

# Factors Affecting Assessment of Student Nurses' Clinical Practice: A Phenomenographic Exploration of the Experiences and Understanding of Mentors of a Mental Health Service in England

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**ABSTRACT** Clinical learning is an important aspect of pre-registration nursing programmes. It enables students to acquire skills and knowledge required for quality care provision. Newly registered nurses do not always have adequate practical skills. This is attributed to inconsistencies in assessments. Yet, research relating to factors affecting clinical assessments of students is limited. This study explored mentors' experiences and understanding of factors that may affect students' assessments. The study utilised a phenomenographic methodology and was conducted in a mental health Trust. Thirty mentors participated in the study. Data were collected using five focus group interviews of six participants each. Data were analysed using Sjoström and Dahlgren approach to analysis. There are multiple factors that may affect assessment of students' clinical performance. Examples of these include anxieties of assessment and placement duration. Mentors need ongoing training and support to improve the quality of students' assessments.

## INTRODUCTION

Mental health nursing is referred to as a practice-based profession in many parts of the world. This is the case in the United States of America, Australia, New Zealand and European countries, such as the United Kingdom (UK) and Finland where clinical teaching and learning form a significant part of pre-registration mental health nursing training and education programmes (Price 2007; Cooper 2014). In these countries, clinical learning plays an important role in improving the practice of both healthcare professionals and student nurses, which in turn contributes to improve care provision. It is probably for this reason that Cassidy (2009) describes clinical learning as the "heart" of professional practice. Acknowledging this, practice placements constitute an important aspect of students' learning. This is because they influence students' acquisition of skills and knowledge for quality care provision as well as serve as the right environments for the application of theory to practice. Fitzgerald et al. (2010) claim that students' knowledge and skill acquisition, and theory-practice integration can be enhanced through mentorship activities.

Mentorship is a model of support used to enable students gain maximum benefit from prac-

tice placements (Higgins and McCarthy 2005). The act of teaching, assessing, supervising and coaching students employed within such a model is what is referred to as mentoring (Carr 2008). In the UK, the region where this study was carried out, registered nurses are expected to assume these roles of mentoring or preparing students to become competent and capable practitioners (Pellatt 2006; Nursing and Midwifery Council (NMC) 2008). A number of terms, such as "mentor", "assessor", "preceptor", and "supervisor" are often used interchangeably to refer to registered nurses with this responsibility of offering support to students in practice. This use of different terminologies do not only causes confusion for students, but also for clinicians and researchers alike. To minimise terminological confusion, this study used the term "mentor" to refer to all registered nurses who facilitate, supervise and assess students' learning in practice (NMC 2006).

It should not automatically be assumed that learning is always taking place in students' practice experience. Historically, there are disturbing anecdotal and empirical evidence which suggest that nursing education programmes do not always produce competent and capable practitioners (Rutkowski 2007). The United Kingdom Central Council (UKCC), now Nursing and

Midwifery Council (NMC), education commission report, *Fitness for Practice* (UKCC 1999) and the Department of Health (DH) publication, *Making a Difference* (DH 1999), highlighted this concern. They emphasised that a significant number of newly registered mental health nurses do not always have sufficient practical skills. Similar concerns are expressed in a range of recent studies, such as Duffy (2004), Price (2007), Fitzgerald et al. (2010) and Ross et al. (2014). This is worrying, as there is a need for patients to be safeguarded from unsafe practice (Flannagan et al. 2002; Neary 2002).

