

**APPRAISAL OF
A CLINICAL EVALUATION TOOL
FOR STUDENT NURSES**

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Appraisal of a
Clinical Evaluation Tool
for
Student Nurses

by

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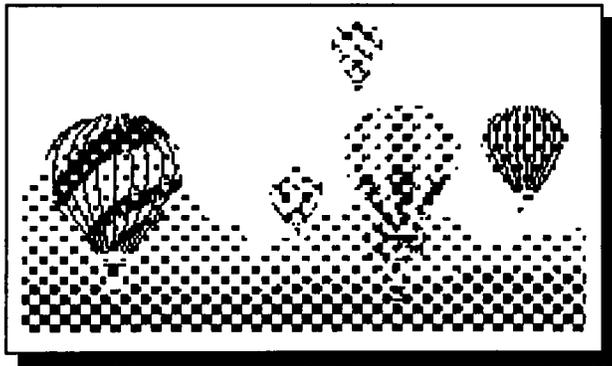


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INTRODUCTION

Evaluation of students of any learning discipline during practica experiences is challenging. In nursing, clinical evaluation is an especially critical process because there is a third party involved, i.e., the patient. Both the student and the faculty need to be absolutely certain that at the very least no harm is going to befall the patient because of the student's progress or lack of progress in clinical skill¹. Evaluation is an ongoing phenomenon, occurring almost minute by minute, undertaken by student, faculty and patient. Occasionally a patient's life depends on the accuracy of evaluation.

I have been a faculty member with nursing students in the clinical setting for approximately six years. The process of evaluation has always been a key part of my role and my thinking in this setting. A number of questions have been a part of my deliberations. Is the process consistent from student to student? Is there a sense of ongoing evaluation? Would the student consider it a fair process? What actions and clues do I pick up from the student which inform me about her or his practice? Does the evaluation tool reflect the clues I have spotted? Although this project focuses on an evaluation tool, it must be recognized that a tool is only one component of the process of evaluation.

The University of Lethbridge, Lethbridge Community College, and Medicine Hat College are in the second teaching year of a collaborative venture of designing curriculum in their Schools of Nursing. This situation provided me with an opportunity to assist in the development of a new

¹ The term "clinical skill" will be used to describe both hands-on practical skills such as injection technique or aseptic dressings, as well as physical and psychosocial assessment skills and clinical judgement.

clinical evaluation tool which would be common to all three sites for use during all four years of the nursing programme. This study describes the development, use, and value of this clinical evaluation tool.

PURPOSE

The purpose of this study was to describe nursing student and faculty perceptions about the value of a clinical appraisal tool which uses an approach to clinical nursing evaluation that reflects current thoughts about education and the practice of teaching student nurses. The process of evaluation undertaken by faculty and student, the details of the tool (including wording and omissions), and the feelings the students report during the evaluation process will constitute the descriptors of the value of the tool.

LITERATURE REVIEW

In order to examine the subject of clinical evaluation of nursing students, I have chosen to review the literature in three areas before reviewing the literature about clinical evaluation. I believe that the current education/curriculum revolution, the practice of nursing, and how nursing students enter into clinical practice all have an impact on how students should be evaluated in the clinical area. In a sense, these three areas of study produced the framework for clinical evaluation. One can think of all sorts of ways of evaluating students, but it is when the framework is clear that the methods that might work become apparent.

Education/Curriculum Revolution

If one were to look back at nursing education through history, one would find evidence of nursing education being in constant reform. This is because the practice of nursing seems to be in continual flux. Of course, it would be difficult to determine which affects which. Does nursing education cause practice to change or does practice sow the seeds of changes in education? There are other factors which cause change as well, such as new knowledge, changing paradigms, and lessons from other disciplines of knowledge. Each seems to be pointing to a new way of thinking about nursing curriculum.

The Work of Paulo Freire

Let us step outside nursing education literature for a moment and look at one important work, written in 1970, which had an enormous impact on education literature and on the curriculum revolution. The volume is by Paulo Freire and is called *Pedagogy of the Oppressed*. In working with the poor of Brazil, Freire analysed pedagogy. To describe what was happening in education, he coined the phrase "the banking concept of education" where the teacher is the "depositor," the person who knows all and is the authority on whatever is being discussed (p. 52). The teacher deposits this information into the receptacle, the student, who is just waiting to be "filled." Dialogue and authentic thinking are not component parts of this type of pedagogy. This is a very transmissive orientation to education. By its very nature, the banking system is oppressive, even if its goal is to liberate. It is designed in order to keep the student in his or her place as receiver of knowledge, and it controls thinking. According to Freire, the banking system

is immobilizing, and its objective is to incorporate "marginals" (which are the poor in Freire's case) into society.

What does Freire's work have to do with clinical evaluation of nursing students? I think that nursing education has frequently been "delivered" using the banking concept. Nurse educators have often designed curricula where content has been extensive and has overloaded the students. Students have been asked to learn numerous facts which are applicable to the scientific, biomedical paradigm of nursing. A biomedical approach to patient care focuses almost entirely on the pathophysiology, signs and symptoms, and medical treatment of the patient's 'disease.' Physicians as well as nurses have been largely educated using this model. While much of this information is relevant to nursing care, it does not cover the art of nursing. It is only when students can combine this knowledge with a sense of meaning about the patient's predicament that the patient is nursed in a complete and holistic way.

Student Voice in Nursing Education

What is striking is the lack of student voice endemic in this banking process. What the students *want* to learn has not often been incorporated into curricular thought. How the students' previous experience has had an impact on them and on their learning has not been part of classroom planning and text book planning. Nurse educators need to move from the delivery of information into the empty vessel mode, towards a modality where the students' voices and experiences are part of the learning 'package.'

Nursing education began to pay attention to the voice of the student in the 1970's. One of the earliest proponents of a kind of student voice was Malcolm Knowles (1975). He emphasized

the importance of self-directed learning, of the student discovering what it is that she or he wants to know, and then learning those concepts through a learning contract. Knowles did not call for the student to articulate what he or she had learned from past experience in order to incorporate this into present learning. However, Knowles did encourage educators to listen to what the student has to say.

New Models of Nursing Education

What is the current revolution about in North American nursing education? Not only is it a process of learning to listen to the voice of the student, but Tanner's (1990) analysis also suggests that there is a current move away from hard science and rational-technical models. Traditionally nursing education has suffered through what she calls "content overload" using a biomedically oriented disease-care model.

Tanner states that it will not work just to reorganize the traditional biomedical content in the nursing classroom into a more nursing focused model. Rather, there is a whole way of thinking which is crucial, a paradigm if you will, that is in the process of shifting. The core concepts of this particular revolution are toward health promotion rather than mere cure, towards the valuing of caring, to an interpretive stance of experience, to theoretic dualism, and to the primacy of teacher-student relationships.

Although there is evidence that this kind of revolution is happening in nursing education, it seems that it is contrary to what is happening in society. A review of current affairs in Canada would suggest that in fact society is devaluing caring. McQuaig (1993) warns Canadians that the social safety net, which has always been littered with holes, is in danger of ripping apart so that

more and more individuals will fall through. It is more difficult for the poor to get welfare, the principle of universality in health care is being eroded at lightening speed, and there is even word that the Canadian Pension Plan will no longer exist in twenty years.

Gordon (1991) acknowledges this same lack of caring in the United States. She cites the hostile, "mean-spirited" debates about social spending (p. 46). New female images of success can preclude women working in caring professions. Yet, in the nursing literature there is renewed emphasis in the caring aspects of the work of the nurse. It is apparent that the revolution in health care and in curriculum will not be easy.

Traditionally, the work of nurses has been divided into tasks and with increasing seniority one progresses from tasks of low status to those of high status (Lawler, 1993). The higher status tasks are generally 'cleaner,' in the sense that they take the nurse further away from the unclean human body. Lawler says that nurses are ambivalent about body care. It is important, but who should do it? Care has shifted toward an emphasis on the patient as an individual and away from the emphasis on the task to be performed. Up until the most recent move towards deficit focused patient care, the registered nurse was often assigned the total care of the patient, body care and all. However, it must be stated that recent government moves in Alberta to 'rebalance' the health care work force are forcing registered nurses away from the bedside at a phenomenal rate.

Humanistic caring is another theme in to-day's literature about nursing. Many authors discuss the caring aspects of the nurse's role. Benner (1984) says that caring cannot be controlled or coerced from others. The implication for educators is that caring can be understood and facilitated with students. I believe that it can also be described and evaluated. Radsma (1994) states that, "the terms 'care' and 'caring' conjure up feelings and thoughts of warmth, respect,

nurturance and regard. However, little recognition is afforded the actual work involved in care” (p. 444).

Care is often perceived as the work of women. It is virtuous and unpaid. Radsma (1994) states that care is often labelled as “soft, subtle and feminine” (p. 446). Nurses should *know* how to care, by virtue of most nurses being women. I would maintain that student nurses, both male and female, do not come to nursing equipped with nurse caring skills. Although students have many caring skills by virtue of their personal experiences, those caring skills used in nursing need to be articulated and nurtured. They even need to be evaluated.

Jean Watson writes extensively about the caring aspects of nursing. Watson (1990) calls for a refocusing of research which would pursue a sound knowledge base of caring. She also encourages a transformation of nursing curricula by introducing "a new caring morality at all levels of nursing education, including faculty-student-administration relationships" (p. 65). This means that caring not only has to be integrated into the curriculum, but needs to be a part of the educational process. Faculty need to care for students and their learning, just as students need to care for patients in a holistic manner.

Impact of the "New Science"

There are other factors, outside the specific field of nursing which have an impact on this education/curriculum revolution. Literature on the "new science" offers the perspective of integrating knowledge, where the lines separating scientific disciplines are being broken (Gleick, 1987; Wheatley, 1992). Knowledge really doesn't come gift-wrapped in discrete packages. Biology, chemistry, anatomy and physiology are part of a whole science curriculum, and perhaps

their integration into curricula would increase understanding.

Reductionist approaches are common to nursing texts and lecture content. For example, student nurses study the cardiovascular system without thinking about the *meaning* of the heart to the cardiovascular patient. Similarly, a physical assessment text may cover transcultural issues to do with a person's skin by examining incidence of skin cancer in an ethnic population, without discussing the cultural *meaning* of skin to that population.

For approximately twenty years, in response to a kind of *angst* about the scientific aspect of nursing knowledge, nurses have used a highly reductionist and linear approach in education called "the nursing process." Students (and staff) are supposed to diagnose every symptom and then design goals with **measurable** objectives, complete with time lines, in response to these symptoms. Whole catalogues of language have been developed in order to categorize these symptoms. This approach has been advocated for nursing education, and has been tried in practice, but has never 'caught on' in practice.

Coppa (1993) discusses the difficulties nurses face when developing strategies involving complex human systems using such reductionist approaches. Jackson (1991) also talks about reductionism resulting in a loss of meaning. I too believe that the reason this nursing process approach has never caught on is that reductionism results in a loss of meaning. Caring for patients, be they well or ill, is a complex process and is highly contextual. Every situation is different and every nurse responds differently. That is the beauty, and the drama, of nursing.

Hagell (1989) reiterates that the scientific approach is inadequate to meet nursing's substantive problems. She says that nursing education should critically examine nursing theorists. Likewise, Taubes (1989) points out that health patterns, just like most natural systems, are

determined by complexities which are chaotic and non-linear in nature. To comprehend these patterns, one must have knowledge from many disciplines. The sciences and humanities can learn from one another. Poetry in anatomy classes is not out of place, because it is meaning which we should be seeking. Meaning and fact are interrelated.

Vicenzi (1993) links chaos theory to nursing indicating that ontologies of nursing are "too complex and variable to permit precise knowledge about discrete objects or events" (p. 37). In other words, the patient is a complex and variable being and there are no rules attached to how a nurse should care for her or him. It follows that nursing education cannot teach rules either. The patient needs to be thought of as an individual who attaches his or her particular meaning to the health experience.

