

Failing Securely:
Enabling Mentors to Fail Underperforming
Student Nurses in Practical Assessments

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Author's Declaration

I declare that:

- While registered as a candidate for the University's research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution.
- No material contained in this thesis has been used in any other submission for an academic award.
- The thesis submitted is entirely my own work and based on my own research; that all sources used are appropriately acknowledged and that where the words of others are used these are clearly placed in quotation marks.
- I have published material relating to this research previously, and reference is made to any such publications in the thesis.

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Date: 28th November 2014

Abstract

This study was undertaken in response to concerns that mentors who assessed practical competence were reluctant to fail student nurses in assessments which generated doubts about the fitness to practice of some registered nurses. This study set out to investigate mentor's experiences of failing students in England and was undertaken in two phases.

In phase one comparative failure rates obtained from 27 universities indicated that, over a three year period, a very small proportion of students failed practical assessments; failure rates for theory outstripped practice by a ratio of 5:1. A quarter of the universities failed no students in practice. These findings appeared to support the initial concerns and raised a number of questions about practical assessment systems and practices.

In phase two, a grounded theory approach was used to explore the experiences of thirty one participants who had been involved in failing student nurses in practice and the factors which enabled them to do this. Findings revealed that a clash of priorities and cultures between universities and health care organisations generated significant obstacles to failing students. The practical assessment process itself functioned on the mentors' goodwill, their informal social support network and local arrangements rather than on timely, formal, organisational systems. A number of effective interventions were identified which, when combined, supported a three stage process that enabled mentors to fail an underperforming student.

This study is the first to examine mentors' perspectives of how and why they were enabled to fail student nurses in practical assessments in England, and resonates with those reported by other vocationally-based professions. The challenges faced by mentors that this study identifies contribute to national understanding of the processes and context which combine to facilitate robust assessment of the future nursing workforce, ensuring patient safety and public confidence in professions which provide essential care and services.

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GLOSSARY OF TERMS AND ABBREVIATIONS

Term	Abbreviation	Definition / Explanation
Branch of Nursing		The four specialisms of pre-registration nursing preparation were called branches of nursing prior to 2010. The branches were: adult, children's, mental health and learning disabilities. Students chose one branch to study and become registered in although dual qualification was possible. http://nursing.nhscareers.nhs.uk/careers
Category		A high level concepts which is the product of intermediate coding, interpretation and analysis in grounded theory. Categories group ideas according to shared properties and dimensions.
Central Category		"The central phenomenon around which all other categories are integrated" in a grounded theory study (Strauss and Corbin 1998:116). Encapsulates and explains the grounded theory as a whole.
Conceptual Grouping		An incremental step in grounded theory analysis. The product of interpretation and analysis in which groups of open codes are united to represent interconnected ideas in the data.
Department of Health	DH	The Department of Health (DH) is a ministerial government department, supported by 24 agencies and public bodies. It leads, shapes and funds health and care in England. https://www.gov.uk/government/organisations/department-of-health/about
Failed and Withdrawn		Failure at all permissible attempts at an assessment resulting in removal from the programme or course.
Field of Nursing		The four specialisms of pre-registration nursing preparation have been called fields of nursing since 2010. The fields are: adult, children's, mental health and learning disabilities. Students usually chose one field to study and become registered in although dual qualification is possible. http://nursing.nhscareers.nhs.uk/careers
Fit for Practice	FFP	The student who is fit for practice is able to practise safely and effectively without supervision, and has met the standards for competence and all other requirements for registration.
Fitness to Practice Processes	FtP	This committee considers cases where a student nurses fitness to practice is alleged to be impaired due to misconduct, lack of competence, a criminal conviction or caution. Panels hold hearings to decide whether a student nurses fitness to practice is impaired and if so to take appropriate action. http://www.nmc-uk.org/Documents/Consultations/FtPruleChange/FtP-rule-change-consultation-glossary20110824.pdf
Higher Education Institution	HEI	Is an institution of higher education and research which awards academic degrees in various subjects at both undergraduate and post graduate level. Offering education in principally non-vocational subjects and having the

