivity to context". This is an important principle as it embraces the ethical principle of not causing harm to the participant. It is important to consider the socio-cultural context within which the participants were employed and their duty of care to health consumers as well as their responsibility for educational processes. Additionally, the context of the relationship between the researcher and participant must ensure that communication enables open and honest dialogue, and the researcher needs to be aware of unexpected information. Yardley (2000a) also notes that participants within interpretive phenomenology have usually been selected and form a purposive sample. This should not be criticised, but rather appreciated within the context of interpretive phenomenology as having participants who can contribute to answering the research questions. IPA must always make use of extracts from participants' interviews, remembering to maintain anonymity and confidentiality, to support any arguments and themes that emerge during the analysis. The chapters relating to the analysis of findings will include extracts from participants' interviews to demonstrate how interpretations have been identified. Using extracts from interviews will also enable the reader to determine the trustworthiness of the research findings. Yardley (2000b) also highlights that sensitivity to context should also include an awareness of research that has

previously been conducted within a similar topic area. A review of the literature was presented in chapter two of this thesis. The discussion that emerges as a result of the analysis of findings will integrate the research referred to in chapter two to identify new knowledge as well as confirm existing findings from other published research. Finally, Yardley (2000b) states the importance of scholarly analysis through the use of philosophical underpinnings. In my thesis I planned to use Heideggerian interpretive phenomenology to analyse the findings from the interviews.

The second characteristic is concerned with "commitment and rigour". Yardley (2000a) acknowledges the commitment that is required of a researcher when conducting interviews – the ability to be an active listener, enabling the participant to articulate their experiences, and demonstrate sensitivity to the issue at hand. This characteristic is predominately about the quality of the interview and the respect that is shown to the participant throughout the research process. The researcher's immersion in the data and thoroughness of interpretation are a measure of commitment and rigour. I planned to immerse myself in the data through transcribing the interviews myself and reading the transcripts to identify themes, rather than using a software programme, such as NVIVO, to identify themes. Again, Yardley (2000b) suggests the judicious use of interview extracts to illustrate themes, which will be presented in chapters five and six.

The third characteristic is that of "transparency and coherence". This is determined by assessing whether the research process been adequately described in the thesis. Would the reader be able to replicate the study based on the information provided by the researcher, for example, how were participants recruited, was any equipment used, how was data collected and analysed? This would also address Cohen et al.'s (2007) interpretation of validity as being measured through replicability. The research process for my study will be explained in more detail in chapter four. Yardley (2000b) recommends that the researcher should be able to reflect on the research process and acknowledge its strengths and limitations; this will be included in chapter eight of this thesis. Another consideration is whether the epistemological foundations fit with the research questions and if the themes link into the theoretical assumption. This will be evidenced through the utilisation of Heideggerian concepts within the findings and discussion.

The final characteristic is "impact and importance". In this final point she states that "however well a piece of research is conducted, a test of real validity lies in whether it tells the reader something interesting, important or useful" (Smith el al., 2009, p. 183). Yardley (2000b) comments that research should be useful and have application to "the community

for whom the findings were deemed relevant" (p. 223). In this case, my research is aimed at the community of clinical nurse educators who ultimately have responsibility for providing sound education to nursing students, and protecting public safety. I believe that readers of this thesis will be interested in the findings, especially the experience of being a clinical nurse educator when assessing "failing" students in clinical practice.

**Conclusion**

In this chapter, I have discussed the process that has guided my research using Crotty's (1998) framework. I have explained my choice of constructionism as an epistemological stance. Interpretivism is the theoretical perspective that has been adopted and Heideggerian phenomenology has been used as the research methodology. The use of semi-structured interviews to collect the data has been discussed and IPA (Smith et al. 2009) has been explained as the method used for analysing the information collected from the interviews. In the next chapter I describe in more detail, how the research was conducted.

# CHAPTER FOUR
# Implementation of the Research Process

In the previous chapter, I explained how Crotty's (1998) framework was utilised to design the research process for my research project. In this chapter I discuss, in more detail, how the research was conducted. More in depth information is provided about the actual implementation of the research including the approval processes, ethical considerations, data collection process and analysis procedure.

## The Research Journey

Research starts with a question that sparks the researcher to investigate an issue or area of interest. My research was triggered by a question from a clinical educator: "What do you do when you have a student who is failing?" I had (wrongly) assumed that the answer to this question was fairly obvious – the student failed. It was this naive assumption that led to this research project. One colleague commented that not all educators "sang from the same song sheet". The spirit of inquiry had been ignited and the spark had been lit for further research into this phenomenon within New Zealand nurse education.

### Research proposal.

The research process commenced with the development of a research proposal which was submitted to the Massey University Graduate School of Education (MUGSE) for approval to conduct the research project. The research proposal detailed the rationale for conducting the research, with a brief overview of literature (detailed in chapter two). I noted that there was research which identified that students were being passed within a clinical placement, despite concerns about their competence. There was limited research which explored why students were not being failed, and about the experiences of educators, or clinical staff, who conduct assessments with nursing students. There was a definite lack of New Zealand related research, particularly within nursing, exploring the experiences of clinical nurse educators who were assessing "failing" nursing students in a clinical assessment. The choice of Heideggerian interpretive phenomenology as the theoretical perspective was included within the research proposal. The overall aim of the research is "To explore the experience of clinical assessment and why clinical nurse educators do not always award "failing" nursing students a fail grade".

**Research questions.**

- How do clinical nurse educators experience the clinical assessment of nursing students?
- What factors influences the grade awarded to a nursing student when a clinical nurse educator is uncertain about whether the student is achieving the standard required to pass a clinical assessment; that is, a "borderline" student?
- How does the clinical teaching model affect the grades awarded by assessors on clinical assessments?
- How do clinical nurse educators experience awarding a grade to a nursing student they do not consider is performing to the standard required to pass a clinical assessment; that is, a "failing" student?

The proposal stated the intention to conduct semi-structured recorded interviews with two to three clinical educators within three polytechnic schools of nursing. I then presented the proposal to an academic panel from MUGSE. Following acceptance of the proposal by MUGSE, an ethics approval application was submitted to Massey University Human Ethics Committee. The ethical approval process provided further information pertaining to sampling processes, conduct of the semi-structured interviews, data analysis and storage and ethical issues, which will be discussed in the next section.

**Ethical approval.**

As this research involved human subjects, ethical approval was obtained from the Massey University Human Ethics Committee prior to the conduct of any research.

Ethical approval required an awareness of the ethical issues which could occur within my research project. Within Heideggerian phenomenological research, the participant is considered to be a co-researcher as the researcher encourages the participant to share stories (Johnson, 2000). It was therefore essential to consider the impact of sensitive information that was shared between me and the participant. The participant may share stories that could challenge the person's integrity as a member of the nursing profession, with their duty to protect the public. The stories may require them to re-live a particularly harrowing experience. I therefore needed to demonstrate how potentially sensitive situations would be dealt with. In most institutions there is an employee confidential counselling service and I therefore needed to ensure that participants would have access to this service, if required. Ensuring the safety of both me and the participant; observing the principle of not doing harm was a major consideration. As I am also a member of the nursing profession, bound by the HPCA Act (MoH, 2003), this could have been potentially

challenging; I needed to ensure that in the event of potential harm being caused to health consumers, I would encourage the participant to report such issues through appropriate channels.

The ethics of confidentiality and anonymity are critical for protecting participants (Massey University Code, 2014, s. 3, para 12). The participants were not anonymous as their identity was known to me; however, their anonymity is protected as far as possible throughout this thesis, as participants are allocated a pseudonym in the interview excerpts used in the following chapters. Furthermore, the participants' confidentiality was maintained as all identifying features have been removed from the transcripts, including place names and names of institutions. I am the only person to have access to the recordings of the interviews and therefore a confidentiality agreement was not required for transcription purposes.

The issue of power was an important consideration as I did not want participants to be threatened by my role as a Head of School. Therefore, I did not conduct any interviews with staff from my own institution. This would have inhibited open and honest communication if staff felt obliged to participate due to my managerial position. Additionally, if I became aware of situations that would need to be dealt with from a management perspective this would contaminate the research process. Any other potential conflicts of interest had to be declared; sponsorship, my role as a Head of School, and other external interest in the research project. This research was not sponsored or funded by any external organisation. Participants were not offered any financial or material incentive for volunteering to take part in the research.

Participants needed to be fully aware of the purpose of the research. I ensured that they were not provided with any misleading information and they received an information sheet (Appendix F) about the aim of the research and how the findings would be reported. The principle of informed and voluntary consent was observed as all participants signed a consent form (Appendix G) which gave them the right to withdraw at any point in the process up to the point of data analysis. The consent forms were stored separately, with my primary supervisor, in a secure location away from the collected data.

Cultural groups were not the focus of this study and ethnicity data was not collected from participants. The Principles of the Treaty of Waitangi - partnership, participation and protection - were observed throughout the data collection and analysis. The relationship I had with participants was a partnership, through respecting their contributions to the research interview and the returning of their interview transcripts. The clinical nurse

educators were referred to as participants, highlighting their participation within the research. Participants' protection was observed through the maintenance of confidentiality. All data were stored securely in accordance with the ethics committee policy. Access to the transcripts is restricted to me and my supervisors. The information will be stored securely at home and on my personal computer for a period of five years in accordance with the ethics committee regulations and will then be destroyed.

**Sampling.**

It was impossible to include all nurses who were involved with assessing nursing students; therefore a sample had to be identified. Converse (2012) states that to enable rich data collection in phenomenological research, sample size can be fairly small and purposive. Smith et al. (2009) recommend that a purposive sample of between four and ten participants provides enough rich data on an experience, which is, assessing students failing in clinical practice. As I wanted to protect individuals' identities and their place of employment, my original intention was to interview between three and five assessors from three schools, giving me a total sample size of between nine and fifteen interviewees. Smith et al. (2009) warn against using too many interviews as the idiographic nature of analysis will be lost. They recommend purposive sampling to ensure that individuals are chosen who will provide relevant data. However, this is difficult to determine prior to an interview as it is not possible to predict the content of an interview. The main research aim was "to explore the experience of clinical assessment and why clinical nurse educators do not always award "failing" nursing students a fail grade". Therefore, it was important to ensure that the purposive sample did not focus solely on assessors who have failed students, but also assessors who have not failed students and to explore their rationale for not failing.

Once ethical approval had been granted from Massey University Human Ethics Committee, the Chief Executives (CE) of three polytechnics were approached, in writing (Appendix H), requesting permission for the School of Nursing staff to be approached to participate in the research. Criteria for choosing the polytechnics were based purely on location and accessibility from Invercargill (a limitation of the study). Permission was granted by all CEs, although two also requested that the proposal be submitted through the institution's own ethics committee. Once ethical approval was obtained from each institution, the Head of each School of Nursing was approached via email and asked to distribute the information sheet, consent form and my contact details. The Heads of Schools of Nursing were not involved in the recruitment of participants; their role was purely to inform the staff of my research. Had the Heads of School been actively involved in the recruitment and known the identities of the participants, this could have been prejudicial

to the information that was obtained and would not have maintained confidentiality. The Heads of School gave permission for me to conduct the research with at least three clinical nurse educators employed for clinical assessment. Heads of Nursing Schools were not aware of the identities of the participants. They were keen to know the final outcome of the research in order to improve the processes associated with clinical assessment.

Educators were encouraged to contact me via email and mutually convenient times were agreed for me to travel to their place of work and conduct an interview. Five participants were identified in two schools of nursing and four participants were identified at the third school, resulting in a total of fourteen participants. Once educators were aware of my presence within a school, a "snowballing effect" took place with more people wishing to become involved in the research. Educators were also keen to be involved where they were experiencing problems with the failing of written assignments. As this research was not about the failing of written assignments, I thanked them for their interest but explained that the purpose of the research was about clinical assessment rather than theoretical assessment. Many of the educators were working full time and finding mutually agreed times proved to be a challenge which impacted on the time available to interview some participants.

As eight per cent of New Zealand nurses were male at the time of conducting this research (NCNZ, 2011) a male perspective was beneficial to avoid sexism within the research (Eichler, 1988). To be representative of the male population in nursing this would mean that in a sample of nine to fifteen participants there would only be one to one and a half male nurse participants. To interview one male would not protect his identity as I may have needed to acknowledge that, as a male, he may have some different experiences. Additionally, it is clearly impossible to have one and a half men. Therefore, in order to maintain confidentiality, two males were selected for interview.

**Conducting the semi-structured interviews.**

The benefits of using interviews as a method of collecting data within phenomenological research were discussed in the previous chapter. The schedule (Appendix E) had nine open-ended questions with prompts to elicit a greater depth of information. The questions were used to explore the meanings behind the experience of assessing clinical practice, particularly with reference to whether a fail grade was awarded.

As I was visiting the participants' institutions, the booking of rooms for conducting interviews posed a challenge as I relied upon the participants to do this for me. Most

participants shared open plan offices with other colleagues. It was important that the interview was conducted in complete privacy, to ensure confidentiality and without interruption. I was aware that there may have been some sensitive information, for example, students who they may have been passed despite not meeting all the assessment criteria. The environments for conducting interviews were not always ideal and varied from the corner of a canteen to outdoor gardens, designated interview rooms, and people's offices. Prior to conducting the interview, all participants were sent the information sheet (Appendix F) and consent form (Appendix G).

At the start of each interview, it was essential to develop a rapport with the participant; to make them feel comfortable and establish a positive relationship. I introduced myself and clarified the purpose of the research. I confirmed that the participant had understood the information sheet and consent form and allowed time for any questions. I emphasised the confidential nature of the interview and that identifying information would be removed. I checked that the participant agreed for the interview to be digitally recorded and explained that I would transcribe the interview.

The interview started with "warm up" questions about their nursing and educational experience and the role of the participant (Fontana & Frey, 2005). Starting the interview this way allowed the person to relax by giving me information about themselves. I would use this information to develop their personal experiences of assessing: their preparation for the role; how they prepared themselves for assessing; how they felt about assessing; how judgements were made; and how they felt once they had made a judgement. I then asked more probing questions about whether the student's stage of training affected the decision-making process; whether professional or relationship issues had an influence; what other factors had impacted on the decision; and whether they felt supported as an assessor. As interpretive phenomenology is based on reflection, I also asked some reflective questions such as would they do anything differently in the next assessment (Gibbs, 1988). I encouraged participants to give examples of assessments in clinical environments and these became narratives which provided rich information about assessment situations.

Smith et al. (2009) recommend that a good interview should last between 45 to 90 minutes. The duration of the interviews in this study lasted from between 35 to 75 minutes. The interview was iterative and needed to be flexible and developed with each participant. As the researcher and interviewer, it was important that I adopted a non-judgemental attitude and focused the interview on the participant with active listening skills. Adopting

a non-judgemental approach was an important aspect of this research as I needed to be able to develop a trusting relationship which enabled the participant to tell me about situations when a student may have been passed despite the participant feeling that the student should have been failed. I needed to ensure that at no time did I share my own personal experiences of failing students with the participant as this would have resulted in distraction from the primary purpose of the research. The participant needed to have trust in me as a researcher that there would be no repercussions if they admitted to passing a "failing" student. Conroy (2003) states that the interviewer must adopt active listening skills and give non-verbal encouragement such as smiling, nodding the head and adopt an open posture. The interview was recorded and transcribed verbatim including pauses, laughter and other paralinguistics using recognised conventions (Fontana & Frey, 2005; Perakyla, 2005). The importance of interpretive phenomenology lies in what is left unsaid as well as what is vocalised, as Steiner states: "in music, ... even the intervals have meaning" (as cited in Conroy, 2003, p. 7). Some participants used the pauses to reflect on their responses, and consider the implications of their actions. For other participants, recalling some events was traumatic and this reinforced the difficulties experienced by clinical nurse educators whilst being with a "failing" student. The non-verbal communication strengthened the validity of the responses of participants.

At the end of the interview, I thanked the participant and asked if they would be prepared to read the transcript to check for accuracy. All participants agreed for the transcript to be returned for verification. I also asked, should the need arise, whether I could contact them again to conduct another interview or to seek clarification. Returning to an original interviewee is recognised as part of the IPA process (Conroy, 2003; Smith et al., 2009). It is the language that is used in interpretive phenomenology that enables understanding of the phenomena. All interviews were conducted in English in order to gain a valid understanding of the language; it was the first language for all participants (Mertens, 2010; Smith et al., 2009).

I also kept a research diary in which I recorded my personal feelings about an interview as soon as I had finished. This noted whether I felt that the participant was anxious, or had rich information. My personal reflections included whether I would do anything differently in subsequent interviews; for example, the interview which occurred in the canteen was not ideal due to excessive background noise.

**Interview transcription.**

Interviews were transcribed verbatim as soon as possible after the interview, so that memories were kept fresh and anything not said was preserved, such as the participant who reinforced the word "tiny" with the use of thumb and index finger. The research diary enabled me to reflect on interviews and note the degree of engagement from the participant. Despite all participants volunteering to take part in the research, three participants were on very tight deadlines to get the interview completed and this may have resulted in missed opportunities to further explore their experiences. Laughter, coughs and pauses were all noted. The recording was then played back and read in conjunction with the transcript a couple of times, to check for accuracy within the transcription. Each time the recording was played, I became more immersed in the data.

Smith et al. (2009) recommend transcribing an interview before moving onto the next one in order to evaluate the schedule. This was not always possible due to the location and timing of interview appointments. However, the interview schedule became more iterative as unexpected issues were revealed. For example, in some of the earlier interviews, the assessment of clinical skills within the classroom was discussed as separate from dealing with skills assessment in the clinical environment, particularly in relation to a "check list", so this was followed through in later interviews. Smith et al. (2009) claim that it can take approximately seven hours to transcribe every hour of interview and anything from one week to several weeks to analyse the first interview, with the process becoming quicker with greater experience (pp. 54-55). I found that it took approximately four to five hours to transcribe each interview depending on the speed at which the participant spoke. Some interviews were more difficult to transcribe due to background noise, especially interviews conducted in the cafeteria, and outside. However, interviews were not analysed until all the interviews had been completed, because I wanted to ensure that the interview process was consistent for each participant. I was aware that my own *fore-structure* could change for each interview if I analysed the interactions prior to conducting another interview.

Following transcription, all scripts were sent back to the participants, which gave them the opportunity to add more details and remove any identifying data. Only four returned their scripts with comments requesting the removal of identifying data. At least two people had moved jobs and did not receive their transcripts and the other eight people did not respond, despite a reminder email. As I was respecting participants' confidentiality, it was inappropriate to ask their colleagues for new contact details. This was disappointing, but I had to acknowledge that all participants were in full-time employment and some of them were engaged in their own post graduate studies.

**Findings.**

I now explain in more detail the process that was used for analysing the data using Smith et al.'s (2009) six stage process, which was described in the previous chapter. This process took place over a period of approximately twelve months; I was constantly going back to the interviews and noting fresh comments, and interpretations.

The first stage was concerned with immersing myself in the data. This started following transcription as I read a hard copy of the transcript in conjunction with the audio recording. This was an essential step of the analysis and I listened to the recordings three or four times, making comments alongside the written transcript. I would perform this act immediately after each transcription as I wanted the interview to remain fresh in my mind. I would take myself back to the interview and visualise the interactions that took place. Using my research diary, I tried to recall the participants' engagement and non verbal cues in an attempt to add to the spoken word. After reading the transcript, I made notes about general impressions from the interview. I used this initial stage as an opportunity to reflect on my own experience as an interviewer, the interview process, questions, and the role of the participant.

Having immersed myself in the transcript and having made initial comments, I could move onto the second stage: examining the transcript for semantic content of the interview. This was about making sense of the language used and the non-verbal cues, whilst making notes and comments about anything of interest, such as the use of laughter to hide embarrassment. Silence and long pauses were also noted as these indicated moments of thought and reflection. Conroy (2003) adds another point here: that when making comments the researcher should start to make interpretations. I explored the option of using a software programme, NVIVO, to analyse the data, but, due to my lack of expertise with the programme, and my own desire to be fully immersed in the data, I decided against it. I therefore absorbed myself in the data by reading and re-reading the interviews whilst listening to them.

I transcribed the interviews using a tabular approach to the conversation. One column was for my questions; the second column was for the interviewee responses; and the third and final column was to make notes about the comments, words, non-verbal communication, and possible interpretations from the interview. I started to note the language that was being used by the participants, their attitudes to clinical assessment, and to identify what clinical assessment meant to the participants. By immersing myself in the transcripts, I started to identify certain words that were used repeatedly by some

participants and by using the "find" option in Microsoft Word I could identify how many times certain words were used. The frequency of some words was used to interpret the meanings of some experiences for the assessors. I also used a highlighter pen to reinforce any comments of particular note.

At this point, Conroy (2003) recommends that a copy of the interview along with the transcript and interpretations is sent to the interviewee for a validity check. As stated above, only four people returned their transcripts and therefore I did not send any interpretations, which is a limitation of the validity of this research. However, assuming that the participants read the transcripts, non-return could indicate that they were satisfied with the content. The second stage of the IPA process signifies the start of the hermeneutic process of data analysis.

Smith et al. (2009) describe the third stage as the start of the search for emergent themes. In this stage, the major shift with the analysis was to consider the notes that were made in the previous two stages. However, that is not to suggest that the transcript was discarded. The interview was broken into chunks of information and reduced to a series of notes. It is at this stage that Smith et al. (2009) acknowledge a move away from the participant and a closer involvement with the researcher. The researcher now starts to live the experience of the participant, and within Heideggerian phenomenology this is an important component of the analysis. The hermeneutic circle here starts to consider the segments as part of the whole, and the whole as related to the parts. The partnership between the words of the participant and the interpretation of the researcher are a key element within the hermeneutic process. It was during this stage that Heideggerian concepts started to emerge, an inductive analysis of the key themes. For instance, an emergent theme was relationships and this related to the Heideggerian concept of *being-with-others.*

Emergent themes started to be identified in this stage and, whilst I could not remove the subjectivity from my perspective as a researcher, I aimed to reduce this by discussing my own experiences of dealing with failing students and subsequent appeals with my supervisors. Heideggerian phenomenology allows the researcher to integrate presuppositions and personal experiences, unlike the bracketing of Husserlian phenomenology. Whilst I was aware of my own experiences of failing nursing students, I did not want to influence and prejudice my analysis, therefore I tried to divorce myself from my own experiences. It was unfortunate that only two of the participants made comments about the meaning of the experiences when they returned the transcripts. The interview

notes made in my research diary also contributed to the notes taken on the transcripts. A search for an understanding was beginning to emerge. The meanings of the participants' lived experience were the focus at this stage.

Having identified three emergent themes of responsibility, relationships and professionalism in the third stage, it was necessary to start to search for connections across the emergent themes in the fourth stage. Smith et al. (2009) suggest that themes are adjusted through a mapping process to look for patterns and connections. These key words were noted on a separate piece of paper as links were made between words and notes. They also note that there may be opposing connections, looking for differences as well as similarities. Identifying connections can be made by returning to the script and analysing the context of the information – again, highlighting the hermeneutic circle. It was at this stage that the emergent themes were considered in terms of Heideggerian philosophy and linked to concepts from *Being and Time* (1953 / 2010). Having identified that the theme of relationships was linked to *being-with-others,* this was further developed to Heidegger's concept of *being-in-the-world.* The theme of *Being-a* professional, was linked to *care,* and responsibility was linked to *disburdenment.* This was an iterative process; the Heideggerian concepts emerged from the key themes identified from the interviews.

The fourth stage involved identifying patterns and connections, constantly going back to the interview and the notes. I felt that this was similar to completing a large jigsaw – looking at the final picture and constantly going through the pieces to see where they fit into the larger picture. For example, looking for the common colours, identifying the frame, and looking for the odd shaped pieces; constantly rooting through all the different pieces. These four stages were conducted with one interview at a time.

Analysing the second interview meant that I was entering the fifth stage of the IPA process. This involved repeating the four stages with the second and subsequent interviews. Each interview was analysed as a new event, not influenced by the previous analysis. Smith et al. (2009) state the importance of reviewing each transcript on its own merits and separating the analysis from previous transcripts. However, they acknowledge that it is difficult not to be influenced by previous analyses and in Heideggerian terms, the *fore-structure* had changed. In an attempt to reduce any influences from previous analyses, I mentally isolated any findings from previous interviews through not starting to analyse a new interview on the same day as completing the analysis of a prior interview.

Once all fourteen interviews had been analysed, I entered the sixth and final stage of the IPA: searching for patterns across all the interviews and tabulating to identify the frequency with which concepts occurred. It is also important to acknowledge an absence of commonality across the interviews; for instance, where an interview has different interpretations, this is just as important as the analysis is about a "whole" picture. The two males had differing perspectives from each other, and they both had different perspectives from the 12 female participants. Their contributions were just as valid and were incorporated into the analysis. At this stage I identified that participants were *being-with-others* in two different worlds – the *world-of-education* and the *world-of-nursing*.

One of my research questions related to the impact of the clinical teaching model on the grades awarded for clinical assessment, as I had hoped to explore whether the DEU model (previously explained in chapter two) influenced assessment. Only one participant had limited knowledge of working with the DEU model. All participants worked within a preceptorship model. Therefore there was no relevant information from the participants that would enable the third research question to be analysed.

Conroy (2003) recommends the use of a Decision Trail Log which is a form of reflective diary for the researcher to record personal feelings throughout the research process. The diary was used to record inspirations, frustrations and reflections that may have affected the research process. Conroy (2003) states that the mood of the researcher on the day of an interview may affect the process and can be reflected on during the analysis. I tried not to let events such as trying to find the venue, parking my car, and the late arrival of a participant affect my mood by staying calm and positive throughout the interview. Feelings were recorded in my diary as a means of acknowledging my mood and its potential influence on analysis.

During the iterative process of analysing the transcripts, I started to identify some themes emerging about the experience of the participants and their attitude towards failing students, so I developed a table that detailed their experience, qualifications and whether they had failed students in the clinical environment (Appendix I). I was also aware that participants spoke about *being-with* students as they progressed through the programme and likened this to being on a journey. The journey considered the past, the present and the future of students as they were learning to become registered nurses. This seemed to be commensurate with Heidegger's (1953/2010) concept of *Time* and *Being,* and the journey into a clearing to search for meaning; that is, what it means to be a clinical nurse educator. Some participants had excellent narratives to illustrate their experiences of assessing and

failing students. I collated these examples into a table, which enabled me to bring them together and facilitate the synthesis of themes.

**Research Validity**

Concerns about validity within Heideggerian phenomenology were discussed in the previous chapter. Smith et al. (2009) suggest using Yardley's (2000a) four main characteristics for assessing validity and quality of interpretive phenomenological research. I will now discuss how these characteristics apply to the validity of to my research.

Yardley's (2000b) first characteristic of "sensitivity to context" is addressed in this research. Ethical clearance was obtained from Massey University Human Research Ethics Committee as well as the ethics committees from two of the participating polytechnics. This acknowledged my role as a researcher to respect the participants and not to cause harm, which included ensuring that participants were able to seek support services when they recounted stressful events. I have also maintained the participants' confidentiality, by ensuring that no identifying features are used in extracts from interviews. The inclusion of many extracts from participants' interviews, stating page numbers from the transcript, enables the reader to determine whether Yardley's (2000b) "sensitivity to context" and "commitment and rigour" have been addressed. All interviews took place in a location chosen by the participant which enabled them to feel more relaxed within familiar surroundings. Interviews were not conducted in shared offices to enable participants to speak openly and honestly without being able to be heard by colleagues. The research was not conducted within my own institution for ethical concerns regarding power issues and the identification of my own place of work. Recognising sensitivity to context, all participants received an information sheet and signed a consent form, which was stored with my supervisors. Chapter two reviews and synthesises national and international qualitative and quantitative research of various professions that have a practical component within the programme of study. The research discussed in chapter two is integrated with the analysis of findings in chapter seven of this thesis. Yardley (2000b) suggests that this characteristic addresses sensitivity to context. In addition, she also states that analysis of the data should be underpinned by philosophical theory to demonstrate scholarly activity within the context of the research setting. To address this characteristic, the interviews were analysed using Heideggerian interpretive phenomenology; this is evident in the presentation of analysis of findings and discussion chapters which follow in this thesis.

The second characteristic of "commitment and rigour" has been addressed through my total involvement with the conduct of all interviews, their transcription, and the multiple readings and immersion of the transcripts and recordings. Some recordings were reviewed on multiple occasions, along with the transcripts, due to difficulties hearing some of the interviews caused by background noise, and difficulty interpreting some accents. Earlier in this chapter, I described how each interview was tabulated to identify key words and phrases. Once all the interviews had been transcribed, in stage six of the IPA process, all the common themes were collated into a table to identify emerging themes which highlighted how Heideggerian interpretive phenomenology was used to analyse the data. The analysis took place over a period of at least twelve months. Occasionally, I had to put analysis aside as work commitments clouded my efforts to be as objective as possible. In my role as Head of Nursing School, I did become involved in student appeals and this did affect my objectivity when analysing interviews. Therefore, I wrote my feelings in the reflective journal and stopped analysis until I was able to remove subjectivity caused through work appeals. I have also provided a clear biography of my own position within clinical assessment in chapter three which enables the reader to assess how my findings may be influenced by my experiences. The analysis of my findings was discussed in depth with my supervisors to address the characteristic of rigour.

This chapter has described my research process in detail, including the process for obtaining ethical approval, recruitment of participants, inclusion of the interview schedule (Appendix E), and how the interviews were transcribed and analysed. This information addresses Yardley's (2000b) third characteristic of "transparency and coherence" and Cohen et al.'s (2007) criteria of "replicability". The information provided in this chapter should allow the research to be replicated. Yardley (2000b) also recommends that the researcher should be able to reflect on their research process and my reflection on the research process is included in chapter eight. I believe that the use of Heideggerian interpretive phenomenology is an appropriate methodology to answer the research questions and contribute new knowledge for nurse education in New Zealand.

The final characteristic is "impact and importance". In this final point Yardley (2000a) states that "however well a piece of research is conducted, a test of real validity lies in whether it tells the reader something interesting, important or useful" (Smith el al., 2009, p. 183). This research explored the experiences of 14 clinical nurse educators and discusses how their experiences influence the assessment of clinical practice. Although this is a small sample size from only three New Zealand polytechnics, and therefore not generalisable to

all tertiary nurse education providers in New Zealand, the contribution to the body of nursing knowledge about clinical assessment and the failing of nursing students in clinical practice that is revealed from the findings of this research are important for nurse education and the maintenance of public safety. The findings from this study provide a platform for further study across New Zealand as the generalisability is limited from this small sample.

**Conclusion**

This chapter has explained in detail how I conducted the research. The research journey started with a literature review which was summarised in the submission of a research proposal. The research proposal provided the research aim, research questions and a justification for using Heideggerian interpretive phenomenology. Following acceptance of the proposal, I have detailed the ethical approval processes that were required prior to any involvement with participants. I have outlined the sampling process, the conduct of the semi-structured interviews, the analysis of the interviews and an overview of research validity. The limitations of the study have also been identified. The findings from the data analysis are presented in chapters five and six using extracts from the participants' interviews as recommended by the literature (Draucker, 1999; McNamara, 2005; Smith et al., 2009; Yardley, 2000). A discussion of the findings will be presented in chapter seven and the research will be concluded in chapter eight.

# CHAPTER FIVE

## Findings: *Being-a* Clinical Nurse Educator

I have explained my interest in the assessment of nursing students' clinical practice and the difficulties associated with awarding a fail grade to a student who is not meeting competency standards. I discussed the literature that explores the phenomena around assessment within practical components of professional academic programmes. In chapter three, I used Crotty's (1998) framework to discuss the research process that I adopted and justified my use of Heidegger's interpretive phenomenology as my chosen research methodology. In chapter four I provided a detailed account of the implementation of this research project, explaining how the research was conducted. The next two chapters will present the findings from the analysis of the interviews. Findings are illustrated with extracts from participants' interviews. To maintain confidentiality, pseudonyms are used for each participant. A reference to the page number of the transcript is also given, e.g. (Helen, p. 32).

A person enters the Bachelor of Nursing (BN) programme with an intention to complete a journey to become a registered nurse, and the participants became part of the students' journey into the *world-of-nursing*. Participants worked with students at different stages on that journey and this was also an important factor for participants when considering the assessment of the "failing" student. As a result, the findings are divided into two chapters because the analysis identified two major components from the participants' interviews. The first component concerned the participants' *being-in* the *world-of-nurse education* and what it meant to be a clinical nurse educator when *being-with* students in clinical practice. The second component was concerned with *being-with* a nursing student who was not achieving (or failing) and therefore not becoming a nurse.

This chapter focuses on becoming, and *Being-a* clinical nurse educator and the experiences associated with teaching and assessing clinical practice. Three major themes emerged from the analysis of the interviews: relationships, *Being-a* professional and responsibility. The theme of relationships is interpreted in Heideggerian terms as *being-with-others* and this will be explained in more detail throughout the chapter. Other Heideggerian concepts to emerge were *authenticity/inauthenticity, temporality*, *historicity, care,* and *tools*, which will be explained in more detail further on. Chapter six will present how the themes of *Being-a* professional, *responsibility*, and *care* emerged when participants were dealing with "failing" students.

I start this chapter by outlining the key Heideggerian concepts that emerged from the inductive analysis from the data analysis of the interview findings.

**Heideggerian Concepts**

Heidegger refers to *Dasein* (as previously discussed in chapter three) as the mode of *Being*. His magnum opus *Being and Time* (Heidegger, 1953/2010) is dedicated to answering the question of what *Being* means and how it is influenced by *Time*. Heidegger acknowledges that there are different modes of *Being* and this can be influenced by *being-in* different worlds, and *being-with-one another*. He uses the example of *being-in* the "work-world of the handworker, showed that together with the useful things found in work, others are 'also encountered' for whom the work is to be done" (Heidegger, 1953/2010, pp. 114-115). This example will be developed through considering the *work-world* of the clinical nurse educator; the *things* used for assessment and how the participants educated and assessed nursing students to become registered nurses. The work-world of participants included the *world-of-education* as well as the *world-of-nursing* and was a significant finding from the analysis of the interviews.

*Being-in* a world involves *being-with* others and we are often absorbed into this world by doing what is right by others, being accepted into the environment that we are *thrown into*. Heidegger refers to this as *everydayness* as we are social beings and desire a sense of *normalcy* (Scott, 2010, p. 58). Experiencing this sense of *everydayness* is not difficult and Heidegger referred to this as the *they self*, that is, *being-inauthentic*. *Being-inauthentic* takes away responsibility from an individual as responsibility is *disburdened* to the *they* (Heidegger, 1953/2010, p. 124). Being true to oneself, and acting according to one's own accord is *authenticity* (Heidegger, 1953/2010, p 283). *Being-authentic* implies having a "conscience" as the *they* have not influenced a *Being's* actions; the "loud, idle chatter of the they's common sense" has been suppressed (Heidegger, 1953/2010, p. 283). Subsequently, the terms *authentic* and *inauthentic* were used in the analyses to determine whether the participants made decisions based on being true to themselves, or by considering what *they* would think when conducting assessments.

Taking care of others, for example, students or health consumers, is described by Heidegger (1953/2010, p. 118) as: " a character of being which being-with cannot have as its own ... is taking care of things ... this being is not taken care of, but is a matter of *concern".* Heidegger describes concern as "nursing of the sick body ... which corresponds to our use of taking care for an existential" (p. 118). Taking care of something can be about creating a dependence of the person being taken care of, by the person who is taking the care of.

Heidegger (1953/2010) refers to this form of care as taking care of "someone who is dependent or dominated" (p. 119). According to Heidegger, another form of care is "authentic care" which enables others to "become transparent to himself *in* his care and *free for* it" (Heidegger, 1953/2010, p. 119). *Being-in-the-world* and "being-together-with is taking care" (Heidegger, 1953/2010, p. 186). Hornsby (n.d.) describes Heidegger's notion of *caring for* (*Sorge)* as a "concern for others" and exists for the present as a component of *authentic Being*. There is, therefore, a distinction to be made between *care of* and *care for* and will be explored when participants refer to *care for* students and *care for* health consumers.

The Heideggerian concept of Time, or *temporality* also emerged from the analysis. Heidegger (1953/2010) is clear that time is a fundamental component to "understanding and interpreting of being" (p. 17). Using the term *temporality*, Heidegger (1953/2010, p. 334) states that "a future that makes present, in the process of having-been". This means that we exist as *being-in* the present, but past events may have significance for the present, in that we have *been-there*; as time moves forward, we move to the future. The term *historicity* is used by Heidegger to describe the historical past, and *having-been* there. I have interpreted this significance of the past, present and future as a journey that is made by a nursing student as they progress from entering the nursing programme towards the future of *Being-a* registered nurse. Students come into the programme with past experiences and hope to become registered nurses after a minimum three year journey. However, some students will take longer than three years, and others may not complete the journey. The participants, *being-with* students, become part of the journey. Additionally, participants have also been on a journey as registered nurses to becoming clinical nurse educators, which will be developed in this chapter. Consistent with the Heideggerian concepts of a journey into the clearing (Heidegger, 1953/2010, p. 133), the chapter will follow the footsteps of a nursing student as the participants are *being-with* students on their journey from *Being-as* first year students to *Being-as* final transition students; the concept of *temporality*.