In nursing this means that content and 'fact' should be enhanced by discussions about meaning. For instance, when studying the physiology of the lungs, it is entirely appropriate to discuss the meaning the students attribute to their own lungs. It is through this connectedness that the students learn, both about the facts and about how to care for patients whose lungs present risk.

Connectedness in education is not new. Dewey (1916) discussed the idea of connecting life experience with learning in his famous *Democracy and Education*. For Dewey, knowledge is a perception of those connections of an object which are applicable to a particular situation. He goes on to explain that "...an ideally perfect knowledge would represent such a network of interconnections that any past experience would offer a point of advantage from which to get at the problem presented in a new experience" (p. 340). Nursing education, because of its mix of classroom and clinical practice, offers an excellent opportunity to connect classroom knowledge

with practical knowledge at the patient's bedside.

The Paradigm Shift in Nursing Education

Heinrich and Witt (1993) acknowledge that the paradigm shift in higher education values both objective and subjective knowledge. The experience of the student is as important as the experience of the teacher. This means that teaching strategies should include experiential learning.

Heinrich and Witt also discuss the relationship between the teacher and the student. They say it should be an egalitarian relationship where the teacher is seen as the midwife, or the facilitator of learning, not as the depositor of knowledge. The language that we use to describe the teacher is indicative of the way we think about the role of teacher. If one uses the term "instructor," there is an underlying assumption that the "instructor" knows what the student does not know, and will demonstrate or instruct the one proper way to do or think.² It is also reminiscent of Freire's banking concept of education, where the instructor will deposit something into the student's empty reservoir.

This coincides with Belenky, Clinchy, Goldberger and Tarule's work (1986) entitled *Women's Ways of Knowing*. According to Belenky *et al.* women learn in many ways, progressing from received knowledge which is acquired from "authority figures" to knowledge which connects with one's own experience and various bodies of disciplinary knowledge, and is in

² In developing the evaluation form, our committee wanted to use the word "facilitator" instead of "instructor." We were overruled by the Curriculum Committee of the Southern Alberta Collaborative Nursing Education venture. It is also interesting to note that when the students refers to faculty, they use the word "instructor." I think this may emanate from what they are used to hearing in the community and in the hospital setting.

a sense created by the learner. Content should be derived with the student at the centre, not the teacher nor the curriculum at centre.

Hezekiah (1993) also discusses power relationships in teaching. If there is shared leadership in the classroom, then the teacher will be relied on less as an authority. She calls for an atmosphere of mutual respect, trust and community in the classroom.

It is apparent that the new science and feminist thought have contributed to a body of literature in nursing education. This literature takes us away from the former teacher/curriculum centred reductionist model which uses a transmissive, banking concept basis, to a more egalitarian type of education with the student at the centre.

The Practice of Nursing

What is it that student nurses do which needs to be evaluated? Much time could be spent reviewing the literature on this topic. There are volumes written about the activities of nurses. However, there is not as much literature written about what it is that the student nurse does in the clinical area. The assumption is made that the student nurse undertakes the same activities as the graduate nurse. To a certain extent this is true. The student must provide the same standard of care almost immediately in his or her student nurse career that a graduate provides. Obviously, the patient cannot be compromised because she or he is being cared for by a student. Therefore, in order to learn what that student nurse does in clinical practice, I turn now to an important work on what it is nurses do in their clinical practice.

In order to discover what nurses actually do, Benner (1984) undertook a study in which

she wanted to "uncover the knowledge embedded in nursing practice" (p. 1). By listening to nurses' stories about providing care, she found that nurses engage in many roles: a helping role, a teaching-coaching function, a diagnostic and monitoring function, administering and monitoring therapeutic interventions and regimes, the effective management of rapidly changing situations, monitoring and ensuring the quality of health care practices, and engaging in organizational and work-role competencies. She concludes that expertise cannot be legislated or standardized, but facilitated, recognized and rewarded (p. 177).

When I look at the focus of traditional nursing education, I would have to say that most education focuses on the diagnostic and monitoring function as well as the monitoring of therapeutic interventions and regimes, with some attention to the teaching function of the nurse. In other words, the graduate often has to learn the rest by herself or himself. I believe that it is possible to focus on the other aspects of the nurses' role, such as engaging in organizational and work-role competencies which includes activities such as coping with staff shortages, building and maintaining a therapeutic team to provide optimum therapy, and co-ordinating and meeting multiple patient needs and requests. Knowing how to do these sorts of things are as important as knowing about effects of medications.

Benner (1984) feels that little attention has been given to what can be learned from expert nurses' clinical experience. Once we really know how nurses make judgements and decisions, then it may be possible not only to coach a student along in this, but also to evaluate it as well.

Benner and Tanner (1987) discuss the nurse's use of intuition. They say that intuition has previously had little legitimacy and has been considered the "black market version of knowledge" (p. 30). They go on to say that clinical observation has itself been devalued and sometimes called

intuition. Intuition consists of pattern recognition, commonsense understanding, skilled know-how, a sense of salience³, similarity recognition⁴, and deliberative rationality⁵. Benner and Tanner go on to say that intuition can be taught by teaching students to recognize patterns. Skilled pattern recognition can be targeted using case studies on paper or from clinical experience. Active inquiry is better than a check-list mentality. Students and faculty can observe expert nurses in a deliberate manner, and can learn from their practice.

The practice of nursing is complex. It involves skilled know-how as well as intuitive ability. In order to practice nursing, the student must draw on knowledge from all disciplines and put this together in order to provide herself or himself with a frame of reference in order to understand the patient. The practice of nursing also requires communication skills and keen observational ability. Nursing requires a frame of mind where one cares meaningfully about the person with whom she or he is interacting. There is a certain commitment to the patient which is real, and occasionally nurses need to act as patient advocates when patients are either caught in the complex health care system or cannot speak for themselves. All these activities present significant challenges to the evaluator of the student nurse.

3 One has a sense of salience when events and nuances stand out as being more or less important. (Benner & Tanner, 1987, p. 27)

4 Similarity recognition is the capacity to recognize fuzzy resemblances despite differences in objective features. (Benner & Tanner, p. 27)

5 Deliberative rationality is being able to try out alternatives. It is the act of clarifying current perspectives by considering how your interpretation would change if your perspective changed. (Benner & Tanner, p. 28)

Nursing Students and Clinical Practice

Student Perceptions of Clinical Practice

There is an entire body of literature about the practice of teaching nursing. I would like to focus on student perceptions of the clinical experience and of clinical evaluation, because this applies most closely to the act of appraising the clinical evaluation tool which I helped develop. I will also look at clinical behaviours of faculty which increase student self-confidence.

Windsor (1987) describes learning within the contextual setting of clinical practice. She says the clinical arena presents challenges which are absent from the classroom. Faculty have little control over the learning environment and must monitor patient and student needs at the same time. Students in the clinical setting must combine cognitive, psychomotor and affective skills. According to Windsor, students want the faculty to challenge, ask good questions and provide frequent and honest feedback. Positive feedback from faculty, staff and patients were highly valued by the students in Windsor's study.

Pagana (1988) surveyed 262 nursing students upon the completion of their first medical-surgical experience and found that twenty-six percent of them saw the faculty as a significant stressor in their learning during the clinical experience. Evidently, faculty had the power to lower the students' self-esteem. Behaviours of faculty were described as intimidating, threatening, demeaning, impatient, strict and demanding. It is not just that these students did not view the faculty as helpful. In reality, one quarter of them explicitly said that faculty represented a threat to them.

Theis (1988) surveyed 204 senior nursing students in three baccalaureate programmes

about unethical teaching behaviours. She found that fifty-eight percent of students in the clinical area had seen teachers who, in their opinion, violated respect for both the patient and the student. Behaviours which students saw as violating respect for them included grilling them in crowded hallways, criticizing in front of the patient or asking them to provide documentation about another student. Twenty-two percent of these students saw faculty violate the principle of justice, and one way this was done was through unfair evaluations.

The evaluation role is an ever-present reality in acute care settings because it is the job of the clinical educator not only to provide learning opportunities for the student, but the educator also has a legal and moral responsibility for the safety of the patient. Thus, evaluation is a necessary and constant process, going on minute by minute. However, I believe that it can be de-emphasized, using encouragement and problem-posing questions in order to redirect students and protect patients. For example, if a student is about to make an analgesic medication choice which might put the patient at risk, instead of chastising, a coach-teacher might try to get the student to project the results of her or his choice on to the future. The faculty member might ask: "What are the possible consequences of giving this patient the full dose of demerol?" This a non-threatening way of suggesting that the student might have erred in judgement.

Loving (1993) states that an evaluation-centred approach increases the notion that nurse educators have all the answers. He found that evaluation interactions with faculty can lead to student feelings of incompetence. When faculty centre on evaluation in the clinical area, Loving says that hinders the efforts at self-directed learning about patient care. He suggests that nurse educators concentrate on reinforcing success so that students are intrinsically motivated to engage in self-competence validation. He also talks about "sticking with the student" in the sense that

the facilitator should be "in tune" with the student and know when to push and when not to push (p. 418).

Wilson (1994) finds that learning often takes place outside the teacher-student interaction. Evaluation is rarely perceived by students as a formative process that helps improve nursing practice. She discovered that it is the students' perception that the teacher is always collecting evidence for their grade.

To add to the bad news, Kushnir (1986) looked at the effects of the presence of a faculty member on student nurse behaviour in the clinical area. Twenty-eight second year (female) nursing students were asked during their social psychology course to describe an interpersonal encounter which they found to be stressful with a person of higher status. Twenty students described interactions with nursing faculty. They saw faculty as having higher status and were keenly aware of their role as evaluators. It seems that when the facilitator is present the student has to focus on self-presentation as well as learning. Kushnir concluded that for the student nurse it may be that the two functions of instruction and evaluation are indistinguishable. The major recommendation from this study is that faculty should de-emphasize their evaluation role.

If evaluation is a constant process for faculty in the clinical area, how would it be possible to de-emphasize it? One way this can be done is to encourage the student to take on this evaluative role for herself or himself. After an interaction with a patient, or following a procedure, it is often possible to ask the student, in a private place, to evaluate the situation. This gives the student ownership of her or his own evaluation. It also allows the opportunity to attend to her or his practice. After all, it is going to be mostly the student's own responsibility to evaluate herself or himself after schooling is finished. In my own experience, I find that this kind

of interaction with a student is frequently quite positive in nature.⁶

What other behaviours can serve to increase student self-confidence? Flagler, Loper-Powers and Spitzer (1988) state that when faculty display confidence in the student, when the teacher is a promoter of good patient care, when there are encouraging and accepting questions, and when there is specific, positive, and frequent feedback, then the clinical faculty is seen as a positive force in the clinical area, instead of a threat. These are all activities which faculty who believe in the student's ability to learn and to provide care would embrace.

Clinical Evaluation of Nursing Students

Knox and Mogan (1985) surveyed 487 students, faculty and graduates from a university school of nursing in Western Canada. They found that although the students rated faculty competence and the interpersonal relationship between faculty and student as somewhat important, by far the most important clinical teaching behaviour rated by these student was clinical evaluation. Although these authors did not delve into what constituted excellent clinical evaluation, it can be seen that it is an important part of the job of the nurse educator.