The lack of adequate practical skills of newly registered mental health nurses is a function of inconsistencies in the conduct of clinical assessment and multitude of factors influencing it, such as personality traits (Price 2007). The multiplicity of factors influencing assessment indicates its complexity and difficulty in ensuring its objectivity and accuracy. It is therefore not surprising to note that students' clinical skills in mental health practice are sometimes not accurately assessed (Roberts 2011). Acknowledging this, poor performing students may slip through the net of education programmes and subsequently enter professional practice. Patients encountering this category of nurses may be at risk of receiving inadequate care that may have a negative impact on their health. Despite this, limited studies have been conducted on factors that may affect clinical assessment of student nurses in practice. This is particularly the case for those in practice placements of mental health services. It is therefore vital to conduct more studies on factors that may influence assessment of mental health nursing students in clinical practice. Doing so will not only contribute to improve the validity and reliability of assessments, but will also help minimise the risk of poor performing students slipping through the educational net and providing inadequate care.

Assessment is the exercise of judgement on the quality of students' work as a way of supporting learning and appraising its outcomes (Higher Education Quality Council 1996:2). Although this definition was put forward over a decade ago, it is used in this paper to offer a comprehensive view of the nature and value of assessment in general. Making a judgement on the quality of students' experiences can be problematic in mental health practice, as performance

of these learners are influenced by a number of variables, such as mentors' understanding of learning outcomes. So, developing understanding of these variables would help to improve clinical assessment. Thus, NMC (2008) advocates for clinical assessment to be taken seriously by mentors and others involved in students' teaching and learning. This is because it is one of the few ways of ensuring that students on registration are competent and fit for practice and purpose they are trained for. This is particularly important in the UK where 50% of pre-registration training takes place in clinical practice. It is for this reason that some academic institutions, like Southbank University and Kings College, advocate for linking the roles of a mentor with that of an assessor, as they claim that judgement on performance of a student outside the mentoring relationship may lack credibility (Price 2007). It is therefore stipulated by some academics that assessment and provision of feedback on clinical competency should be carried out by a nurse (mentor) who works closely with students (Higgins and McCarthy 2005). Mentors need support to effectively carry out these roles, a view acknowledged by Dean (2013) in a paper entitled "finding a better way to support mentors".

Carr (2008) wrote on the notion of a good and bad mentor. She claims that a good mentor is a nurse who is willing and committed to facilitate students' development by enabling them to practice learnt skills with reducing supervision. In contrast, she refers to a bad mentor as a nurse who is not only unwilling to engage in students' learning, but also evaluates their clinical competency against personalities instead of knowledge. Competence is a construct, which is not directly measurable, but can be inferred from the assessment of performance (Stuart 2003). But such inferences can be erroneous. So, in assessing or judging performance, all aspects of practice or factors that can influence assessment and learning should be taken into account if the goal is to make safe inferences of clinical competency. Yet, there is limited literature on this subject in mental health settings.

### **Aim**

This paper reports on a study that explored mentors' experiences and understanding of factors that may affect assessment of student nurses' clinical practice in a mental health Trust in England.

## METHODOLOGY

### Design

This study utilises a phenomenographic methodology to offer a range of descriptions and interpretations of mentors' experiences and understanding of factors that may influence assessment of student nurses in practice placements. This methodology, which was developed in the early 1970s in Sweden within the domain of learning, enables researchers to discuss variations in experiences and understanding of phenomena under investigation (Marton 1981; Struksnes et al. 2012). Given that people will not experience a given phenomenon in the same way, phenomenographers seek to identify the multiple experiences and understanding referred to as conceptions that a particular group of people have for a particular phenomenon. They also seek to report the underlying relationships between conceptions.

Conceptions are central to phenomenographic methodology. They are the product of an interaction between people and their experiences with their external world. Specifically, conceptions are results of individuals thinking about their external world. Although these conceptions can be accessed in different ways, language, using conversation is considered a potent means of doing so (Svensson 1997; Langdridge 2007). In essence, conceptions are themes that capture the meanings of people's multiple experiences and understanding of phenomena studied. Open, deep interview is the method of conversation usually employed for revealing themes or conceptions and their corresponding meanings (Booth 1997). Open indicates that there is no definite structure to the interview, as researchers using this approach are prepared to follow any unexpected lines of reasoning that the interviewee might address. Deep indicates that the interview will follow a certain line of questioning until it is exhausted. This is when both researcher and participant have reached some kind of common understanding about the topics of discussion. This indicates that experiences and understandings of a phenomenon are jointly constituted by researchers and participants.