Another significant Heideggerian concept which emerged was the use of *tools* to achieve an objective, as discussed in chapter three. Heidegger uses the example of how a hammer is used to make a dining table for a family. However, the hammer is used differently by different people; its usefulness can be dependent upon the type of material that is being used. He continues to describe that it is not only the person who is making the table that is "at hand", but that it is in a "public world" in which the consumer of the table also needs to be considered (Heidegger, 1953/2010, p. 70). The analysis identified that participants used

a variety of assessment tools to judge a nursing student's performance. Additionally, the use and interpretation of the same assessment tool varied amongst participants. Therefore, the Heideggerian use of *tools* emerged from the analysis when considering the use of various assessment forms and criteria to assess the suitability of a nursing student to become a registered nurse. The next section presents the participants' journey to *Being-a* clinical nurse educator.

## *Being-a* Clinical Nurse Educator

I begin this section by exploring the *Being* of a clinical nurse educator; the participants' experiences associated with this sense of *Being-a* nurse and *Being-a* clinical nurse educator. *Being-in-the-world* is, for Heidegger, a more complete explanation of how humans not only consciously perceive the world around them, and that they are *thrown into* this world, but interact within it (Heidegger, 1953/2010, p. 131). Heidegger maintains that one's relationship to the world takes the form of a "mood" or state of mind (Heidegger, 1953/2010, p. 130). As such, Dasein is a projection of self towards the possibilities that *being-in-the-world* has to offer, and all subsequent interpretations and understandings that this may bring. *Being-with-others* is therefore an extension of *being-in-the-world* that may offer some reflective awareness of one's perceptions and possibly the perceptions of others, that is, being "interested in the world".

### Becoming-a clinical nurse educator.

*Being-a* clinical nurse educator meant that all the participants were registered nurses employed as academic staff by polytechnics to teach and assess nursing students within the clinical environment. I wanted to know about my participants – their previous nursing experience, and their preparation for *Being-a* clinical nurse educator. This information was used as a warm up at the start of the interview, but also gave me the opportunity to identify how their preparation and experience affected their *Being-as* clinical nurse educators. I will now present the findings about becoming a nurse educator.

In New Zealand, to enter the *world-of-nurse education*, a registered nurse needs to be qualified for a minimum of three years, be prepared to complete a masterate degree, and complete a formal programme in adult education (NCNZ, 2014). The National Certificate/Diploma in Adult Education (NZQA, 2010) does not have a specific component for nurse education, or clinical teaching and assessing. With the exception of a sixteen hour preceptorship education programme (New Zealand Nurse Educators Preceptorship

Subgroup, 2010), and some post graduate courses[4], there is no formal, national programme for clinically based nurses who supervise nursing students. Therefore, any member of the nursing team can supervise and assess nursing students. Table 5.1 presents the data about the qualifications of participants and whether or not they had failed students.

Table 5.1

*Participant qualifications and who had failed students*

| Qualifications | Number of participants | Number who had failed a student in clinical practice |
|---|---|---|
| Masterate degree and teaching certificate (meets Nursing Council criteria for academic staff) | 5 | 4 |
| Masterate degree and studying towards a teaching certificate | 2 | 1 |
| Post graduate papers and no teaching qualification | 3 | 3 |
| No post graduate study; has teaching qualification | 1 | 0 |
| Currently studying post graduate papers and teaching qualification | 3 | 0 |

Table 5.1 demonstrates that only five of the participants met the criteria (NCNZ, 2014) for *Being-as* nurse educators. Two had masterate degrees and were studying towards the National Certificate/Diploma in Adult Education and three were pursuing masterate study and a teaching qualification. Two participants had either completed or were studying towards doctorates; one had failed students. No participant studying both adult teaching

[4] Post graduate courses for RNs are provided by various Universities and Polytechnics in New Zealand for clinical teaching, e.g.: Auckland University of Technology, PG Cert/Dip Health Science in Health Professional Education; Otago University, Post graduate paper (NURS418) Nursing Education – Principles and Practice.

certificates and masters programmes had failed students. One of the two male participants had failed a student. Participants who were new to the role (less than two years) tended not to fail students, unlike those who had been educating for a longer period of time. Analysis of the findings pertaining to *being-with* "failing" students will be presented in greater depth in the next chapter.

**Preparation to become an educator.**

Despite *Being-as* nurses, participants felt that they lacked preparation for their entry into the *world-of-education* for becoming clinical nurse educators. Six of the participants (just less than half) felt ill-prepared for *Being-as* clinical nurse educators and assessors. Participants felt that clearer guidelines and support were required. Despite being highly experienced nurses, with general adult teaching qualifications (not specific to nurse education), two participants commented about lack of preparation for the clinical teaching role which could be interpreted as their being *thrown into* the *world-of-education*. For instance, without any specific preparation for *Being-a* clinical nurse educator, Caroline stated that she needed to be aware of her own [nursing] practice which implies that she was aware of her own *Being-a* nurse to be *authentic* when *being-with* students. If Caroline had been aware of what *others* were telling her to do, this could be interpreted as *inauthentic* behaviour. This suggests that her previous experience of *Being-a* nurse is being *disclosed* (Heidegger, 1953/2010, p. 85) as relevant to her current *Being-a* clinical nurse educator. Using an extension of *disclosedness* of the Dasein-with others it can be interpreted that knowing oneself as a nurse educator enables the participant to *be-with* students.

> *It's really been on the job ... hasn't been a lot of* [professional] *development to be honest ... so it's looking at practice, being very familiar with practice myself and deciding what are pass / fail criteria really* (Caroline, p. 5).

Helen suggested that she was *thrown* into the *world-of-nurse education* without any preparation and guidelines specific to nurse education:

> *In this job I would really appreciate clearer guidelines and support ... I mean I basically started and I was suddenly teaching in the first few weeks (laughter)* (Helen, p. 21).

Interviews with participants highlighted different expectations between polytechnics for *Being-a* clinical educator. A lack of specific preparation for becoming clinical nurse educators, lack of national guidelines and criteria led to subjectivity and inconsistency within institutes, meaning that there is no national consistency for the education and

assessment of nursing students. Participants also had different interpretations of *Being-as* clinical nurse educators. Oliver suggested that, due to lack of clear norms, individual expectations of students differed:

> *We are not very good at being explicit* [about the different levels] *and there is a little bit of variability amongst us as a group in what we expect* (Oliver, pp. 19-20).

Caroline uses the word "subjective" to describe the conduct of assessments which would suggest that assessments are conducted differently:

> *Felt it was very subjective* (Caroline, p. 24).

*Being-with-others* means that students are perceived differently by other nurses and clinical nurse educators, which is also described by Keith as "subjective":

> *Sometimes attitudes* [of students] *are misconstrued and misunderstood and so there is almost a subjective thing* (Keith, p. 15).

Lack of clear preparation to become a clinical nurse educator resulted in participants devising their own interpretation of what it meant to *Be-a* clinical nurse educator. Participants spoke of subjectivity when *being-with* students. This is an important consideration when analysing the participants' interviews from the Heideggerian perspectives of Dasein and *being-in* the world because depending upon who conducts the assessment means that students could be assessed differently, resulting in inconsistency for determining a student's future for becoming a nurse.

### ***Being-a*** **Clinical Nurse Educator as** ***Caring***

Six participants mentioned *caring for* students; five said caring was a requirement for *Being-a* nurse. The following extracts highlight some of the participants' awareness about *caring* when *being-with* students. Eve describes wanting to "take *care of*" students which could be interpreted as encouraging students to have a dependence upon her:

> *Hesitant about failing students and want to take care of them* (Eve, p. 27).

Imogen talked about *caring for* students suggesting that she is *being-authentic*:

> *When I was caring for a student* (Imogen, p. 8).

Whilst Nadine spoke of *care about* students:

*I care about them and support them* [students] (Nadine, p. 26).

Helen referred to herself as "caring" (and has not yet failed a student) and used "caring" twice in the interview. Firstly she says "*I like to be caring"* (Helen, p. 15) and later states that:

*Nursing students need care themselves and that they are going into a caring profession* (Helen, p. 23).

Nadine and Helen identify *Care* as a component of *Being-a* clinical nurse educator. *Care* is an important consideration for *being-with* students when they are being assessed and this important notion will be developed further later in this thesis.

**The journey from teaching to assessing.**

The journey from teaching to assessing was not always a clear transition for some participants. They struggled with deciding the time at which they stopped *Being-an* educator and were *Being-an* assessor to make an assessment judgement. This was particularly true if a fail grade was being considered. Imogen stated:

*So, if you prompt someone ... at what point do you stop teaching and start assessing? At what point do you assess without teaching?* (Imogen, p. 26).

Imogen pursued this concern when she emailed me with her thoughts about her transcript, commenting that there was a fine line to draw between learning and assessment. Lucy likened the process to that of continually assessing clients, linking to her *Being-a* nurse:

*So you do lay down (sic) a relationship to get them through that, and because you are assessing all the time, (laugh) like you do with your clients (laugh). So there are parallels there I think in mental health nursing and when you are a clinical lecturer (laugh)* (Lucy, p. 16).

Eve referred to students' ability to use reflection as a means of learning, but when learners were unable to reflect and learn from past experience, she would fail a student. Using the concept of *temporality*, the journey for a nursing student means that they should be able to use the *past* to determine their *present* actions and reflect again for the *future* as a nurse. If the student was unable to reflect, then Eve suggested that they are not able to move towards the *futurity* of *Being-a* nurse:

> *It's* [assessment] *about their learning, so that's again their reflection should be about learning. So if it's something they did that wasn't particularly good or right, but what would they do next time or how did that come about? Certainly if there was, if aspects of their clinical practice that were totally not meeting competencies in any way shape or form, that would be a fail* (Eve, p. 10).

Grace demonstrated *caring for* a student through not failing a first year student; giving her the "benefit of the doubt". Through *being-with* the students she wanted to assist the student to continue with her journey to becoming a nurse:

> *So I think that in reality you have to give the benefit of the doubt, you have to listen to a lot more voices because at the end of the day we are there to support the student in the best possible manner and we really want to give them the runway they deserve if they are going that way* (Grace, p. 20).

Caroline stated that students need to be supported when they made mistakes which would be mean *caring for* the student. She believed that failing students can be interpreted as punishment:

> *Punish the student by failing them, you haven't taught them anything ... you need to be supportive of the mistakes they make, you won't get open disclosure if they hide everything that they do* (Caroline, p. 27).

These narratives have highlighted that there is a caring, and supportive educative role as well as a parallel punitive or judgemental assessing role for educators. *Being-an* educator also means *Being-an* assessor which means making decisions about whether a student is to continue on the journey to become a nurse.

**Being Self-Aware**

Stapleton, (2010, p. 55) states that an "authentic being-in-the-world, is predicated on a lucid self-awareness of the truth of Dasein's Being, a *Being* that is cultural, historical and social". This self-awareness comes through reflection on experience. Participants were asked how they felt about the experience of assessing students. Participants' multiple roles of *Being* exist because they were within, and between, two different worlds, namely those of nursing, and education. *Being-a* nurse has professional responsibility to protect the public, and *Being-an* educator has a responsibility for facilitating the students' journey from *Being-a* student to *Being-a* nurse. As well as educating, the participants also assessed

students and made judgements about their future continuance on their journey. Taking *care of* health consumers would also be a characteristic of *Being-a* nurse and so it may be interpreted that participants have divided responsibilities for health consumers as well as students.

Oliver described his awareness of *Being-an* educator and *Being-an* assessor. He demonstrated *care for* the student through awareness of what may be occurring within the student's *Being* – their personal life. He described how his *past*, *Being-a* student, had informed his present beliefs and values as *Being-an* educator/assessor, an example of Heidegger's *historicity*. Oliver indicated that *Being-an* assessor is about knowing yourself, and your values, demonstrating the importance of *authenticity* as fundamental to being able to make judgements about others:

> *I guess there are a whole set of competencies associated with the role of assessing people. And it's not just the skills of being able to work the paper work, being able to watch someone, be able to ask particular questions, it's more than that. It also involves how you treat a person, because in my experience ... when you assess a nurse ... you have got to be able to see the person holistically, and you've got to realise first: Where do I come from? What's my training? What do I believe?... people will still hold their own values and so I think it's important to know your own self and what you believe is right and wrong and accept that other people don't necessarily believe, have the same values, but that doesn't make them incompetent. Not to judge people early, to consider that maybe I am misjudging this situation so maybe I need to validate what I think is going on here, not just negatively but also positively. Students who in theory can be lovely, pleasant, professional, very respectful always turn up to meetings on time, but, yet what is going on underneath is not what is required or reached the level that they are supposed to be demonstrating.... I think you do have to validate your assessment in lots of different ways* (Oliver, pp. 30-31).

Oliver demonstrated *being-caring* through acknowledging the importance of time with students; not making judgements early; not being influenced by personality, and ensuring the validity of an assessment. His views contrast with Phillipa's, who was clear that clinical assessment should not be influenced by personal factors, but based around competency and *caring for* the health consumer. She used her *past* experiences, her *historicity*, of witnessing a poorly performing student complete the journey to become a registered nurse and later be referred to NCNZ for competence issues:

> *So I think the hardest thing about failing people is.... Being quite clear about not getting into personalities ... I think that is the hardest, most difficult thing. Being very clear about "you're not meeting your competencies because of this, this and this" and the students saying because "you don't like them, because of race or gender"... or they have got so much going on at home* (Phillipa, p. 9).

Participants' time *Being-as* educators was an important factor in their attitudes towards assessing students. Melissa acknowledged that this could result in having unrealistic expectations of students as she had acquired her knowledge over many years. She should not expect the same amount of knowledge from a student with fewer years of experience. Students entering the *world-of-nursing* have not had the same amount of time to generate knowledge for the *presentness* of *Being-a* nursing student:

> *It's interesting when you start working with the students and, you, like me have had 35 years of getting your knowledge and you have to keep taking yourself back to actually thinking that's not common knowledge, my knowledge. So you have got to weed out the expectations that what you are actually expecting is stuff that you might be aiming a bit high for* (Melissa, p. 22).

Imogen believed that after 24 years in nurse education and many more years in clinical practice, she was able to identify those first year students who would not complete their journey to become a nurse. She questioned why some students continued their journey to create "issues". Imogen used *having-been* there, her *historicity*, to predict which students would complete the first year of the programme. Imogen's judgements may be incorrect as students learn to become nurses over *Time* and she is placing more importance on the *futurity* of the students than their *presentness.* Her views contrast with those of Oliver's earlier, who does not make judgements early. She was concerned when *others* made comments about why students had not failed earlier in the programme and why they were in the third year of the programme. This is linked to the concept of *temporality* as the present determines the future – identifying students who may not continue their programme:

> *With years of experience ... I'm quite good at identifying in year one the ones who won't get through, or will cause issues even if they do manage to get through year one ... having these huge number of students coming to year one, it's*

*progressing to year two that we need to be very careful about and I think often people will say ... how come they get to year three?* (Imogen, p. 10).

Being self-aware is important for *Being-a* clinical nurse educator. That is, being aware of one's beliefs and values and not allowing these to influence student assessment. Additionally, with more time as *Being-a* clinical educator, participants were able to use their *past* experiences of *being-with* students to predict the *futurity* of students in the nursing programme. Participants, *Being-as* nurses, were also able to articulate care as a component of *Being-a* nurse when *being-with* nursing students. I will now focus on how *being-with-others* influenced the participants *Being-as* clinical nurse educators.

**Being-with-others**

The participants had multiple relationships as part of the clinical learning/assessment process. I have used an extension of the Heideggerian term of *Being/Dasein*, as in *being-in-the-world* and in particular *being-with-others*, to present the interactions with other educators in the School of Nursing, the clinical staff and students. I will then develop the rest of the chapter about *being-with students*.

***Being-with* other educators**.

As Heidegger noted, *being-in-the-world* involves "Being-there" or Dasein, and the subsequent realisation that others are in a similar predicament; that they are also *being-in-the-world* and capable of comprehending what it means to *be-with-others.* In the case of the participants, one important element of *being-there* was loyalty towards their colleagues. All participants were members of the School of Nursing staff and were aware that a degree of solidarity with others was a necessary state of *being-with* those who are *present* (in Heideggerian terms, they have *presentness*) in the immediate *world-of-nursing education*. For instance, Caroline stated the need to be aware of not challenging colleagues when giving feedback to students:

*There is a bit of pressure for me to give positive feedback because I think it's hard if I am critical towards a lecturer's point of view* (Caroline, p. 8).

Not challenging others is in effect a way of *being-with-others* that reflects the need to "exist" and interact, not necessarily on our own terms, but on or within the presence (and thereby within the perceived and interpreted world) of others. As noted earlier in this thesis, this has been described as *theyness* or *alterité* (Steiner, 1978, p. 90). This phenomenon is reflected in the next extract where Deborah indicated that she was aware that her personal *Being-as* an educator also affected the other staff:

*I think you need very strong support from all around for something like that. And if you are not well supported, and especially if the student knows that, if they threaten to sue, to bring lawyers and all sorts of things ... my whole credibility as a lecturer has had huge ramification for us staff personally* (Deborah, p. 13).

This particular extract illustrates a considerable amount of not challenging *others* and *being-with-others* that suggests the drift towards *theyness*; it reflects the notion of *being-with-others* in regards to the maintenance of *authentic self* ("credibility") within that community, and, arguably, as *being-with-others* who are perceived to be like minded, such as one's colleagues.[5] This can also create tensions when considering the professional code of ethics to protect the public and there may be occasions when one has to challenge colleagues where public safety is being compromised.

***Being-with* clinical staff.**

*Being-a* clinical nurse educator required the participants to *be-with* students in clinical placements in the *world-of-nursing*. Yet students were *being-with* nursing staff for most of their time in a clinical placement. As well as *being-with* students, the participants were *being-with* nursing staff who support and supervise the students in the absence of educators from the *world-of-education*. The participants were demonstrating another perspective of *being-with-others*. *Being-with* clinical staff was about *caring for* the student within the *world-of-nursing* by supporting the RNs as the students enter the *world-of-nursing*.

Participants, *Being-as* nurses, were aware of the importance of good relationships with clinical staff to enable students to have positive clinical experiences and facilitate their journey from *Being-a* student to becoming a nurse. Having recently come from the *world-of-nursing* into the *world-of-education*, Keith was aware that *being-with-others* within the clinical environment was an important part of *Being-a* nurse educator for supporting students through *being-with* clinical staff:

*Because I am fairly fresh from the DHB to here* [polytechnic], *I feel that I am still half DHB and I know a lot of people in the DHB. So, I feel quite comfortable walking into most wards and saying, "Hi, how are you?" So having that sort of*

[5] There are more extracts from participants relating to *being-with-others* in the next chapter, which deals with failing students.

*rapport and relationship helps me gain a decent understanding of how the ward is approaching the student* (Keith, pp. 27-28).

Grace reinforced the importance of *being-with-others* in the clinical placement:

Y*ou have got to form a very good relationship with all these places* (Grace, p. 5).

Nadine adopted another means of *being-with* clinical staff in the form of communication through emails, texts and phone calls. Without clear guidelines she interpreted her *Being-a* clinical nurse educator between the two worlds as ensuring the clinical staff knew what they were doing based on her own interpretation of *being-with* others:

*I was asked to be the polytech liaison. I don't really know what I was supposed to be doing but what I did was I spent a lot of time liaising with the nurse manager of the education. I have had lots and lots of meetings with them, lots of emails, lots of texting, lots of phone calls just to make sure they really knew what they were doing* (Nadine, p. 7).

Many participants acknowledged that *being-with* clinical staff was about supporting them and ensuring that they were aware of the learning requirements for the students' level of education in their journey. *Being-with* clinical staff in a supportive role could be interpreted as forming a bridge between the *world-of-education* and the *world-of-nursing*. Whilst the participants were all registered nurses, they recognised that, as they were not permanently within the *world-of-nursing,* they were not considered clinical experts. Therefore, not *being-in-the-world* permanently could remove some of the *authenticity* of the participants *Being-as* nurses:

*They are preceptored by a registered nurse who is seen as the clinical expert, so the role in this school is to pull back from being the clinical expert – it's the person on the ward who provides that expertise and demonstrates practice* (Caroline, p. 3).

For Grace, entering the *world-of-nursing* and *being-with* clinical staff was about showing *care for* the students and ensuring that clinical staff were aware of where the student was on their journey to becoming a registered nurse:

> *Making sure the preceptor understands the level they* [students] *are at ... because a lot of them* [preceptors] *will still try and get them to do something that is completely out of their boundary* (Grace, pp. 6-7).

Participants highlighted the importance of identifying the expectations of nursing students within their journey and supporting clinical staff. *Being-with-others* was about participants *being-with* clinical staff who were *being-with* students within the *world-of-nursing*. Essentially, *being-with-others* was interpreted as visiting the staff at the clinical placement and communicating electronically or by telephone. I now present the findings from *being-with* clinical staff when they assess nursing students.

***Being-with clinical staff as assessors.***

Participants referred to *being-with* clinical staff when conducting clinical assessments, which can be interpreted as making a judgement about another entity, for example, a student. This is because, as Heidegger (1953/2010) states, searching for the truth involves making judgements which are based on "agreement of something with something" (p. 207). Clinical assessment is a judgement about a student's clinical performance which can be made through *being-with* clinical staff and the clinical nurse educator.

Nadine and Fiona indicate that they are not *being-with* students, but they sign the assessment forms through *being-with* preceptors; this would be termed *inauthentic* as *others* are telling them what to write. *Being-with* preceptors to make assessment judgements, when they spend more time with a student is good practice. When assessment judgements are made through being-*with* others, both clinical and application of knowledge can be considered:

> *I sign the students off with lots and lots and lots of input from the preceptor* (Nadine, p. 8).

> *I had a couple of students who were practically with the RN most of the time so she actually did their assessments because she's there all the time whereas I'm only there for half an hour or an hour, so, to me, that worked better* (Fiona, p. 3).

Whilst participants recognised their role in assessing students, they acknowledged that they were unable to witness the student's practice. Making a judgement about a nursing student is about determining their *futurity* for *Being-a* nurse. The participants were demonstrating *care for* the students by ensuring that the person who was *being-with* the

student, was able to contribute to the judgement, although concerns were voiced about the responsibility given to preceptors. However, some participants described differences of opinion regarding a student's performance.

In the next narrative, Helen used her instinct to disagree with a preceptor's assessment of a student:

> *I have had a difficult situation, in the medical centre where we had a preceptor, ... and she was feeling that the student had met the criteria, was providing the evidence and was trying to say that she was fine to get through, and I* ***had a gut feeling that she wasn't safe*** [emphasis added] *and that she wasn't meeting criteria. The problem with that was I hadn't worked with her ... we hand over the assessment to the preceptor more than I (sic) should be, because I feel if they have worked with the student they'll know, whereas I'm just an outsider that comes in and I found that quite difficult because I found she probably wasn't up to standard, but the preceptor was saying that she was* (Helen, pp. 10-11).

Helen acknowledged that she was not *being-with* the clinical staff or the student, but had a "gut feeling" that the student was not safe. This could be interpreted as *intuition* (Heidegger, 1953/2010, p. 30) because Heidegger refers to *intuition* as being more that what is seen, but relies upon all the senses to disclose the "being of human being.... genuine truth lies in pure intuition" (Heidegger, 1953/2010, p. 165). Helen highlighted the trust that is placed in clinical staff to make judgements about students and that not *being-with* the staff and students can lead to tension in the final judgement. This may indicate that as there was no agreement between the parties, a truthful outcome had not been achieved for the student.

Grace described *being-with-others* as collaboration between student, preceptor and educator in order to make a judgement. She was clear about *Being-a* clinical nurse educator but acknowledged that she acted differently to her colleagues. This reiterates the inconsistency that exists amongst clinical nurse educators within a polytechnic:

> [The assessment form] *gets signed by all three, the student has to sight it, obviously, and agree with what has been said and written, the preceptor has to be included. Now there are clinical lecturers who get the preceptor to do this form, and I might be one of the only clinical lecturers that do, don't know ... we are their* [preceptor] *support as well* (Grace, p. 8).

Participants noted that *being-with* clinical staff was about forming good relationships to enable students to have a positive learning experience. Participants identified that they were not *being-with* students for long periods of time and assessments were conducted through *being-with* clinical staff. Despite clinical staff *being-with* students for longer periods of time, not all participants agreed with the decisions made by clinical staff. The next section will focus on participants *being-with* students.

***Being-with* students.**

*Being-with* students is a variation of *being-with-others* within the *world-of-nursing education.* It implies a particular type of inter-relational aspect that is based on one party, that is, the educator, being "responsible" for others who are deemed to be both *within* the world (of nursing and as recipients of nursing education) but also *outside* the world in a sense of not being full members of that world of professional nursing. This relationship is therefore connected to, but not a strong example of Heidegger's "mutual recognition in the intersubjective world" (Ha, n.d., p. 7). There is an element of sharing reflections and interpretations of the *world-of-nursing*, but these are limited because of the differences between learner and educator. The educator may be seen as a companion, guide or mentor, but one with considerably more power, and limited self-disclosure, than the student. That power is exercised by offers of companionship (as in the extracts below), and by control or disciplinary acts (as in later extracts).

The majority of participants agreed that students are not their friends. Whilst Heidegger does not explore the term "friend" he does refer to relationships with others as a way of reflecting one's *being-in* the world through *being-with-others.* Grace illustrated this by referring to professional boundaries between *Being-an* educator and *Being-a* student:

> *You're not their friend. That's not the reason you are there, and there needs to be that boundary. They are the student, but however we are here to support you in any absolute way I can* (Grace, p. 30).

All the participants recognised their supportive and caring role for students, especially within clinical placements. This care and support is illustrated by participants who described being "visitors" into clinical placements as being about concern for students by ensuring that clinical staff were aware of the educational requirements for the students. They described themselves as *Being-visitors*, briefly entering the clinical world, to check and support students without any direct clinical involvement:

> *Permanent role is with second years at the moment and that involves* ***visiting*** [emphasis added] *them for an hour each week and discussing with them what they have learnt experientially and how that fits with theory. So it's very much a separation, um, I visit them at the hospital for a sense of convenience for them* (Caroline, p. 2).

> *I* ***visit*** [emphasis added] *them once a day in clinical and just to support them in their clinical placement* (Fiona, p. 1).

Keith described his role as ensuring that the student is *being-with* the preceptor:

> *I'd pop in and see them. Check they were happy and working with the preceptor* (Keith, p. 3).

Nadine demonstrates another way of *being-with* students by texting to offer support and check on progress:

> *I was texting her: "How are you going? Are you ready for tomorrow? Have you got your stuff done that we talked about?"* (Nadine, p. 15).

The participants acknowledged that *being-with* students was a major part of being within clinical environments, but there were different interpretations of *Being-a* clinical nurse educator and supporting students in practice. *Being-with-others* is an important consideration for *Being-a* clinical nurse educator which involves *being-with* other educators, clinical staff, and students. Participants described *being-with-others* as supporting students through visiting them in the clinical placement, or communicating via texts. *Care for* students was fundamental to *Being-a* clinical nurse educator. *Being-with* students was about being there for learning, but also for assessing. *Being-a* clinical nurse educator is about *Being-a* nurse, an educator and an assessor. I will now present the findings from *being-with* a nursing student through their journey to becoming a nurse.

**Temporality and Becoming a Nurse – Being Part of the Nursing Student's Journey**

Continuing with the analogy of taking a journey towards becoming a nurse, this section will present the findings of participants *being-with* students. The progression of the students' journey, from entering the programme, to the final transition placement will be used to present how participants made assessment judgements; that is, the *temporality* of the student. The use of various assessment tools and the NCNZ (2012a) competencies will be integrated into this section.

**Becoming a nursing student.**

When developing the research questions for this study, I concentrated on *Being-a* clinical nurse educator and *being-with* students for clinical assessment. I had not considered the students' past *Being*, their *historicity***,** before commencing their journey to becoming a nursing student. Five participants expressed concern about why students started this journey. Nursing students have diverse backgrounds, ages, cultures, gender and previous experiences. Keith thought *Being-a* nurse is mis-represented by New Zealand hospital television dramas, such as Shortland Street. He also commented on students' lack of awareness of the academic component:

> *I feel there is almost a misconception of what nursing is about ... it's either Shortland Street or it's a rest home. People come onto the course not realising that they are going to have to do 3,000 word assignments* (Keith, p. 17).

Additionally, some students had previous experience as *Being-a* health care assistant (HCA)[6] which created a lack of understanding about the differences between *Being-an* HCA and *Being-a* nurse:

> *People do not appreciate what a degree is, what it means, just think they're a glorified HCA ... the implications of being a registered nurse; I don't think we've made that transition in people's eyes of what being a nurse is* (*Melissa, p. 20).*

Another reason for people coming into nursing is because of family members in the profession. This could be interpreted as *being-with-others* during their upbringing influencing their future for *Being-a* nurse. Lucy discussed a student who was over confident as her mother was a nurse:

> *Her mother was a nurse, and in mental health. So, the first thing she did was name drop everyone she knew, and she never stopped. She had been brought up being taken into nursing offices and so she went in there and behaved like she had been in there forever* (Lucy, p. 11).

Whilst it is not the remit of this research to explore the nature of nursing, it is a fundamental consideration when trying to determine what *Being-a* nurse means. If the expectations of a nursing programme are unclear, or obtained from television dramas,

[6] An HCA is an unregulated care worker.

students may be ill-prepared for the expectations of the programme and what it means for *Being-a* nurse. It influences what we are trying to achieve through assessment of individual nursing students if they are to become nurses.

There are limited selection criteria for entry into a nursing programme[7]. Participants frequently expressed concern about why some people wanted to become nurses. Nurses are generally considered to be caring, therefore it could be interpreted that to have a caring personality is part of *Being-a* nurse. Jackie was aware of nursing students with mental health diagnoses and questioned whether their caring personalities attracted them to become nurses:

> *There's a couple of students who have an underlying mental health diagnosis – why are they attracted to nursing? It's quite scary, and often, too, they are being pushed towards nursing because they have got caring personalities* (Jackie, p. 13).

Helen also voiced concern for nursing students with mental health problems and generalised this to a concern for *being-in* the *world-of-nursing*:

> *I was worried about the mental health of the students I was seeing coming through. It made me worried for nursing* (Helen, p. 23).

Students are accepted into the programme from details submitted on an application form. Keith raised this as an issue and questioned why some people were in the programme, as he came from a country where nursing students were interviewed and indexed with the regulatory body. He felt that not assessing their suitability to become a nurse, could result in them failing to complete their journey:

> *Who vetted this person? Why did they get here?... setting them up to fail* (Keith, p. 18).

The comments relating to nursing as a career choice were an unexpected element of my research. The concerns raised by the participants certainly require further research but the motivation to study nursing was not my primary research aim. All participants acknowledged that nursing students came from different backgrounds with *past* life

[7] The NCNZ (2014, p. 12) state the entry criteria for studying a Bachelor of Nursing degree is "in line with university entry criteria for entry to a bachelor degree".

experiences. Becoming a nurse means that participants considered the students' *past* experiences and how this affects their *Being-a* nursing student within the *present*. I will now follow the participants *being-with* students on their journey to becoming nurses.

***Being-with* first year nursing students.**

Three participants were aware that within the first year, for some students, there was a whole process of socialisation for *being-in* the *world-of-nursing*, including seeing a naked body for the first time:

> *They start on day one all shy and won't say boo to a ghost really, and a lot of them find it difficult to talk to patients. A lot of them haven't seen a patient naked or haven't seen a naked person. So, it's helping them get through those initial, you know ... they have to sit down and talk to somebody about that person and that's very difficult to do you know when you are 18, 19, 20* (Grace, pp. 31-32).

Phillipa acknowledged the diversity of students' *past* experiences and that whilst they are all on the same journey, some students require more time:

> *One might have had a lot of health care work, and one might have worked in a shop or something like that. And just seeing a naked body ... like their catch up is so great* (Phillipa, p. 11).

Jackie reflected on her past experience of *having-been* a first year nursing student and was able to recognise the anxieties of first year nursing students:

> *I was probably a nightmare to start off with ... I didn't know what I didn't know when I went into practice and I was scared ... we were terrified the whole time* (Jackie, p. 20).

Once in the BN programme, students learn the art and science of nursing. Teaching nurses the clinical skills of the profession appeared to have two distinct phases; the initial teaching of fundamental skills in a clinical skills laboratory within the polytechnic *(world-of-education)*, and the implementation and assessment of skills and competencies within the clinical environment *(world-of-nursing)*. Interviews with participants revealed different attitudes to teaching, learning and assessing in these two phases.

***Pre-clinical skills in the world-of-education.***

Participants described the students' journey as starting with learning fundamental skills, such as hand washing, blood pressure monitoring, medication administration, and bed-making, within the controlled environment of a simulated clinical room at the polytechnic. After a period of education, students were assessed to judge their basic competency and safety prior to entering the *world-of-nursing* in a clinical placement. The rationale for determining which skills were assessed follows no national guideline or policy. There was no consistency between the institutes as to what determines a fundamental skill. In some areas it was a random choice of clinical skill, so not all students were assessed in the same skill. In the example below, Deborah explained how students were assessed using Objective Structured Clinical Examination (OSCE). Students learnt four different skills prior to placement, but were assessed in only one skill. This could assume that competence in only one skill implies competence in the three others, enabling them to go into a clinical placement:

> *They sit OSCEs for their technical skills. They potentially select one OSCE but they had four that they had to learn. Then they have got another two at the end of the year so there are six in total ... they are just tested on a step by step ... two of the OSCEs they need to give medications.... So, it's taken through step by step and its quite hard to hard teach that whole step by step process to an en masse group* (Deborah, p. 2).

Deborah acknowledged the difficulties associated with teaching skills to large groups within a classroom. Caroline suggested that it is made harder by the use of mannequins, which are not a true representation of *being-in* the *world-of-nursing*:

> *We don't have real patients if we do OSCEs, we have mannequins ... I think it makes it harder. A real person responds to you* (Caroline, p. 23).

A checklist was used as the assessment tool for assessing clinical skills. The checklist breaks each skill into its component parts. For students to pass an assessment when the checklist is the tool, they must pass every component part of the skill. Some participants liked the use of the checklist as the students were aware of the assessment criteria:

> *We give them all the criteria; they know what's going to be tested. They know that it is a process, dat, dat, dat, pass* (Caroline, p. 22).

However, another participant felt that checklists resulted in assessment being punitive; one item on the list, such as not drying a thumb, resulted in a fail:

> *All of the students have actually failed one of the skills and it's normally been some very **tiny** little thing because it's very detailed. There's a very **tiny** step by step. I was quite amazed (laughter) you know, like hand washing. The thumb wasn't quite dry, so, um, yes, so they say they failed ... I thought they may be competent but there was just one **tiny** little step missing (p. 6). So I think all the time they failed it's always been a **tiny** little matter. It's not that they have been unsafe, being incompetent. Just a **little** part of the assessment criteria was missed* [emphasis added] (Fiona, p. 7).

Fiona provided an interesting insight into the triviality of the assessment of the skill of hand washing. Whilst she described the "tiny**"** aspects of the hand washing skill, she re-enforced this with the use of her index finger and thumb to reiterate "tiny". This example highlights that the tool had explicit, clearly stated criteria to be assessed. Whoever devises the assessment tool, determines what is to be assessed. A checklist should mean that there is consistency about what is being assessed, irrespective of the assessor. Fiona described the importance of getting every detail right within the pre-clinical skills, yet students were able to go into clinical placements without achieving all the criteria, as long as they would be assessed within the placement. This also highlights the tensions between learning and assessing:

> *They've got to do a model of skills in the lab here, but some of them end up having a couple that they haven't passed. Done one **tiny** little thing wrong like they haven't got the bed at the right height or they didn't tell the patient that the temperature was low. Because there is such a strict criteria for these clinical skills, so just one **little** point that they've not passed, so they've got to do it again on their placement* (Fiona, p. 5).

Fiona was uncomfortable with the stated criteria in the tool and questioned its appropriateness for measuring competence as she did not feel that students were unsafe if a thumb had not been dried. This is Fiona's interpretation and may not have been the same for all participants, highlighting the justification for explicit criteria on a checklist. Fiona was new to nurse education and had not failed students in clinical practice. Throughout her interview she demonstrated *care for* students. Her attitude to the pedantic nature of the assessment could be interpreted as her unease at having to fail students if they did not meet

specific criteria on the check-list, and dislike of the tool. Other participants felt that using a detailed skills checklist meant that it was very clear to make a judgement – they had either washed the thumb, or not – pass or fail. This clear black and white segregation of component parts makes no allowance for grey areas and interpretation on the part of the assessor. If it is on the check list, it gets assessed; if it is not, it cannot be assessed; criteria cannot be changed to fail (or pass) a student, acknowledged by Helen:

> *You can't fail someone by changing the criteria* (Helen, p. 13).

Jackie, an experienced nurse educator, stated that nursing is more than a series of tasks detailed on an assessment check-list. Heidegger (1953/2010, p. 69) acknowledged that "'practical' behaviour is not 'atheoretical' in the sense of a lack of seeing", meaning that actions must have a theoretical understanding. Therefore, when applying Heidegger's theory to tools being useful for something, a checklist would appear to assess only that action which can be observed. A check-list does not enable a student to explain their actions. *Being-a* nurse means being able to apply evidence based practice as detailed in NCNZ (2012a) competencies 2.1, 2.2 and 2.9 (Appendix C):

> *We are trying to get them away from the task orientation.... We want them to look at continuousness of care.... It's more about seeing the hospital stay through the eyes of the patient rather than a whole heap of tasks that you have to do* (Jackie, p. 8).

