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Citation: Parker, P. M. (2009). What should we assess in practice?. *Journal Of Nursing Management*, 17(5), pp. 559-569. doi: 10.1111/j.1365-2834.2009.01025.x

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What should we assess in Practice?

Abstract

Aim

This article reports on a PhD study and follow up work undertaken to review and develop a tool for assessment of practice.

Background

The assessment of practice in nursing and midwifery education and, other health professions has been the source of concern, criticism and research for a number of years with the conclusion that it might not be possible to develop an assessment tool that could encompass all aspects of professional practice.

Methods

A qualitative evaluation study was undertaken using the naturalistic method of inquiry. A combination of tools was used in order to collect the data and enable progressive focusing and cross checking of the findings. These included documentary analysis, a questionnaire and focus group and individual interviews. The data was collected from documents analysis, focus group interviews, individual interviews and questionnaires.

Results

The results showed that the assessment tool in use at the time did not encompass all criteria assessors used and six areas were identified as those to include in any future tool.

Conclusion

The six areas identified by subjects as those to include in any assessment tool were further developed with specific statements so that they could be used within a tool.

Implications for Nursing Management and Education

Within the changing nature of health care there is a need to review whether the tool used for assessing pre-registration education of nursing and midwifery students practice is 'fit for purpose'.

Key Words

Assessment, Practice, Nursing, Midwifery, Assessment tools

Introduction

This article focuses on the issues of assessing nursing practice and the tools and frameworks that might be used for this. It reports on a study undertaken in 2001 – 2003 for a PhD and the follow up work undertaken in one large inner city School of nursing and midwifery in the United Kingdom.

The impetus for the study arose from personal interest but also anecdotal evidence that suggested assessors might use criteria other than those within the assessment tool. Criteria cited as those used included intuition about students being safe or caring in their practice and the students' interest and enthusiasm in practice. There were concerns about students' professional behaviour and it was felt this was not sufficiently reflected in the tool used at this time. In addition the increased focus on inter-professional learning both nationally and locally, had led to some questions about the use of a framework within the tool which was predominantly nursing focused (DoH 2001; DoH/ENB 2001; GMC 2003; NMC 2004). Lastly there had been some concerns raised by students and lecturers about consistency in the assessment process. The researcher believed that these issues merited greater attention and therefore undertook an evaluation of the process of assessing practice for pre-registration nursing education. This study encompassed many aspects of this process but within this article the focus will be upon the suggested criteria for a tool and the format the tool took.

Aims

The aims of this component of the evaluation were:

- To compare the framework in use and specified formal criteria with those used by the assessors and outline the criteria used
- To explore if the current tool was appropriate and consider what other tools might be used
- To make recommendations about any changes that might be required in relation to the criteria and the tool.

Background

Despite a plethora of research and, the interest and progress made in this area, the author found a common theme within the health profession literature which questioned the possibility of developing a process and tool that could assess all aspects of 'nursing' and professional practice (Cross, Hicks & Barwell 2001;Phillips, Schostak & Tyler 2000; Robb, Fleming & Dietert 2002).

Historically in the United Kingdom assessment of student nurses' practical skills has moved from being undertaken in practical rooms by medical staff and senior nurses to continuous assessment undertaken in practice by the practitioners working side by side with the students (Neary 1999). Whilst the earlier assessments undertaken in practical rooms or assessed in practice areas by

senior staff have been criticised for being unrealistic in terms of environment and staged performances those used now are also subject to criticism (Priest & Roberts 1998). There are concerns about consistency and how continuous this assessment is when performance is judged at a local level by a large number of assessors (Jinks & Morrison 1997). In addition students are sometimes allocated to a practice setting for a very short period of time (four weeks) thus making integration into the team difficult but also there is increased pressure upon the registered staff such as increased patient turnover, reduced staffing numbers, reduced budgets and increased student numbers all leading to the risk of limited assessment (Duffy 2003 & Watson & Harris 1999).