### Sampling and Participants

The mental health Trust where the study was carried out consisted of nine clinical areas. There were five mentors working in each of these clin-

ical areas. These clinical areas offered a range of practice placement experiences to mental health student nurses. A letter was sent to all mentors inviting them to a meeting to discuss the study. Discussions during this meeting focused on the aim of the study, its significance and eligibility criteria. Each nurse was given an information leaflet and a letter of invitation to take part in the study. Highlighted in the letter of invitation were the study's aim and inclusion criteria (see below). At the end of the meeting, mentors present were reminded to carefully read the information leaflets given to them, and if they met the eligibility criteria, to contact the researchers either in writing or via telephone if they wished to be interviewed. 40 mentors made contact with the researcher and expressed their willingness to participate.

Sampling was criteria purposive and 30 of the 40 mentors met the inclusion criteria for participation, and were therefore eligible to be interviewed. A follow-up letter was then sent to each of the 30 mentors eligible for participation confirming date, time and venue of interviews.

### *Inclusion Criteria of the Study*

1. Registered mental health nurses with two or more years of experience of mentoring students in mental health settings.
2. Registered mental health nurses with "mentorship in practice" qualifications that are willing to share their experiences of mentoring students.

### *Exclusion Criteria of the Study*

1. Registered mental health nurses with no / or less than two years experience of mentoring students in mental health settings.
2. Registered mental health nurses with or without a "mentorship in practice" qualification, and unwilling to share their experiences of mentoring students in mental health settings.

### Data Collection and Analysis

Ethical approval was gained from the National Research Ethics Services and Research site Ethics Committee. Consent was sought and obtained from each mentor before data collection. Data was collected using a semi-structured in-

interview guide within focus group interviews. The interviews were held in clinical practice in a designated room. Two interviewers conducted the interviews. One was a moderator with a remit to take notes and observe body language. The role of the other was to ask questions. The interview format was open and deep. Prompts and probes were used for elaboration and clarification purposes. Focus groups allow active engagement between participants, which often lead researchers to access people's experiences and understanding, including their differences and similarities of phenomenon. Five focus groups interviews with six mentors each were conducted. Each interview lasted for about 60 minutes and was audio taped.

All interviews were transcribed verbatim and transcripts were analysed manually using Sjöström and Dahlgren (2002) seven steps approach to analysis (see appendix 1). The analysis was carried out by two researchers in parallel with the interviews, and was conducted iteratively throughout the interview period until category or theme saturation was achieved.

## RESULTS

Four main themes emerged from the analysis: learning outcomes, transparency, assessment and clinical placements. These themes have two sub-themes each, and they are illustrated by excerpts from participants' narratives to enhance understanding of discussions presented. The initials, "F" and "M", which stand for female and male respectively, are used at the end of each excerpt to identify the gender of participants.

### Learning Outcomes

This theme has the following sub-themes: "to develop understanding" and "to be involved". They relate to the difficulty mentors sometimes experience in understanding students' clinical placement learning outcomes.

#### *To Develop Understanding*

All participants reported that learning outcomes are critical for shaping students' clinical learning. However, most of the participants stressed that some of the learning outcomes, particularly those related to abstract concepts,

such as empathy, were unclear and difficult to understand.

*I have been mentoring students for many years, but I still find it hard to understand some learning outcomes (M).*

Similar concerns were repeatedly expressed by participants throughout the interview period.

*Learning outcomes relating to reflective practice in students' assessment are confusing as indeed the process by which the students are expected to achieve them (F).*

Participants reiterated on a number of occasions that this difficulty of understanding learning outcome could have a negative impact on their judgement of students' clinical performance.