Wosley (1977), in an article entitled "The Long and Tortured History of Clinical Evaluation," views evaluation as tortured in that nurse educators have flown from one method of evaluation to another, and she feels that we have still not got it right. She talks about head nurses evaluating students in the early 1900s using a list of procedures and traits. Weighted scores were

⁶ I also find that the student gravitates first to the one thing she or he did "wrong". I will often phrase this question to enquire, "How do you think you did in there and be sure to give me the positives first?" I have also discovered that during this on-the-spot self-evaluative process the student is excruciatingly harsh on her or himself. The student will often point out minute infractions of technique that I have not noticed. I will admit that I have occasionally found a student will say, "I think I did OK" and be unable to critique herself or himself in a detailed way. However, with practice, because self-evaluation is a skill, the student usually improves in this regard.

then used. In the 1940s anecdotal notes were kept by head nurses, with emphasis being given to unsatisfactory behaviour. In the 1950s nursing education went to normative rating scales and in the 1960s evaluation was based on the objectives of the programme and on observed behaviour, being careful not to mix fact with the opinion of the evaluator. Check-lists which break procedures into every possible observable step were used. In the 1970s and 1980s we moved to simulated clinical experiences and evaluating the students' reactions to videos. Student nurse behaviours have been computerized, with matching prescriptions for improving performance once a behaviour has been observed. Wosley believes that none of these methods has succeeded in evaluating student nurses in the clinical learning situation.

There are many issues in clinical evaluation. While (1991) talks about fairness in clinical evaluation as well as the subjectivity of the observational process. There is no universal student nurse, so uniformity is difficult. The faculty do not constantly observe a student, so faculty observation represents only a sample of the student's nursing care. Objectives related to clinical experience are accomplished in an educational environment which is not controlled by the educator. There is much variety. And in addition, patients present a multitude of issues.

Ferguson and Calder (1993) state that it is difficult to identify entry-level competencies. Their study looked at the similarities and differences between preceptors⁷ and educators in valuing selected clinical competency criteria in the evaluation of clinical performance of baccalaureate nursing students. Preceptors and educators are more similar than different in selecting clinical competencies, but there was still a difference. Ferguson and Calder went on to conclude that

⁷ A preceptor is a practising Registered Nurse who volunteers to pair with a student nurse who is near completing his or her nursing education. The preceptor has responsibilities to assist in the education and evaluation of the student nurse.

evaluation is still difficult, even if standards are defined. Added to the issues which While identified above, they add that there is a reluctance to record negative ratings in written reports.

Students in the clinical area are being evaluated at the same time as they are learning. This is difficult and stressful. On top of this, because the students rotate through many different clinical areas, they are constantly adapting to new environments.

Since there are so many issues inherent in the clinical evaluation of nursing students, what is 'the answer?' How can the educator participate in fair, unbiased evaluation of the student nurse in the clinical situation? What is it that gives educators justifiable hunches about the competency of the student nurse?

I believe that educators function using the same intuitive skills that expert nurses use. We use pattern recognition where we see subtle variations in student behaviour in context. Looking at situations from a different perspective and trying out alternatives is useful. Educators too have a sense of salience, where certain events stand out as being more or less important than others. Nursing faculty can also use the self-evaluative work in which the student engages in order to provide a picture of the student's ability.

Girot (1993) states that measurement is complex. She says what needs to be assessed is "knowledge-in-action" (p. 118). What clinical judgements does the student make and what decisions come out of these judgements? Girot states that there are four themes of competence and non-competence. They are: knowledge/adaptability, trust, caring, and communication skills. These are themes which cannot be assessed using a check-list approach. They are themes which I believe are best explored through narrative.

The stories about the student nurse's experience are the clue to the practice (and hence the

evaluation) of the student nurse, just as the stories Benner (1984) explores are the clue to knowledge embedded in nursing practice. In more traditional evaluation forms, the stories have been translated into check-lists and curricular objectives which are reductionist in nature. I think that direct, written examples of the student's reactions to varying clinical situations speak for themselves. I also believe they provide a holistic picture of the student nurse's practice as it is in the day to day life of the student nurse, which is both subjective and objective.

It can be seen that the current education/curriculum revolution, the practice of teaching clinical nursing, and the practice of nursing all have an impact on how students should be evaluated in the clinical area.

Summary of the Literature

The literature review has focused on the revolution in education and curriculum, the practice of nursing, and nursing students and clinical practice. What has emerged from this review is the strong move to enhance and articulate the role of caring in nursing and nursing education, set against a backdrop of hearing the voice of the student. There is a definite move away from reductionism and hard science, towards a caring curriculum. The role of faculty is that of coaching and mentoring. That is not to say that science is to be thrown out of nursing curricula. There is still a body of scientific knowledge crucial to nursing. However, excessive reductionism and the fragmentation of knowledge can blur the picture of the whole, and it is indeed a tight-rope act to balance science with humanism.

Given current thought, how does one go about evaluating the work of students in the clinical area? How does one amalgamate these important trends into the act of evaluating? In

order to do this, the concept of caring must be central to the process. Caring for patients and caring for students and their learning are pivotal. Listening to the voice of the student throughout the evaluation process is not only important pedagogically, but is also a central act of caring for the student.

An evaluation tool must show that caring and advocacy are important. Students should be evaluated on how they care and how they advocate for patients. How is it that students show their empathy? What do they actually do when they care for a patient with values and a lifestyle different from their own? In what situations do students choose to share their knowledge? How do they show that they are caring for family as well as patient? What can students tell us about their care?

The literature has shown that these are complex issues. The human condition even at the best of times is indeed multi-faceted. The student, patient/family, and faculty triad cannot be summarized by lists of behaviours which require mere check marks. I believe that the literature review calls for narrative in the evaluation of nursing students in their practica. It should be a narrative that combines the details of the care that the student is giving with the learning that the student feels is important.

THE CLINICAL APPRAISAL TOOL

Description

The clinical appraisal tool (Appendix 1) responds to many aspects of the current literature. The questions on the tool ask for word portraits about student/patient situations. In this way it follows the lead of the curriculum revolution by moving away from a reductionist model of evaluating. Instead of breaking down tasks the student performs into small parts or using a check-list approach, it asks for narrative. These descriptions of situations provide a way to evaluate the student in the context of her or his actual care.

The appraisal tool emphasizes the caring role of the nurse, which is congruent with current literature about nursing practice. The student is asked to give concrete examples about how she or he advocated for the patient, how the patient's cultural diversity was attended to, and how the student empathized with the patient. The student is asked to give examples of when she or he actually demonstrated dignity and respect for the patient. It is not enough that she or he knows that dignity and respect is important. Demonstration of both is required.

The examples which the student is asked to provide also respond to Girot's themes of competency and Dewey's sense of making connections. There are queries about the student's ability to transfer knowledge from the classroom and other disciplines to the clinical situation. What did the student remember from class, from her or his reading, and from her or his previous experience which assisted in the clinical situation? This also validates the student's previous knowledge and experience, incorporating more than one 'way of knowing'.

The literature emphasizes the importance of the voice of the student. The appraisal tool uses principles of student directed learning. The first question on the tool asks the student to list her or his three most important learning objectives for the clinical rotation. Asking initially for the student's objectives takes the student's learning seriously immediately. What the student wants to learn, is what the student is going to learn. It also serves to equalize the relationship between faculty and student. It attends to what is important for the student, and thus does not use the banking concept of education where the teacher knows all.

It can be seen from the literature that the process of evaluation between faculty and student is critical to the student's comfort in the clinical situation. It is crucial that the appraisal tool be owned jointly by the faculty and the student and used often by both. Self-evaluation is an integral part of this process, because often it will be the student who will relate the story. This allows an opportunity for learning because the student will have an opportunity to analyse during its telling. Stories are more accurate when told soon after the event. Inherent meanings can be discovered. There will also be a chance to examine alternative courses of action that might have been taken.

When the student is asked for goals for the next clinical rotation there is an opportunity for the student to examine her or his progress and set goals for next time. This allows for the student's ownership of learning and allows for a summary of the progress which the student feels she or he has made. The student has an early opportunity to plan and look forward to her or his next learning experience. There is a sense of movement forward.

The purpose of this study is to describe the perceptions of faculty and students about the appended clinical appraisal tool with respect to the process of evaluation undertaken by student

and faculty, the details of the tool (including wording and omissions), and the feelings the students report during the evaluation process. The effectiveness of the tool as a means of evaluating the student will be explored. Strengths and weaknesses will be identified. The ease of use of the tool will be commented upon.

Development of the Tool

In the Spring of 1995 the Southern Alberta Collaborative Nursing Education Programme required a clinical evaluation tool for student nurses in their first practicum which could be used in all years of the Programme. A committee of six from the three involved educational sites was struck in order to develop this tool. A brief review of the literature was conducted by this committee. One of our tasks between meetings was for each committee member to develop what she thought would be a useable evaluation tool. When the next meeting occurred, it was my tool which was selected, as it coincided satisfactorily with the literature we had reviewed. This tool formed the basis of our discussions for the next six months as the committee worked to reword and revise. The finished evaluation tool used the same basic narrative style as what I had originally proposed.

Six months later, the evaluation tool was presented to the faculty of all three sites at a Retreat. The faculty was then asked for feedback. Our committee received written feedback from approximately twelve faculty members. Based on this feedback, the tool was modified and then submitted to the Curriculum Committee which oversees curriculum issues for the Southern Alberta Collaborative Nursing Education venture. After this committee made comments, the tool

was amended. At this point it was used for all first year nursing students, and some second year students. Students receive a pass/fail grade for their clinical rotations, using the information on this evaluation tool, and the tool was then put in their student files. It is this first used version of the tool which this study explored.

METHODOLOGY

Participants and Procedures

This study included two sets of participants: students and faculty. Student and faculty participants in this study all possessed knowledge of the tool. Furthermore, they all had had first hand experience with the tool immediately preceding the study.

Students were given the clinical evaluation tool during their first day of their twenty day clinical practicum. Each clinical faculty member discussed the tool with her or his entire group of six students. After this discussion, faculty met on a one-to-one basis with each student to discuss and write on the tool.

I met with faculty before the commencement of the clinical practicum and presented the revised tool and answered questions. I asked faculty to meet with the students frequently and to write on the tool with the students, not for the students. I explained to faculty that the process of evaluation was very important to the nature of this tool and encouraged faculty to allow the students the ownership of their own clinical evaluation and to allow the students to keep the tool in their possession.

Data were obtained from the students during a one hour focus group discussion. These data were taped, transcribed, and analysed. Data was obtained from faculty using a written questionnaire. This data was analysed. Both sets of data were incorporated together using the same themes, and are reported below.

The faculty were asked questions in writing, which called for written narrative responses. I chose this method for faculty because the clinical course occurred at the end of the academic year, and the seven faculty members who had used the tool were dispersing to all parts of the globe, therefore finding a mutually agreeable meeting time was an impossibility. However, only three out of the seven faculty who used the tool responded in writing, which is a (disappointing) participation rate of forty-two per cent. The advantage of this method for faculty was that they could respond without constraint of finding a meeting time, and they did have time to think in private about some of the issues pertaining to evaluation which they have thought about over many years. The disadvantage is that a full exploration of ideas might have been tempered by faculty not having an opportunity to explore thoughts about evaluation with each other.

The participants are crucial to any research project. They act as translators of the group's culture. Participants express the shared sense of reality within the group. Morse (1991) speaks about the qualities of a "good informant" which are having knowledge about the topic to be studied, possessing an ability to reflect and a willingness to talk and examine critically. Gilchrist (1992) says that participants possess special knowledge, status or communication skills. Because they are willing to share their knowledge, participants provide access to perspectives or observations which are otherwise denied the researcher.

Student Participants in the Focus Group

In May and June of 1995, five groups, each consisting of six or seven first year baccalaureate nursing students each used this evaluation tool at the same time in their first clinical rotation in the Spring of 1995. Three groups of second year diploma students used this tool at the end of their second year. The second year students were not interviewed as they are in a different nursing programme because they are diploma students, not baccalaureate students. Their educational process had been different, as their education has been more traditional and content-driven. However, two of the faculty members who entered the study had used the tool with second year students. Each clinical group was facilitated by a different faculty member.

The purpose of the study was explained to the thirty-two first year students. Students from each first year clinical group were asked to volunteer for a group focus interview after their evaluation process was completed. In total, fifteen first year students participated, which was a participation rate of forty-seven per cent. There was equal representation from each clinical group. Three students were male, and twelve were female. Their ages ranged from eighteen to forty-two years of age, including both the youngest and oldest members of the class. Written consent (Appendix 2) was obtained from all students.