The lack of a reliable tool also adds to the risk of the assessment being limited and not focusing on essential criteria. In the 1960's the focus was upon behavioural objectives being used that were very general and that led often to student performance being compared rather than objective assessment of individual student ability. These objectives were also open to subjective interpretation by those using them. However in the 1980's these behavioural objectives became more specific and enabled students' performances to be assessed according to pre-determined standards/criteria. Today the Nursing and Midwifery Council (NMC 2004) who are responsible for Nursing within the United Kingdom have adopted a broad competency based approach which retains the notion of pre-determined criteria focused upon core outcomes specific to nursing, but which are transferable and, consistent with the philosophy of lifelong learning. These are provided as broad statements about what a student nurse can do on progression to the branch programme and on entry to the register. The NMC provided little guidance as to the valid and reliable assessment of these competencies and so Schools of Nursing here in the United Kingdom had flexibility about how these were assessed (Calman 2006).

Tools that have been used also vary across the United Kingdom but there was for many years a reliance upon a theoretical framework developed by Benner (1984) from Dreyfus and Dreyfus (1980) who studied the skills acquisition in airline pilots, chess players, automobile drivers and adult learners of a second language. Benner's (1984) research and descriptions of nursing performance were based on the Dreyfus and Dreyfus (1980) model of novice to expert with the same five stages used but applied directly to nursing in practice. This model proposed that as experience is built up, formal understanding of rules is replaced by intuitive comparisons of the current situation to past cases. The view is that as action from past occasions and the consequences of this action are reviewed, guidance for present situations is gained. In the final stage, that of 'expert' the person is performing at an intuitive level and is not making conscious decisions at all. Experience and critical reflection are key elements in this model. Benner developed the model further and outlined seven domains with 31 competencies that could be used to assess students.

Benner's (1984) research became popular in some Schools of Nursing and Midwifery in the late 1980s and early 1990s despite there being little research evidence about the effectiveness of Benner's (1984) work as a tool for assessment (Johnson 1996; Sharp, Wilcox, Sharp & Macdonald 1995). However, there were strengths in Benner's (1984) research that led to its use. These were that the emphasis was placed upon clinical nursing care, which highlighted the importance of the context of that care as well as the emphasis upon knowledge arising from practice and the promotion of continuing education (English 1993; Gatley 1992). Darbyshire (1994) also considered that the range of educational approaches Benner (1984) advocated such as seminars to develop clinical knowledge, dialogue related to clinical narratives and research participation were additional strengths of this research.

Other similar frameworks were those of Kolb (1982) and Steiner and Bell (1979). Kolb's (1982) framework consists of the student developing through repetition of concrete experiences, observation and reflection, conceptualisation and testing of the conceptualisation in concrete contexts. This cycle of events enables the students' learning to spiral through repetition of events. Steiner and Bell's (1979) framework is based on an experiential taxonomy where students' learning progresses from initial exposure to events, to participation, identification, internalisation and then dissemination. This facilitates students' application of theory to practice as they progress from initial exposure. Another tool similar to that of Benner (1984) was Bondy's (1983) tool which, evaluated students across three dimensions, standard of procedure, quality of performance and assistance needed to perform the behaviour. Bondy (1983) then graded the three dimensions with five levels of competency, independent, supervised, assisted, marginal and dependent and there was a formula to give a numerical score to each level of competency.

Some of the criticisms of these tools are that they do not take account of the individual student ability and the range of clinical experience as well as being unclear and complicated (Duffy & Watson 2001, Priest & Roberts 1998). This combined with a shift in educational policy towards more student involvement in their education led to a rejection of the traditional tools of assessment and the adoption of tools that encouraged more student responsibility (Bradshaw 1997). These tools included learning contracts, critical incident analysis, reflections, portfolios and objective structured clinical examinations (OSCEs) (Bradshaw 1997; Nicol & Freeth 1998; O'Connor, Pearce, Smith, Vogeli & Walton 1999).