*Not understanding the learning outcomes equates to not knowing what to look for when assessing students (M).*

Not knowing what to look for during assessment is probably one of the reasons for some students to complete their pre-registration training programmes without achieving the required competencies. In contrast, few participants claimed that learning outcomes are generally understandable even though they are sometimes not clearly expressed. These participants therefore acknowledged the need for learning outcomes to be regularly reviewed with the view to enhance understanding of the same.

All participants recounted experiences of students' understanding of their clinical placements learning outcomes. They reiterated that such understanding was a function of pre-placement briefing sessions, offered by link lecturers that focused on the nature of clinical areas and learning outcomes. This suggests that involvement in learning outcomes discussions and/or their formulation could result in enhanced understanding of these standards.

#### *To Be Involved*

This theme relates to participants' expressed need to work closely with link lecturers and other Higher Education staff to formulate clinical placement learning outcomes as well as to gain insight into other educational matters that may impact upon students' learning.

*Working with lecturers enables us to learn how to support students. We can seek clarification about issues, such as learning outcomes that we sometimes don't understand (F).*

Indeed a supportive relationship between mentors and link lecturers ensures effective fa-



cilitation of students' leaning and assessment in practice. A large number of mentors agreed with this and expressed a desire for ongoing support from link lecturers.

*I feel well supported by link lecturers. They enhanced my preparedness, readiness and willingness to support and assess students (F).*

A contrasting view was expressed by some mentors. Although all mentors were aware that link lectures were the main link between practice placements and universities, few felt that they were not adequately supported by the latter.

*I have not seen a link lecturer for while. You cannot reach them even in instances when you need clarification about students' assessments (M).*

This indicates that better communication is needed between link lecturers and ward staff, particular mentors who deserve regular and frequent support to enhance students' learning and assessment.

### Transparency

This theme consists of the following sub-themes: "to be open" and "to seek support". They illustrate the need for mentors not only to seek help when the need arises, but also how to access appropriate support.

#### To Be Open

Few participants reported that they were sometimes not open about their limited understanding of learning outcomes, particularly when discussing with students.

*It is hard to openly admit that you don't know. It is even harder to admit ones limitations to a student (M).*

Most participants stressed that lack of openness may not only negatively impact on mentors' personal and professional growth, but it may also hinder student-mentor relationships, which in turn may deter learning. Some participants claimed that not being open on the part of mentors is not new in clinical practice. Few attributed mentors' lack of openness to feelings of inadequacy to support and assess students.

*I have not attended any update workshops since my mentorship in practice training four years ago. So, I am not sure of my role as a mentor (M).*

Not attending mentor update workshops is not uncommon among mentors of mental health services, as assessment and general support for student nurses, in the face of clinical pressures, are often seen as lesser priorities.

#### To Seek Support

Some participants recognised the need for support to help improve their mentoring ability. They reiterated that this could be in the form of training and education and / or supervision, a forum to express feelings about the difficulties they may encounter during their engagement with students.

*Mentoring is an added pressure. Apart from supporting students, I have full clinical responsibility to provide care to patients (M).*

Similar claims were made by female participants:

*The clinical working day is full of interruptions and our workload prevents us from adequately supervising and assessing students (F).*

Participants stressed that workload was one of the factors that can generate pressure and anxiety for mentors. Apart of the value of multi-disciplinary working in improving patient care, some participants believe that incorporating mentorship within a multi-disciplinary team framework can help reduce work pressure. Not being updated on the mentoring process for over a long time because of sick and / or annual leave was another concern expressed by participants. There was a general feeling that even the mentors who had been on update workshops had difficulties identifying parameters on which to base their assessment.

*The learning outcomes are usually not clear. So, I normally find it hard to assess students. This is also true for my colleagues (M).*

### Assessment

This theme has the following sub-themes: "to get a structure" and "to alleviate anxieties". Generally, they relate to the conduct of assessment and anxieties associated with it.