Jackie critiqued the use of check lists as assessment tools - they do not allow for students to demonstrate the processes involved with undertaking a clinical skill such as a wound dressing. She used her *Being-as* a nurse and duty to protect the public by not causing harm as a means of assessing a nursing student:

> *There are some basic skills and understanding that you see in the lab and ... if it is pretty clear that they don't have it ... what was the mistake and would that have killed somebody?... So it's constantly, taking them back to the basics and ... the underlying principles of care. We're not procedural based at all, but they have to understand a wound dressing is aseptic.... If a person doesn't do it exactly to the dot, doesn't mean they are not a good nurse, and that you can't be that rigid* (Jackie, pp. 18-19).

Participants had mixed feelings about the use of clearly defined criteria. The different opinions about the use of check lists highlighted different ways of *Being-an* assessor and *Being-an* educator.

Two participants stated that limited time affected the ability to assess pre-clinical skills thoroughly and this could mean that not all "failing" students are identified prior to going into a clinical area:

> *Running scenarios in the lab – this is where we need the resources, they slip through, just smile and stand back, failing the lab is where we should ... pick up that they are not measuring up before they go out* (Melissa, p. 20).

Deborah was aware that an assessor could be influenced by the personality of the student (also acknowledged by Oliver earlier in this chapter):

> *Because you can get that very nice person who actually isn't that great at the end of the day or the real kind of cocky student who presents you with a beautiful portfolio of documentation but actually not very good on skills* (Deborah, p. 9).

Whilst clinical skills were taught and assessed within the *world-of-education*, participants noticed problems with teaching and assessing large groups, and having insufficient time. Using mannequins highlighted differences between what occurs within the *world-of-education* and the *world-of-nursing*. Having completed the learning of fundamental clinical skills within the polytechnic, students continue the journey and enter clinical placements in the *world-of-nursing* to consolidate their learning, despite not necessarily passing the pre-clinical assessments. This is a cause for concern.

***Clinical skills in the world-of-nursing.***

Two participants stated that assessment differed between the polytechnic and the clinical placement. This could be interpreted as suggesting that the students were not prepared for *being-in* the *world-of-nursing*:

> *There's a difference what goes on in the lab* [polytechnic] *and what goes on in practice (laughter)* (Fiona, p. 6).

Deborah acknowledged that teaching in the *world-of-education* can be different to the application of the teaching into the *world-of-education.* This can also be interpreted that assessment will also differ between the two worlds. *Being-a* student means that they may

be in a different state of *Being* when taught and assessed in the *world-of-education* and then move to the *world-of-nursing.* This is illustrated by Deborah who noticed that students can be different *Beings* when they move between the two worlds:

> *Feel quite disjointed. Feel that because you are teaching them practical things, it's really nice to go into the clinical setting because you only get half the picture and someone who appears very confident in the lab might not be great out in, in the* [clinical setting]*, so you need a whole lot of other skills* (Deborah, p. 26).

This difference can be attributed to the different dynamics within the two worlds of nursing and education. Some District Health Board (DHB) policies do not allow polytechnic staff to deliver care, such as medication administration, within the hospitals, unless they had attended DHB mandatory training days. This could also mean there are different practices within the academic world of the polytechnic and the clinical world of the hospital:

> *They can't officially do it here* [the hospital] *because they have got a policy that says you have to complete a medication test before you come in* (Jackie, p. 9).

The differences between skills acquisition in the polytechnic, and their implementation within a clinical setting could be attributed to the fact that hospitals and polytechnics are in different locations, which can be interpreted as *being-with-others* within different locations, which was highlighted earlier when participants talked of "visiting" the clinical placements. Keith described the different worlds as "an us and them":

> *We are out here and the hospital is over there and there is such an us and them attitude* (Keith, p. 27).

This section has highlighted the importance of skills acquisition as a fundamental component of nursing practice. However, differences have also been highlighted between learning skills in the classroom and their implementation within a clinical placement which can be interpreted as *being-in* the *world-of-education* and *being-in* the *world-of-nursing*. Educators and students therefore find themselves in differing worlds and negotiating different paths to achieve the ultimate aim for the student to be in the *world-of-nursing* as *Being-a* registered nurse.

***Appropriateness of clinical assessment in the first year.***

The acknowledgement that there is more to know about nursing than just clinical skills led some participants to question whether clinical assessment should occur in year

one. Fiona believed that it was a time of confidence building, developing communication skills and providing encouragement. It is a time for enabling students to confirm whether they really want to become a nurse and prepare for the journey towards becoming a nurse:

> *How can you know if you want to be a nurse unless you have a least a month, six weeks out in placement? So definitely you make a decision whether this is for you* (Fiona, p. 12).

Deborah commented that year one should be an "experience" and not a time for assessing. She commented that *being-in* the clinical environment for seven days was insufficient time to make a judgement about a student, particularly if they had been exposed to different preceptors. This highlights the Heideggerian themes of *time* and *being-with-others* as components of *Being-a* nursing student and looking to the future towards becoming a nurse:

> *How could you honestly do a formative and a summative in seven days, and spread over months.... I think the clinical practice thing should just be an experience, albeit the person still has to meet certain things ... most of them have had several preceptors* (Deborah, p. 28).

Grace also considered the first year as an opportunity for students to learn from mistakes and review whether they should continue the journey towards *Being-a* nurse in the future:

> *You have to actually let them make mistakes and learn from them. If they cannot get it right, then they need to re-consider pursuing their studies* (Grace, p. 11).

Eve highlighted that students who are in placement earlier in the year will have had less time to learn than students who are in placement later in the year which means that students are at different stages within their same year group:

> *At the same time remembering that the first students in the placement are at a different place than that final placement* (Eve, pp. 7-8).

Imogen illustrated this progression through the first year using the example of taking a blood pressure; a first year student initially concentrates on performing the procedure, rather than the person. By the end of the first year, the student should be able to relate the

procedure to the person, highlighting the continual journey of a nursing student towards becoming a nurse and linking the education to *Being-a* nurse and *being-with* people:

> *They can't take a blood pressure and necessarily look at the person yet, so perhaps by the end of the first year connect the information of objective data with the actual person in front of them* (Imogen, p. 12).

This section has indicated that year one forms the foundation for *Being-a* nursing student and for becoming a nurse. The teaching and assessing of clinical skills takes place within the *world-of-education* before students move into the *world-of-nursing*. Participants acknowledged that differences existed between the two worlds. The assessment of clinical skills was ad hoc and involved the use of checklists with skills being broken down into component parts. Some participants also believed that the first year should be a period of learning and not assessment. Having successfully completed the first year of their journey, students continue to become second year nursing students.

***Being-with* second year nursing students.**

As students continue their journey and progress into the second year of the programme participants acknowledged that students should have increasing independence and ability to *care for* one or two patients. Caroline noted that different students learn at different rates and some students will "*fly into their second year"* (p. 17).

The second year was a time for students experiencing a variety of clinical placements, including district nursing, community nursing, primary care, and Plunket[8]. These were considered speciality areas where *Being-a* student was about observation through *being-with* a specialist nurse, and therefore difficult to assess. NCNZ competencies (2012a) were used in most assessment tools to assess clinical nursing practice which challenged some participants as they are a measure of competence for *Being-a* registered nurse. Keith questioned the relevance of registered nurse competencies for the assessment of nursing students:

> *I suppose the competencies we are given to assess the students on are certainly a good starting point ... some of the competencies aren't. Aren't really relevant to what the student is doing but, um, sometimes they don't always capture exactly how good or bad the student is* (Keith, p. 22).

[8] Plunket is New Zealand's largest provider of support services for the development, health and well being of children under five years.

Helen felt that using the competencies was inappropriate for assessing year two students in speciality placements as they were not tailored to those environments. Helen demonstrated *caring for* the student as she stated the process was unfair for students:

> *Plunket nursing is a specialty nurse, yet here we are with students going out with a practice nurse assessing them on a whole lot of nursing domains and not appropriate for a nurse, for a student nurse to be acting in there. And we are saying whether they are competent or not based on that, so it's inappropriate.... So what we are doing is just playing with words to fit into the competencies ... I'm quite angry about how we assess these* [competencies] – *I think it's unfair on the students* (Helen, p. 18).

Imogen described assessment of students *being-with* district nurses as "farcical":

> *I actually felt it was farcical when we did the assessments. I got the district nurse to be there and in fact I probably put words in their mouth, but sort of dictated what I thought they could be saying based on what the students were telling me and what they were telling me. I was really the scribe, not the assessor* (Imogen, pp. 3-4).

Imogen described *Being-an* assessor as *Being-a* "scribe" when completing the assessment form as the clinical nurses would provide her with a verbal report about the student's progress. She took advice from the RN to complete the assessment form, despite not actually conducting the assessment, and she signed the form, not the RN. As Imogen is not actually conducting the assessment but *being-with-another* to make the assessment, this could be interpreted as Imogen demonstrating *they-self*, being *inauthentic;* she is writing the words of others, that is, the district nurse and student. Imogen did not explain why the district nurse did not sign the assessment form although this would have been *authentic* assessment.

Mental health was another speciality area where second year nursing students were learning through observation. Assessment within mental health areas was about acknowledging how the competencies (NCNZ, 2012a) related to *Being-a* registered nurse:

> *I set them some specific things to look at. One is to identify what is the role of the nurse in relation to the competencies ... they are identifying the skills that*

*they need to have, the knowledge they need to have and how they see that happen* (Eve, pp. 5-6).

Eve believed that nursing students cannot be assessed delivering care within the mental health area of nursing as it is a specialist area. They are assessed through observation and analysis of their understanding of what is means to *Be-a* mental health nurse. The student was not demonstrating any clinical application of the theory of mental health nursing. An assessment which requires the student to explain the role of the nurse could be considered more theoretical than clinical. A nursing student who completes the journey and becomes an RN could be employed within a mental health area, yet has not demonstrated clinical competence in the area but has been assessed through observation of the role.

One participant was concerned about *Being-an* assessor within mental health as she was not registered to practice within that field. She therefore relied on clinical staff and used the term "mental wellness" to legitimise *Being-an* assessor. This could be described as *Being-inauthentic* as she was displaying *they-self,* rather than *Being-authentic* which would require her to state that she was unable to assess students within mental health due to her own lack of competence in the area. She is *Being-an* assessor through *being-with-others* and takes advice from the clinical nurses who are the clinical experts within that speciality.

Keith questioned the fairness of allowing a weak second year student to continue the journey to become a third year nursing student. However, a student is assessed for their *presentness* as a second year nursing student and Keith was considering their *futurity* for becoming a third year nursing student. Keith acknowledged that the student is "barely passing", that is, considered as a marginal student[9], but questioned whether the student should be failed:

*It's unfair for us to see a student in the second year, who are (sic) barely passing, though. Is it right?* (Keith, p. 20).

Another participant used the students' *futurity* to determine whether a second year nursing student should continue their journey, as she felt they should not be failing in their third year:

[9] The assessment of marginal students will be dealt with in greater detail in chapter six.

*Second year is the year to sort them out – they shouldn't be failing in third year because they have got there* (Melissa, p. 21).

Lucy, who was new to teaching and had not failed a student, adopted an optimistic approach by hoping that students would improve with time, an acknowledgement of *Being* changing with *Time*. She recognised that *being-with* different nurses means that standards differ and influences assessment decisions:

*Seeing things through the student's eyes and hoping that it will get better, you know, all those things of hope and recovery (laugh)..... Nurses have different standards. What's ok by one nurse will not be ok by another* (Lucy, p. 20).

*Being-an* assessor with second year students presented challenges for participants. Firstly, the diversity and specialities associated with the clinical placements; secondly, the use of NCNZ (2012a) competencies for *Being-a* nurse to assess students, and the clinical credibility of the participant not qualified within the speciality; and thirdly, the dilemma associated with allowing weak students to continue the journey to the third and final year of the programme and *Being-a* nurse.

***Being-with* third year nursing students.**

Students entering the third year of the nursing programme will be nearing the completion of the journey to *Being-a* nurse. However, they are still *Being-as* students and continue to learn and be assessed. Fiona and Helen did not feel comfortable with failing students in their third year, reinforcing comments from the previous section about the second year being the time to fail students:

*You don't want to be failing someone in their third year would you because they have already passed the first two years* (Fiona, p. 12).

*Ah well, it would be dreadful. I'd be angry at the system ... I'd feel we'd let them down, been taking their money pushing them ahead when they are not actually up to standard* (Helen, p. 19).

These two extracts could highlight *caring for* students who had already spent time and money on a journey which they may not complete[10].

[10] Further examples relating to time and money will be presented in chapter six.

Participants highlighted different expectations of third year nursing students. Nadine and Caroline were clear about "initiative" being an important part of nursing in New Zealand, despite initiative not being mentioned within the competencies (NCNZ, 2012a). This also highlights differing interpretations of the competencies:

> *Nursing in New Zealand is not about standing back and being told what to do, it is about using your initiative* (Nadine, p. 12).

> *Talk about things like they don't show initiative, they don't take a patient load* (Caroline, p. 16).

Being able to think more critically and apply theory in year three was mentioned by participants. Keith used an example of taking blood pressure to illustrate how a student's journey develops increasing critical thinking:

> *It's the critical thinking associated with a blood pressure ... we have got to accept and expect them to be at certain levels within the three year course.... By the end of first year is kind of an expectation almost depending upon their relating to the papers they have taken, and as you say, by the time third year comes around you are talking about what would influence blood pressures and ... actually analysing a bit more* (Keith, pp. 14-15).

Eve used the link between knowledge acquisition from the *world-of-education* and application to practice into the *world-of-nursing* as an expectation of *Being-a* third year nursing student:

> *The theory integration of knowledge and how that has informed their practice so their portfolio has to demonstrate that they can critique practice, that they are aware of what is informing their practice* (Eve, p. 7).

Imogen also acknowledged different expectations as students journey from year one to year three students:

> *How come we've let them get into year three and we're not wanting to achieve* [pass] *them? And I don't actually have any problem with that, because you're expecting different levels of competency in different levels of different analytical skills, synthesis, that and much more anticipation, much more the role of the*

*nurse in year three ... whereas in year one, you take them by the hand and guide them a lot more* (Imogen, p. 11).

Participants identified that year three nursing students should require less guidance, and require higher order skills than those identified in year one, such as critical thinking and analysis. The expectations of the requirements of year two and three students' clinical skills lacked clarity as there are no clear guidelines for skill progression through the programme as NCNZ (2012a) competencies for *Being-a* nurse were used to assess *Being-a* nursing student.

***Being-with students in the final transition placement.***

As students entered the final transition placement, they had almost completed their journey towards becoming a registered nurse. Assessment within this placement is about meeting the NCNZ (2012a) competencies at novice registered nurse level. Students are *being-with* a clinical preceptor for the duration of the placement and the preceptor has significant input into the assessment of the student. Once they have successfully completed their degree and passed state finals students will become a registered nurses.

Eve was primarily with students in the final transition placement and believed competencies were appropriate for making an assessment judgement. Competencies have more relevance for their *futurity* as *Being-a* nurse:

*It has been assisted by the competencies and by us aligning our outcomes to those competencies when it is a clinical practice course and to really trust that judgement* (Eve, p. 38).

The personal responsibility involved with assessing a transition student was highlighted by Keith who was aware that his decision could determine whether a student was able to complete their journey to become a nurse:

*Quite nervous in that the sense it would be my assessment that would say yeh or nay to her Being-a registered nurse or not. So, it was a little bit of pressure there* (Keith, p. 12).

Two participants voiced concern that a nursing student can complete the degree component (academic) of the programme but not pass the state final examination (nursing) and therefore not entitled to *Be-a* registered nurse, yet possess a Bachelor of Nursing Degree:

*There is a view in nursing that you can do a Bachelor of Nursing, you don't have your competency nursing certificate at that stage. It is about the nursing degree becomes just a degree and not actually a nursing competency practising and I have trouble getting my head around that* (Helen, p. 19).

*I think there's a lot of compassion for what ... people are paying for their education; that she can get a Bachelor of Nursing and not become a registered nurse* (Lucy, p. 15).

The final two comments above demonstrate that the nursing programme has an academic element and a professional element meaning that a student can complete their journey with a degree, but not become a registered nurse. This highlights that nurse education consists of the *world-of-education* (gaining a degree) and the *world-of-nursing* (entering a profession). *Being-a* clinical nurse educator is about *Being-a* nurse and *Being-an* educator, through *being-with* a nursing student on their journey towards becoming a nurse.

This section has highlighted how the temporality of a nursing student's journey was an important consideration for participants. Acknowledgement of the students' *past*, their *historicity*, prior to coming into the BN programme was considered by some participants. It was thought that the first year of the programme was about enabling students to learn fundamental nursing skills, and participants were aware that there was diversity amongst students' previous experiences. In the first year, the learning of clinical skills began within the *world-of-education* and consolidated within the *world-of-nursing*. Clinical practice was assessed against clear criteria on a checklist assessment tool. The second year of the programme was about students *being-in* clinical specialities and being assessed against the NCNZ (2012a) competencies. Participants questioned the suitability of this assessment tool, and also considered the *futurity* of students entering the third year of the programme. Assessment of students within the third year of the programme was about students nearing the end of the journey and some participants felt that the use of competencies was an appropriate assessment tool within the final transition placement. Participants identified the difficulties associated with determining how assessment measured progression as students journeyed; increasing critical thinking was used as a measure of advancement along the journey.

## Conclusion

The chapter started with outlining the key Heideggerian themes which were identified from the analysis of findings. This chapter has dealt with what *Being-a* clinical nurse educator means; how the participants, *Being-as* nurses, are also *Being-as* educators and *Being-as* assessors of nursing students. Participants articulated difficulties between their state of *Being-as* educators and *Being-as* assessors and discussed their lack of preparation for *Being-as* clinical nurse educators. They also acknowledged their accountability for protecting public safety *Being-as* nurses, and responsibility to students through *Being-as* educators. *Being-as* nurses and *caring* were introduced and will be developed further in the next chapter as the analysis of the findings pertaining to *being-with* the "failing" student will be presented. *Being-a* clinical nurse educator means *being-in* the *world-of-nursing* as well as *being-in* the *world-of-education*. It means that they are *being-with* other educators and clinical-staff as well as *being-with* students. The participants are *being-with* students as they take a three year journey to becoming registered nurses.

Participants spoke of various clinical assessments tools that are used throughout the journey, including check lists, portfolios, and clinical assessment sheets. A tool is designed to meet a need (Heidegger, 1953/2010), in this case to determine whether *Being-a* nursing student can become a registered nurse who will *care for* people. The next chapter will focus on the findings associated with students who are not achieving competency and the experiences of *being-with* failing students in clinical practice.

# CHAPTER SIX

## Findings: *Being-with* the "failing" student

Chapter five presented findings from participants' experiences of *Being-as* clinical nurse educators; *being-with* students and *being-with* clinical staff, as students take a journey from *Being-as* nursing students toward becoming nurses. Findings about participants' *Being-as* educators as well as *Being-as* assessors and making judgements about students' potential to become nurses were also presented. This chapter focuses on findings from participants' experiences of *being-with* the student who is considered to be failing within clinical practice. *Being-with* students within the *world-of-nursing* meant the participant had to consider the *futurity* of student to *Become-a* nurse. From a Heideggerian perspective, Hornsby (n.d) interprets this as follows:

> Not everything is possible for every human being. Every person's options are limited in one way or another and 'concern' is a way that humans can decide what decision could be the correct one in order to move from one condition to another. Choices are made in the world in which humans exist surrounded by other humans (Hornsby, n.d, para. 9).

When students did not display behaviours that were considered to be consistent with *Being-a* nurse, the participants were faced with either failing the student, or passing them and allowing the journey to continue. Failing a student could mean that they are able to have a second enrolment, or it may mean that their journey to becoming a nurse is terminated, if they are failed in a second enrolment.

**Heideggerian Concepts**

I will develop the concept of *care* in terms of concern when *being-with* the "failing" student. Participants, *Being-as* educators demonstrated *care for* students, and *care for* health consumers through *Being-as* nurses. Heidegger (1953/2010, p. 118) discussed the concept of *care* as a characteristic of *Being* which is "*being toward* ... as taking care of things" (Heidegger, 1953/2010, p. 118). When beings are *being-with* others, this is described as "a matter of *concern"* (Heidegger, 1953/2010, p. 118). The second mode of care is termed "authentic care" which has previously been described as to "become transparent to himself *in* his care and *free for* it" (Heidegger, 1953/2010, p. 119). I will be interpreting this as participants' *care for* students when *Being-as* educators, and *care for* public safety when *Being-as* nurses. However, when *Being-a* clinical nurse educator, participants

demonstrated *care for* both students and public safety which will be demonstrated in this chapter.

In chapter five I described the Heideggerian concepts of *authenticity/inauthenticity*, which will be developed in this chapter to explore the *authenticity* of participants when they were *Being-as* assessors with "failing" students. Heidegger (1953/2010) states that "an authentic way of existing is one that requires individuals to take responsibility for their attitudes and actions" (p. 63), and so the theme of *responsibility* will also be presented at the end of this chapter. How *being-with* a "failing" student at a specific point in their journey towards becoming a nurse affected participants' decision-making will also be presented. This will be linked to the concept of time as a journey towards becoming a nurse.

Five participants said that they had not failed students despite having concerns about their competence and some openly stated that they would avoid failing students. These responses may be associated with feelings or, as Heidegger (1953/2010, pp. 134-5) acknowledges, as an aspect of the phenomena of moods that are a part of *being-in-the-world*. In particular, Heidegger (1953/2010) discussed the phenomenon of anxiety which is described as "a way of being-in-the-world" (p. 185). Heidegger (1953/2010, p. 175) explains that when we are *thrown* into the world and everyday familiarity collapses, the being of Dasein shows itself as anxiety, which is differentiated from fear. Anxiety results as the *Being* loses *authenticity* and becomes a part of *being-with-others-in-the-world.* Anxiety is part of the *disclosedness* of Dasein and the being of Dasein "reveals itself as care" (p. 177).

Another phenomenon of mood that Heidegger refers to, is guilt which he defines as "a *lack*, when something ought to be and can be is missing" (p. 272). Interpreted as something missing within a clinical assessment, means that a nursing student may not be competent in all areas of clinical assessment. Indeed, Heidegger further explains that a deficiency in Dasein (Being) "such as a failure to fulfil some requirement, has been 'caused' in a way characteristic of Dasein" (p. 272). Carman (2005) interprets Heidegger by saying "This is not to say that I am to *blame*, but simply it is *because of me.* Owning up to my guilt is therefore something like recognizing *(sic)* myself as a locus of accountability" (p. 291). Heidegger's (1953/2010, p. 275) notion that "being guilty constitutes the being that we call care." Using an extension of Heidegger's concepts of anxiety and guilty are part of the *Being* that is *care.* I will now present how the participants, *Being-as* nurses, were *being caring* when assessing nursing students in clinical practice.

### *Being-a* Nurse as Caring

Two participants commented that they enjoyed *being-with* students on their journey to becoming nurses. Lucy explained the difficulty associated with failing students was attributed to *Being-a* nurse who is caring, and the need to show "compassion and empathy":

> *Because we're nurses, because we come from hopefully places of compassion and empathy, that sometimes get in the way of our decision making ... seeing things through the students' eyes and hoping that it will get better you know, all those things of hope and recovery (laugh)* (Lucy, p. 19).

Helen, who had not failed a student, mentioned that her own caring personality made it difficult to fail students. Helen could be described as being *authentic* as she is being true to her own sense of care; Heidegger (1953/2010) stated that "authentic people care for the care of others" (p. 274). However, Helen also stated that educators did not fail students as "*they were not strong enough!"* (p. 16), meaning that educators are influenced by *others* and could be interpreted as being *inauthentic,* the *they-self*:

> *Oh, that will be my dis-profile (laughter) ... I want to be everybody's friend (laughter) I like to be caring and everybody's friend* (p. 15) .... *What I might be doing, is avoiding making the decision by making sure that I am not actually in the position where I have to fail them.... What makes it difficult is, I guess, my identity is that I get on with people and I also accept difference and I can work across different walks of life, cultures and behaviour, and so when you have got to make a judgement it's actually quite hard to face up to* (Helen, p. 17).

When some participants failed a student, they did not regret the decision, but "felt bad" or in Heideggerian terms felt *guilty. Being guilty* has been described by Heidegger (1953/2010, p. 270) as "taking care of things" which can also be described as "depriving, ... withholding, taking". In this sense, by failing a nursing student, the participant takes away the students' opportunity to complete a journey to becoming a nurse which can lead to feelings of *guilt*. Additionally, Melissa may have demonstrated an *authentic* approach to failing the student as she was confident that she had taken responsibility and made the "right decision":

> *I felt bad, but it was absolutely the right decision* (Melissa, p. 9).

When a student failed, some participants blamed their own teaching, which could be interpreted as the participant being responsible for the student failing, which could also be

described as *being guilty*. This is highlighted by Deborah who felt sad for the students and she took responsibility for students being unable to become nurses:

> *Felt pretty gutted for them really ... I felt quite sad because I thought maybe I hadn't taught them well enough* (Deborah, p. 31).

Four participants inferred that it was harder to be true to themselves, that is, to be *authentic*, and to fail a student whom they liked. *Being-with* a student whom they liked meant that the judgement was influenced through *being-with* others. Melissa, for example, recognised that *being-with* students she liked made it harder to fail a student:

> *You develop a relationship with the student. I mean, it's easier to fail someone who is (sigh) for want of a better word, "pissing you off" (laugh) than someone you are having a really nice relationship with, but they're not kind of making it (laugh)* (Melissa, p. 15).

Nadine also acknowledged that *being-with* a lovely student could influence the assessment decision, especially when *being-with-others*, including *being-with* clinical staff, possibly meaning that she was being *inauthentic* through being *they-self* as she was influenced by *others*. *Being-lovely* means that students are more acceptable to others and may cause assessors to pass students who are not competent; this becomes apparent later in the thesis. However, Nadine's judgement would become *authentic* as she considered a student's knowledge rather than being influenced by *others-in-the world*:

> *So I have been quite significantly swayed by the student. Might have just been really chatty, sociable, lovely attractive, pleasant team member who's had a good time and they've* [preceptors] *loved her, him or her, and they've been ok with their patients' cares. But for me it's always been that knowledge base* (Nadine, p. 29).

Nadine believed that *being-with* students was about supporting them. She felt that students appreciated that they were being *cared for* and therefore accepted being failed if they were being *cared for*. When Nadine was being transparent and *caring for* students in this way would be termed *authentic care:*

> *Failing students has really helped me in my overview ... the students tend to accept, because they know I care about them and support them 100% ... they tend to accept it better when its enveloped in care* (p. 26).

This section started to consider how *Being-a* nurse is about *being-caring*. *Being-caring* is a component of Dasein, and being *authentic*, which challenged the participants, especially when *being-with* a student whom the participants liked. *Being-caring*, as *Being-a* nurse, made it harder to fail a student, which challenged their *authenticity* as assessors. Having considered participants as *being-caring*, the next section will use the journey of the nursing student and how *being-with* the student influences the decision to fail a nursing student.

### *Being-with* Students on their Journey

In chapter five the concept of *time* was mentioned to illustrate the journey of a student from entering a nursing programme to becoming a nurse after three years. The concept of *temporality* will be used to interpret how assessors made judgements about students' clinical practice depending upon where they were on the journey. The concept of *presentness* will also be discussed when participants assessed students in the *present* but considered their *future* towards *Being-a* nurse. As students progress on their journey from the first year, participants commented that they knew students. Interpreted within a Heideggerian framework this is participants having *fore-structure*, a "fact [which] has already been noticed" (Heidegger, 1953/2010, p. 147).

#### *Being-with* first year nursing students.

Findings in chapter five revealed participants' concerns about people who were attracted to becoming nurses and whom they did not think would be able to complete the journey towards becoming a nurse. Participants were concerned about the students' past, their *historicity* before they entered the programme, and their *futurity* as nurses, the *temporality* of the nursing student. In the next extract, Lucy stated that not all students will complete the journey to becoming a nurse and highlighted "the courage" it takes to inform a student that they are not going to become a nurse. By apologising to the student, she is demonstrating *care for* a student, but she is also *caring for* the public by acknowledging that the student should not become a nurse. *Caring for* both students and the public is an example of Lucy's *authenticity* as *Being-a* nurse and *Being-an* educator, that is, *Being-a* nurse-educator, integrating the two worlds of nursing and education. Lucy also reinforced that to *Be-a* nurse, one needs to *care*:

> *I think we sometimes come across students that are not meant to be registered nurses and we have to have the courage to say, "I'm sorry you're not meant, right for this profession" and that's a difficult thing for us to do (laugh) ... "if you can't find your professional hat then please go somewhere else where it's not needed, (laugh) and if you don't care, go and mow lawns!"* (Lucy, p. 27).

Imogen described working with a student who was failing and recognised that "*she wasn't sure if she was doing the right job"* (p. 20) and would say to students "*if you are going to come nursing, you have got to take this seriously"* (p. 31). Jackie acknowledged that during the clinical placement, or *being-in* the *world-of-nursing*, a nursing student will really decide if *Being-a* nurse is the right career choice:

> *Students love them* [clinical placement], *or hate them. If they hate them, then it's best to say "hey, what's this about? If you can't do it, you can't do it ... right now it's the wrong thing for you"* (pp. 14-15).

These two extracts have indicated that when participants are *being-with* students on their journey, they are considering the student's *futurity* for *Being-a* nurse. Being able to recognise the future potential means that participants influence whether *Being-a* nurse is the right choice for these students, that is, being able to determine who enters the *world-of-nursing*.

Findings from chapter five highlighted that *Being-a* first year student should be an opportunity for students with different past experiences to become socialised into becoming a nurse, and become adept at *being-in* the *world-of-nursing.* Heidegger (1953/2010) described how a *Being* can be thrown into a world and "everyday familiarity collapses" (p. 182). He likens it to "Not-being-at-home" (p. 183). The threat to everyday *Being* can lead to anxiety, as *being-with* is about *being-with-others* in a different *world-of-nurse education*. *Being-thrown* into the *world-of-nurse education* would suggest that students must negotiate a completely different world from the one they are used to if they are to become nurses upon successful completion of their education. Phillipa acknowledged the difficulties associated with failing first year nursing students due to their different past experiences prior to coming into the *world-of-nursing* and considered their *being-thrown* into the world:

> *I think it's more difficult to fail a first year student because they are all starting you know from different ... like their catch up is so great and it's easy to be influenced by the people who appear to be confident* (Phillipa, p. 11).

Jackie identified difficulties involved with failing a young first year nursing student due to the student's limited knowledge, and personal health issues (competency, 1.4, NCNZ, 2012a). Jackie's *care for* the student was evidenced by concern for the student's health and suitability for nursing due to her young age and lack of maturity. Jackie was also clear about

assessing the student as *Being-a* first year student, her *presentness,* with limited knowledge and time in the programme. She also described the anxieties that students exhibit as they experience everyday unfamiliarities, yet another example of *being-thrown* into the *world-of-nursing*:

> *What I've noticed, first year is actually really quite hard to fail, because you* [student] *don't have a huge knowledge bank, and it's often because they are not well themselves, and they're not in a good space to even be in this environment, or they're shit scared (laughter) ... I've failed one first year student .... She was a younger person, she wasn't ready, she wasn't mature enough to manage it and so we talked ... "you know, right now maybe it's the wrong thing for you".... The other thing you do find is some students who are shy, who aren't so out there, who aren't so active and keen, or they're a bit frightened; they do get bullied by staff ... and I think that is the hardest thing about failing, you have to make sure they are actually meeting competency at the minimum level as opposed to looking forward to them being second year students* (Jackie, pp. 13-15).

The NCNZ (2012a) competencies for assessing students with personal problems posed challenges for participants, as personal problems are not reflected within the domains. Imogen illustrated this by describing a situation with a first year nursing student with personal problems. Imogen used *Being-an* educator as *caring for* the student through *being-with* the student to enable her to continue her journey into the second year of the programme. It could also be questioned whether the student would be able to continue the journey into the third year as she required intensive time and support through *being-with-others*:

> *This student has had great personal difficulties, (laughter) ... the competencies are not the things she is not achieving in. Perhaps some of the interpersonal skills are the things that she is not going to achieve in ... the student might get through at a year one level because you are working with them all the time, so therefore you are, you know, filling this form in with them, and then, you know, they get to year two and they are not capable of making that step* (Imogen, p. 6).

Assessing nursing students for their *futurity* towards becoming a nurse, and not in their *presentness*, raised conflicting opinions. At least half the participants expressed concern that students were allowed to continue into the second year, despite problems being identified in their first year. Participants, like Grace, expressed concern for students

wasting time and money if they were passed in first year but likely to be failed later in their journey. This could be interpreted as participants *caring for* students:

> *What you don't want is students getting to the second year or third year and failing something that hasn't been picked up in the first year. With this particular example this was my concern by the second year if she carried on this way that she would be paying a hell of a lot more money, um, spending a lot of time, wasting people's time, ending it all there and wasting her own time. Yeh so, the first year, the first year assessment is very important, in my view, probably the most important, as well as the transition* (Grace, pp. 13-14).

Nadine also voiced concern, and took personal responsibility by using the personal pronoun, for allowing a student to continue wasting money when it was known that she would probably not succeed in becoming a nurse. However, this is making an assumption about the student's *futurity;* given time, the student may succeed. Nadine is demonstrating *authentic* c*are for t*he student:

> *I felt we ripped her off. I just felt, she's spent all that money; we let her spend all that money, knowing that she was pretty hopeless, you know* (Nadine, p. 24).

Contrast Nadine's extract with the following extract from Fiona, who had not failed any students. Fiona demonstrated *care for* students who were spending time and money, studying towards becoming a nurse. This could be interpreted as Fiona feeling *guilty* about students who are working hard to complete the journey to become nurses. She also demonstrated a *they-self* by claiming that no-one wants to fail a student, suggesting that *others* did not want to fail students either:

> *Well I guess you feel for them if they are trying their best.... Nobody wants to fail a student really do they? They've put all that time and money into their study, yeh* (Fiona, p. 11).

However, for some participants *being-thrown* into the *world-of-nursing* meant that some students do require more time on their journey towards becoming a nurse. For instance, Melissa was clear about giving the "benefit of the doubt" to a first year nursing student, allowing them to continue their journey:

> *You can give them the benefit of the doubt in the first year unless it is blatantly wrong* (Melissa, p. 21).

Similarly, Deborah demonstrated *care for* students by ensuring that students did not fail a re-sit assessment as this would end their journey to becoming a nurse. By enabling the students to re-sit the paper at the end of the year, they were being given more time and more opportunities of *being-with* others to practise the skills. This reinforces comments in chapter five about the difficulties of identifying the boundary between teaching and assessing:

> *Now the decision that we didn't make them re-sit it this time was because if those people fail again that means they've failed the paper. So, er, we felt that it was better to let them sit at the end, when they've done the whole year. I've made sure that they all had a good opportunity to actually practise the skills where they could* (Deborah, p. 6).

These extracts have demonstrated how participants' *care for* students means that it is difficult to fail first year nursing students. However, failing a student was described as being the right decision to make and was justified by acknowledging that some students need more time and further opportunities to continue the journey into the second year. By enabling students more time they may improve and succeed in becoming nurses or fail at a later point in the journey, which made some participants feel *guilty* about students being able to continue and waste more time and money.

***Being-with* second year nursing students.**

As students' journeys continue from *Being-a* first year student to *Being-a* second year student, the challenges associated with failing a nursing student were concerned with enabling them to *be-in-the-world* of diverse nursing environments, such as mental health, and primary care. As students had already spent at least a year in the programme, some of the second year students were known to the participants and this is interpreted as participants having *fore-structure*. This is evidenced by Melissa who failed a nursing student in the second year. She had already passed him in year one, describing him as "*a lovely boy*", that is *being-lovely,* but had identified him as a student who "*wasn't dangerous, he just wasn't going to get it*" (p. 10):

> *He just didn't get the lower stuff ... he just wasn't operating at a supervised level ... he had no knowledge behind what he was doing ... he didn't know anything ... in the end I failed him and they* [the GP practice] *were absolutely furious because they thought he was wonderful ... they had just seen that nice little boy that was helpful ... he got upset and got his mother onto it* (pp. 11-12).

*Others* had wanted to pass the student as they liked him. Melissa did not allow *others* to influence her decision as she believed that the student did not possess the required knowledge, therefore she failed him. Melissa possibly demonstrated an *authentic* approach to assessing the student as she used her own *Being* as a nurse and an educator to take responsibility for failing the student. The student had a second enrolment enabling him to have more time towards becoming a nurse. He passed the second enrolment and continued the journey into year three. Melissa said that "*he shouldn't be here* [year three] *but no-one had taken that step"* (p. 14). Melissa believed that he should not be in year three, but she had no evidence to support her beliefs. Melissa may well have believed that when she failed him in the second year, she assessed him for his *presentness* and that he should not continue the journey into the third year, at that time. However, with more time, and more learning opportunities, he eventually passed the clinical assessment and continued the journey. When Melissa suggested that he should not be in year three, she is making that judgement from her past experience with the student and not acknowledging that with time, students can improve. This example can also highlight how clinical nurse educators may use their previous knowledge, their *fore-structure,* to influence their future assessments of students.