Learning contracts require students to negotiate their actions to achieve the learning outcomes and often require evidence to support this. This can be advantageous in terms of exploiting the unique learning opportunities in the workplace and engendering student commitment and motivation (Priest & Roberts 1998). Toohey, Ryan and Hughes (1996) examined the literature related to assessing practice across many professions not just the health professions. In their review they discussed the

advantages of this approach but also the potential problems which include the difficulty in agreeing actions, the quality and range of evidence collected to support the actions, the level of skill the actions demonstrate and the issue of the time needed to discuss and negotiate these contracts (Toohey, Ryan & Hughes 1996).

Critical incident analysis, reflections on care and maintaining a portfolio are tools that all encompass an element of self assessment (Fearon 1998). These tools are all subject to similar problems identified with the learning contracts but self-assessment adds another dimension. Self assessment means involving students in the process of determining what is good in any given situation (Boud 1999). Students need to be able to identify what competent practice is and apply the criteria for this to their work and performance if they are to become competent practitioners (Boud 1999). Self assessment must be regarded as significant and actionable and the person self-assessing must be allowed to take responsibility for the outcomes of their own judgements and decisions. Problems with this however, include the issue of the writing being of a very personal nature and students may choose to discuss just achievements with omission of their mistakes. There may be inconsistencies between the student's written reflection of their performance and their actual performance (Toohey, Ryan & Hughes 1996). Despite these problems the use of these tools and in particular portfolios has increased. The National Vocational Qualification scheme has used this approach for students to build up their evidence of achievement extensively and it is widely accepted in this scheme as a valuable tool. Other professions have increasingly used this as a tool, which increases the skill of self-assessment and individual responsibility for learning (Phillips, Schostak & Tyler 2000; Toohey, Ryan & Hughes 1996). The UKCC (1999) supported this and in their review cite this as a tool, which enables the student to develop a portfolio of their experience and a record of their achievement.

OSCEs were introduced into medical education programmes in 1975 and then into Nursing in 1984 to provide additional approaches to assessing clinical skills (O'Neill & McCall 1996). The OSCE involves setting up several stations related to clinical skills and the student being assessed on each station by an assessor. OSCEs have been used across medicine and nursing for a number of years and there are a range of studies published now about its use with the numbers of subjects ranging from 50 – 200 (Nicol & Freeth 1998) It is now an accepted tool for assessing practice especially for areas that require simulation because practice may not always be available such as cardiac resuscitation. It is seen to provide acceptable levels of reliability and validity in comparison with other approaches to assessment and its main advantages are a high level of objectivity and a manipulation of student learning towards clinical skills (Nicol & Freeth 1998). However criticisms of this tool are that it is set up in a simulated environment and is therefore inadequate in terms of replicating the practice environment, and it is more stressful for the students than being assessed in practice.

The range of available tools is diverse but as the discussion demonstrates all have positive and negative characteristics. No one tool appears to encompass all the positive characteristics and although this is desirable it may not be possible if the tool is still to be practical for those who use it.

Method

Context

The Setting within which this study took place was a School of Nursing and Midwifery situated within a large inner city University. Practice placements were provided within the National Health Service (NHS) Trusts, including primary care as well as private and non-voluntary sector placements.

For every programme, there was an element of practice-based assessment (PBA) and each student was allocated an appropriately qualified assessor. Continuous assessment was undertaken through the use of a framework adapted from Benner's (1984) work. The assessors indicated the student's level of achievement for the learning outcomes using the framework and the student's overall performance against five overall areas using a score of 1 – 4 before writing the final report. Students then also wrote action plans and supplied evidence for each of the learning outcomes. These however were marked by the personal tutor and not all mentors read them.