#### To Get a Structure

Participants unanimously agreed that assessment of students is generally opportunistic and haphazard, as they claimed that specific times were usually not allocated for this process.

*I only assess students when I have time. You cannot plan assessment. It has never worked for me (M).*

The need for “protected times” to conduct assessment was repeatedly mentioned by most participants. They reiterated that setting stipulated times for assessment would enable both mentors and students to plan and prepare for the process. They also highlighted that planning and preparing for assessment, including the methods to use would help improve consistency in judging students’ progress. Participants unanimously agreed that the most commonly used assessment methods were observation and feedback. However, they admitted that these methods are usually not consistently applied in practice.

*No two observations are the same. What mentors observe and the feedback they provide are influenced by the degree to which they like the students (F).*

While some participants agree that observations from two or more mentors may not be the same because of differential perceptions, they did not support the view that mentors’ assessment outcomes are influenced by the degree to which they like the students. Some participants recounted that inconsistencies in assessments can be reduced by the use of learning contracts. But they went on to say that each learning contract should reflect specific learning outcomes.

### **To Alleviate Anxieties**

Some participants highlighted that just the thought of being subjected to assessment may add on to students’ stress levels, which in turn may retard their clinical performance. All participants expressed similar assumptions about assessment. They believed that assessing students is an anxiety provoking exercise.

*Some students usually perform poorly in practice. The thought of failing them sometimes makes me feel very anxious (F).*

Making decisions on whether to fail or not to fail a student was frequently mentioned by participants as the most common and significant source of anxiety. Few participants stressed that mentors should not feel anxious about failing underperforming students, as failing to fail them is a disservice to the nursing profession.

*We should be confident to fail students who have failed to achieve the minimum competen-*

*cies or standards. Mentors should not be worried about this (F).*

Other examples of anxiety provoking events repeatedly mentioned by some participants include making decisions on when and how to assess, justifying judgement on performance and deciding on the nature and timing of feedback. Most participants reiterated on few occasions that regular mentor updates, mentor support groups and partnership working with link lectures may help address these concerns about students’ assessment.

### **Clinical Placements**

This theme is made up of two sub-themes: “appropriate student population” and “adequate placement duration”. This theme relates to the number of students at any given time in a practice placement and the impact of this on their assessment of learning. It also relates to the length of time students spend in each practice placement and the relationship of this with quality of assessment and learning.

#### **Appropriate Student Population**

Some participants reported that the numbers of students in practice placements were increasing. They claimed that this growth in student population was a function of increasing number of intakes per year. Few participants repeatedly stressed that this has implications for mentoring.

*Last semester, I had three students to mentor, but hardly made contact with them (F).*

Given that students work shifts in practice placements, some participants claimed that the former can be effectively supported if only two students are scheduled to work per shift. There was some disagreement with this view, as most of the participants reported a decline in placement capacity, which in their opinion often result in more than two students in a clinical placement per shift.

*What some of us don’t realise is that the number of placements have reduced, and will continue to do so. We do not have enough of them to cope with the student numbers (M).*

Apart from the issue of student numbers, length of placement is another factor some participants claimed to have an impact on the quality of support available to students.

### *Adequate Placement Duration*

The majority of participants shared a common view that a short practice placement may hinder comprehensive mentor assessment, as it will not offer enough time for students to familiarise themselves with clinical environments. Participants also stressed that short placement duration do not offer adequate time for the development of quality mentor-student relationships.

*The three week placement is too short for students to familiarise themselves with clinical areas and for mentors to carry out comprehensive assessments (M).*

Most participants stated the duration of clinical placements do have an influence on the credibility and dependability or reliability of assessments. Whilst some participants agreed with this notion, few took another stance. They claimed it is the quality of mentor-student relationship, not the length of placements that may have a significant influence on the quality and robustness of assessments.