Oliver provided a comprehensive account about a second year nursing student whom he failed whilst she was working in the post-operative recovery area. Oliver had no previous knowledge about this student, that is, no *fore-structure.* During Oliver's observation of the student in the clinical area he got *"an initial impression that she was just a little bit distant"* (p. 18), which could be described as *intuition* (previously introduced in Chapter five). Heidegger (1953/2010) draws on other philosophers such as Kant and Descartes to describe *intuition* as a phenomenon which does not show itself initially. It is "the behaviour of the soul, of consciousness" (p. 202) … "intuition guides all interpretation of knowledge" (p. 34). Heidegger (1953/2010) also refers to Aristotle who believed that intuition was primordial and where genuine truth comes from (p. 165). This could mean that assessment decisions are not immediately obvious and require more than seeing the immediately obvious. It could also mean that intuition influences assessment judgements. Through *being-with* this student for extensive periods of time, Oliver's initial concerns, his *intuition,* about the student were confirmed when she admitted that she had an irrational fear *"about absorbing drugs through her skin"* (p. 20). This fear affected her *being-with* health consumers and was incompatible with *Being-a* nurse. She eventually failed the clinical assessment and discontinued her journey towards becoming a nurse.

Keith described *being-with* a second year nursing student who had problems with her attitude towards *being-with* clinical staff (competency 3.3, NCNZ, 2012a). She did not

respond well to feedback and he commented that clinical staff were quick to make a consensual judgement about her attitude. As discussed in the previous chapter, this could be interpreted as the nurses adopting a *they-self*, that is, judgements reinforced by *being-with-others* and being *inauthentic*:

> *Quick in judging students on the floor and quite good at labelling students ... I feel that does sometimes influence how we feel the student is progressing on their placements ... her attitude was a bit more questionable ... how she interacted with her peers* (pp. 6-7).

Keith did not allow *others* to influence his judgement, as he took responsibility for passing the student when *others* would have failed her for attitude when *being-with-others*, an example of Keith's *authenticity*. Keith was aware that this student was of concern in her first year, he had *fore-structure*, and believed that she would also have problems with future placements. Keith's reluctance to fail the student could be interpreted as *caring for* the student as he believed that through *being-with-others* her attitude could be changed. It could also be interpreted as Keith not wanting to accept responsibility for failing and feeling *guilty* if she was unable to continue with her journey to becoming a nurse. He assessed the student in her *presentness* enabling her to continue her journey to becoming a nurse, despite acknowledging that she could continue to cause concern. Enabling students to continue the journey to third year, and giving them more time to become a nurse, also meant that participants found it harder to fail students in the third year as will be presented in the next section.

### ***Being-with*** **third year nursing students.**

*Being-a* third year nursing student means that the journey to becoming a nurse is nearing completion. Because these students have been on the journey for at least two years, six participants did not feel comfortable failing students in their final year. Students should not be failing when they have got this far, they argued, as they had wasted time and money to fail after at least two years of study. This would be linked with the participants' *care for* the student and feeling *guilty* about students who had travelled so far on this journey. However, another five participants acknowledged that, as students were still learning, they were comfortable to fail them, stressing their *care for* the health consumer. Failing a student within a first enrolment of a clinical paper was made easier for the participants as they knew that the student could have more time and another chance. As NCNZ (2014) permits only two enrolments in a clinical placement, failing a student in their second enrolment was more difficult, especially in year three.

Jackie described how her experience of failing a third year student in their fifth year of study[11] was made easier because the student was also failing academically in the *world-of-education*:

> *Oh, I felt sick, because I think if someone is failing, they should fail in their first or second year. It's hard to do that unless academically they are not sound. Then you can fail them, 'cos a fail, that's easy (laughter)* (Jackie, p. 25).

Although Jackie was assessing the student in the *world-of-nursing* for their clinical skills, she displayed *inauthenticity* as she considered the student's performance within the *world-of-education*; that is, how *others* were assessing the student. Jackie believed that students should fail the programme earlier in their journey and that an academic fail is easier to award than a clinical fail. Grace also considered academic progress, from the w*orld-of-education,* that is, the nursing school management, to pass a "failing" student when making a clinical assessment decision; Grace was *being-inauthentic* as others influenced her judgement to pass the student:

> *I didn't fail her. I had spoken to* [nursing school] *management ... and her marks in class, she was doing very well ... you have got to give the benefit of the doubt* (Grace, p. 23).

The next extract provides an example of the difficulties of *being-with* a "failing" student in their final transition (elective) placement; the student had almost completed her journey towards becoming a nurse. Knowing that students have a second opportunity to enrol in the paper, and more time, made Eve's judgement to fail the student easier as the student can stay on the path to becoming a nurse. However, she was concerned for the student being able to succeed in the second enrolment. Eve started to consider what *others* thought about allowing students to become nurses, an example of *inauthenticity*. Not only was she experiencing doubt from colleagues, the student was also transferring responsibility to the participant by blaming *others* for letting her continue on her journey. Eve acknowledged that the student was still learning:

> *When it's the first elective and, you know, they can re-enrol, I don't have a problem with it really, and I think my experience of being a bit iffy and seeing*

[11] Five years is the maximum time allowed in the Bachelor of Nursing programme according to NCNZ regulations (2014).

> *them as RNs and having people coming to me and saying, "what the heck did you do allowing that person to get through - weren't there concerns about them?" It's a lot harder when it's their second placement and you're wondering oh my goodness,* are *they going to make it or not? 'Cos you really feel for them and hardest part of it is when they say "so how come you guys let me get to this point?" And now I can say, because we teach you so much in, even in that third year placement, it's still about learning* (Eve, pp. 24-25).

Participants recognised that students were failed because of risks to public safety. Whilst this demonstrates *care for* the health consumer, participants were also *caring for* a student who had almost completed their journey to becoming a nurse, but required extra time to become a safe nurse. This links to Heidegger's notion of *temporality*, that our sense of *Being* evolves over time, and that we are in the world at the *present*, but that we are also moving into the *future*. For nursing students, the future is about *Being-a* nurse, which requires time, its "not-yet" (Heidegger, 1953/2010, p. 235). I use Heidegger's analogy of ripening fruit: "the unripe fruit moves towards its ripeness. In ripening, what is not yet is is by no means pieced together as something not-yet-objectively-present" (Heidegger, 1953/2010, p. 234).

The emotional difficulties associated with failing students in the final extended clinical placement are highlighted in the next extract. The student was creating stress when *being-with* clinical staff, which was affecting health consumer care due to staff spending extra time *being-with* the student, which could be interpreted as *anxiety*. The student failed the first enrolment and was given more time and a second opportunity to enrol. However, being aware that failing a second enrolment means that the student is unable to complete the journey, the clinical staff, *Being-as* nurses, demonstrated *care* by suggesting that she should pass "with certain conditions" on her scope; this is not permitted by NCNZ. Eve's judgement to fail the student was *authentic; Being-a* nurse, she was concerned about public safety if the student became a nurse. However, the student appealed the judgement within the *world-of-education*. Despite regulations from the *world-of-nursing* stating that no more than two enrolments are permitted in a clinical paper, the student was allowed a third enrolment, over ruling the NCNZ (2014) standards. This means that the *world-of-nursing* that protects public safety was over ruled by the *world-of-education*. Eve's account highlights the tensions that occur when *being-with-others* involves *being-with* so many others, such as students, clinical staff, colleagues and lawyers. Through her *authentic* self, in the *world-of-nursing*, Eve demonstrated *care for* the health consumer by failing this

student, yet the w*orld-of-education* challenged her *Being-a* nurse and accountability for public safety:

> *I don't want to delay* [awarding a fail], *it was just terrible. It was a very emotional time, there was a lot of decision making that has to be in partnership with them* [preceptors] … *The staff had to take less clients in order to be able to supervise 'cos of her care ... so it was a fail of the placement. Then she had another re-enrolment in the transition course. And of course, according to Nursing Council you can only enrol twice in any practical course.... You've failed, terribly sorry ... he* [preceptor] *said yes, and she was able to be put forward with certain conditions ... Nursing Council would be on us like a ton of bricks.... Said to the student, you have failed.... She came back to appeal. Went through our appeal process within the school, everyone who has that level of ability ... said no, absolutely this is a fail. So the student then took it to beyond the school to the academic whoever ... she could re-enrol and could have another go because the first one she withdrew from and didn't effectively fail ... it must have been a legal person (laughter) determined that there was something in that first process that she could have grounds to say that she didn't actually fail, despite Nursing Council saying no more than two enrolments ... it wasn't fair, and it was terrible, and I wasn't able to deal with these kind of things* (Eve, pp. 18-20).

Only three participants were *being-with* students in the transition placement as students were generally with preceptors, who assume the main responsibility for supervising and assessing the students. As this is the final clinical placement for students, there were limited examples of students who failed this placement, which could mean that poorly performing students had exited from the BN programme at earlier stages in the journey. Alternatively, it could be suggested that it is too difficult to fail a student in the final placement as evidenced by Eve's account.

Participants, *being-with* students on their journey to become nurses, demonstrated *care for* the student in the first year. Some participants were reluctant to fail students early in their journey as they acknowledged that *being-thrown* into the *world-of-nursing* meant that students needed to be *cared* for. However, other participants *cared for* students by not wanting them to waste time and money if they thought that they would not become a nurse; they would fail those students, that is, assessing their *futurity*. As students continued their journey to become nurses, the participants demonstrated increasing *care for* the health consumers and considered their state of *Being-as* nurses for protecting the public as a

reason for failing students. The next section will present findings from the analysis about how judgements were made to fail students, commencing with failing as being about *care for* the health consumer.

## Failing as *Caring for* the Health Consumer

When discussing criteria for failing students, participants described their accountability as registered nurses to protect the public, which can be interpreted as *caring for* the health consumer. This section will present findings about how *caring for* the health consumer assisted with the judgement to fail a student; *being-with* borderline students; and how *being-with-others* affected the *authenticity* of the participant. As stated in chapter five, only eight of the fourteen participants had failed students in clinical practice. Key themes that presented for failing students were identified as not *Being-a* professional, *being-unsafe*, and knowledge deficit. These will now be presented in greater detail.

### Not *Being-a* professional.

Domain one of the competencies for RNs (NCNZ, 2012a) is "professional responsibility". It is about *Being-a* nurse, yet participants spoke of difficulties failing students when they were not *Being-a* professional, described as being dressed inappropriately, using inappropriate language and being disrespectful. Only two participants directly linked *Being-a* professional to domain one. One participant failed a student for not *Being-a* professional due to the use of recreational drugs. Some participants described students' behaviour as being unprofessional due to their being born in a different time, with a different history, that is, *being-from* different generations to health consumers and participants. Heidegger (1953/2010, p. 19) discusses generation as an interpretation of being from the *past* and "goes ahead of it". He acknowledges that "history signifies the whole of beings that change 'in time'" (1953/2010, p. 361) which highlights generational differences between participants, students and health consumers. This can be interpreted as *Beings* differ depending upon their *past;* the *historicity* of the person, influences their *being-in-the-present.* This section will now present participants' interpretations of not *being-professional* through *being-disrespectful*; being dressed inappropriately; and using inappropriate language.

#### *Being-disrespectful.*

Grace highlighted how a younger nursing student failed a clinical placement due to *being-disrespectful* of older residents (competency 1.5, NCNZ, 2012a). Grace demonstrated *Being-a* nurse as *care for* residents by failing the student for *being-disrespectful*. Grace noted that the student was young and *being-from* a different generation to both residents and

colleagues, can affect our sense of *Being.* A resident in an older care home will have more *historicity* than a younger student with less *historicity,* interpreted as *being-from* different generations. The student was able to continue *Being-a* student with theory papers and would repeat the clinical placement the following year, having been given more time to develop her sense of *Being* towards becoming a nurse:

> *Too confident, too smart comments, inappropriate language for different generations and obviously became very stuck working with the older generations in an older generation home. And sadly it was picked up right from day one, with disrespect of even the furniture that we were allowed to be using ... all that sort of stuff that other generations, young generation, you know, and this was just the natural way of society ... this is a different generation there's a certain respect.... She failed her placement because of that* (Grace, pp. 14-15).

It was not always younger students that were *being-disrespectful*. Grace provided another example of failing an older first year student in her first placement due to lack of respect and professionalism (competency 1.1, NCNZ, 2012a). With a second enrolment and more time, *being-with-others*, this student passed, highlighting that some students need more time on their journey:

> [She was a] *student who was quite hard to reign in as a person, and basically she was failing on her professionalism more than anything, and sadly that is like the area, that first domain with disregard to everything else that first domain, if you don't get it right, you're not going to make a nurse.... She* [student] *was quite brash, was quite disrespectful* (Grace, pp. 10-12).

Grace was not from New Zealand; she had trained overseas and worked in various countries within the developing world. She provided two examples of failing students, an older and a younger student, for not *being-respectful*. This could mean that Grace interprets respect and assessment differently from other participants due to her *being-from* a different *world-of-nursing* and *being-in* different *worlds-of-nursing* around the globe. Using Heidegger's analogy of who holds the hammer determines how the nail is hit into the piece of wood (1953/2010, p. 69) these two examples highlight that the meaning of respect depends upon who holds the assessment tool.

***Being dressed inappropriately.***

As stated earlier, students should be assessed against criteria stated on checklists, and reflect NCNZ (2012a) competencies. The competencies (NCNZ,

2012a) do not explicitly state what a nurse should wear; however, three participants failed students for being inappropriately dressed, as not *Being-a* professional. Imogen failed a first year male student for not *Being-a* professional as he wore different coloured socks, not considered to be the "uniform":

> *I failed a student for professional behaviour, year one ... it was around dress. It was around preparedness for work.... It was a very difficult situation because he was being outright defiant in terms of ... I can't remember now if it was pink socks and psychedelic green band or you know, it was that sort of combination. It was very defiant in terms of, and he had been warned that he needed to come wearing the correct uniform.... Sent him off the ward and he didn't achieve for professionalism* (Imogen, pp. 13-14).

She did not state whether the wearing of coloured socks was stated within the assessment criteria and this could be considered a punitive criteria (as stated by Fiona earlier). Alternatively, it could be an interpretation of criteria. A uniform could be described as a means of determining what it means to *Be-a* nurse, that is, *Being-a* nurse. When an individual chooses not to wear the uniform, they are making a choice to not be the same as *others;* an example of *being-authentic*. Wearing a uniform is about *being-with-one-another* which Heidegger (1953/2010, p. 122) describes as being "subservient". When an individual becomes defiant, as described above, Heidegger (1953/2010, p. 158) described this as "turning away" from *being-in-the world.* The student complained about the participant before eventually deciding that becoming a nurse was not for him and he left the programme.

In another example, Nadine failed a nursing student for his appearance, which included the wearing of jewellery, another example of not following a uniform dress code and not *being-with-one-another*:

> *Like turning up two minutes late to work; like having two studs in your ear instead of one; like, um, keeping your tongue ring in* (Nadine, p. 27).

Caroline found it straightforward to fail a student for inappropriate dress, although she did not explain what she meant by "inappropriate":

> *Simple issue which was a wee while ago now which was the student was coming to work dressed inappropriately (laughter) that was fairly straightforward* (Caroline, p. 16).

From these extracts *Being-a* professional is interpreted by the participants as about the clothes nurses wear as *being-with-one-another* and doing what *others* do. That is, our sense of *Being-as* nurses is displayed by being dressed appropriately, even though dress is not explicitly stated within the NCNZ (2012a) competencies for *Being-a* nurse.

***Using inappropriate language.***

Heidegger (1953/2010) explores how language is part of Dasein, the use of words is part of "worldly being" (p. 156). Words take on significance for *being-in-the-world* and *being-with-one-another* can lead to different interpretations of speech. Heidegger refers to listening and interpreting what is talked about as an important component of communication and language. Heidegger (1953/2010, pp. 156-158) discusses how the use of language determines our *being-in-the-world* as *being-with-one-another* as acceptable. The use of language is a powerful determinant of *Being* and the following extracts have demonstrated how language used by nursing students is interpreted by others as being appropriate or not.

Four participants commented on nursing students' inappropriate use of language (links with competency 3.3, NCNZ, 2012a). Grace previously mentioned "*inappropriate language"* (p. 14) and Nadine used the words "*like saying 'sweet as'"* (p.27*)* as not being professional. The following extracts provide more examples of inappropriate language, specifically the use of the "f" word for not *Being-a* professional:

> *One thing I have noticed that, um, I've been probably a little bit, not shocked about, but, taken back, is some of their language, I have found their everyday language. You know, saying the "f" word in front of people and things you know like I've been like shocked* (Phillipa, p. 11).

> *When you are training to be a student, a professional nurse, you can't be saying f*** this, and f*** that* (Nadine, p. 23).

The two extracts above have highlighted the use of inappropriate words for *Being-a* nurse. Heidegger (1953/2010) also refers to the manner in which speech is delivered as *being-in-the-world* and expressing the person's mood through the "way of speaking" (p. 157). The next extract describes how a nursing student became angry when Nadine had asked her to describe patients' conditions, which she was unable to do. The manner in which she was speaking was inappropriate. The student was failed for not *Being-a* professional; she appealed the decision, but the fail was upheld:

> *She absolutely almost absolutely yelled and screamed at me for almost an hour and a half so we talked about the professional behaviours ... I am not going to allow you to complete the placement* (Nadine, p. 13).

The extracts above demonstrate reasons for failing students relating to using inappropriate language as not *Being-a* professional. Whilst domain one of the NCNZ (2012a) competencies is "professional responsibility", participants highlighted different interpretation of not *Being-a* professional. *Being-disrespectful*, *being-from* a different generation, being inappropriately dressed as not *being-with-one-another*, and using inappropriate language, were cited as not *Being-a* professional. Assessment of borderline students highlighted differing criteria for making judgements which will be presented in the next section.

**Assessment of borderline students.**

One of the research questions concerned decision-making about the borderline or marginal student. This was a dilemma for the participants because the *futurity* of the student becoming a nurse is dependent upon the judgement made. The analysis of the findings identified two main themes to determine the assessment decision about a marginal student. The two themes of *being-safe* and *being-with-others* will be presented below with extracts from participants.

***Being-safe.***

Participants mentioned "safety" as a criterion for failing a borderline student. The word safety had many interpretations for the participants. This could mean that *being-safe* as a component of *Being-a* nurse is highly subjective as there was not a consistent definition of *being-safe*. Participants who failed students based on safety were *caring for* health consumers' receiving safe and competent care. Caroline said the NCNZ (2012a) competencies did not clearly explain how safety can be demonstrated, and consequently developed her own interpretation, highlighting that she may have a different interpretation from her colleagues:

> *What does it mean that the student demonstrates safety?... So many ways you can demonstrate safety ...* [I] *started to ignore the domains and develop my own kind of interpretation ... which I had to make clear to the students* (Caroline, p. 25).

When Lucy was asked about assessing borderline students she stated that "safety" would be her "bottom line" but she recognised three categories of safety:

> *Safety is very broad. There is professional safety; there is client safety; there is staff safety* (Lucy, p. 20).

Lucy stated that safety involved "staff safety" and was illustrated by an example from Deborah who described having to consider her personal safety after *being-with* a student who was unable to control his temper. Whilst she was concerned about herself, she also discussed her *Being-a* nurse and *care for* public safety and questioned this male student's suitability for becoming a nurse:

> *I believe that you have a duty to nursing as a whole and if that person is not suitable and clearly the person, I don't believe is suitable, um, there is a wider issue than us just protecting the student because they have threatened things.... I mean, this was a student who had a terrible time controlling their temper* (p. 12).

Imogen was clear that safety was difficult to define, but considered the relevance of safety about *being-with* a patient, highlighting *care for* the health consumer:

> *Do you want me to write a book on it* [safety]*?... So anything that I thought that doesn't contribute to a patient's health to the level they should be contributing to, I would call unsafe practice, but that's a big philosophical question (laugh)* (Phillipa, p. 10).

Participants acknowledged that *being-safe* when *being-with-others* was a key determinant for making an assessment decision for a marginal student, but there was no definition of *safety.* Participants interpreted safety based on two main themes of medication administration, and knowledge deficit which will be presented below.

*Unsafe medication administration.*

Medication administration has previously been described as being a fundamental clinical skill. Failure to administer medications according to the five rights[12] (NZNO, 2012) may cause harm to the health consumer. Therefore, medication administration was about

[12] Right patient, right dose, right medication, right route, and right time.

*being-safe* with the public. Caroline provided a lengthy account of a "failing" second year student whom she was *being-with* at the time of the interview (pp. 9-13). Within the first week of her placement, the student was unsafe with regards to medication administration (competency 2.1, NCNZ, 2012a). In all other aspects of her practice, the student was demonstrating competent care, but continued to make medication errors. Caroline was aware that the student *being-with* the preceptor was creating a conflict of personalities which affected the student's learning. A learning contract was initiated. Caroline had not yet failed a student, but she was quite clear that, as she was following due process, if the student continued to make medication errors, she would not hesitate to fail the student; this was about *caring for* the health consumer:

> *This is non-negotiable. It's just the way it is. I have followed due process ... it's a clear cut process in medication administration (Caroline, p. 12).*

Imogen was also clear about the importance of correct medication administration and following the medication guidelines. She was *being-authentic* by failing the student as she was *caring* for the health consumer; she then had to defend her decision within an appeals process in the *world-of-education*:

> *You've given the wrong medication here. So he appealed and, um, and it was a very unpleasant situation, incredibly unpleasant situation, and he brought in whanau and I was over ridden.... This is about safety* (Imogen, p. 16).

However, not all participants thought that medication errors were clear cut. Deborah thought that making mistakes was part of learning and she demonstrated *care for* students, stating that the mistake may not have been the student's fault:

> *Like a one off safety thing issue. If you harm someone ... I'd find that difficult as well, you know, we're only humans and people have, you know, like even going and giving someone the wrong medication. It might not be that student's fault. So there is always, often, more sides to the story (Deborah, p. 33).*

These three extracts have demonstrated different viewpoints about medication administration as safety and a reason for failing a student. Medication administration is a fundamental component of *Being-a* nurse; incorrect administration may have fatal consequences for the health consumer. Therefore, the safety of administering correct medication is a responsibility of nurses, yet Deborah acknowledged that mistakes can occur and should not necessarily be the only reason for failing a nursing student. This could be

interpreted as *caring for* the student as Deborah was primarily *being-with* first year nursing students which meant that students would have more time to learn to become nurses.

Whilst the criteria for determining safety varied amongst the participants, what did emerge was participants' *care for* health consumers not being harmed. This was also described as ensuring that students were able to apply theory from the w*orld-of-education* to provide safe care in the *world-of-nursing*, which will be presented in the next section.

*Knowledge deficit.*

All participants stated that knowledge deficit would be a reason for failing a student. The application of knowledge to health consumer care and critical thinking were key determinants for participants. Imogen (p. 10) described a first year student who did not understand how someone with knee problems could not stand, and did not appreciate the falls risk for the health consumer. The lack of knowledge application, such as being unaware of the side effects of medication, or implications of abnormal vital signs, could be interpreted as not having *care* for the health consumer:

> *Connect the objective data with the actual person in front of them* (Imogen, p. 12).

Eve *cared for* the safety of a health consumer and failed a third year student for not being able to link a diabetic's health condition, with their impaired ability to choose an appropriate diet as a consequence of having a head injury:

> *Diabetic, taking a meal to the person, not checking what's on the tray, not thinking about whether this person had the ability to make decisions for themselves ... putting in front the full meal, including the pavlova ... and with this particular client there had been an issue of managing blood sugar levels over a period of time* (Eve, p. 16).

The next example highlights how not having the required knowledge to *care for* a health consumer, resulted in Nadine failing a second year student. Nadine failed the student for her *presentness* and links her decision with the NCNZ (2012a) competencies. The student passed following a second enrolment, having had more time:

> *I had asked her to explain to me conditions that were experienced by the patient she was looking after, and she was just never able to do it ... you're not explaining that you are meeting, that you are displaying the competencies, where*

*knowledge, and if you can't do this, to be honest I couldn't pass you on this placement* (Nadine, p. 9).

All participants believed that not being able to apply theoretical knowledge to *care for* health consumers would be a reason to place a student on a learning contract and fail the student if improvements had not been made. This highlights the link between the *world-of-education* and the *world-of-nursing* as a fundamental requirement for the nursing student to become a nurse; *Being-a* clinical nurse educator should facilitate that link.

Whilst *being-safe* and *being-caring* through applying knowledge were criteria to be considered when making a judgement about a borderline student, other participants considered their *futurity* for *Being-as* nurses within a team. This will be presented in the next section.

***Being-with-others in a team.***

*Being-a* student in the *present* is about becoming a nurse in the *future*. *Being-a* nurse is *being-with-others* in a team in the *world-of-nursing* and is assessed using NCNZ competencies, domains three and four (NCNZ, 2012a). *Being-with-others* was used by some participants to determine whether a borderline student should pass or fail a clinical assessment. Jackie and Eve used the criterion of the *futurity* of a student as *Being-a* nurse in the ward team. This is interpreted as *being-with-others*, enabling the staff to clearly articulate why a student is failing. However, it could also be suggested that this is not about assessing the student in their *presentness* but looking to their *future*:

*Yeh, well fail is horrendous isn't it? But if you fail you frickin' fail don't you? (laugh) ... you have to have a safety standard and it's really interesting when you talk with ward staff and say "would you give her a job?" "Oh no, she's safe to practice". "But would you give her a job?" "Oh, no." "So, talk to me about that. Why do you think she is OK to pass if you wouldn't employ her?" And that's really interesting because that's when they verbalise the issues and unfortunately a lot of it is personality. So it's hard to fail (*Jackie, pp. 15-16).

In the next extract Eve was *being-with* a "failing" transition student. *Being-as* a nurse, she acknowledged her accountability to health consumers. She *cared for* future health consumers that the student would *be-with* if she passed the assessment to become a nurse. The clinical staff *cared for* the student, highlighting nurses as *being-caring,* and did not want to fail her. This highlights tension between clinical staff expectations and those of educators; clinical nurses *being-in* the *world-of-nursing* making different judgements from

those of participants *being-in* the *world-of-education*, but also *Being-as* nurses. As Eve and the clinical staff had different expectations about the student, Eve asked the staff whether they would want the student *being-with-them* in the team in the future:

> *We also have a responsibility for clients that these people may have to take responsibility for, um, and the colleagues they are going to be working with.... The main thing when I am talking to RNs who are hesitant about failing students and want to take care of them; "now I understand there is this position in your ward coming up are you telling me you want this person to have the job?" and that makes them stop and think* (Eve, pp. 25-26).

Lucy considered *being-a* family member to determine whether she would be "happy" with the student *caring for* herself or her family, a criterion mentioned by other participants:

> *I suppose the other thing is "would I be happy if that person was caring for me or my loved one. Would I want them coming into the room when my child was sick, or would I want to run a mile?" Litmus test – would I want them looking after me?* (Lucy, p. 20).

Nadine also referred to *being-with* family as a criterion to fail a first year nursing student. The student appealed the fail, which Nadine described as a "hassle" but the student eventually left the programme:

> *It was such a hassle at the time, but just not the sort of person I would want looking after anybody that I loved* (Nadine, p. 19).

The participants were able to state reasons for failing students yet the link to NCNZ (2012a) competencies and domains was limited. *Being-a* nurse in New Zealand is about being competent in all nursing environments, the diverse *world-of-nursing*. Some participants found this challenging; *Being-a* competent student in one area, such as surgical nursing, but weak in mental health meant that students could not complete their journey to become a nurse. In the following extract, the nursing student was not from New Zealand. This is one example of participants recognising cultural implications for assessing students when *being-with-others*. A student who comes from another country is not only being *thrown* into the *world-of-nursing*, but *thrown* into the culture of New Zealand which may be very different from their *past* world. Lucy explained how a student from another country was experiencing difficulties with language and communication:

> *I think the issues that I had around communication was cultural. She was never going to be a mental health nurse, but I think that ... she would be a safe and competent nurse, and she would be excellent in some areas. She was very, very bright, but that empathy and the verbalising and the asking questions was, for her, very difficult and we had to literally make her ask us questions, because she didn't want to question, because culturally it wasn't, she was Asian* (Lucy, p. 22).

Making judgements is about identifying whether students will become nurses. Within clinical assessment all participants were able to talk about the difficulties of making a judgement about a borderline student. Whilst safety was commonly cited, it was interpreted differently by the participants, as it is not explicitly defined in the NCNZ (2012a) competencies. Another consideration was whether the student would *be-with-others* within a nursing team as a registered nurse, that is, their *futurity*. The diverse worlds of nursing posed challenges for participants as they recognised that a student may be a good nurse within one environment, but not in another. *Being-a* nurse in New Zealand is about *Being-a* nurse in diverse environments in the *world-of-nursing*. I will now present the experiences of participants who were challenged when they failed students.

**Being Challenged as a Nurse Educator**

The decision to fail a nursing student in a clinical placement became an academic decision in the *world-of-education*. Students who did not agree with the fail decision, were able to enter an appeals process which takes place within the *world-of-education***.** This process was possibly the biggest cause of anxiety and stress for participants who spoke about the emotional demands when faced with a litigious student. This section will present findings from participants whose decisions to fail students were appealed and sometimes overturned. Litigation challenges one's *Being-a* nurse as a protector of public safety, and *Being-an* educator to enable nursing students to become nurses. Participants did acknowledge the need for an appeals process, and even encouraged students to complain. Jackie encouraged a student to appeal, which the student did, but the fail was upheld:

> *She did write a letter ... to the CEO, yeh. They're very well informed students these days. Actually I did say to her, "look if you're not happy with me, you can write to the, you know, you have this form of re-dress"* (Jackie, p. 16).

Caroline also acknowledged the need for an appeals process, but she also described how students use *being-with-family* to help support them through it:

*Well, the appeals process has to be in effect. The student has to be able to know about the process. So when you've got a student with a lot of parental support, parental knowledge and parental stamina (laugh), they will take them through that appeals process* (Caroline, p. 19).

Helen described how some nursing students used their *historicity* of being secondary school students, finding it difficult to accept a fail upon entering a different world of tertiary education:

*They weren't allowed to fail* [at school] *you know – so they just got re-assessed, and the assessment just goes on and on, and they come to this environment and they actually fail! ... They* [students who had failed] *were just blown away that they didn't meet the standard then they didn't get to re-submit (laughter) ... they felt it was their right to have another chance* (Helen, p. 22).

Nadine discussed a situation about a student with severe personal issues, which impacted upon her *Being-a* nursing student. The appeals process threatened Nadine's state of *Being,* both as a nurse and as an educator:

*I wrote my concerns about the student and of course this went to the head of school. Then the student went to the international relations officer and accused me of bullying and being really racist and all of that. So I just documented, documented, documented ... then she did one dangerous thing in the ward. All my documentation had to go to the Dean and to everywhere else because the student contested it ... she had failed the placement.... we went to the lawyers ... I was quite scared about that.... I had identified in my daily things which competencies I was concerned about.... The student took it all the way* (Nadine, pp. 14 - 18).

The outcome was that the fail grade within the clinical environment was upheld, but the student was able to continue with theoretical components of the programme. The student was removed from the *world-of-nursing* but allowed to continue within the *world-of-education.* However, her personal issues escalated and eventually her journey to becoming a nurse was discontinued. Nadine's *authenticity Being-as* a clinical nurse educator had been challenged.

Participants, with their *care for* public safety, who failed students were aware that this impacted upon the polytechnics' enrolment numbers, retention of students, and completion rates for funding purposes. In the next extract Deborah is *being-authentic* as she is clear about *Being-a* nurse and *caring* for public safety rather than retaining students within the *world-of-education:*

> *We've got a very money hungry polytech system or university. We want to keep bums on seats, but at what cost? You know, it shouldn't be at the cost of a person's life* (Deborah, p. 16).

Imogen also described how failing students made her unpopular with the *world-of-education* because failing students affected student numbers within a programme:

> *It became much more important to have the bums on seats, sort of thing, so I wasn't terribly popular when I didn't achieve students* (Imogen, p. 18).

One CEO had a specific position that the polytechnic was not the "gatekeeper" to nursing, highlighting a clear division between the worlds of education and nursing:

> *We've been told that very clearly by our CEO, that we are not the gatekeepers to nursing. So there's that culture, and I completely disagree* (Melissa, pp. 14 15).

The *world-of-education* is about enabling people to become successful students and support them throughout their journey in the programme. However, nursing students are travelling on a journey to become nurses, in the *future*, within the *world-of-nursing*. Therefore, it could be assumed that the polytechnic is a gateway to nursing and the two worlds should not be discrete entities; *Being-a* nursing student means that they are preparing to become a nurse with responsibility for health consumers lives, and the participants are part of that students' journey. The appeals process caused distress for the participants as their state of *Being-a* clinical nurse educator was being challenged. They were aware of having the necessary evidence and following correct processes for failing students to justify their decision to fail a student. Participants, *Being-as* nurses, were *authentic* due to their *care* and commitment to protect public safety, but *Being-an* educator caused tension due to their obligations to the polytechnic and the *world-of-education.*

**Decisions being overturned.**

Many participants spoke of their judgement to fail a student being overturned by School of Nursing management or polytechnic academic boards. Lack of support within the

schools of nursing led to them question *being-with-others* within the school. Their *authenticity Being-as* nurses and *Being-as* educators was challenged. The next two highly experienced participants felt that it was not worth the effort of failing a student (although they were both able to cite many cases of failing students), that is, their *authenticity* was being challenged:

> *Couldn't be* bothered *because it was too difficult to fail. Yeh, well not being supported by people. People saying "ah yes, but" ... Sometimes when you fail someone and it gets taken to another level and then you found that somebody has passed them and you think "what is the point of my professional judgement?" So if it goes to a different level and on appeal ... but you haven't got any part of that appeal you almost feel as if your professional judgement is being questioned and I think that can be quite difficult. But I think possibly my experience has made me quite clear about this is ... and get beyond all the garbage.... Like are they meeting these competencies or not?* (Phillipa, p. 15).

Imogen also stated the importance of maintaining public safety and refused to change her own standards of practice to meet *others'* standards. Not accepting *others'* decisions demonstrates her *authenticity* as she remained true to herself, *caring for* health consumers as *Being-a* nurse:

> *It made me feel this is just farcical, you know. I may as well just give them the certificate now and there is no point in, but then, you know, I am not changing my standard. This is about safety* (Imogen, p. 16).

Eve described how a transition student had been given more time to enable her to complete her journey after a failure in the first enrolment. Eve referred to what *others* say and how she maintained an *authentic* self by failing the student on a second enrolment. Eve also acknowledged her *Being-a* nurse and safety for the health consumer. She was "gutted" when her decision to fail the student was overturned in the appeals process:

> *Gutted, because after the second time, it was absolutely clear. After the first time I felt really sure it was a fail, it was not a problem because she had so many opportunities ... and that's the other thing, people say "oh but, she's anxious and it's not fair and she's got to this point" .... So if they can't reflect on their ability to perform as RNs to me they are not safe practitioners – it's easy. It's a bit black and white unfortunately (laughter*) (Eve, pp. 25-26).

Imogen described not receiving support from the Head of Department, but support came from *being-with-other* colleagues which would link to Jackie's later comments about the reputation of the school:

> *I suppose, not that I had a lot of respect for the Head of Department or director, but I lost what slither of respect I had ... I think, probably, when I don't achieve students, there's a support that comes in lots of ways from other colleagues* (Imogen, p. 17).

Jackie stated that there was support from within her school as it was about maintaining the reputation of the school and *being-with-other* colleagues:

> *But the reality is a failing student is very easy to identify and I think we are all pretty strong about the fact that we want to maintain safety and school reputation because we don't want to have unsafe nurses from our school* (Jackie, p. 16).

This section has presented the findings about how *being-with-others* influenced the *authentic/inauthentic state* of *Being* of participants. *Being-with-others* to fail students challenged participants' *authentic* self, but they recognised that the judgement about a student needs to be made through *being-with-another* if others are spending more time with the student.

Working as nurse educators within the polytechnic system created different experiences for participants. Participants were employed by the polytechnic within the *world-of-education*. An assessment of competency within the *world-of-nursing* became an academic decision within the *world-of-education.* Students appealed a fail grade as an educational process. The *authentic Being* of many participants was being challenged when students appealed the fail which participants highlighted as being traumatic and distressing. Participants acknowledged that there were difficulties associated with failing students and for some, it was too difficult to fail. The next section is concerned with taking responsibility for failing students.

**Taking Responsibility for Failing Students**

A major theme from the interviews was about who took responsibility for failing a student. Scott (2010) interprets Heidegger by stating that "an authentic way of existing is one that requires individuals to take responsibility for their attitudes and actions" (p. 63).

In some cases participants took personal responsibility for failing the student, demonstrating *authenticity*. Other participants thought students should take responsibility for failing themselves, whilst others felt it was a managerial decision. Allowing others to make the decision can be interpreted as *being inauthentic,* because as Heidegger (1953/2010, p. 272) states, the "concept of guilt is about taking responsibility for", which means that when participants did not take responsibility for failing a student they cannot feel guilty as it would be others that have made a decision. Lack of responsibility has been referred to in Heideggerian terms as *disburdenment* which he describes as "the responsibility to make a judgement is taken away from the Dasein to the they, disburdening of one's being" (Heidegger, 1953/2010, p. 121). As stated previously, there is a reluctance to fail students at the start of their journey, and consequently concerns are raised about a students' performance later in their programme. Melissa used the example of trying to fail a second year nursing student, but others in the *world-of-nursing* enabled him to pass because he was *"such a nice little boy ... he got his mother onto it"* (p. 12) and he was allowed more time in order to continue the journey into year three. When the student was in year three, *others* were asking why he had continued his journey, but no-one had taken responsibility for failing him. This could mean that having previous knowledge of trying to fail the student in year two, that is having *fore-structure*, meant that there was a reluctance to try and fail him again:

> *He's third year. Interestingly though, he had been in other areas and people saying he shouldn't be here but no-one had taken that step (Melissa, p. 14).*

Although Melissa had failed three students she also accepted responsibility for not failing other students, an example of *disburdenment*; stating that she had passed students at the start of the journey and hoped that someone else would take responsibility for failing them later:

> *I've probably passed a student and thought, I hope someone else catches them later, particularly with the first years* (p. 20).