Research Design and Methodology

Qualitative approaches were particularly appropriate to this study because the detailed descriptions of the situation and the interactions of the people involved in this process were required. This study aimed to make sense of the situation without imposing pre-existing expectations but it had to be sensitive and adaptable to the influences and values that might be encountered during the stages of data collection (Lincoln & Guba 1985; Patton 1987). The study asked questions about the experiences of the assessors and students and looked for unique characteristics (Patton 1987).

The purpose of this study was to accumulate sufficient information about the process of assessing practice to understand and explain the elements of this process and synthesise this information so that a clear indication of the 'worth' of this activity could be established and so an evaluation approach was used (Lincoln & Guba 1985; Robson 1993). The naturalistic method of inquiry requires the natural setting to be considered because it is central to the understanding of the reality of the situation and data should be collected from those involved because of the importance of the meaning of different interactions and how these might indicate personal values and biases (Lincoln & Guba 1985).

Data collection Tools, Sample and Analysis

A combination of tools was used in order to collect the data and enable progressive focusing and cross checking of the findings. Documentary analysis was used to both analyse the practice based

assessment document template to obtain information about its main characteristics, and to identify from a sample of completed assessment documents what detail was provided about the assessment process, the criteria used to assess the student and the final pass/fail decision. In total 29 documents were used of these there were 19 passes and 10 fails. Four focus group interviews were undertaken with a total of 63 practitioners doing the ENB 997/998 mentorship preparation course and these were counted as one assessor per group when the data was analysed. Individual interviews were undertaken with 6 assessors, 7 students and 10 lecturers. All interviews were audio taped to ensure there was a full and accurate record of the interview. Questionnaires were also completed by, 10 students and 6 assessors. A pilot study was undertaken for the focus group interview and, the individual interview schedule, and, the questionnaire was reviewed by colleagues. Minimal changes were required so the focus group data was included with the study data. These numbers whilst being small, enabled saturation of the data to be achieved.

Ethical approval was granted by the appropriate ethics committees, and the Dean of the School. In addition all lead nurses and, nurse managers in the Trusts where practitioners, assessors or students were recruited granted their permission. All subjects were given the information about the study and a consent form, which was signed prior to their participation. All subjects were assured of confidentiality and anonymity in the discussion of the findings and the final report.

The data analysis was aimed at developing an explanatory account of what was happening in this particular event through the experiences of those involved (Mason 1996). Inductive analysis of the data was used to uncover information and make it explicit (Lincoln & Guba 1985). Two processes were used for this, 'unitising' and 'categorising' (Lincoln & Guba 1985). Unitising enabled raw data to be developed into a description, which indicated some understanding or action for the researcher but as the smallest piece of information that could stand by itself (Lincoln & Guba 1985). This information was then put into categories that provided a description about the context, setting or process (Lincoln & Guba 1985).

Presentation and Discussion of Results

The nursing branch of all subjects was collected and this showed that 60% were from the adult branch, 30% were from the child branch and 10% were from the mental health branch. This was a close representation of the practice areas although there was some under representation in relation to mental health.

Data was also collected about the length of time students had been on the programme and the mentors' length of experience. The student sample (including the PBA documents) was 46 subjects of these 7 students were in their first eighteen months of the programme whilst the remaining 39 students had more than eighteen months experience of the programme and the assessment process. The assessors' experience could not be collected from the PBAs but from the subjects

who completed the questionnaires and interviews the experience ranged from 1 – 13 years with the 9 (75%) of the 12 subjects having in excess of eight years. This data was not collected for the focus groups.

What was being assessed?

Data was collected on what was being assessed because the researcher felt that this closely linked to the criteria that assessors were actually using when making decisions about the students' performance. The data demonstrated that priorities differed for the subjects however there were six areas that appeared to be significant.