Faculty Participants

The other group of participants were the faculty. All seven faculty members who had used the tool were asked to provide answers to a written set of questions. Three responded. Two who responded used the evaluation tool with second year diploma students, and one had used it with first year baccalaureate students. The faculty members who used this tool with second year

students responded with a different level of student in mind. This could mean that their comments affect the reliability of the study, because they were not thinking of the same general type of student when responding to my written questions. I included their comments because they had used the tool and were able to provide some interesting comments about its general use.⁸ However, their inclusion perhaps constitutes a limitation of this study. The faculty participants were all female, and have been teaching nursing between two and twenty years. Faculty participants signed a letter of consent (Appendix 3). In addition, I used the tool with first year students, and some of my observations are also included.

Focus Group Procedures

A focus group is a group of participants, meeting together with a moderator in order to discuss the subject to be studied, which was in this case clinical evaluation and the clinical evaluation tool. A focus group was used as the major method of data collection in the hope that the idea of one student would spark a thought in another and that as much information as possible would be forthcoming about the students' feelings regarding clinical appraisal and this appraisal tool. To ensure as much participation as possible, the students were given post-conference time⁹ in order to participate in this project. The disadvantage of using the focus group was that it might be possible that dominant students could sway the group, or that silent students might not be

⁸ In addition, there was only one respondent from the first year group of faculty, and I was interested in obtaining a more varied response.

⁹ Post conference time is a one hour classroom session held at the end of each clinical day, in which the students and faculty discuss clinical situations which have arisen during the day. Students are required to attend these sessions. The focus group was conducted instead of one of these sessions in the hopes of obtaining a high student participation rate. This strategy was successful, as the student participation rate was forty-seven percent.

heard. In order to mitigate this, the moderator was asked to try to elicit opinions from everyone in the group.

In thinking of some pragmatic issues, Lankshear states that the optimum size of a focus group is five to twelve people (1993) and Howard *et al.* (1989) say that six to ten people is optimal. The focus group session took place on the second to last day of the students' clinical practica. All students who participated had completed the written evaluation process with their faculty member by this time. The group focus session lasted fifty-five minutes. Lankshear (1993) states that forty-five minutes is a reasonable time frame for a group session.

Because I sought perceptions of students, the purpose of the group session was to elicit thoughts and stories about the evaluation tool. The students who participated in the focus group had never before participated in a clinical rotation or clinical evaluation. Therefore, questions about comparing one method of evaluation with another would hold very little meaning to these students. A sense of the meaning inherent in the evaluation process and in the clinical lessons learned was sought from students.

Brink (1991) states that when multiple interviews are not used, then equivalence is the reliability check of choice. Equivalence is obtained by working with participants using different forms of questioning. Asking the same question in different ways (using different words) and receiving similar answers constitutes reliability. The moderator did repeat questions and the reliability of the information was checked in this way.

The Moderator

The role of the moderator in a focus group is absolutely critical. Nyamathi and Shuler (1990) state that the role of the moderator is multifold. The moderator must maintain group enthusiasm and interest, must direct, think, encourage participation, must be knowledgeable, must be able to summarize and finally needs to have mild and unobtrusive control over the group. According to Lankshear (1993) the moderator must also allow participants to think individually about topics raised. He or she poses the trigger questions which are open-ended and which define the area of study so that participants can explore the area of study using their own terms.

The moderator must also ensure that all participants be permitted to speak. There is a risk, according to Nyamathi and Shuler (1990) that passive participants may be influenced or inhibited by more active participants. One way around this problem is to explain at the outset that one response is not better than another. Lankshear states (1993) that it might be necessary for the moderator to exert some control so that one person does not dominate the discussion.

I was not the moderator of my focus group, due to the risk of my own bias pervading the group. It was important that the students felt free to express their true opinion and my known ownership of the evaluation form might have precluded that. Therefore, one of the most important tasks I faced was to choose a moderator who would be able to fulfil the role enunciated above. The moderator I chose has an understanding of the nature of qualitative research. She is skilled in group work, and has participated in qualitative research herself. She is not a nurse and has not been involved with the development of the form or with the students in any other way.

I met with the moderator prior to the focus group for two reasons. One reason was to advise her about issues in the clinical evaluation of nursing students. I realized this by reviewing

the trigger questions with her, and told her some of my reasons for including these questions. The second reason was to appraise her of the nature of qualitative research in general, and of focus groups in particular. I reviewed with her what the literature says about the role of the moderator in focus groups.

Trigger Questions for Focus Group and Faculty

The same basic trigger questions were asked of both faculty and students. The following questions served as a guide to the moderator. They also formed the basis for the written guide sent to faculty (Appendix 4).

The trigger questions were developed based on the literature review and to fit the nature of the evaluation tool. Just as the evaluation tool sought narrative, so did the research design. Because caring and student voice were so important, it was vital that the questions elicited this type of information. Process is crucial to clinical evaluation because uncovering the process tells about the relationship between faculty and student, as well as giving information about the power the student feels in the evaluation agenda. Feelings also elicit similar information. For example, if the student feels intimidated, then the power balance between student and faculty is different than if the student **feels** he or she is an equal partner in the process.

The following are the categories of questions which were asked to both students and faculty.

Process

What process did you engage in with faculty [the student] to complete the evaluation? When did you fill it out? Who wrote on it? How much input did you have in the completion of the form? Who kept it during the rotation - you or the faculty member [student]? If you felt like you disagreed with what was being written on the form, did you feel free to discuss this with your clinical faculty person [the student]? Will you be receiving a copy of the completed form [giving a copy of the completed form to the student]?

Tool

How did the tool itself teach you [the student] about nursing? Was there any particular question which stands out in your mind as being particularly helpful? Were there questions that weren't particularly helpful?

Were there things that were not included on the form that you think should have been?

Feelings

What did it feel like to be evaluated while you were actually learning in the clinical situation [evaluate the student while learning in the clinical situation]?

Summary

How well did this evaluation tool describe your [the students'] clinical practice during this rotation? Do you believe this evaluation was a valid indication of your [their] abilities? What changes would you suggest and why?

Faculty Data

In order to elicit feedback from faculty, I sent each faculty member who had used the form in both the first and second years of the nursing programme a list of the same trigger questions which the moderator used to guide the group interview. They were asked to respond in a paragraph for each set of questions in written form on computer disc. Each faculty member was

asked to sign a written consent. Written responses from faculty were gathered together and coded using the same coding themes used in analysing the student transcript from the focus group.

Transcription

Two tape recorders were used to record the student focus group, and I transcribed the interview after the final marks for the course had been returned to the students. Even with two tape recorders, there were sections of the interview which were difficult to hear, due to the hospital overhead speakers and the number of students present. These sections which could not be heard are represented below by asterisks.

It was not possible to discern on the tape which student was speaking at all times. Therefore, I was only able to distinguish between students on the written transcript by using S₁ and S₂ etc. When more than one student is saying the same thing at the same time, Ss is used. The moderator is denoted by Mod. below.

Analysing the Transcript

The written transcript was 1067 lines long on twenty-one pages, single-spaced. After transcribing, the transcript was colour coded using four categories. The categories chosen were the same categories used in developing the trigger questions: Process, Tool, Feelings, and Summary. Following colour coding, the following themes emerged from the above categories: goal development, who actually evaluated the students, questions which were helpful to the students, vague wording, omissions in the form, feelings, and summary statements. The themes

were chosen based on the amount of interest displayed by the students about a particular aspect of the topic. Amount of interest was gauged by the amount of discussion which emerged.

The themes which emerged from the student focus group provided the basis for coding faculty comments. The written comments from faculty were collected and coded separately. When written faculty comments were about the same topic as what the students were saying, then the comments were included in the above themes. When faculty comments were different thematically than student comments, they were inserted into the analysis where appropriate.

Limitations of the Study

This study had several limitations. These limitations had to do with the student sample, the faculty sample, and my own bias.

The study consisted of fifteen student participants, all in the same year of the same programme. The fifteen students experienced the tool with different faculty members, who used the tool in markedly different ways, as will be seen below. One can only say that the findings are valid for these students at this time in this nursing programme. The results cannot be broadened to include the span of all nursing programmes.

These fifteen students were only provided an opportunity to appraise the tool in a one hour focus group session. No other kind of student data collection was undertaken. The study would have provided a broader scope of information individual interviews with students, a formative assessment, and questionnaires had been used as well.

Another limitation regarding the student data was in its transcription. Because I

transcribed the data from an audio tape, I did not know for certain which student was speaking. My only option was to transcribe using S₁, S₂, etc. in order to distinguish between students during each section of the group interview. Thus, when transcribing, S₁ is only the same person during that section. S₁ is not the same student throughout.

Another limitation could be in the qualitative nature of deciding what parts of the transcript I would include in this report. I attempted to include one or two sections of the transcript on each topic that the students covered. I frequently omitted sections of the transcript which reiterated what students had already said. In doing so, I might have omitted nuances of student interpretation.

The study was also limited by the fact that second year students, who had previously taken part in clinical evaluation using another type of form, were not included in the study. I chose not to include the perceptions of second year students, because I felt that this tool and the process which it encourages is part of a whole paradigm of nursing education. This paradigm, as illustrated in the above literature review, encourages ownership of learning and an egalitarian relationship between faculty and student throughout an entire nursing curriculum, with the student at the centre of the learning process. The second year students had not had an opportunity to explore this paradigm in the sense that they had so far been involved in a somewhat traditional content-driven programme.

Another important limitation was that only three faculty members responded to my requests to enter the study. There are several possible reasons for this poor participation rate. One reason is that my request was made near the end of a busy year for faculty. Secondly, the faculty who had used the form with first year students had given verbal feedback during a wrap-

up meeting for that course, and might have felt that they had contributed in this way to the appraisal of the form. Indeed, the study would have been richer if more faculty had submitted written comments.

In addition, the faculty who responded differed in two significant ways. First, these three faculty were teaching in essentially two different nursing programmes. This meant that the level of students and the education of the students they were thinking about when responding were different from one another. Secondly, these faculty members were all practising in quite different clinical settings with their students. The faculty member with first year students was practising in extended care, and the two faculty members with second year students were in maternity and paediatric settings. However, the intent of the form is that it be able to be used in a variety of settings, so this did provide an opportunity to explore whether or not it would work in different setting.

Again, with regards to faculty, only one type of data collection was formally undertaken. Faculty did give me ongoing verbal feedback, but this was not included in the study, although it might have had an unconscious impact on my analysis.

Finally, one of the most pivotal limitations of the study was that as the researcher, I was appraising a tool which I had a significant role in developing. I obviously wanted it to work. I attempted to mitigate this in a small way by choosing another person to be the moderator of the focus group. However, admittedly I was the person to analyse the verbal transcript and written comments.

Although this study did have some limitations, it can be said that despite these limitations, a window into the clinical evaluation process for nursing students has allowed a little more light to

shine through. However it must be admitted that the findings cannot be generalized to include different situations.

INTERPRETATION OF THE INTERVIEWS/WRITTEN FEEDBACK

Process of Evaluation

The process which faculty were encouraged to undertake with the students was important in that it allowed the students to identify what **they** wanted to learn when they set up their goals. Because faculty were asked to meet frequently with the students, and write on the evaluation form with them instead of for them, it was hoped that the students would maintain ownership of their own learning, and would see the evaluation as a partnership, not as a power relationship in which they were the lesser power.

The students described different ways of using the evaluation form, depending on which faculty member they worked with. A short discussion of faculty styles is needed at this point. All seven faculty members were given an orientation to the form. They were all asked to meet frequently with the students during the rotation on a one-to-one basis, to allow the students to develop their own goals, and all were encouraged to write on the form **with** the students, using this one joint form.