Clinical staff and educators question why students have been able to continue their education until someone eventually takes responsibility to fail them. Lucy was responsible for providing information to the nursing school management when she was *being-with* a "failing" student. It was not her responsibility to fail a student; this was *disburdened* to managers in the school of nursing. This could also be an *inauthentic* decision by the managers as they were relying on what *others* say:

> *That was someone else's decision; I supply the evidence and the progress notes there and then. It's out of your hand because I was only a pleb (laugh), such was the hierarchy at the time* (Lucy, p. 10).

Melissa acknowledged that failing a student is "traumatic" but it gets better with more experience and time as *Being-an* educator. Melissa is referring to the example cited at the start of this section and recognised how the student's personal mental health and *being-with* his mother made the process of trying to fail him difficult. Here she is *being-authentic*:

> *I think that as you get better at it, every time you fail someone it's actually quite a traumatic experience, and certainly with that boy I really felt I was being portrayed as the baddy. That I had done it, and yes, there were issues and his mental health came into question and his mother, and it was just a real mess, but I don't regret that I did it* (Melissa, p. 20).

Helen is illustrating *being-with-others* by recognising that preceptors are *being-with* the students more than herself. She accepted that she should take more responsibility and has *disburdened* the responsibility to those who are with the student. Helen is *being-authentic* as she *disburdens* the responsibility for assessment to the clinical nurses who are *being-with* the student for longer periods of time to make assessment judgements. Helen has not failed a student and has demonstrated *care for* students in earlier extracts which could also explain her *disburdenment*:

> *I probably should take more responsibility; actually I will shoot myself now. I have probably devolved that responsibility to the preceptor (laughter) more than I should be and I have done that because ... the preceptor works with them, for 16 hours, or whatever, so I would rely on their expertise of their jobs and how their students get on* (Helen, p. 24).

Oliver recognised that through *Being-a* nurse he was taking responsibility for public safety:

> *I think part of our role is to facilitate that process balanced with our responsibility to the public, patient safety* (Oliver, p. 31).

Participants were anxious when they failed students but they were aware of their accountability, as registered nurses, to the NCNZ to protect the public. Having responsibility to protect the public *Being-as* nurses was about them *being-authentic.* However, some

participants, whilst acknowledging their responsibility to protect the public, *disburdened* the responsibility to *others*, either in management, or later in the programme. Some participants *disburdened* the responsibility of failing, to the student, which I will present in the next section.

**Students fail themselves.**

The notion that students have failed themselves removes the responsibility for failing the student away from the participant and *disburdens* it to the student. This would appear to mean that the participant is demonstrating a *theyness* as the student takes responsibility for not learning. Whilst the participant has the tool to make the assessment of the student, and will ultimately sign the assessment tool as a fail, they are clearly illustrating the concept of *disburdenment* - as demonstrated in the extracts below. By transferring responsibility for failing students to student, participants could not feel *guilty* about students failing. Deborah believed that students who do not take responsibility for their learning fail themselves:

> *A person who is completely disinterested and doesn't want to do stuff, to me is probably easier to fail because they've failed themselves* (Deborah, p. 33).

Nadine demonstrated *disburdenment* as she removed the responsibility for failing the student from herself, to the student. Her responsibility/accountability to the Nursing Council also highlights her *Being-a* nurse and *care for* the health consumer:

> *One thing I have done is, I've removed myself from the responsibility of it being my fault if a student fails. I will say to a student, I'm not failing you, you are failing yourself. So if a student is failing, I am just saying you have got time to redeem yourself ... but it's my responsibility with the Nursing Council to make sure that you are competent* (Nadine, p. 28).

These examples have demonstrated how participants moved responsibility for failing students from themselves to the student, even though they make the decision. In this section, the extracts that have been used have highlighted the difficulties associated with taking responsibility for failing students which includes *being-with-others* from both the *worlds-of-nursing* and the *world-of-education*.

**Conclusion**

This chapter commenced with outlining Heideggerian concepts of *being-in-the-world, authenticity/inauthenticity,* and *guilt* as part of the concept of *care.* When *being-with* "failing" students, participants, *Being-as* nurses *caring for* students and *caring for* health

consumers was presented. Participants *cared for* students and this was particularly evident when *being-with* first year students as they had been *thrown* into the *world-of-nursing*. Some participants spoke of not assessing students for their *presentness* but for their *futurity* and their potential to continue of the journey. Judgements being made through *being-with-others w*as presented as well as participants not accepting responsibility for failing students and *disburdening* responsibility to *others.*

Participants also used the criterion of *caring for* the health consumer for awarding a fail. This was particularly evident when a student was failing a second enrolment, and when they were near to completing the journey to becoming registered nurses. Assessment using the NCNZ (2012a) competencies presented challenges, especially within domain one for *Being-a* professional. Other key themes for failing students were concerned with *being-unsafe* and knowledge deficit.

The anxieties associated with students challenging a fail and appealing the participants' decision highlighted how participants were being challenged for *Being-as* nurse educators. The appeals process also further highlighted the tensions that exist between the *world-of-nursing* and the *world-of-education.*

This chapter has highlighted the criteria that are used for making a judgement to fail a student. The experiences of participants *being-with* "failing" students were also presented. Participants with more experience *being-as e*ducators were more likely to fail a student. Less experienced educators were more likely to devolve the responsibility for failing a student to senior colleagues or back to the student. Participants experienced various feelings about failing students and some felt that the *care* of *Being-a* nurse was challenged, but acknowledged their responsibility to protect the public.

Having presented the analysis of findings about the experiences of *Being-a* clinical nurse educator and *being-with* "failing" students, the next chapter will discuss how the findings from my research link to the literature identified in chapter two.

# CHAPTER SEVEN

## Discussion: Entering the Clearing

The thesis began with my rationale for undertaking this research into the experience of clinical assessment and the difficulties associated with failing nursing students in clinical practice. An overview of the literature concerned with assessment of practical components within nursing and other professions has been presented and will be integrated within this chapter. Heideggerian Interpretive Phenomenology was chosen as the theoretical philosophical framework and was used to analyse participants' interviews. The analysis of findings from the interviews was divided into two chapters - the participants' experiences of clinical assessment, and their experiences of assessing a "failing" student.

I now return to the main themes from chapters five and six to interpret and construct meaning from the experiences of *Being* clinical nurse educators when *being-with* nursing students. The analysis of the fourteen interviews revealed that within New Zealand polytechnics, there are concerns regarding the clinical assessment of nursing students, particularly in relation to "failing" students. Heideggerian phenomena of *Being-in-the world, Being, Care, temporality, authenticity/inauthenticity, tools,* and *disburdenment* will inform the development of key discussion points. I will continue to use the analogy of participants *being-with* students as they take a journey from entering the BN programme and continue into the final third year of the programme. The chapter will conclude by entering a clearing which will uncover meaning from the participants' experiences of clinical assessment. In particular, I will discuss the phenomenon of assessing students who are considered to be "failing" and how this impacts upon participants' judgements.

I identified five major phenomenological discussion themes which are addressed in this chapter. The first theme is concerned with the tensions that clinical nurse educators experience through *being-between* the *world-of-nursing* and the *world-of-education*. The second theme is connected to the concept of *care* and the tensions between *care for* the student and *care for* the health consumer. Thirdly, how various clinical assessment tools challenged participants when determining a judgement about students' clinical performance. The concept of *disburdenment* and taking responsibility for failing a student will be the fourth discussion theme. The final theme will discuss how participants felt about students appealing their assessment decisions. The tensions that exist for participants through *being-in* the two worlds of nursing and education was a major theme that emerged from the analysis of data. Therefore, I will start the discussion with this particular phenomenon.

**Tensions Between Two Worlds**

Clinical nurse educators experience tensions between the *world-of-nursing* and the *world-of-education*. According to Heidegger (1953/2010) *being-in* the world determines a person's sense of *Being* and participants were *Being-as* nurses and *Being-as* educators. Participants, *Being-as* registered nurses, means that they have a duty to protect the public, in a professional, moral, and a legal sense (for example, as expected under the HPCA Act [MoH, 2003]). They are regulated by the NCNZ and have to be competent as measured against the NCNZ (2012a) four domains of competence in order to possess an annual practising certificate. All participants were experienced registered nurses and committed to the profession of nursing to provide high standards of competent care to health consumers.

*Being-as* experienced registered nurses, participants were employed by polytechnics and had entered the *world-of-education*, thus also *Being-as* clinical nurse educators. They became part of students' journeys towards becoming nurses. Entering the *world-of-education* meant that *Being-a* clinical nurse educator became part of a world governed by the Education Act (Ministry of Education [MoE], 1989) because polytechnics, as tertiary education institutions are governed by this Act. This means that "Academic Freedom" (s. 161), enrolment of students (s. 224), employment of staff (s. 198), monitoring institutions (s. 162) and programmes (s. 223) are controlled by the Education Act (MoE, 1989). Employment of the clinical nurse educator, by the polytechnic, is governed by the Education Act (MoE, 1989), yet their professional accountability for *Being-a* nurse is regulated by another Act, the HPCA Act (MoH, 2003). Being governed by two different Acts for professional accountability and responsibility, highlights potential tensions for the clinical nurse educator. There is no separate register for nurse educators, as a scope of practice, under the HPCA Act (MoH, 2003) or provision for nurse education in the Education Act (MoE, 1989). The participants, *Being-as* nurses and *Being-as* educators are *being-in* two different worlds which may explain the tensions that emerged during their journey through *being-with* a nursing student. Having discussed the two worlds of the participants, I will now discuss how the world of the nursing student differs from that of the participants.

**Becoming a nursing student.**

The position of nursing students appears to be placed within the *world-of-education*. Students enter the *world-of-education* for a future in the *world-of-nursing,* yet the *world-of-nursing's* regulatory body does not control who enters the programme. This is delegated to the Head of Nursing who is employed by the polytechnic, but regulated by the NCNZ. This is

unlike countries such as Australia, Ireland and South Africa where nursing students are indexed with the regulatory authority (Boak, Mitchell, & Moore, 2012; Zasadny & Bull, 2015). Participants, at the time of interviews, recognised that the polytechnic system was concerned with enrolment numbers, although during the course of this research, funding changed from enrolment numbers to completion rates (Tertiary Education Council [TEC], 2013); this may have further implications for failing students. Failing nursing students will lower completion rates for a course, which may affect funding and the institute's ability to provide a course, which could pressurise staff to pass students. This is a concern as failing nursing students is about protecting public safety in the *world-of-nursing*, yet the *world-of education* is concerned with retention and completion statistics (TEC, 2013).

The entry of students into the nursing programme caused tensions for a few participants, who questioned why some students were on the programme. A few participants felt that nursing was misrepresented by television drama programmes, and the academic element of the programme was underestimated by some students. Additionally, some participants expressed concern about students with underlying health issues. Nursing students in a polytechnic nursing programme are governed by the Education Act (MoE, 1989), but are not regulated by the HPCA Act (MoH, 2003). The Education Act (MoE, 1989) (s.224) states the criteria for eligible students, which can be determined by the polytechnic council. However, students over the age of 20 years are exempt from meeting minimum entry criteria under s. 224 (3) (a). The NCNZ (2014) criteria for entry into the programme are University Entrance and an English language requirement; the Head of Nursing has the responsibility for accepting students into a nursing programme. The NCNZ (2014) criteria for entry into the BN programme are vague and make no comment about age restrictions, or academic pre-requisites. Therefore, a person who is over the age of 20 years may cite the Education Act (MoE, 1989) as a right for coming into the programme. This means that the Education Act (MoE, 1989) may determine who comes into the BN programme as the NCNZ entry criteria are ambiguous. Only one polytechnic has an interview process to select nursing students and was not part of this research. Consequently, most students are accepted into a nursing programme from details submitted on an application form.

**Accrediting nurse education programmes.**

Section 12 (2) of the HPCA Act (MoH, 2003) requires educational programmes to be accredited by the regulatory authority which concurs with the Education Act (MoE, 1989) which states that education institutes and programmes must be monitored. This indicates that there is congruence of sorts between the two Acts for the necessity to monitor programmes, but there is incongruence between the requirements of the two Acts, demonstrating another tension between the worlds of nursing and education. The BN programme is monitored against seven standards (NCNZ, 2014) (Appendix B) by representatives from the NCNZ. The standards for nurse education are established by the NCNZ (2014), meaning that the *world-of-nursing* is determining what occurs within the *world-of-education* in as much as the NCNZ is using its regulatory powers to monitor the quality of nurse education being offered in the *world-of-education.* Clinical nurse educators, *Being-as* educators have to meet NCNZ (2014) standard three for *Being-an* educator, yet employment is with the polytechnic under the Education Act (MoE, 1989). *Being-as* registered nurses, clinical nurse educators are accountable to the NCNZ. I would argue that when a polytechnic is being monitored by the NCNZ, there is a tension between the standards within the *world-of-education* and the *world-of-nursing.* As stated earlier, the participants are employed by the polytechnic and would not wish to jeopardise their employment, or the viability of providing a BN programme by exposing unmet NCNZ (2014) standards.

Within the findings presented, it was evident that polytechnics were ignoring NCNZ (2014) standards, in particular with reference to the number of enrolments permitted within a clinical paper (standard two). For instance, two participants (from different institutions) highlighted examples of students who appealed an educator's decision to fail within a second enrolment; the polytechnic ignored standard two of the NCNZ (2014) guidelines and permitted a third enrolment for the students. This was about the rights of the student during appeals processes in the *world-of-education* which will be discussed later in the chapter. The tensions that are created due to the students' position *being-in* the *world-of-education* emerged when students challenged the participants' decision to award a fail grade.

**Preparation for *Being-a* clinical nurse educator.**

Earlier in this chapter, I highlighted how participants were being part of two different worlds. I will now discuss how the participants described their preparation for *being-in* the *world-of-education.* Participants indicated that they were unprepared for *Being-a* Clinical Nurse Educator. *Being-as* nurses, the participants entered the *world-of-education* in which they acquired a state of *Being-an* educator. *Being-an* educator and *being-with* students was a different experience to *Being-a* nurse, thereby creating tensions for them. All the participants were experienced nurses, but less than half were experienced educators (defined as having more than two years employment with the polytechnic). They had come from the *world-of-nursing* into the *world-of-education* with minimal educational preparation for *Being-an* educator. They were being *thrown into* the *world-of-education* as many participants described being ill-prepared for *Being-an* educator. Some participants used their past experiences as *Being-a* nursing student to be with students. As such, the participants' *historicity* informed their *presentness* for *Being-as* clinical nurse educators. The majority of participants used their *Being-as* nurses for *Being-as* educators as they had received insufficient education for becoming an educator. I would suggest that this wrongly assumes that *Being-a* nurse means knowing how to teach and *Be-an* educator.

Less than half the participants possessed an educational qualification to assist with the education and assessment of nursing students. This is a concern because it could be argued that decisions about the *futurity* of students to become nurses are being made by people who are not prepared or qualified to make such important decisions. Within New Zealand, there is no specific scope or part of the register to regulate nurse educators, although there are different NCNZ competencies for nurses in education within domains two and three (management of nursing care, and interpersonal relationships). Thus, without a recognised scope for *Being-a* clinical nurse educator, there is no regulation of nurses who are involved in determining who becomes a nurse in the future.

In contrast, UK nurses wishing to become educators in a tertiary institution must attend a Nursing and Midwifery Council (NMC) approved course, and have their qualification recorded on the register as either a Lecturer/Practice Educator (LPE) or a Teacher (TCH) (NMC, 2010). As a nurse educator in the UK, this was a system that I was familiar with. I would argue, it helped prepare nurses for *Being-as* nurse educators, because clinical assessment is conducted by clinically-based nurses who have studied NMC approved courses for clinical teaching and assessment. Nurses involved in assessing students in the final clinical placement undergo further education and have their name

recorded on the register as a "sign off" mentor. Educationally-based nurse lecturers are not involved in clinical assessment (NMC, 2010). However, despite these requirements, a UK survey of nearly 2,000 nurse mentors identified reluctance to fail nursing students, with 37% claiming that they had passed students who should have failed (Gainsbury, 2010). The two main reasons cited for not failing students were having insufficient evidence to support their decisions, or that students would challenge the fail and universities would overturn the fail grade. The latter was a major factor for mentors not failing students, especially for the final placement sign off mentors. This highlights the tensions between the *world-of-nursing* when a mentor fails a nursing student and the decision is overturned by the *world-of-education*. A fifth of respondents also stated that they were inadequately prepared for how to deal with "failing" students, particularly with the amount of paperwork that is required to support the decision to fail a nursing student. In New Zealand where there is no formal process for preparing nurses to educate and assess nursing students, just under half the participants in my study had not failed students despite expressing concern about students' competence. This was highlighted by eight participants stating that they had passed a student and later regretted the decision. Whilst my research is a considerably smaller sample than that of Gainsbury's (2010) study, it is still to be acknowledged that clinical nurse educators in New Zealand are reluctant to fail nursing students. The lack of preparation for New Zealand clinical nurse educators is a cause for concern if it leads to reluctance to fail those nursing students in clinical practice who are not meeting the required assessment standards.

*Being-an* educator presented another tension for the participants – *Being-an* educator, as well as *Being-an* assessor. Whilst they acknowledged *Being-an* educator was about *being-with* nursing students on the journey to teach them about becoming a nurse, they also acknowledged that students need to be assessed. These two states of *Being* caused tension which has been recognised in other studies. Studies with medical students have discussed the tension that is created when conducting assessments through *Being-a* supervisor and *Being-an* assessor (Rees, Knight, & Cleland, 2009; Wilkinson & Wade, 2007). Tiwari et al. (2005, p. 304) also noted lecturers felt that they "wasted a lot of time" assessing students rather than helping them to learn. Duffy (2003) describes how nursing students have difficulty recognising that lecturers are also assessors, and students become angry when the lecturer, who had been teaching them, failed them. This is a good example of students having difficulty acknowledging that *Being-a* clinical nurse educator is about *Being-an* educator and *Being-an* assessor which can cause confusion and tension for the student, a phenomenon that requires further research in New Zealand.

Lack of preparation for *Being-an e*ducator, and *being-thrown* into the *world-of-education*, led to inconsistencies and subjectivity for assessing clinical practice. Other studies have highlighted that lack of preparation led to clinical assessments being subjective (Duffy, 2003; Skingley et al., 2007; Scholes & Albarran, 2005). Skingley et al., (2007, p. 30) also noted that practice teachers used their "gut feeling". In my study, Helen also used her "gut feeling" (see Chapter five), and Oliver had "a feeling" (see Chapter six) about a student which I interpreted as *intuition*.

*Being-as* educators and *Being-as* assessors, created another tension for the participants which was identifying when teaching/learning stops and an assessment decision is made. Unlike a written assignment, which has a clearly identified submission date, and possibly time, there is no clear delineation as to when a clinical assessment is due, apart from the end of the placement, unless students produce a clinical portfolio of evidence. There is a finite time for students *being-in* a clinical placement; it is unrealistic for all clinical assessments to be conducted at the same time at the end of a placement. However, Lucy likened the assessment of a nursing student as a continuous process, similar to that of continually assessing the health consumer (see Chapter five). Therefore, participants identified learning as being about the amount of support and prompting that students required. When students continued to require prompting and support at the end of a clinical placement, this influenced the assessment decision; a student who continued to require support and prompting was considered as "failing".

It became apparent from the findings of this research that inexperienced participants with less *time* as *Being educators* and lack of preparation wanted to be liked by students, and felt unsure of their teaching. They were also less likely to fail a nursing student. Lack of preparation for becoming a nurse educator caused inexperienced participants to blame themselves for students failing assessments; they considered it a reflection on their teaching which led to feelings of guilt. This was reinforced by two examples of angry students who had failed an assessment and blamed Nadine and Deborah (see Chapter six). Other studies (Black et al., 2014; Gainsbury, 2010; Hawe, 2003; Ilott & Murphy, 1997; Rees, 2009; Rutowski, 2007; Wilkinson & Wade, 2007) have reported similar findings to my own study that failing a student could be viewed as a failure of the educator's teaching and therefore assessors were reluctant to fail students. This is a cause for concern as reluctance to fail students will result in unsafe students being able to continue the journey and become unsafe nurses. It cannot be assumed that *Being-an* experienced nurse means that the person does not require preparation for the different state of *Being-an* educator/assessor and *being-in*

the *world-of-education.* This also confirms my argument from the findings that preparation to become an educator also requires preparation to become an assessor.

My research findings also showed that experienced participants with more *time* as *Being-an* educator, were more likely to fail a student, feeling that it got easier with more experience. This could be attributed to the *historicity* of participants and acknowledging that past experiences of failing students can assist with failing students in the future. This was also linked to experienced participants being aware of students who had not been failed and became incompetent nurses. This was about ensuring the *world-of-education* produced competent nurses for *being-in* the *world-of-nursing.* With more *time,* experienced clinical nurse educators had met the NCNZ (2014) criteria for *Being-a* clinical nurse educator and had more self-confidence for *Being-an* educator. I would argue that meeting the NCNZ (2014) criteria for *Being-a* nurse educator does not necessarily mean that they are better prepared to assess clinical competence; it merely validates their *Being-as* an educator. The NCNZ (2014) criteria require nurses in education to possess a national teaching certificate, but this course does not have a clinical assessment component. Anderson's (2008) New Zealand study of competency assessment with third year nursing students would also support the requirement for assessors to have more preparation for the role of competency assessment. Whilst my research identified that more experienced participants were more likely to fail a nursing student, they also commented that it was difficult to accept their decisions being overturned during an appeals process. Other studies have highlighted decisions being overturned as a reason for assessors' reluctance to fail students (Duffy, 2003; Gainsbury, 2010). A Canadian study of poorly performing medical students (Dudek, Marks, & Regehr, 2005) had similar findings to my study that confidence to fail students developed with experience.

**Clinical education in the *world-of-education*.**

*Being-with* students on their journey to becoming a nurse started with teaching fundamental skills of nursing within the polytechnic, situated within the *world-of-education.* The importance of teaching fundamental clinical skills in the first year was recognised by most participants as preparation for students entering the *world-of-nursing*. Many clinical skills are required of a nurse, although there is no national consistency about what identifies a clinical skill as "fundamental". Nevertheless, most participants agreed that hand washing and medication administration were important fundamental skills. Similarly, Lauder et al. (2008) identified the skills of hand decontamination, drug calculations and communication as fundamental skills as they are concerned with protecting the health consumer. These

skills should be learnt early within the *world-of-education* to ensure public safety before students enter the *world-of-nursing* and then developed throughout the programme.

Some skills, for example pulse oximetry, were being taught within the polytechnic and not applied within the initial clinical placements due to unavailability of equipment. This raises tensions about why it was being taught in the *world-of-education* when it could not be practised in the *world-of-nursing* soon after being taught. The importance of being able to relate the teaching that occurs within an educational institute to *being-in* the *world-of-nursing* and *being-with* health consumers, has been identified as a fundamental component of nursing education to strengthen student learning (Cederbaum & Klusaritz, 2009; Ralph et al. 2009; Walker & Wimmer, 2009). Concerns about lack of learning clinical skills with the move of nurse education from hospital based training into university based education in the UK was identified in the UK by the Peach Report (cited in Lauder et al., 2008). The report recommended the importance of the teaching clinical skills in the first year of the programme ensuring that learning in the *world-of-education* takes place within the *world-of-nursing*. This concern could be applied to nurse education in New Zealand as my research would indicate that not all polytechnic-based education is being implemented within clinical placements. This demonstrates another tension between the two worlds of education and nursing. The clinical educator should be able to bridge the learning of appropriate skills from the *world-of-education* into the *world-of-nursing* and vice versa.

**Clinical assessment in the *world-of-education*.**

Participants discussed the value of assessing first year nursing students prior to going into a clinical placement and *being-with* real health consumers. I believe that the purpose of assessment is to ensure that students are safe, and have basic knowledge to be with members of the public within a clinical placement. However, there were different requirements between polytechnics. Some polytechnics allowed students to go into the *world-of-nursing*, *being-with* the public, even though they may not have passed their pre-clinical assessments. This means that despite a student failing an assessment, which would indicate that they are not safe or do not possess basic knowledge, they were able to be with the public. Participants spoke of students who had failed pre-clinical assessments but would be offered more supervision and opportunities to practise. They believed that with more *time*, there is greater *potentiality-of-being* a nurse if the student passed. This is a cause for concern as it means that they have not demonstrated safety, yet they can practise on the public.

Whilst fundamental clinical skills were being taught within the *world-of-education,* there were differences between the polytechnics regarding the assessment of clinical skills. Perhaps surprisingly for some, there are no NCNZ (2014) standards for the assessment of clinical skills. This means that another tension exists as the *world-of-nursing* does not provide any direction about the teaching and assessing of clinical skills within the w*orld-of-education.* Therefore, there is inconsistency within the *world-of-education* about preparing students for *being-in* the *world-of-nursing.* It may be inappropriate to have a nationally recognised set of standards for clinical assessment, as each nursing school needs to meet the requirements of their local stakeholders. However, all nursing students must meet a nationally agreed set of competencies (NCNZ, 2012a) to become a registered nurse. Others have recognised similar problems; for instance in their small quantitative Irish study of 29 degree students and 27 preceptors from three universities in Dublin, O'Connor et al. (2009) acknowledged the need for a unique clinical assessment tool to meet the individual requirements of education and clinical placements; a consistent national assessment tool is inappropriate as local needs are not addressed. Their study would highlight a means of reducing the tensions between the *world-of-education a*nd the *world-of-nursing,* although I would question whether having a locally prepared assessment tool prepares the student for national employment as a registered nurse if they have only been assessed against criteria to meet local stakeholder needs.

Participants spoke of time constraints and large group size as a reason for being unable to assess all skills prior to going into the *world-of-nursing.* Fundamental clinical skills were chosen at random for determining students' safety and competence to practice within a clinical placement. Lauder et al. (2008) noted that demonstrating safety and competence within one skill, did not mean that students are competent within all skills. This means that although a student may have passed a clinical assessment to demonstrate safety within the skill of hand washing, they may not be safe when monitoring blood pressure readings. This raises an issue about the safety of first year nursing students *being-with* health consumers unless their preceptor is aware of which skill(s) the student has been assessed and demonstrated safe practice. Nicol and Freeth (1998) noted that all skills cannot be assessed prior to students going to clinical placements due to time limitation, and this supports my findings. Nicol and Freeth (1998) developed a clinical assessment process that centred around one simulated patient who required multiple clinical skills, rather than students being assessed in a variety of OSCE skill-specific stations. This also had the benefit of assessing the application of fundamental skills relevant to a person, rather than a skill being a task assessed for the component parts thus recognising that knowledge, and attitudes are also required for being deemed competent. Being aware of public safety and

teaching/assessing skills that are relevant to protecting health consumers should reduce the tensions between the two worlds. I now discuss how *Being-a* clinical nurse educator is about *Being-with-others* in a clinical placement.

***Being-with-others* in a clinical placement.**

All the participants in this study were employed by the polytechnic to *be-with* students in a clinical placement. Clinical learning environments were located on different sites to the polytechnic and Keith referred to this as an "us and them" (see Chapter five). *Being-a* clinical nurse educator was described as "visiting" students within the clinical learning environment, implying that participants felt that they did not belong to the clinical learning environment. Moving between different sites also highlights *being-in* two different worlds – education and nursing.

Participants discussed how they were also *being-with* clinical nurses (preceptors) to provide them with support; ensuring that preceptors knew the expectations of the nursing students. This is interesting as less than half the participants had any more educational preparation than the preceptors. They had acknowledged that they were relying on their *Being-a* nurse for *Being-an* educator, yet they were *being-with* preceptors to provide educational support.

Participants, despite *Being-as* nurses, were rarely *being-with* students to deliver nursing care to health consumers. They would visit students and monitor progress, but they relied upon *being-with* preceptors, considered the nurse experts, for feedback about a student's progress. However, tensions existed between different expectations of participants and preceptors. *Being-as* educators, participants expected students to display critical thinking and initiative, whilst preceptors, *Being-as* nurses, wanted students to be able to deliver nursing care. The majority of participants in this study spoke about assessing students with lots of input from the preceptors. A few participants spoke of the assessment as being a three-way partnership between preceptor, participant and student (see Chapter five). When a preceptor is spending more time with a student, I would suggest that the preceptor should conduct the clinical assessment, possibly in conjunction with the clinical nurse educator for educational input as a tripartite collaboration. The important contribution from preceptors means that they should receive preparation for *Being-as* educators and assessors within the *world-of-nursing.* Cassidy (2009) states that *Being-an* expert nurse does not necessarily mean *Being-a* competent assessor.

As indicated earlier, making a judgement to fail a nursing student was usually made by collaboration through *being-with* the educator and *being-with* clinical staff, a collaboration of both worlds. Yet preceptors were more inclined to fail a nursing student who was unable to deliver nursing care, rather than a student who was unable to explain care and apply critical thinking. This tension can be explained by preceptors *being-in* the *world-of-nursing* with a duty of care to the health consumer, to ensure that the student is delivering safe care and participants, *Being-as* nurse educators, have a responsibility to maintain educational standards, as well as protecting the public. Preceptors do not have any accountability under the Education Act (MoE, 1989) as they are not *being-in* the *world-of-education,* therefore, when a preceptor expresses concern about a nursing student, they are upholding their accountability to the NCNZ for maintaining public safety. Conversely, the participants are upholding their accountability to both the NCNZ and the polytechnic for academic integrity. The collaboration between nurses and educators could be considered good practice as both nursing and education standards are being assessed. However, where others' views are driving the decision, this can be described as *being-inauthentic,* or the *they-self* which will be discussed later in this chapter.

Limited time, such as a seven day placement, for a student to learn and be assessed was identified by some participants as a reason for not failing students as it was unrealistic and unfair to make a judgement. There should be sufficient time within the *world-of-nursing* to make a fair assessment decision. NCNZ (2014) standard 2.10 states that "clinical experiences must be long enough to achieve the competencies identified". My research has identified that some students require longer *time* than others to achieve competence, whilst others will not be able to achieve competence and will ultimately fail. Therefore standard 2.10 is vague and open to interpretation as to what constitutes a sufficient time-frame for students to achieve competence. Only in the final transition placement does NCNZ (2014) require an extended placement of 360 hours (standard 2.14). The amount of time to learn and be assessed, *being-with* different preceptors due to differing shift patterns is also identified as a concern in other studies, especially when there are speciality placements (Anderson, 2008; Duffy, 2003; McIntyre et al., 2009; O'Connor et al., 2009; Ralph et al., 2009; Walker & Wimmer, 2009). There is limited research about the optimum duration of a clinical placement, especially when a student is to be assessed (Levett-Jones, Lathlean, Higgins, & McMillan, 2008). O'Connor et al., (2009) expressed concern about the regulatory board for nursing in Ireland, reducing clinical placements from five to two weeks, as this was inadequate time for assessing nursing students. Additionally, Duffy (2003) also noted that students of concern are usually identified very early in a placement, yet despite first year placements being typically four to six weeks duration, mentors were still reluctant to

fail a student, suggesting that there was insufficient time for remedial support. It should be noted that because the preceptorship model was used by all participants, no comparison can be made with other clinical teaching models for supervising students.

Participants were able to speak about how the personality of a student could influence the assessment judgement; it was harder to fail a lovely student. This reinforced the notion of the halo effect (Ried & Douglas, 2015; Tiwari et al. 2005; Wilkinson & Wade 2007). As well as students who were liked, there were examples of personality clashes which can also influence assessment. To reduce the risk of personality clashes between a student and an assessor, assessment judgements should be a collaboration between preceptors and nurse educators. Other studies have demonstrated that nursing student assessment is influenced by how well a student in accepted within the nursing team (Calman, Watson, Norman, Redfern, & Murrells, 2002; Kevin, 2006; Webb & Shakespeare, 2008). Cederbaum and Klusaritz (2008) acknowledge that personality clashes may occur between a student and their preceptor which can impact student learning. They advocate a strengths-based approach to develop the educator/student relationship to facilitate student learning and address some of the tensions between the two worlds.

The tensions for participants can be explored using Heidegger's concepts of *authenticity/inauthenticity.* Being *authentic* in the state of *Being-a* nurse, means that clinical nurse educators are primarily accountable to the nursing profession for the delivery of safe competent nursing care, that is, making decisions in the best interests of the health consumer. However, being *authentic* in the state of *Being-an* educator means that they are responsible for educating students to become nurses. Clinical nurse educators face a dilemma when they recognise that the student is not learning and therefore not becoming a nurse; the educator's *authenticity* as *Being-a* nurse is challenged because of their duty to public safety. Whilst participants had accountability for *Being-as* nurses to the regulatory body for maintaining patient safety, nursing students have no responsibility to a regulatory body. Public safety remains the responsibility of registered nurses. The crux of nurse education is to ensure public safety – health consumers who, for participants, are situated within the *world-of-nursing*. This juxtaposition of education and clinical placement creates tensions for clinical nurse educators in New Zealand. The *authenticity* of participants in this study was being challenged as they are situated within two different worlds; yet nursing students, with whom they are taking the journey, are situated predominantly within the *world-of-education.*

Belonging to two major worlds creates multiple tensions for clinical nurse educators. *Being-a* nurse as well as *Being-an* educator is about *being-with* students between the *world-of-education* and the *world-of-nursing*. In part, this is because the Education Act (MoE, 1989) has more provision for nursing students than the HPCA Act (MoH, 2003) and this creates tensions for the clinical nurse educator, governed by both Acts. Participants, *Being-as* nurses were being thrown into the *world-of-education* with minimal preparation for being educators and assessors which meant that inexperienced educators were less likely to fail nursing students. As well as having minimal preparation for *Being-as* educators, some participants stated that they wanted to be liked, or they were unsure of their own teaching abilities; this resulted in being concerned about how they would be supported by the school of nursing if they failed a student.

*Being-with-others* as *being-with* clinical staff was an important aspect of participants' *Being* to ensure that students were receiving a good learning experience through bringing the two worlds of education and nursing together. *Being-with-others* in the *world-of-nursing* highlighted tensions between the different expectations of students between preceptors and participants. Clinical staff spent more time with students and contributed to assessment judgements, yet they also lacked preparation for *Being-as* assessors. *Being-in* the two worlds challenged the *authenticity* of participants. Tensions between the two worlds led to inconsistent assessment which affects health consumer safety as "failing" students are not being failed. The next section will discuss how participants used the concept of *care* as a theme for making an assessment judgement with a "failing" student.

### Tensions between *Caring for* Students and *Caring for* Health Consumers

Participants experienced tension between *caring for* students and *caring for* public safety. My research highlighted that *Care* is a component of *Being-a* clinical nurse educator; *caring for* students as *Being-an* educator, and *caring for* health consumers as *Being-a* nurse. *Being-in-the-worlds* of education and nursing created tensions when assessing students who were considered to be failing. I will discuss how the phenomenon of *Care,* as discussed in chapter six, was used to justify failing a student. I will start by discussing how *caring for* students can be used to justify failing, and follow by discussing how *caring for* the health consumer justifies the fail.

#### Failing as *caring for* the student.

*Care for* students was evident when discussing the assessment of first year nursing students. Students started the journey with different *past* experiences; therefore, for some

participants, it was argued that the first year should be an opportunity for learning and not assessing. First year nursing students were being *thrown* into the *world-of-nursing* and learning about *being-with* strangers, which may have included seeing naked bodies for the first time. Recognising that students are being *thrown-into* a different world with new experiences could be interpreted as *caring for* students and supporting them at the start of their journey. Other participants felt that assessing first year students would assist with determining the *futurity* of the student to become a nurse. If a student did not have the potential for becoming a nurse, failing them would mean that they would not be wasting time and money, a consideration that was enveloped in *care for* the student. Other studies have identified that there is a reluctance to fail students in their first year because it was hoped that students with improve with more time (Black et al., 2014; Duffy, 2003). Failure to identify "failing" students early created issues of moral distress when assessors failed students later in the programme (Black et al., 2014). Using an extension of the Heideggerian concept of making judgements as being about defining the truth (Heidegger, 1953/2010, pp. 33-34), and based on my own experiences, as well as the findings from this research, I would argue that it is not possible to make a truthful judgement about a first year nursing student's potential for becoming a nurse so early in their journey. It takes *Time* to learn about becoming a nurse, a point that will now be discussed when considering the assessment of nursing students.

Some students require more *Time* to learn to become a nurse and take longer than others to complete the journey. Therefore, when a student was not achieving competence, sometimes attributed to short clinical placements as noted by Deborah (see Chapter five), failing a student within the first enrolment was justified as *caring for* the student. Enabling a student to have a second enrolment and more learning opportunities was vindicated as *caring for* them, as it allowed more *time to* learn. Through *caring for* and nurturing students Vallant and Neville (2006) demonstrated that third year nursing students' anxieties decreased and their confidence increased. Whilst their study was not specifically about failing students, it was concerned with enabling students to have meaningful learning experiences to succeed, through support and *Care.* Clinical nurse educators should demonstrate a sense of *care for* students as this allows them to observe the caring personalities required of *Being-a* nurse. This is supported by an Iranian study of nurse educators who *cared for* nursing students who were failing in the academic component of the programme; when students observed a caring approach from educators, their academic performance improved (Peyrovi et al., 2009).