The only areas that were common to all subjects were communication skills and the ability to apply theory to practice. Communication skills were identified by 21 (49%) of the subjects and in 10 (34%) of the PBAs and, applying theory to practice was identified by 24 (56%) of the subjects. These two areas are important to any health profession and so were expected. Communication skills are essential to so many aspects of a health professional's role as noted by one assessor, "I would argue that communication comes into absolutely everything that they do regardless of whether it's a clinical skill or not there's got to be an element of communication..." (Assessor interview a4). The ability to apply theory to practice is also essential to the provision of care that is based upon sound evidence as noted by the same assessor when saying she assessed "...whether they can identify the rationale for why they are doing what they are doing..."

8 (31%) of the lecturers and assessors and 9 (31%) of the PBAs identified teamwork as important but statements about this were very general and focused upon the need for the student '...to work well within the team...'. The NMC (2008:5) explicitly discussed the registered nurse or midwife having to "...work cooperatively within teams and respect the skills, expertise and contributions..." of colleagues and share these for the benefit of the patient. This is particularly relevant with the increased focus on interprofessional learning (DoH 2001, DoH 2004, NMC 2004). The positive effects of interprofessional learning have included addressing negative attitudes, an enhanced understanding of other professionals' roles and enhanced preparation for interprofessional teamwork and collaboration (Parsell & Bligh 1998; Richardson & Edwards 1997). Taking account of issues such as respecting and sharing each other's skills and expertise should, therefore, be an explicit component of any tool.

Professional behaviour was indicated as important by the 9 (21%) of the subjects and in 9 (31%) of the PBAs. Professional behaviour covered a range of issues such as time keeping, attitude, appearance and professional conduct. Some quotes that highlight this are:

"...is aware of boundaries that dictate behaviour" (Student questionnaire 8).

“...knowledge of professional aspects...ensuring respect and dignity are maintained for patients...”
(Assessor interview 6).

“Its to do with the students behaviour things like constantly being late for work...not turning up”
(Assessor interview 1)

“its their general way of behaving or, their attitude or, the fact they’re late all the time...” (Lecturer interview 1),

“they get picked up for inappropriate behaviour that sort of thing, saying the wrong thing to a patient or saying the wrong thing to a member of staff” (Lecturer interview 10)

“she was not performing as a professional nurse and was not punctual at the beginning of her shifts...” (PBA document 17).

This area cannot be underestimated in terms of importance because whilst not all assessors and lecturers indicated this as an area that was assessed many indicated when discussing concerns about students that if a student’s behaviour raised concerns their whole practice was scrutinised more closely than if they behaved professionally. Often documentation however does not include aspects of attitude and personality (Duffy 2003). Duffy (2003) outlined the need for learning outcomes on professional behaviour and attitude to be given prominence in assessment documentation Given the fact that all qualified nurses and midwives are bound by the NMC Code (2008) and the ‘fitness to practice’ agenda this must be central to any future tool.

A student’s willingness, interest and enthusiasm was raised by 11 (25%) of the subjects and in 13 (45%) of the PBAs. There is some mention of this in the literature however there is a lack of specific examples or criteria and it raises the issue of subjectivity (Burchell, Higgs & Murray 1999). Comments that reflected this area included:

“They usually comment on the student’s enthusiasm its one of the key things whether they seem keen to learn motivated...”(Student interview s5)

“...to recap there’s the interest the level of motivation...” (Assessor interview a4)

“A keen student takes an interest in her work.” (PBA document 9)

“Has shown willingness to be taught new areas” (PBA document 10)

Assessors who have many demands upon their time feel that supporting a student who is not willing to learn or is not interested is not a rewarding or essential part of their role and this appeared to influence how much time they invested in the student (Hrobsky & Kersenbengen 2002, Phillips, Schostak & Tyler 2000). Duffy (2003) found that weak students often lacked interest and did not participate as fully as they should in learning opportunities. Whilst this is a subjective judgement it clearly influences the relationship and could impact on the outcome of the assessment and should therefore be included in the tool.