The students reported that two faculty members did vary from these requests. One faculty

member filled out her¹⁰ copy, while the students filled out theirs separately. The other variance was that one other faculty member told the students what her goals would be for the students which included a computer print-out of these goals at the beginning of the rotation.

Mod: Were you aware of what the goals were that she had for you when you started out?

S₁: ...she gave us a hand out. (Lines 90-91 and 98)

S₂: She had personal goals that she wanted us to try and achieve, and she wanted us to try and achieve the goals that we had set out for ourselves. (Lines 68-70)

Other than these variances, most faculty adhered to the requests made during the orientation session.

Most students were the 'keepers' of the form. It was hoped that this would send a strong message to the students that the evaluation was theirs, and that the students were to be trusted with this important document. There was one exception to this for the first year students:

S: *X (i.e. the faculty member)* kept ours, but we got to take it home whenever we wanted. (Line 21)

One faculty member chose to go over the form twice with students, once at mid-term and once at the end of term, instead of on a more frequent basis. Thus all but one faculty met with students frequently on a one-to-one basis, once or twice a week, in order to facilitate a frequent exchange of ideas, information, and feedback.

S: What we did was we'd sit down, usually twice a week is how it would work out, and, bring this in with us. It was on a one-to-one basis, and we'd look at the goals that were established, and see if there were any situations that had arisen... (Lines 52-55)

Another student expressed appreciation of the process of frequent discussion with faculty as

¹⁰ The pronoun "her" or "she" will be used to describe all faculty and students in order to protect anonymity.

follows:

S₁: I found it interesting that when we got on to our one-to-one talk that I didn't realize that I had done some of the things that the questions had asked and it made me look back and think that, 'Oh, I guess I did do that.'

Mod: So, you were making more progress than what you realized?

S₁: Yeah.

S₂: Mhm.¹¹ (Lines 163-171)

For this student the process allowed her to see progress and development in her own learning.

With the help of faculty, she could articulate what it was she was learning.

Articulating learning and progress was also expressed by a faculty member:

Some students were exceedingly insightful and provided excellent examples from their practicum experience. Some had a difficult time, at first, to recognize exactly what was applicable to each category. In either case I was able to provide examples from my own observations and notes. For the less insightful student this seemed to provide an understanding of what "counted" and thereafter the ideas flowed more freely. Some students were so astute in recognizing examples of their performance that all I could do was concur.

Another faculty member said:

Allowing students to participate on a regular basis in identifying examples of their performance, inspires the development of metacognitive skills: (1) because it requires students to consciously monitor and regulate their thinking and their performance; and (2) it involves a degree of self-knowledge, theoretical knowledge, skill knowledge, and self-monitoring, which if recognized can be enhanced through conscious attention. The other really neat thing about this tool is that it forces learners to acknowledge their own capabilities, thus encouraging function from an internal locus of control, which I feel is an absolute necessity if one is to survive/thrive in the profession of nursing.

Finally, one faculty member felt that the process she engaged in with students was due to the nature of the form:

¹¹ In transcription, if I understood agreement from the tone of voice of the student, I used the word "Mhm."

The interactive nature of the tool is conducive to the development and maintenance of collegial relations between the facilitator (instructor) and the learner (student).

The Development of Goals

All students were asked to develop their three most important learning goals at the beginning of the form. The goals were often used as a focus of discussion during the one-to-one meetings. Many students developed their goals with their faculty member and described this development as a “partnership.” One faculty advisor described the process as follows:

The student was asked what his or her goals were. Some students had their goals well developed and were able to articulate them...about half (3) wrote their goals statements on the form and the others allowed me to write them as they were articulated, refined, and occasionally reworded for clarity reasons. Three goals were stated at this time. The one student who could not come up with three goals was approached again in two to three days and then had a better idea of what a third goal might be.

As the students worked with this form, and with the faculty, they began to value the process of self-evaluation:

S: ...We basically said everything that [were] our goals and she helped us and put in her opinions, but I felt like what it helped us do is learn how to evaluate ourselves and I think it...where the nursing profession is going which is in the community, we're not going to have instructors there or supervisors to evaluate us in the community and I think we have to learn to evaluate ourselves, and if we can't admit when we're doing right or wrong, then we're going to go nowhere, we're just going to be poor nurses... (Lines 272-282)

There is a very strong sense here of the value of self-evaluation, perhaps emanating from the encouragement the students had to develop their own goals, and from the ownership they had over the evaluation process.

Mod: Was there any question that you really like on the form?

S₁: I enjoyed the goals, cause I'm not one to make goals on myself.

S₂: Yeah, goals are good.

S₃: Yeah, for me too.

S₄: Yeah. (Lines 906-912)

Who Actually Evaluated the Students?

For the most part the process of clinical evaluation in which students and faculty engaged was one of partnership. Most faculty filled out the form with the students.

S: I'm glad that our instructor had taken the time to complete the form with us, because it made us feel less stressful. (Line 1035) .

Students were encouraged to find their own examples to write, and faculty helped to clarify. However, one group noticed that the Registered Nurses on the nursing unit had some input into their evaluation:

S: ...for our evaluation our instructor would talk to the RN...which surprised me...she wrote that on the evaluation, what the RN had said about...the way we worked. (Lines 778-780)

This action may have jeopardized the partnership between faculty and student, by introducing a third party. The student would not have had an opportunity to go to the RN to discuss the feedback given, unless that student actually knew who the RN was and was very assertive.

In one clinical group the faculty filled out one copy of the form, while the students filled out their own. I believe that when there are two copies of an evaluation, one faculty and one student, often both copies are not treated equally. Often only the faculty copy is filed, and of course that lends a tremendous weight to the faculty document, and virtually no 'official' importance is attached to the students' self-evaluation.

In summary, the process engaged in was one of joint meetings on a frequent basis, with abundant input from the students. For the most part, students developed their own goals, with

varying degrees of assistance from faculty. Some students recognized the value of self-evaluation during this process.

Although the process of evaluation is extremely important, the tool itself must lend itself to a process of cooperation which is part of the curriculum/education revolution. What did students and faculty have to say about the evaluation tool ?

The Tool

Questions Which Were Helpful to the Students

Students were given the opportunity to express opinions about specific questions they did or did not find helpful on the tool. As we have seen, they generally thought that setting their own goals was a useful question. In addition, one student commented:

S: I like that it gave you the opportunity to add goals, but I think it should give you more room on the paper. (Lines 443-444)

The students also saw that the summary question which asks “What areas need improving?” would be the basis for their goals in their next clinical rotation.

S: In my case it could be, because like there’s a couple of things I know of that I have, have trouble with right now and of course when I get back to clinical this Fall I’ll likely still have the same obstacles to overcome at that time, so it’s something I can look back on and read some stuff I’ve written on it.

Mod: So, it would be helpful for you to have the form from last year?

S: I think so, yeah, just to read it back over again. (Lines 351-356)

Thus, the learning process is one of development, as seen in the eyes of this student, carrying over from one year to the next. A sense of development, of moving during learning is

important for students. They can see their own progress:

S₁: Yeah, I think that I liked the question on uh “Comment on the student’s development of skills in this clinical area,” because there are things that came up as time went along that I was able to improve on once I was able to identify that I was you know, weak in a certain area...

S₂: Mhm.

S₁: ...so that was like a form of development or whatever.

S₂: Yeah.

S₁: That was something I liked. (Lines 935-943)

Another student found it useful to comment on integrating theory and research into practice, as follows:

S: ...‘integrate the theory and research into practice.’ That was one thing that I kind of had difficulty with...I’d get in there and I’d just read it; like I’d jot down all the notes and stuff that I was supposed to have done... but I didn’t apply it really and think through the processes ...that should have been done. And I think that’s an important point that we should be looking at and that’s a good question I think, because that integrates our theory and our skills ... that we had from last year...into our practice, into actual experience . . .If you don’t do this and if you don’t have this you’re endangering the patient and even yourself as well, and that’s really important... that’s a good question; I think, so. (Lines 944-961)

The students also appreciated having the opportunity to give an example of how they had educated their client:

S: Probably question number eight, um, to discuss how the student educated the client in relevant health matters. I think that one’s really important because...as nurses, that’s what we’re supposed to be doing is educating our residents and so forth, so I think that one’s really important.. (Lines 963-967)

The students had differing opinions as to whether or not the addition of the course aims to the form was helpful:

Mod: So, does anybody have anything else they'd like to add about this evaluation tool? Do you feel ... if you look at the 235 outline, did it assist you in meeting the goals of that course description? ...It's on there...

S: It just made me aware of the fact that I had done these, I had completed these course aims....so that I just kind of ...*¹² It just made finality to this particular course. (Lines 971-983)

However, another student said:

S: I don't know, I could take 'em or leave 'em you know. It's not like I had looked at these and went "Oh yeah, yeah, I do that..." *Laughter* . I'm there to learn, I'll do the job ... but you know if I'm making a mistake, well tell me * you know. (Lines 987-990).

Perhaps in this case the student was looking for more direction from the faculty member.

It can be seen that there were many questions which the students found helpful to their learning. Setting goals, specifying skills, delineating areas which require improving, and integrating theory (or text book learning) were all mentioned by students.

Vague Wording

There were some questions on the form which the students felt were vague. Either they felt that the questions did not relate to the clinical situation they were in, or the concepts in the questions were not defined consistently so that the student could connect with the definition.

One question ("Give an example of how the student showed sensitivity to the client's diversity (eg. Socioeconomic, spiritual, educational, life-style or culture) in providing care") was discussed by one student as follows:

S: Some of the questions as well I thought weren't really based for the floors we were on.

12 An asterisk (*) indicates that I could not hear what was being said, either because of the voices of other students, or because of the hospital overhead speakers.

Like, um, that one about the socioeconomic and stuff like that, like on Extended Care.... I was kind of taken aback by it but they said um that my residents were farmers and that I didn't hold any grudges or like think that they were poor or anything and...cause where I come from is a bunch of farmers, so...it seemed kind of odd that I know a lot of times you don't realize when you didn't take race into account, or their, or whether they were poor or anything, maybe if we were on wards where like let's say, maternity where there's a woman coming in five times that's on welfare and having kids, maybe that would be a little more appropriate, but on a floor like Extended Care you don't know what their bank account is like. You're just changing medipants and some of them can't even talk to you, so you don't know. So, it just seemed really inappropriate for the floors we were on. (Lines 467-485)

In analysing this statement, I would have to say that at this level of exposure to patients, the student had not been exposed to enough patients where she thought she could apply her "sensitivity" skills in this regard. She did not have the holistic picture that the residents are people with bank accounts, different resources at their disposal, and of differing backgrounds. However, this is the first year of a four year programme, and it is to be hoped that as the students take courses in the socio-cultural aspects of nursing that they will be able to consider these factors with all their patients, regardless of the clinical setting.

One faculty member felt that questions number five (which asked for examples of empathy, dignity and respect) and number six (which asked for examples of sensitivity to diversity) should be combined, as she felt the same examples often applied to both questions.

The next question on the form, "Describe a situation when the student advocated appropriately for the client" was generally understood by students, although one faculty member provided an example of advocacy, with which the students had some difficulty.

S: Another question that I found was very vague was the one about advocating appropriately for the client. Because I always think of advocating as you know going toward, going to and standing up with the client against you know umpteen dozen ...and my instructor said 'Oh, well, you looked in somebody's chart and they hadn't had an

Argo¹³ for a week and you took the initiative and took him for an Argo...' And I thought, 'That's advocating for patient¹⁴ rights?' That was the example and ... to me that didn't answer the question, and ... I felt that was too vague. (Lines 620-629)

It can be seen in the above comment that the faculty member was defining 'advocacy' in a way which did not resonate with the student. However, another student offered an alternative kind of example of advocacy:

S₁: See, I advocated on behalf of my client to another staff member that he didn't like; he does not like the fact that this staff member was going to be his caregiver for a few days and he would get himself worked up into a frenzy over it and, and he would worry himself sick about it and so I was, you know I tried advocating on his behalf to that caregiver. So that's the way I understood that.