## DISCUSSION

It is apparent from the outcome of this study that learning outcomes are important structures for judging learning in clinical practice. Yet, they are sometimes ambiguously expressed, which makes it difficult for mentors to understand them. This is particularly the case for learning outcomes with abstract concepts, such as empathy. Learning outcomes are usually developed in Higher Education Institutions and mentors are generally not involved in this process (Stuart 2003). It is therefore not surprising to note mentors' expressed lack of understanding of some learning outcomes. If mentors are encountering such difficulties, then one needs to question the validity and reliability or trustworthiness of their assessments. In other words, one should be cautious about the credibility and dependability of mentors' assessment outcomes. For assessment to be fair and credible, learning outcomes should be understood by mentors. One way of ensuring this, indicated in this study, is for lecturers and clinical staff, including mentors to work in partnership in designing these structures (Fitzgerald et al. 2010). Anecdotally, this hardly happens. However, one possible solution to this problem is for lecturers to organise

discussion groups that would include mentors. The essence of these forums is to enable these practitioners to clarify issues, analyse differences in perceptions and assumptions relating to learning outcomes and their assessment. Doing so may enable them to develop better understanding of learning outcomes. Such understanding may not only enhance the credibility and dependability of assessment and alleviate mentors' anxieties, but it may also enhance their confidence even in instances of failing poorly performing students (Price 2007).

Failing a student requires enormous courage and energy. The conviction that a fair assessment has been carried out would provide this courage. Mentors have a duty to prepare competent nurses (NMC 2006). They therefore need to be aware of their professional responsibility when assessing students, as failing to fail those who could not attain an acceptable level of competence, would result in them being registered on the professional register (NMC 2008). Such nurses may at some point during professional practice jeopardise patient care.

The literature revealed instances where students irrespective of poor performances passed assessment because mentors are not committed and/or lack appropriate skills (Duffy 2004). A similar finding was also noted in this study. This is worrying, as patients could be exposed to unsafe practices (Flannagan et al. 2002; Fitzgerald et al. 2010). It is therefore vital that mentors are prepared for their roles, which include assessment. Link lecturers are well placed to provide this support. Universities have assessors' workshops, which are usually facilitated by link lecturers. Credibility and dependability of assessment approaches, in other words their validity and reliability, are discussed in these workshops and mentors are also encouraged to examine their practices. Such a "sharing of experiences" relating to assessment is a good way of improving assessment in practice (Fitzgerald et al. 2010). Thus, mentors are encouraged by their respective Trusts to regularly update themselves by attending mentor update workshops, which may help them to learn how to involve students in their learning. However, some mentors of this study had not attended update workshop because they were away from work on sick and/or annual leave. Some of these mentors were not open to students about their lack of understanding of learning outcomes.

The lack of openness of mentors could be attributed to the feelings of inadequacy to supervise and assess students and the questioning approach that students of the 21<sup>st</sup> Century tend to adopt. This avoidance behaviour towards students may not only lead them to feel undervalued, unaccepted and stressed, but may also hinder “active clinical participation”, a crucial factor for maximising learning and the validity of assessment (Price 2007). Apart from these negative emotions, clinical experience can be stressful for both students and mentors. This is probably because of the requirement to achieve specific learning outcomes within a stipulated time-frame. Additionally, just the thought of being subjected to assessment may add on to mentors’ and student’s stress levels, which in turn may cause a negative impact on assessment and clinical performance. Deterioration in clinical performance could result in students experiencing lowered self-efficacy (Neary 2002). Such experiences of assessment may not only be demotivating and dispiriting, it may also have negative effects on the credibility or validity of assessment (Stuart 2003).