Requests for and use of help or supervision and direction was raised in 8 (28%) of the PBAs and was indirectly referred by other subjects when discussing other issues. The NMC (2008) state that, you must have the knowledge and skills for safe practice when working without direct supervision and, that you should recognise the limits of your competence. This has not been explicitly included as a criterion of assessment in any literature although reference to help and supervision is included in some of the tools used to assess practice. In light of the above statements from the NMC (2008) it is perhaps time to include a criterion about the ability to request help rather than the ability to be independent. The NMC (2008) are reliant upon practitioners recognising when they are being asked to undertake an aspect of practice that they do not feel competent to do. It is therefore important that this is included in any tool used to assess practice.

It is interesting to note that whilst practical skills were mentioned they were not identified as a priority area in the study. It may be that subjects took the assessment of these skills for granted and they were referred to in discussion of other areas. However, there have been concerns about the nurses' lack of skills on completion of pre-registration nursing education programmes (Glen & Clark 1999).

The areas seen as essential are compatible with any health professional performance but there was little insight into the actual performance or criteria that assessors were examining. There is an increasing pressure for institutions and individuals to be more accountable, and so, the identification of specific criteria that can measure performance with increased validity and reliability is essential.

Assessment Tool

Data was also collected about the use of Benner's (1984) framework because this was the tool used as part of the process but the researcher had received a range of feedback that indicated it was not used. The data showed that there was mixed use of it. Those who had difficulty considered it as providing only limited guidance about actual performance and not encompassing all the areas seen as essential. 6 (50%) of the assessors who were interviewed or completed the questionnaire did not use the tool at all and made their decision based upon a 'gut feeling' or intuition. Assessors also found that assessing the learning outcomes and stating what level they were achieved at difficult and similar to having two processes. This was supported by the findings of the ACE report (1993) where using levels was found to be problematic for some staff and often a simple safe or unsafe was the criteria. However, there was some evidence that even those who said they did not use it did as guidance for example one assessor said "When a student is not performing Benner is an effective tool to demonstrate this to students." (Assessor questionnaire a3) and one student said, "I can analyse what's said at each stage and how this relates to me." (student questionnaire s5).

Failing students

In the early stages of the study despite data being collected about the areas assessed and whether Benner's (1984) framework was used there was still limited data related to the criteria used and so it was decided that in the interviews a question would be added that asked for reasons students were failed. In addition the PBA documents were analysed for comments on those where a fail had occurred.

The area that was indicated most commonly was that of student behaviour and the following comments are some of those made:

"Professional behaviour often what a student doesn't do, for example not reporting an abnormal observation such as blood pressure, what the student fails on particularly at the later stage is behavioural aspects..." (Lecturer interview I4)

"It's to do with students behaviour things like constantly being late for work...not turning up..." (Assessor interview a1)

"She was not performing as a professional nurse and was not punctual at the beginning of her shifts....There were problems and safety issues with patients..." (PBA document 17)

The findings of this study were that the current tool was not consistently used and that some of the criteria being used to assess practice were not within the tool used at the time. It was therefore recommended that a new tool be developed that included the six areas most commonly used.

These areas were:

- ability to apply theory to practice
- professional behaviour
- student's interest, motivation and enthusiasm
- communications skills
- requests for help
- teamwork

Whilst these areas would provide a framework more work was needed to develop these areas with criteria that could be used. This was undertaken gain with practitioners from the mentorship preparation courses and some mentor updates. There were 250 practitioners from a range of areas involved in this. Their discussions and thoughts enabled a professional and practice behaviour framework to be developed that encompassed criteria that could be used with first year nursing and midwifery students through to senior staff nurses and midwives (Table 1).

Conclusion

The School the author was employed within at that time was reviewing its pre-registration nursing and midwifery education and so it was decided to use this tool for assessing practice. The tool

underwent further development over the period of another year so that it could be used within a student portfolio for each year of the programme with specific activities the students had to undertake. In order to assist students and mentors see how the activities linked to the NMC outcomes and competencies the appropriate outcome/competency was linked to the professional and practice behaviour framework for each year of both the nursing and midwifery programmes. A small scale pilot study was undertaken with students and mentors and following minimal changes the framework become the assessment tool in September 2006.