My study highlighted the importance of *being-with* students to facilitate learning, but it was also acknowledged that students are not their friends and there must be professional boundaries. Other studies (Anderson, 2008; Kevin, 2006; Luhanga et al., 2008a) acknowledge the caring nature of nurses can dilute the relationship between an assessor and student, resulting in students not failing, and supports the findings from my study.

Experienced clinical nurse educators were more likely to fail a student, and not allow them to progress on their journey. I have interpreted this as *caring for* the student through enabling more *time* at their level of study to develop confidence in the w*orld-of-nursing.* However, less experienced clinical nurse educators tended to give the "benefit of the doubt", did not fail students and allowed them to progress, hoping that they would improve with *time* within the next placement. Sometimes the next placement was in the same year, at the same level of education, but sometimes it was about allowing students to progress into the next year and into a higher level of study. I would suggest that this is setting a student up to fail as progressing to a higher level becomes more of a challenge if they are unable to meet competence at a lower level. Not failing students was also considered as *caring for* students by less experienced assessors, but this could also be understood in terms of not accepting responsibility, which will be discussed later in this chapter. The benefit to failing students and offering a re-sit assessment was found in a study of medical students which identified that students did learn and improve if they had a re-sit after a failed assessment (Pell et al., 2009). However, there are no New Zealand nursing studies concerned with how many enrolments a student should have in order to prepare students to achieve competency within clinical assessment.

Failing nursing students was not an easy decision for participants, but none regretted awarding a fail once the decision had been made. Many participants stated that they did not want to fail a student, even stating that it was punitive. This could mean that they were *caring for* the student by acting in this way, which creates tension when assessing nursing students who are "failing". That is, there was an element of protection for the student, a feeling of not wanting to hurt the student, particularly when an educator could see potential within a person; this could be justified as *caring for* the student. However, whilst *caring for* students was a consideration, there was also a tension about *caring for* the safety of the health consumer. This could be regarded as prioritising and promoting *caring for* the most vulnerable member of the health care environment, which will now be discussed.

**Failing as *caring for* the health consumer.**

*Being-as* nurses and *caring for* the safety of health consumers became a significant criterion for assessing students in the third year. Students in the third year are still learning, but *care for* health consumers became a major consideration for failing students. Assessing and failing third year students was particularly difficult for the participants as they *cared for* how much money and time students had wasted. There was a sense of frustration about failing students in year three who had been identified earlier as potentially weak students, but had not been failed because assessors had apparently *cared for* the students as discussed earlier. Comments in the data included "why had students got here", and "why were they not identified earlier" were made by a few participants (see Chapter five), which seemed to indicate that students should not be failing in year three. These comments are supported in a study by Black et al. (2014) who identified that when a student failed later in the programme, assessors became angry and upset with colleagues who had not failed weak students earlier in the programme; they argued that allowing students to continue with their studies created false hope.

Within a final transition placement, the imminent *futurity* of students becoming nurses and entering the *world-of-nursing* was a critical factor to consider. *Caring for* the health consumer was a major consideration for failing students, especially when assessing marginal students, and when students were in a second enrolment. Some participants considered whether they would want the student *caring for* a member of their family, and this was referred to by Lucy as the "litmus test". Other studies have also identified that where there is doubt about whether a student should pass a clinical assessment assessors have considered whether they would want the student *caring for* a family member to determine whether a student should pass the clinical assessment (Anderson, 2008; Luhanga et al., 2008b; Paton, 2007; Scholes & Albarran, 2005; Whelan, 2006). My study has confirmed that being *cared for,* as a health consumer, assists assessors to make a judgement about the students' *futurity* to become a nurse.

After students have passed the final transition placement, and the final state examination, their next clinical placement will be *caring for* health consumers as a registered nurse as part of a team. The *futurity* of the student, *being-with-others* as being part of the nursing team, was also used by some assessors to identify the strengths and weaknesses of a transition placement student. I believe that this is a valid consideration for students who are completing their final transition placement as the *futurity* of the student is about them *Being-as* registered nurses. This has been explained in other studies as

protecting public safety and c*aring for* the health consumer through a gatekeeping role for student becoming nurses (Anderson, 2008; Luhanga et al., 2008a).

Tension exists between *caring for* students through *Being-an* educator and *caring for* health consumers through *Being-a* nurse. Whilst failing nursing students has been considered the antithesis of nurses as caring *Beings* in other studies (Duffy, 2003; Kevin, 2006; Luhanga et al., 2008a; Stokes, 2007), I have argued previously that failing is about caring. This may be a difficult concept for some students to accept, but they need to be aware of the importance of *time* as a component of becoming a nurse. I maintain that allowing "failing" students to progress on their journey cannot be justified in terms of *care for* either students or health consumers.

In this section I have discussed two facets of *Care*; *care for* the student, and *care for* the health consumer. I have discussed how failing a student allows them to have more *Time* for learning, especially in the first year of the programme. As students continue the journey, or where they are failing in a second enrolment, *care for* the health consumer becomes a consideration for making a judgement to fail a student. Ultimately clinical assessment is about *caring for* the safety of the health consumer as required by the HPCA Act (MoH, 2003) and failing students can be enveloped as *Care.* I will now discuss how assessment tools are used to make decisions about students' progress.

**Clinical Assessment Tools**

Clinical assessment tools presented challenges for determining nursing students' competence. The variety of clinical assessment tools, such as check-lists, OSCE marking guides, clinical portfolios, and NCNZ (2012a) competencies, presented challenges for assessing clinical practice. I now discuss how the participants used various assessment tools to make assessment decisions.

**Check lists as assessment tools.**

Participants discussed the use of check lists, with clearly identifiable criteria, to assess fundamental clinical skills at the commencement of the journey. Most participants felt that assessment of skills was made easier through the use of check lists as criteria had either been achieved, or not. Criteria cannot be changed to either pass or fail a student, although the interpretation of criteria can be changed. Only one participant felt that check lists were punitive because to fail one criterion meant that the student had failed the whole assessment. A few participants felt that checklists, did not allow for the underlying theory and processes of skills to be assessed. Some participants believed that using check lists with

clearly identifiable criteria also enabled students to identify what needs to be learnt for an assessment. Other studies have also acknowledged that check lists enable a student to be aware of what is required in an assessment (Calman et al., 2002; Dolan, 2003; Tan & Prosser, 2004). However, a clinical skill is more than a series of component parts and this was discussed as being a disadvantage of check lists. Cassidy (2008) suggests that a checklist only assesses behavioural components and does not make an allowance for affective components. Therefore, I believe that as students progress on the journey to becoming a nurse, check lists are inappropriate as students need to learn the rationale and processes relevant to performing a clinical skill; this was discussed in terms of identifying the progression of the student throughout the BN programme. As students progressed through the programme, the NCNZ (2012a) competencies were used in assessment tools which I will now discuss.

**NCNZ (2012a) competencies in assessment tools.**

NCNZ (2014) education standards for the RN scope of practice, standard six, requires assessment to be mapped against the NCNZ (2012a) competencies for RNs. This means that the assessment tool should identify the competencies that are being assessed. The NCNZ (2014) standards also state that students should demonstrate progression of their clinical competence, but there are no competencies for nursing students. This presented challenges for the participants as assessors. Lack of clear criteria to measure clinical progression led to assessors making their own interpretations, although a few participants were able to describe how the monitoring of a blood pressure should progress throughout the three year programme.

Nursing students are assessed against NCNZ (2012a) standards of competences for *Being-a* registered nurse, yet it could be maintained that this is an unrealistic assessment as this means the student is being assessed for their *futurity* as a RN. I would argue that students should be assessed in their *presentness* as students because their *futurity* to be competent as required for a registered nurse, develops with *time.* The term "competent" presented challenges for assessing students. A nursing student who passes an assessment would be termed "competent", yet Benner et al. (2009) would suggest that a nurse is not competent until they have been practising for two years. The antonym of competent would be "incompetent", yet this term was not used when a student failed an assessment. The language used to describe failing students was highlighted; students did not "fail", they just "did not complete", or were "not yet competent". I think that "incompetent" is an unfair phrase as a nursing student cannot be competent according to an interpretation of the

definition by Benner et al. (2009). The language that is used to describe a non-achieving grade is an important consideration as language is a powerful reflection of our sense of *Being* (Heidegger, 1953/2010, p. 156). To "fail" has also been described as an emotive term, which is not used where possible. Avoiding the use of the term fail can lead to students passing (Ilot and Murphy, 1997, p. 308). I suggest that assessors should not avoid using the term fail and accept that this is a potential consequence of conducting assessments.

This study has highlighted that using NCNZ (2012a) competencies within the assessment tool for speciality placements, such as mental health and primary care, presented challenges, especially within the second year of the programme, because students were generally observing care rather than delivering supervised care. Therefore clinical assessment was not about their competence but ability to observe care; an unrealistic assessment. Participants also spoke of having to "fit the words" to suit the competencies within the assessment tool (see Chapter five). A registered nurse in New Zealand can be expected work in any area of nursing, such as mental health, medicine, surgery, paediatrics, elder care, primary and community health. Therefore, students need to be assessed within these areas to ensure competence within those areas for their *futurity* as registered nurses. Failure to pass an assessment in one speciality means that a student cannot become a nurse in New Zealand. Differing periods of time within speciality placements also created challenges as there are no specified number of hours required in specialities. MacIntyre et al. (2009) have also identified the problems of assessing nursing students in multiple speciality placements within nurse education in California; students citing the appropriateness of generic competencies within specialities as a challenge. In the UK, students choose a speciality area of nursing and their education is directed to their *futurity* within the chosen area of nursing (NMC, 2010). My study suggests that there should be clearer guidelines regarding the required number of clinical hours within specified areas of practice to ensure consistency throughout New Zealand.

NCNZ (2012a) competencies within the assessment tool presented challenges for participants *being-with* preceptors. The language of the competencies created tensions for participants when preceptors did not understand what was being assessed, which confirms findings from Anderson's (2008) research about competency assessment in New Zealand. Lack of understanding and training about the use of assessment tools led participants to make their own interpretations about the requirements of clinical assessment; a finding supported in research by O'Connor et al. (2009). With the exception of the final transition placement, participants highlighted the difficulties of using competencies for assessing students especially for behaviours that could not be measured against the NCNZ

competencies (2012a). They suggested issues such as personal/health problems, poor attitude, not accepting feedback and not taking initiative. I will now discuss how using the competencies presented challenges for participants when assessing *Being-a* professional and *being-safe.*

***Assessment of Being-a professional*.**

Professional responsibility is the first domain of the NCNZ (2012a) competencies for *Being-a* registered nurse and is therefore a criterion that is assessed. This domain created tensions due to the interpretation of *Being-a* professional. Perhaps surprisingly, *Being-a* professional was interpreted by some participants as being about the clothes that nursing students wear and was used to fail some students (see Chapter six). Yet whether wearing differently coloured socks affects students' ability to be a safe nurse is debateable. Nevertheless, the participants who cited these examples were highly experienced clinical nurse educators and their beliefs are supported by the findings of research by Clendon et al. (2015), who found that experienced nurses considered professional behaviour being about the clothes a nurse wore. I would agree that a student could fail a clinical assessment if one of the criteria on the assessment tool was concerned with dress; if not, then the assessor is making the judgement based upon their own interpretation of *Being-a* professional.

Not *Being-a* professional was also interpreted as *being-disrespectful*, and using inappropriate language, which were also linked to *being-from* different generations, by some participants. However, Killam et al. (2011) suggest that students who used abusive language, did not accept feedback and shouted at educators would be classified as unsafe to practice. I will explore how safe care was determined in the next section.

***Assessing safe care*.**

Participants, *Being-as* nurses were committed to ensuring that students delivered safe nursing care. Within the NCNZ (2012a) competencies this is explicitly stated within competency 2.1; "undertakes practice procedures and skills in a safe and competent way" (Appendix C). However, participants had different interpretations of safe care within assessment tools. There was a general consensus that safe nursing care was about having the underpinning knowledge to *care for* health consumers, and ensuring that medications were administered without error. Ensuring that students delivered safe care was considered to be the "bottom line" criterion for determining competence, particularly with regards to the marginal student. Many other studies have highlighted the difficulties associated with determining what constitutes safe care within clinical practice (Drake &

Stokes, 2004; Gregory et al., 2009; Mossey et al., 2012; Scholes & Albarran, 2005). Regardless, an integrative literature review by Killam et al. (2011) identified a lack of clarity around the interpretation of patient safety by nurse educators. They identified three main themes for classifying *unsafe* care which included "ineffective interpersonal interactions, knowledge deficit and skill incompetence, and unprofessional image" (p. 439). My study would support that knowledge and skill incompetence would constitute unsafe practice, but ineffective interpersonal interactions and unprofessional image were considered as not *being-a* professional. This would imply that *being-safe is a component of Being-a professional.* Public safety must be at the core of nurse education and demonstrated within clinical placements.

Medication administration errors were generally regarded as unsafe practice and a reason for failing a nursing student. Medication administration was assessed against clear criteria on a check list highlighting the transparency of the assessment tool. Other studies support failing students for medication errors, and not achieving 100% in drug calculation tests, because of concerns about protecting public safety (Gregory et al., 2007; Killam et al., 2011). However, in my study, Deborah thought that there are more factors to consider when administering a medication; that is, one error was not reason to fail a student. Boley and Whitney (2003) also caution against failing a student for a single error in their discussion about students who appeal fails; they state that assessors should identify a pattern of unsatisfactory performance to fail a student (see Chapter six). I would agree that there could be other factors that should be considered when failing a student for a drug error. However, when assessment is against the five rights (NZNO, 2012), students should have learnt these and be prepared for the assessment. The five rights for medication administration are designed to protect public safety and reduce the risk of a fatal error.

Heidegger's (1953/2010, p. 70) explanation of a tool being designed for a specific purpose can be applied to the participants' use of an assessment tool. The purpose of the clinical assessment tool is to determine whether a nursing student can continue their journey towards becoming a nurse. However, judgements are influenced by the person with the tool and how criteria are interpreted. In effect, the assessment tool is placed in the hands of a registered nurse, who may, or not, be trained to assess a student's performance. Whilst the criteria on a check list remain the same, the interpretation of the content may vary depending upon who is holding the assessment tool. Whilst a consistent tool may be used to assess students, it is subject to the time and nature of the clinical placement; the person making a decision with the tool, and the person being assessed. Indeed, my research identified that it was difficult to fail a student who was liked (see Chapter five for examples)

and this is not well acknowledged within other nursing studies. However, in two New Zealand studies, Anderson (2008) recognised the difficulties of failing a nursing student who was liked by the assessor, and Wilkinson and Wade (2009) also identified how the "halo effect" of a lovely medical student can inhibit supervisors from failing them. In other countries, Pell and Roberts (2006) state that reliability is compromised in clinical assessment of medical students due to different patient scenarios, different assessors, locations, hospitals, subjectivity and assessor fatigue. Their findings can also be applied to clinical assessment of nursing students in New Zealand because, as my study has revealed, nursing students are assessed in a diverse range of clinical placements, by many different assessors, who may use their own interpretation of the assessment tool for assessing students. I will now discuss why participants did not take responsibility for failing a nursing student.

**Not Failing Students as *Disburdenment***

Failure to accept responsibility has been termed as *disburdenment* (Heidegger, 1953/2010, p. 274) and my study demonstrates that participants frequently *disburden* the responsibility to award a fail. As noted earlier, participants acknowledged *Being-as* educators, they were also *Being-as* assessors; yet a few, especially inexperienced participants, did not feel that it was their responsibility to award a fail grade. Yet I would argue that *Being-a* clinical nurse educator means being able to assess as well as educate. If clinical nurse educators are not prepared to fail nursing students, then they should not be clinical nurse educators; correctly assessing another's behaviour is part of their *Being* - their *Being-as* an educator to uphold educational standards, and their *Being-as* a nurse to maintain public safety.

This study noted that most of the participants who had not failed a student were less experienced *Being-as* educators. The analysis of the findings could attribute the reluctance to fail students to the Heideggerian phenomenon of *being responsible.* Participants did not want to have the responsibility of failing students and ending their journey. Participants believed that their responsibility was to submit the paperwork to nursing school management, but the responsibility for failing would be management's, not the participant's. Less experienced participants had not received sufficient education for *Being-as* an assessor, therefore it could be assumed that this would be a reason for not taking responsibility for failing. However, Duffy (2003) also identified that mentors did not think that it was their responsibility to award a fail, even though they had received education for

*Being-a* mentor and assessor. This is a cause for concern, that despite receiving education, mentors did not take responsibility for failing students.

My study suggests that lack of preparation for *Being-a* clinical nurse educator, the differing worlds of education and nursing, and the ambiguity of the assessment tool can make an educator feel vulnerable and possibly open to scrutiny within an appeals and legal situation. Experienced participants, with more *time, Being-as* clinical nurse educators were more confident about their judgements to fail and better prepared to defend their actions within an appeals process. This may be due to previous experiences, but it may also be connected to their understanding of a duty of care to protect public safety as previously discussed.

The threat of being challenged by the student, and not supported by faculty led some participants not to take responsibility to fail a student. The threat to self, *Being-as* a clinical nurse educator, became a barrier to awarding a fail grade and the responsibility to protect the public had been absolved. The need for evidence, and even considering the academic marks, was highlighted by participants to justify an assessment decision; a student who was succeeding within the theory components influenced participants' decision not to fail a student. This could be interpreted that the participants were integrating knowledge from both worlds of nursing and education to make a judgement. Using evidence from other sources to support a fail decision is supported in other studies and would be termed good practice if students were taking the decision through an appeals hearing (Boley & Whitney, 2003; Duffy, 2003; Hawe, 2002; Luhanga et al., 2008a; O'Connor et al., 2009). The concerns about having to defend a fail grade awarded to a nursing student and the subsequent risk to public safety is a concern. It would seem that fear of processes within the *world-of-education* threatened their *authentic* self *Being-as* nurses, and that their *authentic Being* has been challenged through *being-in* two worlds. Interestingly, more novice participants, talked about wanting to be popular, being "everybody's friend". I would suggest that this is because they lack experience as educators and lack self-confidence as assessors. It may be posited that they are protecting their own state of *Being* rather than protecting public safety through *Being-a* nurse.

In essence, some participants who had failed students, *disburdened* the responsibility to the student, claiming that students had not learnt what they had been taught. As suggested earlier, taking responsibility for failing nursing students can be discussed as *being-authentic.* When responsibility is *disburdened* to *others*, this can be interpreted as *being-inauthentic* because *others*, the *they self*, are making the decision. *Being-authentic*

means recognising their state of *Being-a* nurse, having a responsibility to protect the public from harm; that is, decisions associated with student assessments are concerned with public safety. In an interesting juxtaposition of reasoning, participants were able to articulate the need to protect the public, yet they still voiced concerns about failing a student. This interesting phenomenon is backed up by many studies (Drake & Stokes, 2004; Gregory et al., 2009; Parrott, 1993; Scholes & Albarran, 2005; Tee & Jowett, 2009) which confirm that nurses do not want to fail students. The term "abdicate" has been used by some researchers (Anderson, 2008; Luhanga et al., 2008a), or renege (Duffy, 2003), to describe their lack of responsibility as assessors.

Clinical nurse educators have multiple responsibilities when *being-with* students; responsibilities to the polytechnic to uphold the educational standards and values; responsibilities to the NCNZ for protecting the public; responsibility to the clinical environment to ensure that students are well prepared to deliver safe care to health consumers, and, I would argue, a responsibility to themselves to uphold the values and attributes for *Being-a* nurse. *Being-a* clinical nurse educator demands multiple states of *Being* and the movement between various responsibilities can prove to be challenging and even create *inauthentic* behaviour.

**Assessment Decisions Being Appealed**

The state of *Being-a* clinical nurse educator was challenged by students who appealed a fail grade. Some participants were required to defend a clinical assessment decision from the *world-of-nursing,* in an appeals process, in the *world-of-education*. A clinical assessment is also about meeting the educational standards for nurse education in the *world-of-education.* As discussed previously, students are frequently failed because of participants' accountability to protect public safety. However, a decision to protect the public from an unsafe student, within the *world-of-nursing,* is being reviewed within the *world-of-education*. This highlights the tensions between the two worlds that were discussed at the start of this chapter.

Participants felt that their integrity and experience of *Being-a* nurse educator were being challenged when a student appealed a fail grade. Being part of an appeals process was described as stressful and created anxieties for participants. Most of the participants who were involved in appeals processes were experienced clinical nurse educators, yet they still described the hassles and effort that was involved. Despite having failed numerous students, one experienced participant commented that it was not even worth the effort; however, she recognised her accountability to protect the public, and would continue to fail

students. However, my study supports research by Tiwari et al. (2005) which identified that experienced assessors who failed students got a reputation for failing. Tiwari et al. (2005) noted that students put more effort into studying if they were being assessed by a person they perceived as being "harsh" (p. 303). I would suggest that being "harsh" means that the assessor is using clear criteria and upholding their position to protect public safety and maintain educational standards; that is, upholding *Being-an* assessor.

Less experienced participants, who were less likely to have failed a student, questioned their teaching abilities of *Being-an* educator. This is a justified concern as I have already discussed inadequate preparation for *Being-a* clinical nurse educator. Participants generally wanted to assist students along their journey to become registered nurses; they did not seek to fail students, and as previously indicated, some stated that it was easier to pass a student, an observation also noted in other studies (Black et al., 2014; Duffy, 2003; Hawe, 2003; Ilot & Murphy, 1997).

The appeals process created anxieties for participants and was described as a stressful event that required support from colleagues and managers. This was described in terms of *caring for* each other. However, my research found that managers did not always support the decision to fail a student as participants spoke of decisions being over turned. Studies have suggested that support from nursing and institution faculty is important for preceptors to have confidence about failing a student (Black et al., 2014; Drake & Stokes, 2004; Luhanga et al., 2008a, Paton, 2010; Pulsford et al., 2002; Stokes, 2007). There is limited evidence of nursing school management not supporting assessment decisions within research for New Zealand nurse education. Hawe (2003), at least, identified that there was pressure to pass a student, which came from colleagues within teacher education courses in New Zealand. However, in my study, Jackie, made a significant comment about maintaining the reputation of the school and supporting each other (see Chapter six). This is about not challenging colleagues and *being-with others*, although surely there may be occasions when a colleague should be questioned about an assessment decision, whether it be a pass or a fail. Challenging colleagues, it may be claimed, should be about maintaining a professional identity and could be considered as an aspect of *Care,* as discussed earlier in this chapter. For this reason, some participants acknowledged the need for an appeals process, to ensure that students are treated fairly.

Appeal hearings were conducted by the polytechnic with lawyers and other polytechnic management staff as illustrated earlier by three participants. The NCNZ standards for educational establishments (NCNZ, 2014) state that a registered nurse needs

to be on all appeal panels, but I suggest that it requires a very strong person to fight for the rights of the public against the rights of the student in the presence of lawyers. Drake and Stokes (2004) highlighted in a survey of 15 nursing schools in New Zealand that some appeal boards did not have nursing representation. Whilst this survey was conducted more than ten years ago, there is anecdotal evidence that nurses continue to be absent from some appeal hearings. Indeed, at least one CEO in this study did not think that the polytechnic was the gatekeeper to nursing; another example of the tension between the two worlds. Whilst other studies have acknowledged assessors as being gatekeepers to protect the public, my study has highlighted the viewpoint that the *world-of-education* does not accept the role of gatekeeping for students going into the *world-of-nursing*. Participants were frustrated when fail decisions were overturned as part of an appeals process; they were concerned about their accountability to protect public safety as "failing" students became registered nurses.

Nevertheless, it was apparent in the data that the threat of being sued by a student, or their parents, inhibited participants from awarding failing grades. That is, it was easier to pass a student, than to fail them, which could account for why some participants did not fail students. This was explained by Helen, with limited educational experience and preparation that educators are not strong enough, and Lucy saying that the underlying qualities of nursing, care and compassion take over (see Chapter five). However, Black et al. (2014) suggest that assessors should not fear appeals processes because they should have faith in the decision that they have made, that is, they do need to be strong.

Appeals processes were stressful and it could be argued that they lead to assessors passing unsafe students, rather than face an appeal from a failed nursing student. Appeals processes which take place within the *world-of-education* must have strong representation from the *world-of-nursing.* Clinical assessment is about the safety of the health consumer within the *world-of-nursing.* Clinical nurse educators must be educated and prepared to uphold assessment decisions that protect the health consumer.

**Conclusion**

This chapter has discussed the experiences associated with assessing nursing students; in particular their experiences of *being-with* "failing" students. Five major discussion themes were identified and were exposed in the *clearing* to explore the experiences of clinical nurse educators. Using Heideggerian phenomenology to interpret meaning from their experiences it was identified that *being-in* two worlds created tensions for being a clinical nurse educator. This was a major theme for exploring the reasons why

educators fail to fail. *Being-a* nurse with accountability for public safety and *Being-an* educator with responsibility for student education created tensions, which could be partially due to the different statutes that governed the two worlds. The second discussion theme highlighted how the phenomenon of *Care* can be used to justify failing a student*; care for* the health consumer and *care for* the student. The third discussion theme applied the Heideggerian concept of *tools* to the use of assessment tools. The discussion highlighted the challenges that are presented by the use of different assessment tools. In particular, the use of the NCNZ (2012a) competencies created unique challenges as the student is assessed for their *futurity* as a registered nurse. The fourth theme discussed the phenomenon of responsibility and lack of responsibility that less experienced clinical nurse educators demonstrated for not failing students. Finally, the stress of having a fail decision appealed within the polytechnic was discussed and identified as a potential reason for not failing students. These five discussion themes have shone some light into the clearing to explain why clinical nurse educators are reluctant to fail nursing students in clinical practice. In the next, and final chapter, I will return to the original research questions and conclude with recommendations for clinical nurse education in New Zealand.

# CHAPTER EIGHT

## Conclusion and Recommendations

I now conclude the journey that started with my desire to investigate the experiences of clinical nurse educators *being-with* nursing students during clinical placements. The aim of the research was to explore the experiences of clinical nurse educators particularly when *being-with* "failing" students. Heideggerian Interpretive Phenomenology was used to analyse and present the findings of the fourteen interviews, in three New Zealand polytechnics. The findings were discussed in the previous chapter which identified five main discussion points. The research journey has now entered the clearing to answer the research questions and interpret meaning from participants' experiences.

The participants were also on a journey, *being-with* students as they progressed to becoming registered nurses. This thesis has demonstrated that *Being-a* clinical nurse educator is *being-in* the *world-of-nursing* and the *world-of-education,* with responsibilities to both worlds. This creates tensions for the clinical nurse educator as discussed in chapter seven. I will now return to the four original research questions and summarise the discussion points from chapter seven. I will note limitations of this study and identify possible further research. Finally, I will suggest some recommendations that could assist with reducing the tensions that have been identified in this study.

### Clinical Nurse Educators Experiences of Clinical Assessment

The first research question was: "How do clinical nurse educators experience the clinical assessment of nursing students?" The findings were presented as participants were *being-with* students on a journey to becoming registered nurses, starting with students entering the BN programme. There was concern that some of the students should not be on the programme and participants questioned the selection criteria for entry into the BN programme. Having commenced the journey, students started to learn fundamental clinical skills in the simulated environment situated in the *world-of-education.* Participants recognised the difficulties of teaching and assessing large numbers of students within the polytechnic. Students were assessed prior to going to a clinical placement in the *world-of-nursing* to ensure that they had a basic level of knowledge to protect public safety. However, some participants acknowledged that some students had not passed the assessment but were able to practise their skills within the *world-of-nursing,* to be re-assessed at the end of the placement. This was justified as enabling students to have time to learn about becoming a nurse. Some participants demonstrated *care for* first year nursing students by suggesting

that they were being *thrown* into the *world-of-nursing* and needed *time* to learn rather than be assessed. Assessment of clinical skills was made easier for most participants through the use of check lists with clear criteria, although for some participants this was considered punitive and did not account for the processes involved with the delivery of clinical skills.

As students progressed along the journey to becoming nurses, participants recognised the limitations of using an assessment tool that used the NCNZ (2012a) competencies, designed for registered nurses. This means that students were being assessed for their *futurity Being-as* registered nurses, and not their *presentness* as students. Participants struggled to identify how assessment progressed throughout the programme, and they developed their own interpretations of progression, leading to inconsistent use of the assessment tool. The use of the NCNZ competencies (2012a) also challenged participants when students were being assessed within speciality placements such as mental health and primary care, as they were generally not directly involved in care delivery.

Participants experienced lack of preparation for *Being-as* educators and *Being-as* assessors, interpreted as *being thrown* into the *world-of-education*. Some used their own experience of *having been* a student to determine how to teach and assess, recalling how scared they had been as students. Participants spoke of the difficulty of identifying the point at which teaching/learning stopped and assessment began; at what point should a student be assessed?

Whilst some participants enjoyed assessing as they used it as a measure of their teaching, others felt anxious, especially when it was a student's second enrolment. Participants also expressed concern about having assessment decisions over turned through appeals processes. The ambiguity of assessment tools and duration of clinical placement caused concern for participants. Some participants were concerned that they were assessing students they had not *been-with* in the clinical placement and relied on *being-with-others* to make assessment judgements. The experience of participants varied depending upon the time they had spent as clinical nurse educators, that is, they developed more confidence as educators and assessors with more time.

**Factors Influencing Participants' Assessment Decisions**

The second research question was: "What factors influence the grade awarded to a nursing student when a clinical nurse educator is uncertain about whether the student is achieving the standard required to pass a clinical assessment; that is, a "borderline" student?" When there were uncertainties about whether to pass or fail a student, that is, a borderline student, the majority of participants cited safety as the key criterion to make the judgement. However, there was inconsistency about the definition of "safety". The key themes to determine safety were identified as medication administration, application of knowledge to the health consumer's care, and *Being-a* professional. Not *Being-a* professional was described as not wearing the correct clothes, using inappropriate language and *being disrespectful*.

For some participants the bottom line for making a judgement was whether the student should *care for* a member of the participants' family, described by one participant as the "litmus test". As students progressed along the journey, participants asked clinical staff whether they would employ the student to belong to the nursing team.

Another factor for making an assessment judgement was the length of time that the student had been in the programme. Participants did not want students wasting time and money if they thought that the student would not complete the journey, but they also wanted the student to have more time to learn. A few participants referred to the students' academic performance and if they were succeeding within the *world-of-education,* they were more likely to pass the student in a clinical assessment. The assessment of a borderline student presented challenges for the participants. Most used the bottom-line criteria of *being-safe; caring for* family members, and future employability. However, a few participants would pass a borderline student to allow them another opportunity, and to be assessed by another person.

**The Impact of the Clinical Teaching Model**

The third research question was: "How does the clinical teaching model affect the grades awarded by assessors on clinical assessments?" A limitation of this study was the lack of different clinical teaching models, especially the DEU model, and interpretation of the preceptorship model being used by the participants; this is an area that requires further study. All participants in this study assessed students through *being-with* preceptors. Participants recognised that a good relationship with the preceptors enabled the students to have a good learning experience. However, it was acknowledged that occasionally there

was a "them and us" as the clinical placements were on a different site to the polytechnic. Occasionally, preceptors and participants disagreed about an assessment judgement. Participants wanted students to demonstrate application of knowledge to practice, and use of critical thinking; whilst a few participants spoke of preceptors who wanted students who were lovely. This created a tension when participants recognised that preceptors were *being-with* students for longer periods of time than themselves. Participants supported clinical staff through explaining the use of the assessment tool, and making sure that clinical staff were aware of the educational requirements of the student. Participants were bridging the two worlds of nursing and education. It was not possible to compare various clinical teaching models to answer this research question more comprehensively.

**The Feelings of Clinical Nurse Educators who are Assessing "Failing" Students**

The fourth and final research question was: "How do clinical nurse educators experience awarding a grade to a nursing student they do not consider is performing to the standard required to pass a clinical assessment; that is, a "failing" student? Failing nursing students has been interpreted as *being caring; caring for* students when participants were *Being-as* educators and *caring for* health consumers when participants were *Being-as* nurses. *Being-as* clinical nurse educators the phenomenon that participants drifted towards was about *Being-a* nurse and protecting public safety. The separation of the two *Beings* is a cause for concern due to the tensions experienced through *being-in* two worlds. Participants felt that they were *caring for* students when a student failed their first enrolment as they would have more time to learn. When students failed a second enrolment and when there were clear indications that public safety was being compromised, this was interpreted as *caring for* the health consumer.

Just more than half of the participants in this research had failed a nursing student in clinical practice. Participants who had failed students felt that it was sometimes a "hassle" and required lots of evidence to support the decision. However, none of the participants who had failed a student regretted the decision; they felt that they were maintaining public safety. The participants who had failed students were generally those with more experience *Being-as* clinical nurse educators. Participants who had not failed students, despite having concerns about performance, felt inadequately prepared for *Being-as* assessors and felt that they had been *thrown* into the *world-of-education*. They questioned their abilities as educators and as nurses. Less experienced participants demonstrated *care for* students and hoped that with more time they would improve. Less experienced participants also

*disburdened* the responsibility to fail students to management or hoped that someone else failed them later in the programme.

There were feelings of anger, anxiety and frustration about decisions being overturned and this led some participants to question whether it was worth the effort to fail a student. Many participants felt dis-credited as nurses and educators by students appealing the fail grade; having to defend their decision to fail the students within the *world-of-education*. Participants were frustrated by the over ruling of NCNZ (2014) standard for only two enrolments in a clinical paper. Whilst it was acknowledged that there should be an appeals process, participants stressed the importance of following correct processes and having the required evidence. Participants felt there was a lack of support from the w*orld-of-nursing* when being with lawyers who were supporting the student.

**Summary**

In summary, this research has identified that clinical nurse educators employed by New Zealand polytechnics experience tensions associated with the teaching and assessing of nursing students' clinical practice. The teaching of fundamental clinical skills to first year nursing students starts in a simulated environment in the polytechnic; students are assessed against criteria stated on a check list of required components. As students progress through the programme, the NCNZ competencies for registered nurses (2012a) form the foundation for assessing clinical practice. Using the NCNZ competencies (2012a) challenged participants for determining progression through the programme. Participants generally felt unprepared for being clinical nurse educators, especially when being with "failing" students. The concept of "being safe" was used to determine whether to pass, or fail, a borderline nursing student, although the interpretation of safety was diverse and included being a professional. The time that a student had been in the programme was a factor that was considered by participants, acknowledging that some students require more time to become a nurse through enabling re-enrolments in a clinical paper. Participants referred to making assessment decisions in collaboration with clinical staff, although disagreements did arise between participants and clinical staff about the competency of students; participants acknowledging that students required critical thinking and underlying knowledge whilst clinical staff were swayed by "lovely" students and wanted students who delivered nursing care. Being with a "failing" student created anxieties for participants, which can in part, be attributed to being in two worlds of nursing and education. Clinical nurse educators require preparation for being educators and assessors, and they require support from their colleagues when being with the "failing" student. Less

experienced participants were more likely to *disburden* the responsibility for failing students to colleagues.

**Contribution to Nurse Education in New Zealand**

Using Heideggerian phenomenology my research has identified that clinical nurse educators belong to two different worlds; that of education and that of nursing. Despite this research involving a small sample from only three New Zealand polytechnics, it has acknowledged that belonging to the two different worlds can present challenges for clinical nurse educators when assessing nursing students, specifically those students who are not achieving the required assessment criteria. The challenges posed due to clinical nurse educators belonging to two different worlds are exacerbated as nursing students do not have a responsibility to the regulatory body for nursing in New Zealand.

This study has also highlighted the lack of formal preparation for *being-as* nurse educators. Clinical nurses who become educators currently lack any formal, nationally recognised preparation to educate, supervise and assess nursing students; especially how to deal with a nursing student who is considered to be "failing". Lack of formal preparation may have led to clinical nurse educators disburdening the responsibility to colleagues to fail nursing students. *Being-a* clinical nurse educator has a responsibility to protect public safety be ensuring that nursing students are being assessed appropriately and may progress onto the nursing register as a competent practitioner. Additionally, nursing students should have confidence that the decisions made by clinical nurse educators are as a consequence of them being competent in educating and assessing. The futures of nursing students are dependent upon informed decisions by adequately prepared nurse educators.

This research has also demonstrated that some students take more time to become registered nurses. Through failing students who are not achieving the required assessment standards means that they are being afforded more time and opportunities to learn and achieve the required assessment criteria. Failing a nursing student can be considered as *caring for* the student if students are aware of the importance of time to achieve their aim of becoming registered nurses.

I believe that this research has made major contributions to the field of nurse education in New Zealand, as stated above. In particular a recognition that failing nursing students presents challenges to clinical nurse educators employed by polytechnics, and this may potentially affect public safety. Recognising that clinical nurse educators belong to two worlds; the lack of formal preparation for becoming a clinical nurse educator; the

inconsistent use of clinical assessment tools, including the use of RN competencies for assessing students, and the acknowledgement that failing can be considered as caring, contribute to the body of nursing knowledge in New Zealand. The research has identified some recommendations for practice that may overcome the identified challenges. However, the research does have some limitations which will be discussed in the next section.

**Limitations**

I acknowledge that there are limitations to the study. Although this was a phenomenological study and Smith et al. (2009) recognise that a small sample size is acceptable within this type of study, the findings from this study cannot be generalised throughout all New Zealand nurse education as only three of New Zealand's 13 polytechnics participated; there were no participants from university based undergraduate programmes. Additionally, there were no examples from the DEU as a clinical teaching model and there was inconsistent interpretation and implementation of clinical teaching models. Another significant limitation of the research was the lack of participant involvement with the interpretation of their interviews. It was disappointing that only four people returned their original interview transcripts.