Assessment of students’ learning are mainly haphazard and opportunistic in clinical settings due to demands on mentors created by nursing events and managerial functions (McSharry et al. 2010), an outcome also reflected in this study. Observation and feedback were the most frequently reported assessment approaches. This is consistent with the extant literature, which indicated that practice assessment heavily relies on these approaches, which in themselves, are inevitably subjective (Price 2007). Subjectivity of assessment could have both positive and negative effects on students’ learning, a notion shared by Cassidy (2009). The positive aspects of learning can be realised if the process of assessment is planned. Clinical mentors are well placed to prepare students for the assessment process. Such preparation may involve discussions of the process of assessment, learning outcomes and setting protected time for assessment.

The structure and component of the clinical environment can influence clinical learning, a central feature for professional development (NMC 2006). It is therefore important for it to be continuously prepared to facilitate learning and improve its assessment. Mentors could be instrumental in assisting in the preparation of the

clinical environment and support its subsequent development (NMC 2006). For example, they could assist in ensuring that clinical placements have the right number of students. They could also work closely with link lectures to ensure that placement durations are adequate for students to achieve their learning outcomes.

## CONCLUSION

The findings of this study indicate that assessment of students’ clinical performance is a significant responsibility that can be both challenging and time consuming. Higher Education training institutions and the Nursing and Midwifery Council seem to agree that nurses, on registration, should be able to provide holistic and comprehensive care to patients. Evidence from this study and the extant literature shows that newly registered nurses are usually not skilled enough to do so. Student nurses should therefore be adequately prepared in order for them to be fit for the purpose they are training for. This study indicates that clinical assessment is one way of achieving this. Observation and feedback were the most commonly reported approaches for assessing students’ performance. However, they are noted in this study to be subjective. The findings therefore suggest that assessment using these approaches need to be continuous. This is to ensure that students attain an acceptable level of competence, which is usually inferred from performance.

The study indicates that assessment of performance could be difficult because of the infinite number of factors that could influence the process. The presence of multiple factors influencing assessment has implications for practice. This means that mentors may find it practically impossible to consider or take into account all the variables affecting assessment. This indicates that it would be difficult for assessors to achieve absolute validity and reliability of students’ clinical assessments. This difficulty is in part a function of mentors’ limited understanding of the mentoring process caused by limited or non-attendance to mentor update workshops.

The author acknowledges that this paper did not include the perspectives of student nurses. The findings reported in this paper were generated from a small sample of midwives of a single hospital. The findings are therefore not generalisable, but are transferable to mentors of other hospitals in and outside the UK.



## RECOMMENDATIONS

Further studies are recommended in order to describe nursing students' views on factors influencing their clinical assessment. Future studies could adopt a quantitative approach with larger sample sizes to help enhance knowledge and understanding of factors influencing assessment of student nurses in clinical practice. The need for ongoing training on mentoring was repeatedly mentioned by participants. Such training would enhance mentors' skills and confidence in mentoring. It is therefore important for the management teams of clinical areas to ensure that all mentors are trained to assess students as well as regularly attend mentor update workshops. Added to this, mentors should work closely with link lectures and to be allocated uninterrupted times for conducting formal assessments of students. Adopting such an approach would improve the effectiveness of assessment, in other words, its reliability, validity and credibility.