S₂: Yeah, that is advocating.

S₃: That is advocating. But, not what I was marked on. (Lines 657-665)

It can be seen that although the faculty may present one picture of a word, the students generally had their own meanings, and wished to use those.

Another interesting aspect of the quotation above is the phrase "...not what I was marked on." This statement was given in the passive voice, as if she did not have input into this question on the form. The idea of being "marked" holds strong evaluative connotations. This came from a student whose faculty member kept the form, and who only had an opportunity to go over it twice with faculty. Could this process have contributed to the feeling that she was 'being

13 An "Argo" is a type of tub bath.

14 The use of the word "patient" here instead of "client" or "resident" is interesting. Personally, I would prefer to use the word "patient" over client in acute care settings. We know who "patients" are. The word patient means a person who suffers. I believe that patients in acute care settings have not consciously chosen their illnesses. The word client suggests a commercial relationship between the health care provider and the person receiving care, and suggests that there was a choice involved in becoming ill. Clients usually pay money in exchange for services. Such is not the relationship envisioned in Canadian health care legislation so far. Since the form was developed by a committee, I was overruled in this matter, and that is why "client" appears on the evaluation form.

marked?'

Another question about which the students felt unclear was the one which asked how the student used a variety of ways of knowing, and the part which gave the students difficulty was the example of "aesthetic knowing."

S: ... we had a conversation of 'aesthetic knowing' ...*Laughter* ..I think we had three or four different definitions because 'aesthetic' is kind of a word that's not [clear], and and I believe that this is formed after the seven threads of the nursing programme which are ... abstract to begin with, so it's kind of hard, like some of those threads I really scratch my head about too, but ...*Laughter* ...sorry, that was pretty...*Laughter*...but that's another study ...*Laughter*. But, just that, like because we, as me and the instructor had pretty much no problem figuring out everything until we got to this question, and then we kind of looked each other, 'Well, what the heck is aesthetic knowing?' so...

Mod: So, what is aesthetic knowing?

S: *Laughter*. We haven't defined it yet. But I thought aesthetic had to do with beautiful things like art or creativity, the creative side of things... (Lines 543-558)

The students then went on to discuss their view of what aesthetic knowing is. One can see the progression of thought the students undertook in order to come to an understanding of aesthetic knowing. One might be able to say that the form produced this evolution of thought, or one might also say that the term is vague, and perhaps needs more interpretation and discussion by faculty and students.

One faculty member acknowledged her discussions with the students around ways of knowing as follows:

What experiences in my personal life have helped me to know about situations I meet here? What is meant by the application of theory to practice? How does knowledge lead to safe care? What is aesthetic knowing? I liked the discussion which arose around the ways of knowing section as I think it gave the student an understanding of the full range of possibilities for knowing within a clinical setting.

Another example of where this kind of exploratory discussion might be useful is in the use

of the Programme Threads (“Becoming”, “Ways of Knowing” etc.) as headings on the form.

S₁: I sort of felt that these titles like 'Becoming' and 'Ways of Knowing and ... when you go to fill it out, you know ...

S₂: *Laughter*.

S₃: ...well, geek, they want some big philosophical ... *Laughter* ... Well, you know we've been exposed to these and ... we're still not [sure] what they mean. *Laughter* I dunno, maybe delete those, that's my suggestion. (Lines 914-921)

One student linked the vagueness of these terms to what she felt was vague in the course aims listed in the summary of the evaluation form:

S: I dunno, some of these you know, the four domains, 'person, environment, health and nursing,' you know we learn that in first semester too and again it's just like 'knowing' and 'becoming' and all this ...*Laughter* I'm pretty down to earth, you know...*Laughter*

Mod: Something a little more concrete?

S: You betcha. *Laughter*. (Lines 993-1000)

It can be seen that while some of the wording was unclear to students at the beginning of the rotation, the words became more comprehensible if there was discussion about their inherent meaning. This kind of discussion produces learning of its own. However, sometimes the wording is so abstract that the meaning is still not clear, as in the case of the Programme Threads typed in bold on the form. Additionally, if faculty do not provide examples which resonate with the students, then the students continue to feel that the wording is vague, as in the example about advocating for patients.

Omissions in the Form

Some students felt the form captured most of the picture of their clinical rotation; others felt that there were some omissions:

Mod: Good. OK. Um...do all of you feel that this paper you end up with is kind of a

good picture of what you did in the nursing rotation?

Ss: Mhm...

Mod: But does it actually reflect what you did?

S₁: No.

S₂: Mine did.

S₃: Certain things.

S₄: Could be.

S₁: But, it's not complete, cause there was lots of times that we had done specific things that, like the task oriented things, that are not put in here.

Mod: OK. Can you give me some examples.

S₁: Poop.

Ss: *Laughter*

S₄: Cleaned up a diaper.

S₁: Medipants.

S₄: *don't do us justice

Mod: *Laughter*.

Ss: Yeah. *Laughter*.

S₁: ...*stuff like that. (Lines 379-391)

Students want to see the things they did reflected on the form. This can be accomplished, I believe, by filling in question number four which asks to "Comment on the student's development of skills in this clinical area." In the first draft of the form the committee had listed some skills, but faculty asked that these examples be removed. Perhaps consideration should be made to listing some skills, depending on the type of clinical area.

Another area which both students and faculty wanted some opportunity to comment on, was in the area of "professionalism," and they saw that as an area where exhibiting dignity and respect would have a place:

S: I would say something about professionalism.....

Mod: OK.

S: ...um, to me in that kind of question worded something like that is where we could express more um about exhibiting empathy and dignity and stuff like that...'cause to me that's involving professionalism. Part of what we're learning and what we're taught is a required asset or a required skill and as a nurse... (Lines 670-676)

Two faculty members expressed the desire to have professionalism added:

There could have been something more on the student's developing professionalism or his or her adherence to the "norms of nursing"..punctuality, deportment, obligation to other team members etc.

If 'professionalism' is to be added to the form, it would have to be defined, with examples given. Professionalism means different things to different people, and the meaning of the term can have a large range, anywhere from dress to demeanour.

Another area which the students found lacking was in assessing their ability to assist other students, both with their tasks, and with their learning.

S₁: I also had something else...I thought that ... maybe even just for the first year that there might be something on there about, helping the other students and teaching other students.

...

Mod: Oh, good.

S₁:because I know in our, like on our floor if we were taught a skill from our instructor and we could do it competently, then she just left us... 'OK, you show whatever else...you know, how to do this' and I found that very comforting in a way; it felt really good just to go to another student to help 'Have you done this before and can you show me how to do it?' And, I think that's a real important skill to develop, as a student to be able and feel comfortable to help your fellow students

S₂: I agree.

S₁: And ask others.

S₂: We helped each other on our floor a lot.

S₁: ...and I think that's something that would really reflect you know, your character and your personality and, and your improvement in skill areas on the evaluation form.

Mod: Teaching is a different skill than actually doing it?

S₁: Yeah.

S₂: Not even wording it as a teaching, as a sharing ...

Ss: Mhm.

S₂: ...experiences or something....

S₁: That's a good point.

S₂: ...supporting. (Lines 690-714)

This discussion then developed into a discussion about team work.

S₁: Just being able to you know, have the feeling that you can depend on somebody else...that they'll be there for you ..that'll develop team work ..

Ss: Mhm.

S₂: ...and

S₁: And that you're comfortable to ask someone else for help not just say, 'Oh, I'll try this by myself first...' that you're comfortable with this. Say, 'I don't know how to do this, help me do it.

S₃: *

Mod: Good. So, did you feel like your team work was ever evaluated throughout the process?

S₁: No.

S₂: No.

S₁: Not really.

S₂: It was just there, automatically. (Lines 715-730)

It can be seen that students find great support from each other on the clinical unit. One can often see students in the hall, consulting with one another. There is a certain safety in asking each other questions, in exposing one's uncertainty to a peer instead of to a faculty or staff member.

One faculty member felt that there should be some comment about the **effort** that the student was making to achieve goals. By this, she meant to discover if the student was reading, seeking out experiences, and asking questions.

Tasks, professionalism, effort, and team work were the omissions the students and some faculty commented on. Although these components were very much a part of the students' clinical experience whether or not they were evaluated, I think students wanted to add value to them, and so recommended that they be added to the form.

Feelings

Nursing students in the clinical area evaluate themselves and are evaluated while they are

learning. The moderator asked if this bothered the students, or caused them to experience some stress:

Mod: Is it hard to be evaluated while you're learning?

S₁: No.

S₂: No.

S₁: It increases the progress in our, our level I guess, of accomplishment.

Mod: You don't feel pressure about, uh...

S₁: Not at all.

S₂: If anything, it's a motivator, keeps you goin', and keeps you ... so you keep your job going and keep interest in, and keep yourself prepared ... in your rotation. And...yeah like I said it's a good motivator, more than pressure.

Mod: So you felt like it kept you on your toes and kept you kind of current?

S₂: Yeah.

S₁: ...Most of it, like it was all encouragement. (Lines 99-115)

Later, they went on to say:

S: "There was, there was never really a really strong sense that you were being tested or evaluated, it was more a matter of ...this is a learning process; the instructor was there to, to help us, in any way we needed help and to, to let us do whatever we were able to do on our own, to help us feel more confident in the skills that we had, and the skills that were developed. It was never a matter of the final exam pressure sort of thing, it was just an ongoing learning process.

Mod: So, you felt more supported than evaluated?

S: Yeah.

Mod: OK. And is that true for everyone?

Ss: Mhm. Yeah. (Lines 186-197)

One can see here a very low key attitude towards evaluation, with the students' stressing the learning process instead.

The suggestion was made by faculty to de-emphasize evaluation even further by changing word "evaluation" the title of the form to "analysis", "assessment", or "report."

One faculty member acknowledged that, although the act of evaluating a student was not a

new process, the new form encouraged a different sort of process.

This process was less threatening in one way..that is it was more of a natural process for the student to develop new goals (second page). In the former process it seemed it was always a criticism if the student was not "measuring up" and had to formulate some new goals ..this lead to the formation of objectives for the student which tended to be punitive and threatening. A student did mention that she appreciated the regular opportunity to sit down with the instructor and to discuss her progress...she found this affirming and reassuring. I felt good about this process.

Students did mention their fears about having something negative written on the form:

S₁: Perhaps the same question could be worded differently in that, in a negative sense where .. 'Give an example of how they **neglected** to exhibit empathy, empathy or respect or something.' Something like that would stick out better for me than when I do [exhibit empathy and respect]. *Laughter.*

S₂: The thing is, I don't like something like that because that's a very negative report to put on your own form.

S₁: But maybe it would at least make you aware of it, if it happened, if you care.

S₂: Well, it could probably come back to haunt you at a later date though....

S₁: Mhm.

S₂: ...like if you had problems somewhere down the line with a totally different thing then they'd look back and they'd go 'Oh, well he had a problem because you know this guy is HIV positive' or something like that, you know, uh, that could be a, you know, real negative question. (Lines 602-618)

On the one hand, it can be seen the students feel positive about the evaluation as a learning process, but it can be seen that there is still caution to be exercised, in the "haunting at a later date."

Another feeling that came through was on one occasion a faculty member asked to speak with a student privately, before the student was used to the faculty's routine of having private discussions:

S: I found that when she first called me in, 'S., I'd like to talk to you...' *Laughter...*I started sweating pretty good there but once we sat down and started going over this, it gave me more of, more of a comfort... (Lines 885-888)

Again, we see caution, but then reassurance once the process was established.

In summary, the students said they did not feel threatened or intimidated by the evaluation process. Instead, they showed a real desire to learn and improve their care of patients. Many appreciated what they perceived as a “positive tone” to the form.

Summary Statements

The students and faculty made a few comments which could be seen as summaries of their opinions about the form and the evaluation process.