**Recommendations**

To ensure that health consumers receive safe and competent care, it is important to ensure that students who graduate from nurse education programmes are safe to be admitted to the nursing register. The current tensions that exist between the *world-of-education* and the *world-of-nursing* mean that students are not being failed for unsafe care and are therefore *being-with* health consumers as registered nurses. I recommend the following to bring the worlds of education and nursing together.

- This research has demonstrated that participants experience tensions between the *world-of-nursing* and the *world-of-education.* This is partly due to clinical nurse educators who are educating and assessing nursing students with inadequate support and preparation. Therefore, I recommend that all educators who are responsible for the education of nursing students must have appropriate, nursing specific teacher education to prepare them for *being-with* nursing students. The education programme must include components for clinical education and assessment which include *being-with* the "failing" student, and not being afraid to use the term "fail". The education programme should be monitored by the NCNZ. *Being-a* nurse educator should be a scope of

practice which is endorsed by the Regulatory Authority. Tertiary education institutes which employ registered nurses as clinical nurse educators must have a responsibility to support staff when they are assessing nursing students, especially those students who are considered to be "failing". Professional development opportunities to learn about the assessment process, including assessment criteria, assessment validity and reliability, providing feedback to students, and maintaining clear records of student performance should be an institute's responsibility. *Caring for* clinical nurse educators through clear institutional processes will enhance the reputation of the school as well as empowering clinical nurse educators to take responsibility for their decisions about student assessment grades. Therefore, I recommend that institutions have a clear orientation programme for all new members of staff, which includes supervision when new staff are conducting clinical assessments; implement continuing education sessions for all staff to discuss current best education practice, including assessment; have clear processes for dealing with the "failing" student and ensure staff are aware of these processes.

- This research has also demonstrated the importance of *being-with* clinical staff who are *being-with* students for their learning and assessment. Therefore, I recommend that clinical nurses who are *being-with* students to make judgements about their suitability to become registered nurses, must also attend formal post graduate education programmes, delivered in tertiary education institutes, to prepare them for their clinical education and assessment role. This course could be an extension/replacement of the current 16 hour preceptorship course. Upon successful completion of the course, the nurse should notify the NCNZ and have the course recorded on the annual re-certification of practice. Tertiary institutes would have a responsibility to also inform NCNZ of successful nurses.
- This research has demonstrated that tensions exist between the worlds of nursing and education due to clinical nurse educators being responsible to the two worlds, whilst the nursing student is governed by the *world-of-education*. I would suggest that the tensions could be reduced by students being responsible to the *world-of-nursing* through a formalised indexing process with the NCNZ. The students would therefore have a responsibility to the *world-of-nursing* which would also be able to intervene in appeals cases. This would also require the NCNZ as the regulator for *world-of-nursing* to determine clearer selection criteria, which could include police vetting. I recommend that on

commencement of a nursing programme, nursing students complete a process of indexing with the NCNZ which is submitted by the Head of the Nursing School.

- Participants highlighted the problems of assessing nursing students using the NCNZ (2012a) competencies for registered nurses. The competencies were not produced for nursing students and do not demonstrate progression. Competency assessment should be a three way approach which is developed in collaboration between educators, clinical staff and supported by NCNZ to enable a consistent national approach to competency assessment of nursing students. The criterion for determining assessment progression must be made clearer within the NCNZ (2014) guidelines to reduce individual interpretation and subjectivity about what is meant by "progression". Clinical progression and assessment must also be considered during curriculum development for the Bachelor of Nursing programme. Therefore, I recommend the establishment of a national group of nurse academics and clinical nurses to develop a national set of competencies for nursing students which reflect progression points throughout the three year programme. Additionally, through Nurse Educators in the Tertiary Sector (NETS), the development of a national competency assessment tool could be investigated and researched.
- Participants spoke of short clinical placements and assessments being conducted after only a few days in a clinical placement. This research has demonstrated that it takes *time* to learn to become a nurse, therefore there should be a minimum duration of time within a placement for a student to learn, to be stipulated within the NCNZ (2014) standards for nurse education. However, due to the lack of research which identifies an optimum duration for clinical placement, I would suggest a minimum of four weeks where a clinical assessment is to be conducted. This allows students time to settle into a clinical environment and develop a relationship with their preceptor. Consideration should be made about the nature of assessments within speciality placements and whether the current BN programme adequately prepares students for *Being-as* registered nurses within specialty placements such as mental health and primary care. I recommend that NCNZ clearly state the recommended minimum hours that a nursing student must spend in speciality areas, and the required assessment criteria in these areas.

**Further research.**

The focus of this research was polytechnic clinical nurse educators' experiences of *being-with* students. Only three polytechnics participated in this study which is a limitation and further research involving university schools of nursing is required because universities are governed by different sections of the Education Act (1989). The role of clinical nursing staff in the assessment of nursing students within New Zealand is also worthy of further research. Additionally, research into the personalities of clinical nurse educators could highlight whether personality factors influence the decision to fail students. Further research about the experiences of nursing students who have failed clinical assessments may also provide insight into why students appeal. The interviews for this research were conducted prior to the implementation of the Diploma in Enrolled Nursing programme in New Zealand. The impact of this 18 month long programme as an alternative route for students who have failed the BN programme is also worthy of further research. Offering suitable students the option of continuing their nursing journey within another programme may affect the judgement to fail a student, knowing that they can still be a nurse, under another scope. There is limited research about the optimum duration of a clinical placement and I believe that this requires further research, particularly for first year nursing students and speciality placements. A 360 hours final clinical placement was introduced by the NCNZ in 2012 and the effectiveness of this placement for the preparation of graduates for being RNs is worthy of research.

## Conclusion

This study has revealed that there is a reluctance to fail nursing students in clinical practice due to the positioning of clinical nurse educators *being-in* two worlds. This thesis has demonstrated that clinical nurse educators within New Zealand polytechnics experience tensions when educating and assessing nursing students. This research has also highlighted that students who are not demonstrating competence are not being failed and continue with their studies and ultimately qualify as being a nurse. Nurse education must not absolve its responsibility to prepare students to become registered nurses within the *world-of-nursing.* Nurse educators and registered nurses who are involved with the education and assessment of nursing students must receive appropriate preparation and support for *being-with* students. Assessment of nursing students should be robust and assure the public that students have been assessed as safe and competent. Not upholding an assessor's fail grade compromises public safety. In chapter three I stated my beliefs that health consumers have a right to safe and competent care and that the health consumer

should be at the core of all nursing care. I also stated that students did not have a right to be a nurse as it may not be the right career choice for some people. I maintain my beliefs, but since conducting this research, I also now believe that nursing students have a right to receive a fair and rigorous education from people who are well prepared for educating and assessing from a well-informed basis. Nurse education must uphold its responsibility to protect public safety and not be afraid to fail students who are not demonstrating competence. Nurse educators must accept their responsibility to be the gatekeepers to the nursing profession and should have support from the *world-of-education* and the *world-of-nursing* to maintain public safety.

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## APPENDIX A

## NZQA Qualifications Definitions and Levels Descriptors

*Table A1*

*NZQA Qualification definitions and level descriptors (NZQA, 2010, pp. 9-13)*

| Level | Purpose | Outcome |
|---|---|---|
| **Certificate level one** | Qualifies individuals with basic knowledge and skills for work, further learning and/or community involvement | Demonstrates basic general and/or foundation knowledge.<br>Apply basic skills required to carry out simple tasks.<br>Apply basic solutions to simple problems.<br>Apply literacy and numeracy skills for participation in everyday life.<br>Work in a highly structured context.<br>Demonstrate some responsibility for own learning. Interact with others. |
| **Certificate level two** | Qualifies individuals with introductory knowledge and skills for a field(s)/areas of work or study | Demonstrates basic factual and/or operational knowledge of a field of work or study.<br>Apply known solutions to familiar problems.<br>Apply standard processes relevant to the field of work or study.<br>Apply literacy and numeracy skills relevant to the role in the field of work or study.<br>Work under general supervision.<br>Demonstrate some responsibility for own learning and performance.<br>Collaborate with others. |
| **Certificate level three** | Qualifies individuals with knowledge and skills for a specific role(s) within fields/areas of work and/or preparation for further study. | Demonstrate some operational and theoretical knowledge in a field of work or study.<br>Select from and apply a range of known solutions to familiar problems.<br>Apply a range of standard processes relevant to the field of work or study.<br>Work under limited supervision.<br>Demonstrate major responsibility for own learning and performance. |

| | | |
|---|---|---|
| **Certificate level four** | Qualifies individuals to work or study in broad or specified field(s)/areas. | Demonstrate broad operational and theoretical knowledge in a field of work or study.<br>Select and apply solutions to familiar and sometimes unfamiliar problems.<br>Select and supply a range of standard and non-standard processes relevant to the field of work or study.<br>Apply a range of communication skills relevant to the field of work or study.<br>Demonstrate the self-management of learning and performance under broad guidance.<br>Demonstrate some responsibility for performance of others. |
| **Certificate level five** | Qualifies individuals with theoretical and/or technical knowledge and skills within an aspect(s) of a specific field of work or study. | Demonstrates broad operational or technical and theoretical knowledge within an aspect(s) of a specific field of work or study.<br>Select and apply a range of solutions to familiar and sometimes unfamiliar problems.<br>Select and apply a range of standard and non-standard processes relevant to the field of work or study.<br>Demonstrate complete self-management of learning and performance within defined contexts.<br>Demonstrate some responsibility for the management of learning and performance of others. |
| **Certificate level five (e.g. Diploma in Enrolled Nurse)** | Qualifies individuals with theoretical and/or technical knowledge and skills within a specific field of work or study. | Demonstrate broad operational or technical and theoretical knowledge within a specific .field of work or study.<br>Select and apply a range of solutions to familiar and sometimes unfamiliar problems.<br>Select and apply a range of standard and non-standard processes relevant to the field of work or study.<br>Demonstrate complete self-management of learning and performance within defined contexts.<br>Demonstrate some responsibility for the management of learning and performance of others. |

| | | |
|---|---|---|
| **Certificate level six** | Qualifies individuals with theoretical and/or technical knowledge and skills within an aspect(s) of a specialised/strategic context. | Demonstrate specialised technical or theoretical knowledge with depth within an aspect(s) of a field of work or study.<br>Analyse and generate solutions to familiar and unfamiliar problems.<br>Select and apply a range of standard and non-standard processes relevant to the field of work or study.<br>Demonstrate complete self-management of learning and performance within dynamic contexts.<br>Demonstrate responsibility for leadership within dynamic contexts. |
| **Diploma level six** | Qualifies individuals with theoretical and/or technical knowledge and skills in a specialised/strategic context. | Demonstrate specialised technical or theoretical knowledge with depth in a field of work or study.<br>Analyse and generate solutions to familiar and unfamiliar problems.<br>Select and apply a range of standard and non-standard processes relevant to the field of work or study.<br>Demonstrate complete self-management of learning and performance within dynamic contexts.<br>Demonstrate responsibility for leadership within dynamic contexts. |
| **Diploma level seven** | Qualifies individuals with specialised and technical knowledge and skills within a professional context. | Demonstrate specialised technical or theoretical knowledge with depth in one or more fields of work or study.<br>Analyse and generate solutions to unfamiliar and sometimes complex problems.<br>Select, adapt and apply a range of processes relevant to the field of work or study.<br>Demonstrate advanced generic skills and/or specialise knowledge and skills in a professional context or field of study. |

| | | |
|---|---|---|
| **Bachelor Degree** | Provides individuals with systematic and coherent introduction to a body of knowledge of a recognised major subject (or subjects in the case of a double degree or a double major) as well as to problem-solving and associated basic techniques of self-directed work and learning. | Demonstrate intellectual independence, critical thinking and analytical rigour.<br>Engage in self-directed learning.<br>Demonstrate knowledge and skills related to the ideas, principles, concepts, chief research methods and problem-solving techniques of a recognised major subject.<br>Demonstrate the skills needed to acquire, understand and assess information from a range of sources.<br>Demonstrate communication and collaborative skills. |

**APPENDIX B**

**Education Programme Standards For The Registered Nurse (NCNZ, 2014)**

1. The educational institution and the programme comply with legislated requirements and the Council's policies and guidelines.

2. The programme has a structured curriculum that enables students to achieve the programme outcomes and the Council's *Competencies for the registered nurse scope of practice*.

3. The programme is implemented by staff who are qualified and well prepared for their roles.

4. Facilities and resources are available to support the achievement of the expected outcomes of the programme.

5. The environment supports the teaching/learning process.

6. Student performance is assessed against learning outcomes relevant to nursing, and the programme outcomes and assessment processes meet the Council's policies.

7. The candidate for registration complies with legislated requirements and the Council's policies and guidelines.

**APPENDIX C**

## Competencies for Registration as a Registered Nurse (NCNZ, 2012a)

## Registered Nurse Scope of Practice

Registered nurses utilise nursing knowledge and complex nursing judgement to assess health needs and provide care, and to advise and support people to manage their health. They practise independently and in collaboration with other health professionals, perform general nursing functions and delegate to and direct enrolled nurses, healthcare assistants and others. They provide comprehensive nursing assessments to develop, implement, and evaluate an integrated plan of health care, and provide nursing interventions that require substantial scientific and professional knowledge and skills. This occurs in a range of settings in partnership with individuals, families, whanau and communities. Registered nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. Registered nurses may also use this expertise to manage, teach, evaluate and research nursing practice. Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. There will be conditions placed on the scope of practice of some registered nurses according to their qualifications or experience limiting them to a specific area of practice.

**Domain One: Professional Responsibility**

**Competency 1.1 Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements.**

Indicator: Practises nursing in accord with relevant legislation/codes/policies and upholds health consumer rights derived from that legislation.

Indicator: Accepts responsibility for actions and decision making within scope of practice.

Indicator: Identifies breaches of law that occur in practice and reports them to the appropriate person(s).

Indicator: Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice.

Indicator: Uses professional standards of practice.

**Competency 1.2 Demonstrates the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice.**

Indicator: Understands the Treaty of Waitangi/Te Tiriti o Waitangi and its relevance to the health of Maori in Aotearoa/New Zealand.

Indicator: Demonstrates knowledge of differing health and socioeconomic status of Maori and non-Maori.

Indicator: Applies the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice.

**Competency 1.3 Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by enrolled nurses and others.**

Indicator: Understands accountability for directing, monitoring and evaluating nursing care provided by enrolled nurses and others.

Indicator: Seeks advice from a senior registered nurse if unsure about the role and competence of enrolled nurses and others when delegating work.

Indicator: Takes into consideration the role and competence of staff when delegating work.

Indicator: Makes appropriate decisions when assigning care, delegating activities and providing direction for enrolled nurses and others.

**Competency 1.4 Promotes an environment that enables health consumer safety, independence, quality of life, and health.**

Indicator: Identifies and reports situations that affect health consumer or staff members' health or safety.

Indicator: Accesses, maintains and uses emergency equipment and supplies.

Indicator: Maintains infection control principles.

Indicator: Recognises and manages risks to provide care that best meets the needs and interests of health consumers and the public.

**Competency 1.5 Practises nursing in a manner that the health consumer determines as being culturally safe.**

Indicator: Applies the principles of cultural safety in own nursing practice.

Indicator: Recognises the impact of the culture of nursing on health consumer care and endeavours to protect the health consumer's wellbeing within this culture.

Indicator: Practises in a way that respects each health consumer's identity and right to hold personal beliefs, values and goals.

Indicator: Assists the health consumer to gain appropriate support and representation from those who understand the health consumer's culture, needs and preferences.

Indicator: Consults with members of cultural and other groups as requested and approved by the health consumer.

Indicator: Reflects on his/her own practice and values that impact on nursing care in relation to the health consumer's age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability.

Indicator: Avoids imposing prejudice on others and provides advocacy when prejudice is apparent.

**Domain Two: Management of Nursing Care**

**Competency 2.1 Provides planned nursing care to achieve identified outcomes.**

Indicator: Contributes to care planning, involving health consumers and demonstrating an understanding of health consumers' rights, to make informed decisions.

Indicator: Demonstrates understanding of the processes and environments that support recovery.

Indicator: Identifies examples of the use of evidence in planned nursing care.

Indicator: Undertakes practice procedures and skills in a competent and safe way.

Indicator: Administers interventions, treatments and medications, (for example: intravenous therapy, calming and restraint), within legislation, codes and scope of practice; and according to authorised prescription, established policy and guidelines.

**Competency 2.2 Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings.**

Indicator: Undertakes assessment in an organised and systematic way.

Indicator: Uses suitable assessment tools and methods to assist the collection of data.

Indicator: Applies relevant research to underpin nursing assessment.

**Competency 2.3 Ensures documentation is accurate and maintains confidentiality of information.**

Indicator: Maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework.
Indicator: Demonstrates literacy and computer skills necessary to record, enter, store, retrieve and organise data essential for care delivery.

**Competency 2.4 Ensures the health consumer has adequate explanation of the effects, consequences and alternatives of proposed treatment options.**

Indicator: Provides appropriate information to health consumers to protect their rights and to allow informed decisions.

Indicator: Assesses the readiness of the health consumer to participate in health education.

Indicator: Makes appropriate professional judgement regarding the extent to which the health consumer is capable of participating in decisions related to his/her care.

Indicator: Discusses ethical issues related to health care/nursing practice, (for example: informed consent, privacy, refusal of treatment and rights of formal and informal health consumers).

Indicator: Facilitates the health consumer's access to appropriate therapies or interventions and respects the health consumer's right to choose amongst alternatives.

Indicator: Seeks clarification from relevant members of the health care team regarding the individual's request to change and/or refuse care.

Indicator: Takes the health consumer's preferences into consideration when providing care.

**Competency 2.5 Acts appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations.**

Indicator: Understands emergency procedures and plans and lines of communication to maximise effectiveness in a crisis situation.
Indicator: Takes action in situations that compromise health consumer safety and wellbeing.

Indicator: Implements nursing responses, procedures and protocols for managing threats to safety within the practice environment.

**Competency 2.6 Evaluates health consumer's progress toward expected outcomes in partnership with health consumers.**

Indicator: Identifies criteria for evaluation of expected outcomes of care.

Indicator: Evaluates the effectiveness of the health consumer's response to prescribed treatments, interventions and health education in collaboration with the health consumer and other health care team members. (Beginning registered nurses would seek guidance and advice from experienced registered nurses).

Indicator: Reflects on health consumer feedback on the evaluation of nursing care and health service delivery.

**Competency 2.7 Provides health education appropriate to the needs of the health consumer within a nursing framework.**

Indicator: Checks health consumers' level of understanding of health care when answering their questions and providing information.

Indicator: Uses informal and formal methods of teaching that are appropriate to the health consumer's or group's abilities.

Indicator: Participates in health education, and ensures that the health consumer understands relevant information related to their health care.

Indicator: Educates health consumer to maintain and promote health.

**Competency 2.8 Reflects upon, and evaluates with peers and experienced nurses, the effectiveness of nursing care.**

Indicator: Identifies one's own level of competence and seeks assistance and knowledge as necessary.

Indicator: Determines the level of care required by individual health consumers.

Indicator: Accesses advice, assistance, debriefing and direction as necessary.

**Competency 2.9 Maintains professional development.**

Indicator: Contributes to the support, direction and teaching of colleagues to enhance professional development.

Indicator: Updates knowledge related to administration of interventions, treatments, medications and best practice guidelines within area of practice.

Indicator: Takes responsibility for one's own professional development and for sharing knowledge with others.

*Although nurses involved in management, education, research and policy making are exempt from being assessed against the above competencies in domain two, they are required to provide evidence of how they contribute to the management of care.*

**Competencies for nurses involved in management:**

**Competency** Promotes an environment that contributes to ongoing demonstration and evaluation of competencies.

**Competency** Promotes a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.

**Competency** Promotes a practice environment that encourages learning and evidence-based practice.

**Competency** Participates in professional activities to keep abreast of current trends and issues in nursing.

**Competencies for nurses involved in education:**

**Competency** Promotes an environment that contributes to ongoing demonstration and evaluation of competencies.

**Competency** Integrates evidence-based theory and best practice into education activities.

**Competency** Participates in professional activities to keep abreast of current trends and issues in nursing.

**Competencies for nurses involved in research:**

**Competency** Promotes a research environment that supports and facilitates research mindedness and research utilisation.

**Competency** Supports and evaluates practice through research activities and application of evidence-based knowledge.

**Competency** Participates in professional activities to keep abreast of current trends and issues in nursing.

**Competencies for nurses involved in policy:**

**Competency** Utilises research and nursing data to contribute to policy development, implementation and evaluation.

**Competency** Participates in professional activities to keep abreast of current trends and issues in nursing.

**Domain Three: Interpersonal Relationships**

**Competency 3.1 Establishes, maintains and concludes therapeutic interpersonal relationships with health consumer.**

Indicator: Initiates, maintains and concludes therapeutic interpersonal interactions with health consumers.

Indicator: Incorporates therapeutic use of self and psychotherapeutic communication skills as the basis for nursing care for health consumers with mental health needs.

Indicator: Utilises effective interviewing and counselling skills in interactions with health consumers.

Indicator: Demonstrates respect, empathy and interest in health consumer.

Indicator: Establishes rapport and trust with the health consumer.

**Competency 3.2 Practises nursing in a negotiated partnership with the health consumer where and when possible.**

Indicator: Undertakes nursing care that ensures health consumers receive and understand relevant and current information concerning their health care that contributes to informed choice.

Indicator: Implements nursing care in a manner that facilitates the independence, self-esteem and safety of the health consumer and an understanding of therapeutic and partnership principles.

Indicator: Recognises and supports the personal resourcefulness of people with mental and/or physical illness.

Indicator: Acknowledges family/whanau perspectives and supports their participation in services.

**Competency 3.3 Communicates effectively with health consumers and members of the healthcare team.**

Indicator: Uses a variety of effective communication techniques.

Indicator: Employs appropriate language to context.
Indicator: Provides adequate time for discussion.

Indicator: Endeavours to establish alternative communication methods when health consumers are unable to verbalise.

Indicator: Accesses an interpreter when appropriate.

Indicator: Discussions concerning health consumers are restricted to settings, learning situations and or relevant members of the health care team.

*Although nurses involved in management, education, research and policy making are exempted from being assessed against the above competencies in domain three, they are required to provide evidence of how they contribute to interpersonal relationships.*

**Competencies for nurses involved in management, education, policy and research:**

**Competency** Establishes and maintains effective interpersonal relationships with others, including utilising effective interviewing and counselling skills and establishing rapport and trust.

**Competency** Communicates effectively with members of the health care team, including using a variety of effective communication techniques, employing appropriate language to context and providing adequate time for discussion.

**Domain Four: Interprofessional Health Care and Quality Improvement**

**Competency 4.1 Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care.**

Indicator: Promotes a nursing perspective and contribution within the interprofessional activities of the health care team.

Indicator: Provides guidance and support to those entering as students, beginning practitioners and those who are transferring into a new clinical area.

Indicator: Collaborates with the health consumer and other health team members to develop and plan of care.

Indicator: Maintains and documents information necessary for continuity of care and recovery.

Indicator: Develops a discharge plan and follow up care in consultation with the health consumer and other members of the health care team.

Indicator: Makes appropriate formal referrals to other health care team members and other health related sectors for health consumers who require consultation.

**Competency 4.2 Recognises and values the roles and skills of all members of the health care team in the delivery of care.**

Indicator: Contributes to the co-ordination of care to maximise health outcomes for the health consumer.

Indicator: Collaborates, consults with and provides accurate information to the health consumer and other health professionals about the prescribed interventions or treatments.

Indicator: Demonstrates a comprehensive knowledge of community services and resources and actively supports service users to use them.

**Competency 4.3 Participates in quality improvement activities to monitor and improve standards of nursing.**

Indicator: Reviews policies, processes, procedures based on relevant research.

Indicator: Recognises and identifies researchable practice issues and refers them to appropriate people.

Indicator: Distributes research findings that indicate changes to practice to colleagues.

## APPENDIX D

### Essential skills clusters (NMC, 2010) and guidance for their use (guidance G7.1.5b)

The essential skills clusters (ESCs) are to be used as guidance and should be incorporated into all pre-registration nursing programmes. How they are incorporated into programmes is left to local determination. Programme providers can use them to develop learning outcomes at different levels or to map them against existing programme learning outcomes. Some programme providers may wish to map them to specific competencies within the domains or use them to develop practice assessment tools. All the ESCs apply to all fields of nursing.

Skills have not been identified for all progression points, therefore not all columns in the ESC table have been filled. Where there is a gap, skills identified at a later progression point might be achieved at an earlier point. Where it is determined that a specific skill can be more appropriately achieved at a different progression point than that indicated the approved education institution (AEI) should show how and at what point it has been incorporated.

ESCs support the achievement of the competencies in section 3 and criteria for assessment at the first progression point in annexe 2. However, the ESCs do not include all the skills and behaviours required of a registered nurse.

There are five **essential skills clusters**:

- care, compassion and communication
- organisational aspects of care
- infection prevention and control
- nutrition and fluid management
- medicines management.

**Guidance related to numerical assessment**

Some ESCs identify the baseline skills needed to calculate medicines, nutrition, fluids and other areas where there is a need to use numbers. These appear in ESCs 9, 27, 28, 29, 31, 32, 33, 36 and 38. They are marked with an asterix **(*)**. Providers should incorporate all these health related numerical assessments, designed to test numeracy skills, into learning outcomes and assessment strategies.

 The focus should be on demonstration of competence and confidence with regard to judgements on whether to use calculations in a particular situation and, if so, what calculations to use, how to do it, what degree of accuracy is appropriate, and what the answer means in relation to the context.

 Providers can incorporate these health related numerical elements into their own learning outcomes and assessment strategies and should use the ESCs to underpin the nature and content of the assessment, including whether to assess through simulation. They should decide on their own pass mark and how many attempts are allowed in order to reach the first and second progression points.

 After the second progression point, and by the point of entry to the register, the ESCs should help programme providers decide the nature and content of numerical assessments where a 100 percent pass mark is required.

 Assessment should reflect competence across the full range of complexity, the different delivery modes and technical measurement issues. This may take place in a combination of settings, including computer lab and simulated practice, but must include assessment in the practice setting. The number of attempts should be decided by the programme provider.

## Appendix D

*Table D1 Essential Skills Cluster* (NMC, 2010)

| **Essential skills cluster: Care, compassion and communication**<br><br>The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register. | | |
|---|---|---|
| **1. As partners in the care process, people can trust a newly registered graduate nurse to provide collaborative care based on the highest standards, knowledge and competence.** | | |
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Articulates the underpinning values of *The code: Standards of conduct, performance and ethics for nurses and midwives* (the code) (NMC 2008.<br><br>2 Works within limitations of the role and recognises own level of competence.<br><br>3 Promotes a professional image.<br><br>4 Shows respect for others.<br><br>5 Is able to engage with people and build caring professional relationships. | 6 Forms appropriate and constructive professional relationships with families and other carers.<br><br>7 Uses professional support structures to learn from experience and make appropriate adjustments. | 8 Demonstrates clinical confidence through sound knowledge, skills and understanding relevant to field.<br><br>9 Is self-aware and self-confident, know sown limitations and is able to take appropriate action.<br><br>10 Acts as a role model in promoting a professional image.<br><br>11 Acts as a role model in developing trusting relationships within professional boundaries.<br><br>12 Recognises and acts to overcome barriers in developing effective relationships with service users and carers.<br><br>13 Initiates, maintains and closes professional relationships with service users and carers.<br><br>14 Uses professional support structures to develop self-awareness, challenge own prejudices and enable professional relationships, so that care is delivered without compromise. |

| **2. People can trust the newly registered graduate nurse to engage in person centred care empowering people to make choices about how their needs are met when they are unable to meet them for themselves.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Takes a person-centred, personalised approach to care. | 2 Actively empowers people to be involved in the assessment and care planning process.<br><br>3 Determines people's preferences to maximise comfort and dignity.<br><br>4 Actively supports people in their own care and self-care.<br><br>5 Considers with the person and their carers their capability for self-care.<br><br>6 Provides personalised care, or makes provisions for those who are unable to maintain their own activities of living maintain dignity at all times.<br><br>7 Assists people with their care. | 8 Is sensitive and empowers people to meet their own needs and make choices and considers with the person and their carer(s) their capability to care.<br><br>9 Ensures access to independent advocacy.<br><br>10 Recognises situations and acts appropriately when a person's choice may compromise their safety or the safety of others.<br><br>11 Uses strategies to manage situations where a person's wishes conflict with nursing interventions necessary for the person's safety.<br><br>12 Acts with dignity and respect to ensure that people who are unable to meet their activities of living have choices about how these are met and feel empowered to do as much as possible for themselves.<br><br>13 Works autonomously, confidently and in partnership with people, their families and carers to ensure that needs are met through care planning and delivery, including strategies for self care and peer support.<br><br>14 Actively helps people to identify and use their strengths to achieve their goals and aspirations. |

| **3. People can trust the newly registered graduate nurse to respect them as individuals and strive to help them to preserve their dignity at all times.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Demonstrates respect for diversity and individual preference, valuing differences, regardless of personal view.<br><br>2 Engages with people in a way that ensures dignity is maintained through making appropriate use of the environment, self and skills and adopting an appropriate attitude.<br><br>3 Uses ways to maximise communication where hearing, vision or speech is compromised. | | 4 Acts professionally to ensure that personal judgements, prejudices, values, attitudes and beliefs do not compromise care.<br><br>5 Is proactive in promoting and maintaining dignity.<br><br>6 Acts autonomously to challenge situations or others when someone's dignity may be compromised.<br><br>7 Uses appropriate strategies to empower and support their choice. |

| **4. People can trust a newly qualified graduate nurse to engage with them and their family or carers within their cultural environments in an acceptant and anti-discriminatory manner free from harassment and exploitation.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Demonstrates an understanding of how culture, religion, spiritual beliefs, gender and sexuality can impact on illness and disability.<br><br>2 Respects people's rights.<br><br>3 Adopts a principled approach to care underpinned by the code (NMC 2008). | | 4 Upholds people's legal rights and speaks out when these are at risk of being compromised.<br><br>5 Is acceptant of different cultural traditions, beliefs, UK legal frameworks and professional ethics when planning care with people and their families and carers.<br><br>6 Acts autonomously and proactively in promoting care environments that are culturally sensitive and free from discrimination, harassment and exploitation.<br><br>7 Manages and diffuses challenging situations effectively. |

| **5. People can trust a newly qualified graduate nurse to engage with them in a warm, sensitive and compassionate way.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Is attentive and acts with kindness and sensitivity.<br><br>2 Takes into account people's physical and emotional responses when engaging with them.<br><br>3 Interacts with the person in a manner that is interpreted as warm, sensitive, kind and compassionate, making appropriate use of touch.<br><br>4 Provides person centred care that addressed both physical and emotional needs and preferences.<br><br>5 Evaluates ways in which own interactions affect relationships to ensure that they do not impact inappropriately on others. | | 6 Anticipates how people might feel in a given situation and responds with kindness and empathy to provide physical and emotional comfort.<br><br>7 Make appropriate use of touch.<br><br>8 Listens to, watches for and responds to verbal and non-verbal clues.<br><br>9 Engages with p0eople in the planning and provision of care that recognises personalised needs and provides practical and emotional support.<br><br>10 Has insight into own values and how these may impact on interactions with others.<br><br>11 Recognises circumstances that trigger personal negative responses and takes action to prevent this compromising care.<br><br>12 Recognises and acts autonomously to respond to won emotional discomfort or distress in self and others.<br><br>13 Through reflection and evaluation demonstrates commitment to personal and professional development and life-long learning. |

| **6. People can trust a newly qualified graduate nurse to engage therapeutically and actively listen to their needs and concerns, responding using skills that are helpful, providing information that is clear, accurate, meaningful and free from jargon.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Communicates effectively both orally and in writing, so that the meaning is always clear.<br><br>2 Records information accurately and clearly on the basis of observation and communication.<br><br>3 Always seeks to confirm understanding.<br><br>4 Responds in a way that confirms what a person is communicating.<br><br>5 Effectively communicates people's stated needs and wishes to other professionals. | 6 Uses strategies to enhance communication and remove barriers to effective communication minimising risk to people from lack of or poor communication. | 7 Consistently shows ability to communicate safely and effectively with people providing guidance for others.<br><br>8 Communications effectively and sensitively in different settings, using a range of methods and skills.<br><br>9 Provides accurate and comprehensive written and verbal reports based on best available evidence.<br><br>10 Acts autonomously to reduce and challenge barriers to effective communication and understanding.<br><br>11 Is proactive and creative in enhancing communication and understanding.<br><br>12 Uses the skills of active listening, questioning, paraphrasing and reflection to support a therapeutic intervention.<br><br>13 Uses appropriate and relevant communication skills to deal with difficult and challenging circumstances, for example, responding to emergencies, unexpected occurrences, saying "no", dealing with complaints, resolving disputes, de-escalating aggression, conveying 'unwelcome news'. |

| **7. People can trust the newly registered graduate nurse to protect and keep as confidential all information relating to them.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Applies the principles of confidentiality.<br><br>2 Protects and treats information as confidential except where sharing information is required for the purposes of safeguarding and public protection.<br><br>3 Applies the principles of data protection. | 4 Distinguishes between information that is relevant to care planning and information that is not. | 5 Acts professionally and autonomously in situations where there may be limits to confidentiality, for example, public interest and protection from harm.<br><br>6 Recognises the significance of information and acts in relation to who does or who does not need to know.<br><br>7 Acts appropriately in sharing information to enable and enhance care (carers, MDT and across agency boundaries).<br><br>8 Works within the legal frameworks for data protection including access to and storage of records.<br><br>9 Acts within the law when confidential information has to be shared with others. |

| **8. People can trust the newly registered graduate nurse to gain their consent based on sound understanding and informed choice prior to any intervention and that their rights in decision making and consent will be respected and upheld.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Seeks consent prior to sharing confidential information outside of the professional care team, subject to agreed safeguarding and protection procedures. | 2 Applies principles of consent in relation to restrictions relating to specific client groups and seeks consent for care.<br><br>3 Ensures that the meaning of consent to treatment and care is understood by the people or service users. | 4 Uses helpful and therapeutic strategies to enable people to understand treatments and other interventions in order to give informed consent.<br><br>5 Works within legal frameworks when seeking consent.<br><br>6 Assesses and responds to the needs and wishes of carers and relatives in relation to information and consent.<br><br>7 Demonstrates respect for the autonomy and rights of people to withhold consent in relation to treatment within legal frameworks and in relation to people's safety. |