Some feedback has been gained from mentors, practice facilitators and students however an evaluation of its use across all years of the programme is about to commence as third years students start to complete.

Implications for nursing management and educators

Whilst there had been evidence for sometime of the concerns about the practice based assessment tool in use and specific criteria assessors used nothing had changed within the author's institution for many years. This is true of many institutions where if no specific problems have been identified there is unlikely to have been a review of the tool in use. However with the dynamic nature of health care and the 'fitness for practice' issues and the development of both nurses and midwives roles it is essential that we all have confidence in the assessment tools we use and the rigour we claim they provide.

It is worth both senior practitioners and educators reflecting upon the processes used in their own institutions and whether these are still 'fit for purpose'.

PROFESSIONAL AND PRACTICE BEHAVIOUR

	First Year Student	Second Year Student	Third Year Student	Junior Staff Nurse / Midwife	Senior Staff Nurse / Midwife
Professional Behaviour	<ul style="list-style-type: none"> ● Awareness of Code of Conduct. ● Appearance is professional ie correct uniform. ● Maintains punctuality. ● Follows correct procedure for absence/sickness. ● Maintains confidentiality. ● Follows instructions. ● Maintains safety at all times. ● Demonstrates respect and dignity for all. ● Is able to identify areas for development. 	<ul style="list-style-type: none"> ● Adheres to Code of Conduct. ● Demonstrates confidence in some aspects of practice. ● Demonstrates some ability to manage time in relation to providing care. ● Is able to follow instructions. ● Is aware of limitations and areas to develop. ● Provides care without omissions. 	<ul style="list-style-type: none"> ● Adheres to Code of Conduct. ● Is confident and competent in delivering Care. ● Is able to manage time and prioritise Care provision. ● Is able to use own initiative and follow instructions. ● Is aware of limitations, areas to develop and actions to take. ● Provides care without omissions 	<ul style="list-style-type: none"> ● Adheres to Code of Conduct ● Is confident and competent in delivering Care. ● Is able to prioritise Care provision and staff allocation. ● Uses own initiative and provides some instruction for others. ● Is aware of limitations and boundaries and how to expand these ● Provides care without omissions 	<ul style="list-style-type: none"> ● Adheres to Code of Conduct. ● Is confident and competent in delivery care. ● Is able to prioritise Care provision and staff allocation. ● Leads, using initiative and experience. ● Extends scope of practice beyond boundaries, but knows limitations. ● Provide care without omissions.
Teamwork	<ul style="list-style-type: none"> ● Aware of different nursing / midwifery roles. ● Knows their own role within the team. ● Is aware of team's way of working. ● Knows how the team functions. ● Always gives information to senior staff. ● Is flexible. ● Is dependable ● Is supportive 	<ul style="list-style-type: none"> ● Demonstrates knowledge of roles within the interprofessional team. ● Can outline the team's ways of working. ● Knows about team's dynamics and how these change. ● Always gives information to senior staff. ● Is flexible. ● Is dependable ● Is supportive 	<ul style="list-style-type: none"> ● Shares the team's common goal. ● Knows about different styles of leadership. ● Shares information with team. ● Is flexible in taking roles within the team. ● Is aware of skill mix issues. 	<ul style="list-style-type: none"> ● Is able to share the team vision with others. ● Is able to use appropriate leadership within team. ● Shares information within team. ● Is flexible. ● Can identify skill mix deficits. 	<ul style="list-style-type: none"> ● Identifies a vision for the team. ● Can identify appropriate leaders dependent upon the role. ● Shares information with the team. ● Is flexible. ● Can identify skill mix needs.