S: *.....after two weeks I pretty much had [an] idea, I could fill out all this form, but there were one or two questions I had really no idea [about]... [and] when I [was] on the floor, I just remembered that question ... and what I [was] supposed to be looking for, and I kind of [kept] my eyes open all day [to see] if I [could] come up with that kind of example and [then I would] go home and fill it out [that] day... (Lines 142-148)

Mod: Good. So, so, in some ways it helped you focus on things that you needed to learn.

Did it also help you focus on, um, your strengths?

S: Oh, yeah. (Lines 159-162)

A faculty member summarized the form as follows:

Therefore, I have to admit that this approach is very refreshing and rewarding. (1) It makes the student think -- analyse decisions, practice and behaviours. (2) It allows the student to identify strengths and weaknesses, if any, before the instructor brings them up. (3) It provides the instructor with information that s/he may otherwise not have been privy to, since no one person can be in seven places at one time. (4) It makes the evaluative process much less onerous and tedious.

She also said she found the form easy to work with, and that it ... "reduced the time I usually invest in writing evaluations by more than 50%."

Another faculty member thought that the form was "...thorough and it was more

individualized than our previous tools." The individualization arises from the students setting their own goals. She also said that the "...tool helped the student see what she was doing that made her a nurse."

The students did have some comment on the use of the word "student" in the summary question, "Please summarize the student's strengths."

S₁: So, I sort of felt that, you know, "Please summarize the student's strengths," I dunno, it's just the wording, like "Please summarize your strengths" you know...I dunno, it's not a big deal, but I didn't like that.

Ss: Mhm. Yeah.

S₂: No, I would agree with that too, because you're trying to think like the teacher instead of yourself.

S₁: Yeah.

S₂: Or maybe you would answer it the way the teacher would want you to answer it, instead of yourself... it's not for the teacher to tell your progress in it and stuff. Right? So, the way it's worded is definitely for her and not for us. (Lines 256-268)

Again, the strong sense of student's ownership of the evaluation process is apparent in this suggestion. One faculty member also questioned the use of the word "student" and made various suggestions about how it could be removed from the form altogether.

One student did not know how many narrative examples to write on each question. In some ways, the students were directed by the amount of space left clear after each question.

Students had been told that they can write on the back of the form if they so desire.

S: This is kind of like summary of what we did, but I think that it depends on what we really did. I mean there was a couple of times I wanted to write more but, I ran out of space, or kind of like, well I think I had enough here, like, I didn't need to write more cause I mean that is enough of what she wants to know. I just talked to her, and she goes, 'Yeah, you can write that down again if you want,' but I mean I had enough information there, so... (Lines 392-399)

We can see a hint of the student wanting to please the faculty in the examples she is giving above:

"...what she [i.e. faculty] wants to know" shows a kind of faculty ownership.

Faculty had quite an influence on what the students thought. It can be seen in the following statement that one faculty member may have discouraged the students from looking for complex examples:

S: ...like she even said that some of the questions were more geared toward second year than first year... (Lines 931-933)

In any type of evaluation system, in which there is more than one faculty member involved, it seems that students are concerned about consistency between faculty.

S: what I'm finding [is] that we were all kind of evaluated differently, ... with the same questions but in different manners and by different people and maybe, ... we should all be evaluated the same way ...

Mod: So your feeling that it should be more *?

S: ...more congruent... (Lines 784-789)

One of the things we tell the students is that this lack of consistency amongst faculty in how they teach skills and how they evaluate, while disturbing, can also be seen as offering the students a variety of styles and techniques from which they can choose as they are developing their own practice. However, some of the students 'buy into' this explanation more than others.

Perhaps the students' concern about consistency accompanies a concern about validity. It could be that students are worried that they will not be accurately assessed. Because the form asks for qualitative descriptions, there is a possibility that different faculty would look for different examples of student practice. However, even with check-lists of behaviour, different faculty could check the lists differently. The one consistent person in this evaluation process as the student moves from faculty member to faculty member is the student. Although this was not discussed in the focus group of students, one faculty member volunteered:

I believe this process does as well if not better than the formerly used process of clinical evaluation as far as accuracy is concerned.

Another faculty member commented on accuracy in the following way:

The evaluation tool described the students' clinical practice very accurately because real-life work-place examples were used to illustrate how each goal or "theme" was being accomplished. It definitely provided valid indicators of the students' abilities.

In any evaluation, whether it is an essay, quiz, or clinical evaluation, the strategic student will try to ascertain what the faculty member wants to see or hear:

S₁: Yes, this could be, this could be...kind of a biased thing because ... you can answer these if you know how your instructor is and marks and what she's looking for ... and you can take these questions and you can sort of answer 'em like that too. Hopefully to meet their needs. How does this instructor know, because she's not with you all the time ... and if you answer it the way she wants of course she'll say, 'Well, good that's what I was looking for and that's good cause we both have the same ideas ...' For example, in my experience on my own evaluation I had a lot of the same examples down for my self and I'd evaluated myself the same as my instructor did so she felt that was great and I had great insight and to my own evaluation, but I just know what she wanted out of me and what she expected of me, so that helped a lot when I was filling it out.

S₂: Mhm.

Mod: So your insight may not have been about yourself but it may have been about your instructor?

S₂: I would probably say that...

S₁: Truthfully, it was about me, but still,... I knew what she was looking for and ... what she expected out of us and that could influence me subconsciously maybe? *Laughter.*

S₂: Maybe not. (Lines 794-819)

Again, this indicates that the ownership of the evaluation may reside with faculty, although this does not negate the possibility that the student did seem to have a grasp on how she was doing. (This student came from the group whose faculty member filled out her copy of the form, while students filled out another copy.)

Students generally felt a positive tone in the form:

S₁: You have to admit though the whole paper is set up for the positives.

S₂: Yeah.

S₁: Positive ... and there is no negative connotations to it. (Lines 832-835)

Faculty also appreciated the nature of the ongoing process in terms of completing their own work:

One reason for feeling good was that it was an ongoing process and I wasn't left at the end of the rotation, trying to remember details of the student's performance. It felt good to have the evaluation completed on the last clinical day...

One faculty member questioned what she would do if there were some negatives she wanted to include:

The emphasis on the positive - with all but one category asking for examples of how the student was demonstrating accomplishment of a theme/goal - is a really important approach in building learner confidence and self-esteem. I did wonder, however, what I'd do if a student was experiencing a lot of clinical difficulties. I suspect we'd talk a lot and write very little for a period of time, in order to allow the student to develop the positive examples that are called for in this form.

I think that negatives could also be dealt with by citing negative examples in the space where positives are requested if necessary. For example, when asked to comment on the student's dignity and respect towards their clients, I felt free to include a written example of "non-dignity" when I observed a student wheeling the patient in the hall naked with only a towel to cover his most private body parts. This negative could have then been included in the summary of the student's goals in the next rotation.

Students also saw that a negative example could become a goal:

Mod: So, your negatives are more goals?

S: Negatives are goals that we would improve on... (Lines 836-837)

The following is a summary statement one student made about the process of evaluation

which she underwent with faculty:

S: I think this way of evaluating though, I thought it was really good, cause ... you had the opportunity to sit down with the instructor and I think for myself, I know I would have felt more intimidated if we didn't do it together rather than her being on the floor just evaluating me. I thought it felt more, I felt more confident in what I was doing. (Lines 1024-1029)

It can be seen that in their summary statements, students indicated that using the form took a little time to become accustomed to. Faculty felt that the form was thorough and took less time to complete than other evaluation tools they had had. The word "student" in the third person on the form made the students wonder if they should fill out the form from a teacher's standpoint. Furthermore, students expressed concern about evaluation consistency among faculty members.

DISCUSSION

Nursing students and faculty have described their perceptions about the clinical evaluation tool used in the Southern Alberta Collaborative Nursing Education venture. We have seen that students and faculty valued the process of frequent feedback and discussions about clinical nursing practice. Current literature calls for an egalitarian approach to education, with the student at the centre, taking ownership of her or his learning. The tool seemed to facilitate this faculty-student process, although there have been and will continue to be revisions to the tool based on student and faculty feedback.

Specific Recommendations

Based on the feedback of students and faculty, several changes were recommended for the evaluation form (Appendix 5). These changes have not yet been incorporated officially, but the Appendix 5 version is being used by some faculty. Not every change the students and faculty suggested was incorporated into this version, because there was some thought that as the students progress through the four years of the programme using the same form, their understanding of some of the less well understood concepts would increase. For example, “aesthetic knowing” was left in because students may come to understand this term as they nurse more and more patients. Other terms which the students found vague, such as the categories “becoming” and “ways of knowing” remain for political reasons. Members of the committee which oversees curriculum development are unwilling to omit these, because they are the conceptual threads of the

programme.

When students and faculty said that a question was particularly helpful, these questions remained. For example, setting goals and integrating theory into practice, as well as many other questions, remain intact.

Some wording was changed for clarity. The word “student” was taken out whenever possible, in response to the comment from students that it did not feel that they were the ones that should be answering the question when they see their title in the third person.

In response to student and faculty comments, I believe that a question about professionalism will be added, using the words from one of the faculty comments. The question will read, “Describe the developing adherence to the norms of nursing (eg., punctuality, department, obligation to other team members).”

In summary, not every suggestion for change was taken, but many suggestions were incorporated into the new form. An evaluation form is a fluid instrument. The form will evolve, depending on what works and what does not work. I foresee that it will need to be reviewed at least on an annual basis so that it remains a useful tool.

Concluding Comments

Recent literature points to the student being at the centre of learning. The student is not an empty vessel which needs to be filled. Rather, the student is an active person, with specific interests and learning needs. This evaluation tool allows for the student to state her or his learning needs, and also allows for her or his evolution through the clinical experience.

Nursing literature also strongly emphasizes the caring aspect of nursing and nursing education. This evaluation tool asks questions about the student's ability to care. Empathy, dignity, respect and advocacy have a presence. The student is asked to think about these things as part of her or his nursing. Students and faculty noticed this presence of caring.

Current trends in nursing education are leading nursing students away from the scientific, rational and medical models. Instead, nursing is coming into its own as an art with a concerted emphasis on caring. Content overload is being replaced by an interpretive sense of experience. When the student is asked to cite narrative examples of instances of patient advocacy and attention to cultural diversity, then the message is clear that these are important aspects to nursing and are qualities that are to be discussed and nurtured.

This evaluation tool does not use a reductionist approach. It does not have check-lists of behaviours or 'measurable objectives' which students either can or cannot 'perform.' There is a contextualization inherent in the tool, because the student is asked to provide a narrative based on a situation. The student is still within the situation when providing the narrative. A check-list does not provide context, nor does it give insight into the complexity of the very human nursing situation in which the student is engaged.

The student is not asked if he or she knows a set of facts. The tool goes beyond that and looks to see if the student can relate the facts and theory acquired to the clinical nursing situation. Connectedness is not new to nursing education, but is being emphasized by this question. Meaning, understanding, and application are being evaluated. Written examples of the student's reactions tend to speak for themselves.

In order to develop understanding, the student needs to have a voice in evaluating her or

his learning in the clinical setting. I believe that this tool provides that voice, in that the student retains ownership of the tool, and provides most of the information about her or his clinical learning. The role of the faculty is to make sense of that learning, and to coach the student towards enhanced understanding.

The literature shows that nursing students' learning in the clinical situation is a complex endeavour. Indeed, it takes the agility of a trapeze artist to put together knowledge from a text and uncertainty about ability with the needs of a complex patient who is sometimes very ill. Cognitive, psychomotor and affective skills need to be used. In addition, at the same time, the student is learning and evaluating her or his own activities and thoughts minute by minute.

The faculty can be a threat inserted in the midst of this boiling cauldron. The process which this evaluation tool encourages requires that the student and faculty evaluate together and frequently. It puts faculty **with** the student in the evaluation process, as a partner. It allows the educator to function using the same intuitive skills that the expert nurse uses. The form allows the educator to use her or his sense of salience, where certain events stand out as being more or less important than others.