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## REFERENCES

- Booth S 1997. On phenomenography, learning and teaching. *Higher Education Research and Development*, 16: 135-159.
- Carr J 2008. Mentoring student nurses in practice. *Practice Nursing*, 19(9): 465-467.
- Cassidy S 2009. Subjectivity and the valid assessment of pre-registration student nurse clinical learning outcomes: Implications for mentors. *Nurse Education Today*, 19: 333-39.
- Cooper K 2014. The role of the sign-off mentor in the community setting. *British Journal of Community Nursing*, 19(4): 192-196.
- Dean E 2013. Finding a better way to support mentors. *Nursing Standard*, 27(45): 17-18.
- Department of Health (DH) 1999. *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. London: DH.
- Duffy K 2004. Mentors need more support to fail incompetent students. *British Journal of Nursing*, 13(10): 582.
- Fitzgerald M, Gibson F, Gunn K 2010. Contemporary issues relating to assessment of pre-registration nursing students in practice. *Nurse Education in Practice*, 10: 158-163.
- Flanagan J, Baldwin M, Clark D 2002. Work-based learning as a means of developing assessing nursing competence. *Journal of Clinical Nursing*, 9: 360-368.
- Higgins A, McCarthy M 2005. Psychiatric nursing students' experiences of having a mentor during their first practice placement: An Irish perspective. *Nurse Education in Practice*, 5: 218-224.
- Higher Education Quality Council (HEQC) 1996. *Guidelines on Quality Assurance*. London: HEQC.
- Langdrige D 2007. *Phenomenological Psychology: Theory, Research and Method*. England: Pearson.
- Marton F 1981. Phenomenography: Describing conceptions of the world around us. *Instructional Science*, 10(2): 177-200.
- McSharry E, McGloin H, Frizzell AM, Winters-O'Donnell L 2010. The role of the nurse lecturer in clinical practice in the Republic of Ireland. *Nurse Education in Practice*, 10: 189-195.
- Nearby M 2002. Supporting students' learning and professional development through the process of continuous assessment and mentorship. *Nurse Education Today*, 20: 463-474.
- Nursing and Midwifery Council (NMC) 2008. *The Code, Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.
- Nursing and Midwifery Council (NMC) 2006. *Standards to Support Learning and Assessment in Practice*. London: NMC.
- Pellatt GC 2006. The role of mentors in supporting pre-registration nursing students. *British Journal of Nursing*, 15(6): 336-340.
- Price B 2007. Practice-based assessment: Strategies for mentors. *Nursing Standard*, 21(36): 49-56.
- Roberts D 2011. Grading the performance of clinical skills: Lessons to be learned from the performing arts. *Nurse Education Today*, 31(6): 607-610.
- Ross C, Mahal K, Chinnapen Y, Kolar M, Woodman K 2014. Evaluation of nursing students' work experience through the use of reflective journals. *Mental Health Practice*, 17(6): 21-27.
- Rutkowski K 2007. Failure to fail: Assessing students' competence during practice placements. *Nursing Standard*, 12(13): 35-40.
- Sjöström B, Dahlgren LD 2002. Applying phenomenography in nursing research. *Journal of Advanced Nursing*, 40(3): 339-345.
- Stuart CC 2003. *Assessment Supervision and Support in Clinical Practice: A Guide for Nurses, Midwives and Other Health Professionals*. Sheffield: Churchill Livingstone.
- Struksnes S, Engelién RI, Bogsti WB, Moen OL, Nordhagem SS, Solvik E, Arvidsson 2012. Nurses' conceptions of how an alternative supervision model influences their competence in assessment of nursing students in clinical practice. *Nurse Education in Practice*, 12: 83-88.
- Svensson L 1997. Theoretical foundations of phenomenography. *Higher Education Research and Development*, 16: 159-171.
- United Kingdom Central Council for Nurses, Midwives and Health Visiting (UKCC) 1999. *Fitness for Practice*. London: UKCC

## APPENDIX 1

### Stostrom and Dahlgren's (2002) Seven Step Approach to Analysis

1. **Familiarisation:** Read transcripts several times to increase familiarity of material
2. **Compilation:** Search transcripts for statements that correspond to the aim of the study
3. **Comparison:** Analyse identified statements for similarities and differences. Group statements with similar content together
4. **Grouping:** Examine identified statements for conceptions. Group statements with similar conceptions together (formation of conceptions).
5. **Articulation:** Re-examine or repeat analysis of conceptions to enhance meaning. This stage informs the formation or identification of descriptive categories
6. **Labelling:** Labels the descriptive categories of conceptions to reflect their meanings
7. **Contrasting:** Compare descriptive categories for similarities and differences to ensure that each has a unique character and they are on the same level of description