	First Year Student	Second Year Student	Third Year Student	Junior Staff Nurse / Midwife	Senior Staff Nurse / Midwife
Student Interest, Motivation and Enthusiasm	<ul style="list-style-type: none"> Asks questions. Gets involved. Uses opportunities. Is willing to participate. Is aware of learning needs. Is interested in what is happening. Demonstrates knowledge in relation to practice undertaken. Knows about resources Requests 'hands on' practice. Has undertaken preparatory reading. 	<ul style="list-style-type: none"> Is enquiring. Gets involved in team activities. Uses opportunities. Is willing to participate. Is aware of own learning needs. Is interested in what is happening. Discusses knowledge in relation to practice undertaken. Uses resources. Requests 'hands on' practice. 	<ul style="list-style-type: none"> Is enquiring and suggests actions. Identifies learning opportunities. Uses initiative. Can identify own learning needs. Is interested in what is happening. Discusses knowledge and deficits in relation to practice undertaken. Is able to identify how to get resources and use them. 	<ul style="list-style-type: none"> Is able to review actions and suggest solutions. Identifies learning opportunities and shares these with others. Identifies learning needs and actions to achieve. Shares knowledge with others. 	<ul style="list-style-type: none"> Identifies actions and solutions for care. Creates learning opportunities. Shares knowledge with others.
Requests for help	<ul style="list-style-type: none"> Open to feedback. Acts on feedback. Needs guidance with practical tasks. Reflects on performance. Works with supervision. Requests help appropriately. Is assertive. Knows limitations in practice. Recognises areas to develop. Is aware of where to find information and resources. 	<ul style="list-style-type: none"> Open to feedback and acts on this. Needs guidance with practical tasks. Reflects on own performance. Requires supervision for some tasks. Is assertive. Knows limitations in practice. Recognises areas to develop. Is aware of where to find information and resources. 	<ul style="list-style-type: none"> Is open to feedback and acts of this Provides feedback to others. Can work with minimal supervision. Reflects on own performance and can identify areas for development Requires advice and supervision for some tasks 	<ul style="list-style-type: none"> Acts as a role model. Reflects on own performance and that of the team. Checks with peers to get when unsure of appropriate actions. 	<ul style="list-style-type: none"> Reflects on team actions and evaluates the effectiveness of these. Provides guidance for others.

	First Year Student	Second Year Student	Third Year Student	Junior Staff Nurse / Midwife	Senior Staff Nurse / Midwife
Application of theory to practice.	<ul style="list-style-type: none"> Asks the rationale for actions. Demonstrates knowledge in relation to practice. Understands principles of nursing practice. Can provide knowledge for different Care. Remembers what is taught. Responds to feedback. 	<ul style="list-style-type: none"> Asks the rationale for actions. Demonstrates knowledge in relation to practice. Can discuss principles and concepts for practice. Is aware of the significance of differences in practice. 	<ul style="list-style-type: none"> Knows the rationale for actions. Shares knowledge with others. Can discuss concepts for practice. Can take action related to differences in practice. 	<ul style="list-style-type: none"> Can explain the rationale for practice. Shares knowledge with others. Is able to expand concepts for practice. 	<ul style="list-style-type: none"> Is able to provide rationale for practice. Shares knowledge with others. Is able to develop concepts.
Communication	<ul style="list-style-type: none"> Able to communicate verbally and clearly to all. Can complete basic observations with supervision. Able to identify some non-verbal communication cues. Able to form relationships. Listens to others Respects others views 	<ul style="list-style-type: none"> Able to initiate verbal communication and provide basic information clearly. Can complete basic documentation accurately. Uses non verbal communication where appropriate. Listens to others Respects others views 	<ul style="list-style-type: none"> Able to initiate verbal communication. Can provide explanations and convey information clearly. Can complete documents accurately. Uses non-verbal communication effectively. Listens to others Respects others views 	<ul style="list-style-type: none"> Able to communicate clearly in writing, verbally and non-verbally, in complex situations. Listens to others Respects others views 	<ul style="list-style-type: none"> Able to communicate confidently and competently in writing, non-verbally and verbally, in complex and diverse situations. Listens to others Respects others views

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