It is only in drastic situations, where the faculty might need to take the lead if the student is unwilling. When the patient is not safe with the care of a particular student, then the partnership may erode if the student is unaware of facets of the patient situation. But, this is a part of any evaluation process in clinical nursing. No evaluation tool will be able to eliminate this sort of power imbalance. This is consistent with the philosophy that the life of the patient is of paramount importance, even in the learning situation. The evaluation tool allows space for negative feedback. It asks for narrative and examples. Examples can be negative as well, and

faculty have used negative examples to assist the students in learning.

In most cases, partnership is present. Students and faculty felt that partnership, as seen in the data presented above. Students appreciated the constant contact with faculty, and that seemed to decrease the tension that frequently develops between student and faculty. The frequency of meeting with faculty meant that the students' whole clinical experience was taken into account, not just particular instances or days. The faculty 'sticks with the student.'

This kind of relationship also fostered the approach that faculty do not have all the answers. Students have many answers as well. When faculty listen to students in matters as important as evaluation, then the message is clear that the student is important. The opinion and voice of the student is central to this evaluation process.

Expertise cannot be legislated or standardized. A measurable objective attempts to standardize a behaviour or body of knowledge. In nursing, it is not the rules which are important, rather the exceptions to the rules. It is the ability to know the nuances of the patient, and come to evolving conclusions. It is to sense the unspoken, to look for the exception which is important. When Benner (1984) worked with expert nurses, she found that it was the subtleties which were important. Expert nurses did not follow rules or objectives. They were intuitive and knew what to do. This did not come to them in nursing school, but long afterwards, with experience. This evaluation tool asks for that kind of expertise, to which the students can become attuned. Naturally, they are not going to be able to function like expert nurses, but they can begin to pay attention to the subtleties of expertise. This evaluation tool accomplishes this to some extent when it asks for examples of patient advocacy, of involving the family in the care of the patient, of examples of exhibiting empathy, dignity and respect, and of paying attention to

patients' diversity.

As for the tool itself, apart from the process, students appreciated clarity and the positive tone which the tool encourages. They also felt ownership of their clinical learning, and this was facilitated by asking them to identify and monitor their own learning goals. They were less enthusiastic about terms which they perceived as abstract.

Students took the evaluation process very seriously. Their learning, and their concerted will to improve were seen again and again in discussion. They wanted to nurse well. This was not only so that their academic success would be ensured, but also they wanted to nurse well for the good of the patient. The details of the ordinary aspects of care, like rinsing hair, finding a safety pin, and looking for a magazine for a patient's spouse, are not generally evaluated. But, it is these details which paint a picture of care for the patient.

In conclusion, it is the **process** of clinical learning and clinical evaluation which stands out as being of paramount importance. This process was expedited by the tool, but that is only one part of the process. The process is also facilitated by the faculty-student relationship. This is an area which requires focused preparation on the part of faculty and students, and is also an area which requires further research.

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**APPENDIX 1 :CLINICAL APPRAISAL TOOL
MEDICINE HAT COLLEGE SCHOOL OF NURSING
PRACTICUM EVALUATION
NURSING 235**

Student's Name: _____

Clinical Area:

Dates:

Instructor: _____

hrs. absent: _____

BECOMING

1. What were the student's three most important clinical learning goals identified at the beginning of the clinical rotation? How has the student met each of these goals?

c) use a variety of ways of knowing, eg. knowledge, experience, intuition, ethical and aesthetic?

4. Comment on the student's development of skills in this clinical area.

8. Discuss how the student educated the client in relevant health matters.

9. How did the student involve the family when caring for the client?

INTERRELATING

10. Give examples of when the student engaged in interdisciplinary collaboration.

SUMMARY

1. Has the student met the Nursing 235 course aims which relate to clinical practice in this rotation?

NURSING 235 COURSE AIMS:

The learners will be offered the opportunity for ongoing advancement of their knowledge through:

1. the development and application of their beginning definition of nursing and health.
2. the development of therapeutic relationships with adult clients experiencing minor health disruptions.
3. the application of various problem-solving methods to the four commonly accepted nursing domains of person, environment, health and nursing when developing nursing care plans.
4. researching the practice of nursing by examining relevant common nursing interventions.
5. integration of group process and interdisciplinary theory in clinical settings.
6. the development of psychomotor skills with subsequent application in the clinical setting.

YES or NO (PLEASE EXPLAIN)

2. What areas need improving?

3. Please summarize the student's strengths.

Student Signature _____

Instructor Signature _____

Date _____

APPENDIX 2:(STUDENT) CONSENT FOR RESEARCH

Dear Student,

I am conducting a research project which will examine twelve students' perceptions about the clinical evaluation tool used in the Spring semester of the University of Lethbridge/Medicine Hat College Nursing Programme. I am inviting you to participate in this study. It is to be hoped that your participation will assist me in describing how you and the other students perceived the evaluation tool, which will lead to the nursing profession's increased understanding of the process of clinical evaluation. Your participation is entirely voluntary, and will not have any effect on your grades.

If you consent, I am asking that you be present during a one hour group interview. The interview will be conducted by another researcher who has not had a part in your clinical evaluation and is not connected with the School of Nursing. It will take place on Wednesday June 7, 1400-1500 hrs. in Classroom C at the hospital. The group session will be audio taped for my own perusal and transcription. It will focus on your thoughts about this clinical evaluation tool. The audio tape will not be available to me until after your grades are in and will be erased after transcription to ensure your anonymity.

The written report which I will develop as a result of this interview will ensure your anonymity because your names will not be used. You have the right to withdraw from the study at any time without penalty.

I very much appreciate your assistance in this study. If you have any questions, please feel free to call me @ 526-8469. Also feel free to contact the supervisor of my study, Dr. Myrna Greene @ (403)329-2424 and /or any member of the University of Lethbridge Faculty of Education Human Subject Research Committee if you wish additional information. The chairperson of that committee is Dr. Rick Hesch and his phone number is 329-2118.

If you wish to consent, please sign below and return to me.

Yours sincerely,

Cathy Harrop,
Faculty,
Medicine Hat College School of Nursing.

Please detach and bring the signed portion with you on June 7

I agree to participate in this study. Date _____

Name

Signature

APPENDIX 3:(FACULTY) CONSENT FOR RESEARCH

Dear Colleague,

I am conducting a research project which will examine student and faculty perceptions about the clinical evaluation tool used in the Spring semester of the University of Lethbridge/Medicine Hat College Nursing Programme. I am inviting you to participate in this study. It is to be hoped that your participation will assist me in describing how you and the other faculty perceived the evaluation tool, which will lead to the nursing profession's increased understanding of the process of clinical evaluation. Your participation is entirely voluntary.

If you consent, I am asking that you provide me with written response to the enclosed set of trigger questions. Your response will be transcribed on to my computer for my own perusal. It will focus on your thoughts about this clinical evaluation tool. Names will be deleted from the transcription to ensure your anonymity. The chair of the curriculum committee has asked that the transcription be provided to the curriculum committee as well. The information I obtain from you will also be used by the SACNE Practicum Evaluation Form Committee in order to evaluate this tool for the collaborative nursing programme. Again, your anonymity is assured in this transcription.

I very much appreciate your assistance in this study. If you have any questions, please feel free to call me @ 526-8469. Also feel free to contact the supervisor of my study, Dr. Myrna Greene @ (403)329-2424.

If you wish to consent, please sign below and return to me.

Yours sincerely,

Cathy Harrop,
Faculty,
Medicine Hat College School of Nursing.

Please detach and submit to me.

I agree to participate in this study. Date _____

Name

Signature

APPENDIX 4: INSTRUCTIONS TO FACULTY

Dear

Thank you for using the new SACNE Practicum Evaluation Form this semester. In order to evaluate the form, I am asking that you write me four paragraphs about your impressions of the form. The trigger questions you see below, can be answered in one paragraph for each set of questions. It would probably be easiest if you responded on your computer, and gave me the disk which I will copy. If you could respond by June 30, I would be most appreciative.

The transcriptions of your responses will be used in 3 ways:

- a) for my M.Ed. research project (please see attached consent)
- b) by the SACNE Practicum Evaluation Form Committee
- c) by the SACNE curriculum committee.

After I have copied your responses on to my computer, I will erase any clues to your identity, in order to ensure your anonymity. You may return your consent separately from the disk if you wish to be anonymous to me. I will then return your disk in a box in Lorrie's office, and you can pick out your own.

Thank you for your participation in this step of the development of the Practicum Evaluation Form.

Sincerely,

Cathy Harrop

Trigger Questions for Faculty

The purpose of this set of trigger questions is so that you can write freely about the clinical evaluation form and the process of being evaluated in the clinical area. You may respond with one paragraph for each set of questions.

Set One: Process

What process did you engage in with the student to complete the evaluation? When did you fill it out? Who wrote on it? How much input did you have in the completion of the form? Who kept it during the rotation - you or the student? If you felt like you disagreed with what the student was writing on the form, how did you handle this? Will you be providing a copy of the completed form to the student?

Set Two: Tool

How did the tool itself inform the student about nursing? Is there any particular question which stands out in your mind as being particularly helpful? Were there questions that weren't particularly helpful?

Were there things that were not included on the form that you think should have been?

Set Three: Feelings

What does it feel like to evaluate the student while the student was actually learning in the clinical situation?

Set Four: Summary

How well did this evaluation tool describe the students' clinical practice during this rotation? Do you believe this evaluation was a valid indication of their abilities? What changes would you suggest and why?

THANK YOU SO MUCH FOR YOUR PARTICIPATION!!!!!!

APPENDIX 5: REVISED CLINICAL APPRAISAL TOOL

The clinical appraisal tool was revised according to feedback from students and faculty, and also with consideration as to what revisions the Southern Alberta Collaborative Education programme would allow. The suggestion revisions which are to be added to the form are below in bold italic type. Bold square brackets indicate that a word or phrase is to be deleted.

MEDICINE HAT COLLEGE SCHOOL OF NURSING PRACTICUM [EVALUATION] ASSESSMENT NURSING 235

Student's Name: _____

Clinical Area: _____

Dates: _____

Instructor: _____

hrs. absent: _____

BECOMING

1. What were the [student's] three most important clinical learning goals identified at the beginning of the clinical rotation? [How has the student met each of these goals?] *Provide examples of how these goals were met.*

c) use a variety of ways of knowing, eg. knowledge, experience, intuition, ethical and aesthetic?

[4] 5. Comment on the [student's] development of skills in this clinical area.

CARING/INTERRELATING

- [5] 6. Give an example of [how the student exhibited] empathy, dignity [and] respect, **and sensitivity to diversity** towards a [patient] **client** regardless of race, gender, culture or age?
- [6. Give an example of how the student showed sensitivity to the client's diversity (eg. socioeconomic, spiritual, educational, life-style or culture) in providing care.]
7. Describe a situation [when the student advocated appropriately] **which demonstrates appropriate advocacy** for the client.

SUMMARY

1. [Has the student met] *Have* the Nursing 235 course aims which relate to clinical practice in this rotation *been met*?

NURSING 235 COURSE AIMS:

The learners will be offered the opportunity for ongoing advancement of their knowledge through:

1. the development and application of their beginning definition of nursing and health.
2. the development of therapeutic relationships with adult clients experiencing minor health disruptions.
3. the application of various problem-solving methods to the four commonly accepted nursing domains of person, environment, health and nursing when developing nursing care plans.
4. researching the practice of nursing by examining relevant common nursing interventions.
5. integration of group process and interdisciplinary theory in clinical settings.
6. the development of psychomotor skills with subsequent application in the clinical setting.

YES or NO (PLEASE EXPLAIN)

2. What areas need improving?

3. Please summarize the [student's strengths] *practicum experience including strengths and continuing goals.*

Student Signature _____

Instructor Signature _____

Date _____