**Essential skills cluster. Organisational aspects of care**

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

**9. People can trust the newly registered graduate nurse to treat them as partners and work with them to make a holistic and systematic assessment of their needs, to develop a personalised plan that is based on mutual understanding and respect for their individual situation promoting health and well-being, minimising risk of harm and promoting their safety at all times.**

| First progression point | Second progression point | Entry to the register |
|---|---|---|
| 1 Responds appropriately when faced with an emergency or a sudden deterioration in a person's physical or psychological condition (for example, abnormal vital signs, collapse, cardiac arrest, self-harm, extremely challenging behaviour, attempted suicide) including seeking help from an appropriate person. | 2 Accurately undertakes and records a baseline assessment of weight, height, temperature, pulse, respiration and blood pressure using manual and electronic devices. (*)<br><br>3 Understand the concept of public health and the benefits of healthy lifestyles and the potential risks involved with various lifestyles or behaviours, for example, substance misuse, smoking, obesity.<br><br>4 Recognisees indicators of unhealthy lifestyles.<br><br>5 Contributes to care based on an understanding of how the different stages of an illness or disability can impact on people and carers.<br><br>6 Measures and documents vital signs under supervision and responds appropriately to findings outside the normal range. (*) | 12 In partnership with the person, their carers and their families, makes a holistic, person centred and systematic assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk, and together, develops a comprehensive personalised plan of nursing care.<br><br>13 Acts autonomously and takes responsibility for collaborative assessment and planning of care delivery with the person, their carers and their family.<br><br>14 Applies research based evidence to practice.<br><br>15 Works within the context of a multi-professional team and works collaboratively with other agencies when needed to enhance the care of people, communities and populations.<br><br>16 Promotes health and well-being, self-care and independence by teaching and empowering people and carers to make choices in coping with the effects of treatment and the ongoing nature and likely consequences of a condition including death and dying. |

| | | |
|---|---|---|
| | 7 Performs routine, diagnostic tests for example urinalysis under supervision as part of assessment process (near client testing).<br><br>8 Collects and interprets routine data, under supervision, related to the assessment and planning of care from a variety of sources.<br><br>9 Undertakes the assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk factors by working with the person and records, shares and responds to clear indicators and sign.<br><br>10 With the person and under supervision, plans safe and effective care by recording and sharing information based on the assessment.<br><br>11 Where relevant, applies knowledge of age and condition-related anatomy, physiology and development when interacting with people. | 17 Uses a range of techniques to discuss treatment options with people.<br><br>18 Discusses sensitive issues in relation to public health and provides appropriate advice and guidance to individuals, communities and populations for example contraception, substance misuse, smoking, obesity.<br><br>19 Refers to specialists when required.<br><br>20 Acts autonomously and appropriately when faced with sudden deterioration in people's physical or psychological condition or emergency situations, abnormal vital signs, collapse, cardiac arrest, self-harm, extremely challenging behaviour, attempted suicide.<br><br>21 Measures, documents and interprets vital signs and acts autonomously and appropriately on findings.<br><br>22 Works within a public health framework to assess needs and plan care for individuals, communities and populations. |

| **10. People can trust the newly registered graduate nurse to deliver nursing interventions and evaluate their effectiveness against the agreed assessment and care plan.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Acts collaboratively with people and their carers enabling and empowering them to take a shared and active role in the delivery and evaluation of nursing interventions.<br><br>2 Works within the limitations of own knowledge and skills to question and provide safe and holistic care.<br><br>3 Prepares people for clinical interventions as per local policy.<br><br>4 Actively seeks to extend knowledge and skills using a variety of methods in order to enhance care delivery.<br><br>5 Detects, records, reports and responds appropriately to signs of deterioration or improvement. | 6 Provides safe and effective care in partnership with people and their carers within the context of people's ages, conditions and developmental stages.<br><br>7 Prioritises the needs of groups of people and individuals in order to provide care effectively and efficiently.<br><br>8 Detects, records and reports if necessary, deterioration or improvement and takes appropriate action autonomously.<br><br>9 Evaluates the effect of interventions, taking account of people's and carers' interpretation of physical, emotional, and behavioural changes.<br><br>10 Involves the person in review and adjustments to their care, communicating changes to colleagues. |

| **11. People can trust the newly registered graduate nurse to safeguard children and adults from vulnerable situations and support and protect them from harm.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Acts within legal frameworks and local policies in relation to safeguarding adults and children who are in vulnerable situations.<br><br>2 Shares information with colleagues and seeks advice from appropriate sources where there is a concern or uncertainty.<br><br>3 Uses support systems to recognise, manage and deal with own emotions. | 4 Documents concerns and information about people who are in vulnerable situations. | 5 Recognises and responds when people are in vulnerable situations and at risk, or in need of support and protection.<br><br>6 Shares information safely with colleagues and across agency boundaries for the protection of individuals and the public.<br><br>7 Makes effective referrals to safeguard and protect children and adults requiring support and protection.<br><br>8 Works collaboratively with other agencies to develop, implement and monitor strategies to safeguard and protect individuals and groups who are in vulnerable situations.<br><br>9 Supports people in asserting their human rights.<br><br>10 Challenges practices which do not safeguard those in need of support and protection.. |

| **12. People can trust the newly registered graduate nurse to respond to their feedback and a wide range of other sources to learn, develop and improve services.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Responds appropriately to compliments and comments. | 2 Responds appropriately when people want to complain, providing assistance and support.<br><br>3 Uses supervision and other forms of reflective learning to make effective use of feedback.<br><br>4 Takes feedback from colleagues, managers and other departments seriously and shares the messages and learning with other members of the team. | 5 Shares complaints, compliments and comments with the team in order to improve care.<br><br>6 Actively responds to feedback.<br><br>7 Supports people who wish to complain.<br><br>8 As an individual team member and team leader, actively seeks and learns from feedback to enhance care and own and others professional development.<br><br>9 Works within ethical and legal frameworks and local policies to deal with complaints, compliments and concerns. |

| **13. People can trust the newly registered graduate nurse to respond to promote continuity when their care is to be t5ransferred to another service or person.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Assists in preparing people and carers for transfer and transition through effective dialogue and accurate information.<br><br>2 Reports issues and people's concerns regarding transfer and transition.<br><br>3 Assists in the preparation of records and reports to facilitate safe and effective transfer. | |

| **14. People can trust the newly registered graduate nurse to be an autonomous and confident member of the multi-disciplinary or multi agency team and to inspire confidence in others.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Works within the code (NMC 2008) and adheres to the *Guidance on professional conduct for nursing and midwifery students*. (NMC 2010) | 2 Supports and assists others appropriately.<br><br>3 Values others' roles and responsibilities within the team and interacts appropriately.<br><br>4 Reflects on own practice and discusses issues with other members of the team to enhance learning.<br><br>5 Communicates with colleagues verbally, face-to-face and by telephone, and in writing and electronically in a way that the meaning is clear, and checks that the communication has been fully understood. | 6 Actively consults and explores solutions and ideas with others to enhance care.<br><br>7 Challenges the practice of self and others across the multi-professional team.<br><br>8 Takes effective role within the team adopting the leadership role when appropriate.<br><br>9 Act as an effective role model in decision making, taking action and supporting others.<br><br>10 Works inter-professionally and autonomously as a means of achieving optimum outcomes for people.<br><br>11 Safeguards the safety of self and others, and adheres to lone working policies when working in the community setting and in people's homes. |

| **15. People can trust the newly registered graduate nurse to safely delegate to others and to respond appropriately when a task is delegated to them.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Accepts delegated activities within limitations of won role, knowledge and skill. | | 2 Works within the requirements of the code (NMC 2008) in delegating care and when care is delegated to them.<br><br>3 Takes responsibility and accountable for delegating care to others.<br><br>4 Prepares, supports and supervises those to whom care has been delegated.<br><br>5 Recognises and addresses deficits in knowledge and skill in self and others and takes appropriate action. |

| **16. People can trust the newly registered graduate nurse to safely lead, co-ordinate and manage care.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | | 1 Inspires confidence and provides clear direction to others.<br><br>2 Takes decisions and is able to answer for these decisions when required.<br><br>3 Bases decisions on evidence and uses experience to guide decision-making.<br><br>4 Acts as a positive role model for others.<br><br>5 Manages time effectively.<br><br>6 Negotiates with others in relation to balancing competing and conflicting priorities. |

| **17. People can trust the newly registered graduate nurse to work safely under pressure and maintain the safety of service users at all times.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Recognises when situations are becoming unsafe and reports appropriately.<br><br>2 Understands and applies the importance of rest for effective practice. | 3 Contributes as a team member.<br><br>4 Demonstrates professional commitment by working flexibility to meet service needs to enable quality care to be delivered.<br><br>5 Uses supervision as a means of developing strategies for managing own stress and for working safely and effectively.<br><br>6 Adheres to safety policies when working in the community and in people's homes, for example, lone worker policy. | 7 Demonstrates effective time management.<br><br>8 Prioritises own workload and manages competing and conflicting priorities.<br><br>9 Appropriately reports concerns regarding staffing and skill-mix and acts to resolve issues that may impact on the safety of service users within local policy frameworks.<br><br>10 Recognises stress in others and provides appropriate support or guidance ensuring safety to people at all times.<br><br>11 Enables others to identify and manage their stress.<br><br>12 Works within local policies when working in the community setting including in people's homes and ensures the safety of others. |

| **18. People can trust the newly registered graduate nurse to enhance the safety of service users and identify and actively manage risk and uncertainty in relation to people, the environment, self and others.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Under supervision, works within clinical governance frameworks.<br><br>2 Reports safety incidents regarding service use4rs to senior colleagues.<br><br>3 Under supervision assesses risk within current sphere of knowledge and competence.<br><br>4 Follows instructions and takes appropriate action sharing information to minimise risk.<br><br>5 Under supervision works within legal frameworks to protect self and others.<br><br>6 Know sand accepts own responsibilities and takes appropriate action. | 7 Contributes to promote safety and positive risk taking.<br><br>8 Under supervision works safely with the community setting taking account of local policies, for example, lone worker policy. | 9 Reflects on and learns from safety incidents as an autonomous individual and as a team member and contributes to team learning.<br><br>10 Participates in clinical audit to improve the safety of service users.<br><br>11 Assesses and implements measures to manage, reduce or remove risk that could be detrimental to people, self and others.<br><br>12 Assesses, evaluates and interprets risk indicator sand balances risks against benefits, taking account of the level of risk people are prepared to take.<br><br>13 Works within legal and ethical frameworks to promote safety and positive risk taking.<br><br>14 Works within policies to protect self and others in all care settings including in the home care setting.<br><br>15 Takes steps not to cross professional boundaries and put self or colleagues at risk. |

| **19. People can trust the newly registered graduate nurse to work to prevent and resolve conflict and maintain a safe environment.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Recognises signs of aggression and responds appropriately to keep self and others safe.<br><br>2 Assists others or obtains assistance when help is required. | | 3 Selects and applies appropriate strategies and techniques for conflict resolution, de-escalation and physical intervention in the management of potential violence and aggression. |

| **20. People can trust the newly registered graduate nurse to select and manage medical devices safely.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Safely uses and disposes of medical devices under supervision and in keeping with local and national policy and understands reporting mechanism relating to adverse incidents. | | 2 Works within legal frameworks and applies evidence based practice in the safe selection and use of medical devices.<br><br>3 Safely uses and maintains a range of medical devices appropriate to the area of work, including ensuring regular servicing, maintenance and calibration including reporting adverse incidents relating to medical devices.<br><br>4 Keeps appropriate records in relation to the use and maintenance of medical devices and the decontamination processes required as per local and national guidelines.<br><br>5 Explains the devices to people and carers and checks understanding. |

**Essential skills cluster: Infection prevention and control**

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

**21. People can trust the newly registered graduate nurse to identify and take effective measures to prevent and control infection in accordance with local and national policy.**

| First progression point | Second progression point | Entry to the register |
|---|---|---|
| 1 Follows local and national guidelines and adheres to standard infection control precautions. | 2 Participates in assessing and planning care appropriate to the risk of infection thus promoting the safety of service users.<br><br>3 Participates in completing care documentation and evaluation of interventions to prevent and control infection.<br><br>4 Aware of the role of the Infection Control Team and Infection Control Nurse Specialist, and local guidelines for referral.<br><br>5 Recognises potential signs of infection and reports to relevant senior member of staff.<br><br>6 Discusses the benefits of health promotion within the concept of public health in the prevention and control of infection for improving and maintaining the health of the population. | 7 Works within the code (NMC 2008) and in keeping with the *Guidance on professional conduct for nursing and midwifery students* (NMC 2010) and in collaboration with people and their carers to meet responsibilities for prevention and control of infection.<br><br>8 In partnership with people and their carers, plans, delivers and documents care that demonstrates effective risk assessment, infection prevention and control.<br><br>9 Identifies, recognises and refers to the appropriate clinical expert.<br><br>10 Explains risks to people, relatives, carers and colleagues and educates them in prevention and control of infection.<br><br>11 Recognises infection risk and reports and acts in situations where there is need for health promotion and protection and public health strategies. |

**Essential skills cluster: Infection prevention and control**

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

**22. People can trust the newly registered graduate nurse to maintain effective standard infection control precautions and apply and adapt these to needs and limitation sin all environments.**

| First progression point | Second progression point | Entry to the register |
|---|---|---|
| 1 Demonstrates effective hand hygiene and the appropriate use of standard infection control precautions when caring for all people. | 2 Applies knowledge of transmission routes in describing, recognising and reporting situations where there is a need for standard infection control precautions.<br><br>3 Participates in the cleaning of multi-use equipment between each person.<br><br>4 Uses multi-use equipment and follows the appropriate procedures.<br><br>5 Safely uses and disposes of, or decontaminates, items in accordance with local policy and manufacturers' guidance and instructions.<br><br>6 Adheres to requirements for cleaning, disinfecting, decontaminating of 'shared' nursing equipment, including single or multi-use equipment, before and after every use as appropriate, according to recognised risk, in accordance with manufacturers' and organisational policies. | 7 Initiates and maintains appropriate measures to prevent and control infection according to route of transmission of micro-organism, in order to protect service uses, members of the public and other staff.<br><br>8 Applies legislation that relates to the management of specific infection risk at a local and national level.<br><br>9 Adheres to infection prevention and control policies and procedures at all times and ensures that colleagues work according to good practice guidelines.<br><br>10 Challenges the practice of other care workers who put themselves and others at risk of infection.<br><br>11 Manages overall environment to minimise risk. |

| **23. People can trust the newly registered graduate nurse to provide effective nursing interventions when someone has an infectious disease including the use of standard isolation techniques.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Safely delivers care under supervision to people who require to be nursed in isolation or in protective isolation settings.<br><br>2 Takes appropriate actions in any environment including the home care setting, should exposure to infection occur, for example, chicken pox, diarrhoea and vomiting, needle stick injury.<br><br>3 Applies knowledge of an 'exposure prone procedure' and takes appropriate precautions and actions.<br><br>4 Takes personal responsibility, when a student knowingly has a blood borne virus, to consult with occupational health before carrying out exposure prone procedures. | 5 Recognises and acts upon the need to refer to specialist advisers as appropriate.<br><br>6 Assesses the needs of the infectious person, or people and applies appropriate isolation techniques.<br><br>7 Ensures that people including colleagues are aware of and adhere to local policies in relation to isolation and infection control procedures.<br><br>8 Identifies suitable alternative when isolation facilities are unavailable and principles have to be applied in unplanned circumstances.<br><br>9 Manages overall environment to minimise risk. |

| **24. People can trust the newly registered graduate nurse to fully comply with hygiene, uniform and dress codes in order to limit, prevent and control infection.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Adhere to local policy and national guidelines on dress code for prevention and control of infection, including footwear, hair, piercing and nails.<br><br>2 Maintains a high standard of personal hygiene.<br><br>3 Wears appropriate clothing for the care delivered in all environments. | | 4 Acts as a role model to others and ensures colleagues work within local policy. |

| **25. People can trust the newly registered graduate nurse to safely apply the principles of asepsis when performing invasive procedures and be competent in aseptic technique in a variety of settings.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Demonstrates understanding of the principles of wound management, healing and asepsis.<br><br>2 Safely performs basic wound care using clean and aseptic techniques in a variety of settings.<br><br>3 Assists in providing accurate information to people and their carers on the management of a device, site or wound to prevent and control infection and to promote healing wherever that person might be, for example, in hospital, in the home care setting, in an unplanned situation. | 4 Applies a range of appropriate measures to prevent infection including application of safe and effective aseptic technique.<br><br>5 Safely performs wound care, applying non-touch or aseptic techniques in a variety of settings.<br><br>6 Able to communicate potential risks to others and advise people on the management of their device, site or wound to prevent and control infection and to promote healing. |

| **26. People can trust the newly qualified nurse to act, in a variety of environments including the home care setting, to reduce risk when handling waste, including sharps, contaminated linen and when dealing with spillages of blood and other body fluids.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Adheres to health and safety at work legislation and infection control policies regarding the safe disposal of all waste, soiled linen, blood and other body fluids and disposing of 'sharps' including in the home setting.<br><br>2 Ensures dignity is preserved when collecting and disposing of bodily fluids and soiled linen.<br><br>3 Acts to address potential risks within a timely manner including in the home setting. | 4 Manages hazardous waste and spillages in accordance with local health and safety policies.<br><br>5 Instructs others to do the same. |

| **Essential skills cluster: Nutrition a d fluid management**<br><br>The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register. | | |
|---|---|---|
| **27. People can trust the newly registered graduate nurse to assist them to choose a diet that provides an adequate nutritional and fluid intake.** | | |
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Under supervision helps people to choose healthy food and fluid in keeping with their personal preferences and cultural needs.<br><br>2 Accurately monitors dietary and fluid intake and completes relevant documentation. (*)<br><br>3 Supports people who need to adhere to specific dietary and fluid regimens and informs them of the reasons.<br><br>4 Maintains independence and dignity wherever possible and provides assistance as required.<br><br>5 Identifies people who are unable to or have difficulty in eating or drinking and reports this to others to ensure adequate nutrition and fluid intake is provided. | 6 Uses knowledge of dietary, physical, social and psychosocial factors to inform practice being aware of those that can contribute to poor diet, cause or be caused by ill health.<br><br>7 Supports people to make appropriate the choices and changes to eating patterns, taking account of dietary preferences, religious and cultural requirements, treatment requirements and special diets needed for health reasons.<br><br>8 Refers to specialist members of the multi-disciplinary team for additional or specialist advice.<br><br>9 Discusses in a non-judgemental way how diet can improve health and the risks associated with not eating appropriately.<br><br>10 In liaison with a registered midwife provides essential advice and support to mothers who are breast feeding. .<br><br>11 Provides support and advice to carers when the person they are caring for has specific dietary needs. |

| **28. People can trust the newly registered graduate nurse to assess and monitor their nutritional status and in partnership, formulate an effective plan of care.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Takes and records accurate measurements of weight, height, length, body mass index and other appropriate measures of nutritional status. (*)<br><br>2 Assesses baseline nutritional requirements for healthy people related to factors such as age and mobility.<br><br>3 Contributes to formulating a care plan through assessment of dietary preference, including local availability of foods and cooking facilities.<br><br>4 Reports to other members of the team when agreed plan is not achieved. | 5 Makes a comprehensive assessment of people's needs in relation to nutrition identifying, documenting and communicating level of risk. (*)<br><br>6 Seeks specialist advice as re3quired in order to formulate an appropriate care plan.<br><br>7 Provides information to people and their carers.<br><br>8 Monitors and records progress against the plan.<br><br>9 Discusses progress and changes in condition with the person, carers and the multi-disciplinary team.<br><br>10 Acts autonomously to initiate appropriate action when malnutrition is identified or where a person's nutritional status worsens, and report this as an adverse event. |

| **29. People can trust a newly registered graduate nurse to assess and monitor their fluid status and in partnership with them, formulate an effective plan of care.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Applies knowledge of fluid requirements needed for health and during illness and recovery so that appropriate fluids can be provided.<br><br>2 Accurately monitors and records fluid intake and output. (*)<br><br>3 Recognises and reports reasons for poor fluid intake and output.<br><br>4 Reports to other members of the team when intake and output falls below requirements. | 5 Uses negotiating and other skills to encourage people who might be reluctant to drink to take adequate fluids.<br><br>6 Identifies signs of dehydration and acts to correct these. (*)<br><br>7 Works collaboratively with the person their carers and the multi-disciplinary team to ensure an adequate fluid intake and output. |

| **30. People can trust the newly qualified graduate nurse to assist them in creating an environment that is conducive to eating and drinking.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| 1 Reports to an appropriate person where there is a risk of meals being missed.<br><br>2 Follows food hygiene procedures in accordance with policy. | 3 Follows local procedures in relation to mealtimes, for example, protected mealtimes, indicators of people who need additional support.<br><br>4 Ensures that people are ready for the meal, that is, in an appropriate location, position, offered opportunity to wash hands, offered appropriate assistance. | 5 Challenges others who do not follow procedures.<br><br>6 Ensures appropriate assistance and support is available to enable people to eat.<br><br>7 Ensures provision is made for replacement meals for anyone who is unable to eat at the usual time, or unable to prepare their own meals.<br><br>8 Ensures that appropriate food and fluids are available as required. |

| **31. People can trust the newly qualified graduate nurse to ensure that those unable to take food by mouth receive adequate fluid and nutrition to meet their needs.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | 1 Recognises, responds appropriately and reports when people have difficulty eating or swallowing.<br><br>2 Adheres to an agreed plan of care that provides for individual difference, for example, cultural considerations, psychosocial aspects and provides adequate nutrition and hydration when eating or swallowing is difficult. | 3 Takes action to ensure that, where there are problems with eating and swallowing, nutritional status is not compromised.<br><br>4 Administers enteral feeds safely and maintains equipment in accordance with local policy. (*)<br><br>5 Safely maintains and uses naso-gastric, PEG and other feeding devices.<br><br>6 Works within legal and ethical frameworks taking account of personal choice. |

| **32. People can trust the newly registered graduate nurse to safely administer fluids when fluids cannot be taken independently.** | | |
|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** |
| | | 1 Understand sand applies knowledge of intravenous fluids and how they are prescribed and administered within local administration of medicines policy.<br><br>2 Monitors and assesses people receiving intravenous fluids. (*)<br><br>3 Documents progress against prescription and markers of hydration. (*)<br><br>4 Monitors infusion site for signs of abnormality, and takes the required action reporting and documenting signs and actions taken. |

| **Essential skills cluster: Medicines management**[1]<br><br>The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register. | | | |
|---|---|---|---|
| **33 People can trust the newly registered graduate nurse to correctly and safely undertake medicines[2] calculations.** | | | |
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| 1 Is competent in basic medicines calculations (*) relating to:<br><br>☐ Tablets and capsules<br>☐ Liquid medicines<br>☐ Injections including:<br>☐ Unit dose<br>☐ Sub and multiple unit dose<br>☐ SI unit conversion | | 2 Is competent in the process of medication-related calculation in nursing field involving:<br><br>☐ Tablets and capsules<br>☐ Liquid medicines<br>☐ Injections<br>☐ IV infusions including:<br>☐ Unit dose<br>☐ Sub and multiple unit dose<br>☐ Complex calculations<br>☐ SI unit conversion | Numeracy skills, drug calculations required to administer medicines safely via appropriate routes including specific requirements for children and other groups. |

1 Medicines management is "the clinical cost effective and safe use of medicines to ensure patients get maximum benefit from the medicines they need while at the same time minimising potential harm" (MHRA 2004). As the administration of a medicinal product is only part of the process, these ESCs reflect the process from prescribing, through to dispensing, storage, administration and disposal.

2 A Medicinal product is "Any substance or combination of substances presented for treating or preventing disease in human beings or in animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a medical diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product" (Council Directive 65/65/EEC).

| **34 People can trust the newly registered graduate nurse to work within legal and ethical frameworks that underpin safe and effe3ctive medicines management.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 1 Demonstrates understanding of legal and ethical frameworks relating to safe administration of medicines in practice.<br><br>2 Demonstrates an understanding of types of prescribing, types of prescribers and methods of supply.<br><br>3 Demonstrates understanding of legal and ethical frameworks for prescribing. | 4 Applies legislation to practice to safe and effective ordering, receiving, storing administering and disposal of medicines and drugs, including controlled drugs in both primary and secondary care settings and ensures others do the same.<br><br>5 Fully understands all methods of supplying medicines for example. Medicines Act exemptions, patient group directions (PGDs), clinical management plans and other forms of prescribing.<br><br>6 Fully understands the different types of prescribing including supplementary prescribing, community practitioner nurse prescribing and independent nurse prescribing. | Law, consent, confidentiality, ethics, accountability.<br><br>Responsibilities under law, application of medicines legislation to practice, include use of controlled drugs, exemption orders in relation to patient group direction (PGD).[3]<br><br>Regulatory requirements: *Standards for medicines management* (NMC 2007), the code (NMC 2008), *Standards of proficiency for nurse and midwife prescribers* (NMC 2006),<br><br>Statutory requirements in relation to mental health, mental capacity, children and young people and medicines, national service frameworks and other country specific guidance. |

3 Nursing students cannot supply or administer under a PGD (*Standards for medicines management* (NMC 2007)).

| **35 People can trust the newly registered graduate nurse to work as part of a team to offer holistic care and a range of treatment options of which medicines may form a part.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 7 Demonstrates awareness of a range of commonly recognised approaches to managing symptoms, for example, relaxation, distraction and lifestyle advice.<br><br>8 Discusses referral options.. | 9 Works confidently as part of the team and, where relevant, as leader of the team to develop treatment options and choices with the person receiving care and their carers.<br><br>10 Questions, critically appraises, takes into account ethical considerations and the preferences of the person receiving care and uses evidence to support an argument in determining when medicines may or may not be an appropriate choice of treatment.<br><br>11 Fully understands the different types of prescribing including supplementary prescribing, community practitioner nurse prescribing and independent nurse prescribing. | The principles of holistic care, health promotion, lifestyle advice, over-the-counter medicines, self-administration of medicines and other therapies. |

| **36 People can trust the newly registered graduate nurse to ensure safe and effective practice in medicines management through comprehensive knowledge of medicines, their actions, risks and benefits.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 1 Uses knowledge of commonly administered medicines in order to act promptly in cases where side effects and adverse reactions occur.. | 2 Applies knowledge of basic pharmacology, how medicines act and interact in the systems of the body, and their therapeutic action.<br><br>3 Understands common routes and techniques of medicine administration including absorption, metabolism, adverse reactions and interactions.<br><br>4 Safely manages rug administration and monitors effects. (*)<br><br>5 Reports adverse incidents and near misses.<br><br>6 Safely manages anaphylaxis. | Related anatomy and physiology.<br><br>Drug pathways and how medicines act.<br><br>Impacts of physiological state of patients on drug responses and safety, for example, the older adult, children, pregnant or breast feeding women and significant pathologies such as renal or hepatic impairments.<br><br>Pharmaco-dynamics – the effects of drugs and their mechanisms of action in the body.<br><br>Pharmaco-therapeutics – the therapeutic actions of certain medicines. Risks versus benefits of medication.<br><br>Pharmaco-kinetics and how doses are determined by dynamics and systems in the body.<br><br>Role and function of bodies that regulate and ensure the safety and effectiveness of medicines. |

| | | | |
|---|---|---|---|
| | | | Knowledge on management of adverse drug events, adverse drug reactions, prescribing and administration errors and the potential repercussions for safety. |

| **37 People can trust the newly registered graduate nurse to safely order, receive, store and dispose of medicines (including controlled drugs) in any setting.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 1 Demonstrates ability to safely store medicines under supervision. | 2 Orders, receives, stores and disposes of medicines safely (including controlled drugs). | Managing medicines in hospital or primary care settings, for example, schools and the home care setting.<br><br>Legislation that underpins practice related to a wide range of medicines such as controlled drugs, infusions and oxygen.<br><br>Suitable conditions for storage, managing out-of-date stock, safe handling medication, managing discrepancies in stock, omissions. |

| **38 People can trust the newly registered graduate nurse to administer medicines safely and in a timely manner, including controlled drugs.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 1 Uses prescription charts correctly and maintains accurate records.<br><br>2 Utilises and safely disposes of equipment needed to draw up and administer medication, for example, needles, syringes, gloves.<br><br>3 Administers and, where necessary, prepares medication safely under direct supervision, including orally and by injection. | 4 Safely and effectively administers and, where necessary, prepares medicines via routers and methods commonly used and maintains accurate records. (*)<br><br>5 Supervises and teaches others to do the same.<br><br>6 Understands the legal requirements. | Involvement of people receiving treatment, management of fear and anxiety, importance of non-verbal and verbal communication.<br><br>Use of prescription charts including how to prepare, read and interpret them and record administration and non – administration. Use of personal drug record cards for controlled drugs.<br><br>Preparing and administering medication in differing environments, places, including the home care setting, hygiene, infection control, compliance aids, safe transport and disposal of medicines and equipment.<br><br>Safety, checking person's identity, last dose, allergies, anaphylaxis, polypharmacy, monitoring of effect and record keeping.<br><br>Where and how to report contra-indications, side effects, adverse reactions. |

| | | | |
|---|---|---|---|
| | | | Skills needed to administer safely via various means, for example, oral, topical, by infusion, injection, syringe driver and pumps.<br><br>Aware of own limitations and when to refer on.<br><br>Legal requirements, mechanisms for supply, sale and administration of medication, self-administration including controlled drugs. |

| **39 People can trust a newly registered graduate nurse to keep and maintain accurate records using information technology, where appropriate, within a multi-disciplinary framework as a leader and as part of a team and in a variety of care settings including at home.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 1 Demonstration awareness of roles and responsibilities within the multi-disciplinary team for medicines management, including how and in what ways information is shared within a variety of settings. | 2 Effectively keep records of medication administered and omitted, in a variety of care settings, including controlled drugs and ensures others do the same. | Links to legislation, use of controlled drugs, the code in relation to confidentiality, consent and record keeping.<br><br>Use of electronic records. |

| **40 People can trust a newly registered graduate nurse to work in partnership with people receiving medical treatments and their carers.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 1 Under supervision involves people and carers in administration and self-administration of medicines. | 2 Works with people and carers to provide clear and accurate information.<br><br>3 Gives clear instruction and explanation and checks that the person understands the use of medicines and treatment options.<br><br>4 Assesses the person's ability to safely self-administer their medicines.<br><br>5 Assists people to make safe and informed choices about their medicines. | Cultural, religious, linguistic and ethical beliefs, issues and sensitivities around medication.<br><br>Ethical issues relating to compliance and administration of medicine without consent.<br><br>Self-administration, assessment explanation and monitoring.<br><br>Concordance.<br><br>Meeting needs of specific groups including self-administration, for example, people with mental health needs, learning disabilities, children and young people, adolescents and older adults. |

| **41 People can trust the newly registered graduate nurse to use and evaluate up-to-date information on medicines management and work within national and local policy guidelines.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 1 Accesses commonly used evidence based sources relating to the safe and effective management of medicine. | 2 Works within national and local policies and ensures others do the same. | Evidence based practice, identification of resources, the 'expert' patient and client.<br><br>Using sources of information, national and local policies, clinical governance, formularies for example, British national Formulary and the British National Formulary for Children. |

| **42 People can trust the newly registered graduate nurse to demonstrate understanding and knowledge to supply and administer via a patient group direction.** | | | |
|---|---|---|---|
| **First progression point** | **Second progression point** | **Entry to the register** | **Indicative content** |
| | 1 Demonstrates knowledge of what a patient group direction is and who can use them. | 2 **Through simulation and course work** demonstrates knowledge and application of the principles required for safe and effective supply and administration via a patient group direction including an understanding of role and accountability.<br><br>3 Through simulation and course work demonstrates how to supply and administer via a patient group direction. | National prescribing centre Competency framework<br><br>www.npc.co.uk. |

## APPENDIX E

### Proposed Interview Schedule

1. What is your current role with student nurses?
    a. How would you describe the clinical teaching model that you use
2. What professional development have you had to help you assess student nurses?
3. How do you feel when assessing a student?
4. Can you tell me about a time when you were assessing a failing student?
5. Have you ever actually failed a student nurse?
    a. If so, how did it make you feel?
    b. How do you think the student felt?
    c. If not, can you explain why you have not failed a student?
6. How do you deal with the borderline student?
    a. Have you passed a student and later regretted that decision?
    b. What reasons would you give for not failing a borderline student
7. What criteria would you use determine that a student is failing in clinical practice?
8. Can you tell me what support mechanisms you receive when dealing with borderline / failing students?
    a. The role of faculty / lecturers / peers
9. What difficulties do you experience when conducting clinical assessments?

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**APPENDIX F**

# 'Failing to fail': experiences of assessing student nurses in clinical practice

**INFORMATION SHEET**

**Researcher Introduction**

My name is Sally Dobbs and I am a nurse lecturer at a polytechnic in New Zealand. I am currently studying for the Educational Doctorate (EdD) through Massey University. The focus of my thesis is the experiences of assessing student nurses in clinical practice. I am particularly interested in the assessment of 'failing students' in the clinical environment. My research will involve in depth recorded interviews which will then be analysed using interpretive phenomenology.

**Project Description and Invitation**

As you are involved in the assessment of student nurses in clinical practice, I would like to invite you to participate in my research. The aim of the research is to explore the difficulties of assessing student nurses who may be considered borderline or failing.

**Participant Identification and Recruitment**

Your Head of School of Nursing has given you this information sheet as you are involved in assessment of student nurses within the clinical environment and you are likely to have information that will contribute towards my research project. I would appreciate it if you would read this information sheet concerning the requirements of the research and if you are prepared to be involved, please contact me directly using the contact details in this sheet. I would specifically appreciate some male volunteers to reflect the male perspective and have a representation from the male workforce as men make up approximately 8% of the workforce in New Zealand.

I am approaching three schools of nursing and plan to conduct in-depth interviews with between 3 and 5 registered nurses from each school of nursing.

I appreciate that I may be asking you about situations where you had to make an uncomfortable decision about a student within the clinical area. All information received will be treated in confidence and not passed onto your employer.

**Project Procedures**

Participation in this research would involve you being asked to be interviewed for approximately 45 – 90 minutes at a location and time that is mutually convenient for you and me. The interview will follow a semi-structured format and will be recorded on a digital recorder. I will transcribe the interview verbatim (taking note of pauses, laughter, and hesitations). Once the interview has been transcribed, I will copy it onto disk and send it to you for verification – you are welcome to retain the disk, but I ask you to return a copy of the transcript with any amendments that you think are necessary. Interpretive phenomenology is an ongoing process and I may need to contact you after the interview to seek clarification, or request another interview that may take approximately 30 minutes. Your confidentiality will be respected by having a code for each interview and contact details will be kept separate from any recording device or disk.

I appreciate any time that you give towards this project.

This research is not being sponsored by any organization other than travel sponsorship which has been sought from Massey University.

If you feel at all uncomfortable during the interview, please feel free to ask to have the recorder turned off or to leave the room.

**Data Management**

The interview will be copied onto two disks, one of which will be kept by myself and locked in a secure safe at home. The other disk will be sent to you, along with the transcript for you to check the accuracy of the transcription. I will be the only person to listen to the disk and any identifying information will be removed from the transcript. Details of participants will be kept separately from transcripts and disks. Once the interview has been placed onto disk, it will be erased from the recorder. The disk will be kept in the secure safe for five years after completion of the project. I will send you a copy of the research findings / abstract. Findings from the research will also be disseminated at nurse educator conferences and in education journals.

**Participant's Rights**

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study prior to the analysis of data being undertaken – that is, once you have read your transcript;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview;
- leave the room at any time

**Project Contacts**

You are welcome to contact either myself or my supervisors if you have any questions about this project.

My contact details are as follows:

Sally Dobbs
School of Nursing
SIT
Private Bag 90114
Invercargill 9840
Telephone: 03 211 2699 ext 8810
Email: sally.dobbs@sit.ac.nz.

My supervisors are:

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Centennial Drive
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Palmerston North 4474
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Email: M.Woods@massey.ac.nz

COMMITTEE APPROVAL STATEMENT

*"This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 11/05. If you have any concerns about the conduct of this research, please contact Professor Julie Boddy, Chair, Massey University Human Ethics Committee: Southern A telephone 06 350 5799 x 2541, email humanethicsoutha@massey.ac.nz."*

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**APPENDIX G**

**CONSENT FORM**

***'FAILING TO FAIL': EXPERIENCES OF ASSESSING STUDENT NURSES IN CLINICAL PRACTICE***

**PARTICIPANT CONSENT FORM - INDIVIDUAL**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I wish/do not wish to have data placed in an official archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:** ..... **Date:** .....

**Full Name - printed** .....

MASSEY UNIVERSITY
COLLEGE OF EDUCATION
TE KUPENGA O TE MĀTAURANGA

**APPENDIX H**

[Chief Executive Officer]

[date]

Dear Sir,

I am writing to you to request permission to approach the Head of the School of Nursing with a view to conducting research within the School. I am the Head of School of Nursing at Southern Institute of Technology and currently undertaking a Doctorate in Education (EdD) through Massey University . The title of my research is 'Failing to fail': experiences of assessing student nurses in clinical practice, and I am hoping to conduct semi-structured in depth interviews with between 3 and 5 staff from XXX who are involved with the assessment of student nurses in clinical practice. For ethical reasons I shall not be conducting this research within my own school, and I shall be approaching other schools of nursing to conduct further interviews and will ensure that the confidentiality of all participating institutes and individuals is maintained. Whilst the institute will not be named explicitly, comments made by the participants may identify the institute and I will endeavour to remove any obvious identifying comments.

Ethical approval has been granted by Massey University and I appreciate that I may be required to submit ethics approval to your own approvals committee.

I am enclosing the information sheet for your information and I am happy to answer any questions that you may have regarding my research.

I thank you in anticipation of your support in this project.

Yours faithfully,

Sally Dobbs (Mrs)

## APPENDIX I

### Profiles/Interpretations of Participants

*Table I1*

*Individual profiles of each participant*

| Participant | Nursing Qualification | Teaching Qualification | Experience | Failed student in clinical practice |
|---|---|---|---|---|
| Caroline | RGON<br><br>Non nursing masterate degree | Yes | More than 10 years in education | 'student of concern' has not failed a student. (ongoing). Failed portfolios as they have extra time to re-submit. |
| Deborah | Doctoral study | Currently studying | Novice educator (less than two years) | Not in clinical practice<br>Failed OSCEs in polytech |
| Eve | Mental health nurse.<br>Enrolled on masterate degree | No | Mental health nurse | Yes |
| Fiona | Overseas trained.<br>No degrees / PG | Yes | Novice educator (less than two years) | No |
| Grace | Overseas trained<br>Currently studying post grad | No | Clinically focussed; previous experience as manager and auditor.<br>Novice educator (less than two years) | Yes |
| Helen | RN<br>Non nursing bachelor degree.<br>Non nursing masterate degree. | Yes | 30 years clinical with management experience.<br>Worked overseas. | No |

| | | | | |
|---|---|---|---|---|
| | | | Novice educator | |
| Imogen | RGON<br>Bachelor and Masterate degrees.<br>Doctoral Study | Yes | Lots of experience<br>More than 20 years education. | Yes |
| Jackie | RGON<br>BN<br>Masters Nursing | Yes | Worked overseas<br>30 years nursing | Yes |
| Keith | Overseas trained<br>Doing PG papers | Currently studying | Med/surg nurse<br>Lecturer 5 months | No |
| Lucy | RN 1991<br>PGCert | Currently studying | Mental Health Nurse<br>Lecturing for three years | No |
| Melissa | RN<br>BN<br>Masters in Nursing | Currently studying | Highly experienced nurse/manager (> 30 years)<br>Travelled overseas.<br>Educator for two years | Yes |
| Nadine | RGON<br>BN<br>Masters Nursing | Yes | Highly experienced nurse.<br>Travelled overseas<br>Educator for four years | Yes |
| Oliver | RN<br>Doing Masters | Currently studying | Lots of overseas experience.<br>Novice educator | Yes |
| Phillipa | RN<br>Bachelors in nursing / sociology<br>Masters in Nursing | Yes | Highly experienced.<br>Travelled overseas.<br>Educator >20 years | Yes |

Novice educator: Less than two years