		power to confer degrees.
Link Lecturer	LL	An academic member of staff, employed by a HEI that holds a professional qualification in health care and who undertakes the role of facilitating practice placement areas in meeting the educational needs of pre-registration students. Where a Practice Education Facilitator is in post, both the Practice Education Facilitator and Link Lecturer work together in providing the optimum support for practice areas.
Learning Environment Manager	LEM	The role is held by a qualified nurse with a Nursing Midwifery Council (NMC) recognised mentorship qualification. The LEM is an expert within the clinical setting and is responsible for ensuring that the practice area is a learning environment that is conducive for all students and staff in the clinical setting. http://www.chesterfieldroyal.nhs.uk/students/support/lem?ts=71920
Mentor		A registered nurse who has who has met the outcomes in stage 2 of the Standards to Support Learning and assessment in Practice (NMC 2008) who facilitates learning, and supervises and assesses students in a practice setting. They must work directly and indirectly with the student for a minimum of 40% of the time they attend placement. A nurse or midwife on the NMC register who, following successful completion of an NMC approved mentor preparation programme, is entered on a local register and is eligible to supervise and assess students in a practice setting.
Mentor's Mentor	MM	An experienced and trusted adviser who helps to guide a less experienced or less knowledgeable person. The focus of mentoring is to develop the whole person and so the techniques are broad and require wisdom in order to be used appropriately.
Nursing and Midwifery Council	NMC	The current nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands. This body was set-up in 2002 to replace the United Kingdom Central Council (UKCC). It exists to protect the health and wellbeing of the public. <ul style="list-style-type: none"> • “We exist to protect the health and wellbeing of the public. • We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers. • We ensure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. • We have clear and transparent processes to investigate nurses and midwives who fall short of our standards.” (NMC 2014). http://www.nmc-uk.org/About-us/Our-role/
Open coding		First step in grounded theory analytic process. “Deriving and developing concepts from data” (Corbin and Strauss 2008:65) and labelling each of these in a meaningful way.
Practice Education Facilitator	PEF	PEFs provide support to those mentoring pre-registration students and also contribute to the enhancement of the wider clinical learning environment within NHS boards.

		<p>PEFs support mentors by ensuring that they:</p> <ul style="list-style-type: none"> - Provide effective supervision, - Are effectively assessing students, - Provide informed decision-making in relation to learners. <p>http://www.nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/practice-education/the-practice-education-network/nhs-board-and-partner-universities-practice-education-roles/practice-education-facilitators.aspx</p>
Practice Placement		<p>A practice placement is any environment in which care is delivered to authentic patients. Here nursing students apply their knowledge, learn key skills and endeavour to demonstrate the required level of competency to register as a nurse.</p> <p>http://www.rcn.org.uk/_data/assets/pdf_file/0011/78545/001815.pdf</p>
Pre-registration Nursing Programme		<p>The programme of study that a nursing student in the United Kingdom undertakes in order to acquire the competencies needed to meet the criteria for registration with the Nursing and Midwifery Council (2010). Comprising 2300 hours practical experience and 2300 hours theoretical study.</p> <p>There are four recognised fields of nursing:</p> <ul style="list-style-type: none"> • Adult nursing: the care of people aged 18 or over, • Children’s nursing: the care of children and young people from birth to late teens, • Learning disabilities nursing: the care of people of all ages who have learning disabilities, • Mental health nursing: the care of people of all ages who have mental health problems. <p>Describes the education programme undertaken by nursing students to acquire the competencies needed to meet the criteria for registration with the NMC. Students may apply for registration after they have successfully completed a pre-registration programme. NMC registration is required to practise as a nurse in the UK.</p>
Progression point		<p>There are two progression points that normally divide the pre-registration nursing programme into three equal parts. Students cannot advance from one part to the next until they have met all the requirements for the current part.</p>
Refer		<p>Failure at the first attempt in an assessment.</p>
Royal College of Nursing	RCN	<p>A professional organisation for both students and registered nurses, the Royal College of Nursing has evolved into a successful professional union which represents nurses and nursing, promotes excellence in practice and shapes health policies in the UK, (RCN 2014).</p> <p>http://www.rcn.org.uk/aboutus/our_history</p>
Sign Off Mentor	SOM	<p>A registered nurse who has met the outcomes in stage 2 of the Standards to Support Learning and assessment in practice (NMC 2008) and who has</p>

		<p>also met the additional criteria outlined in the standard who must make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved.</p> <p>A nurse or midwife mentor who has met additional NMC requirements in order to be able to make judgements about whether a student has achieved the overall standards of competence required for entry to the register at the end of an NMC approved programme.</p>
Standards to Support Learning and Assessment in Practice	SLAiP	<p>The standards indicate the outcomes and competencies for mentors, practice teachers and teachers' roles. They take the form of a single developmental framework, which defines and describes the knowledge and skills nurses and midwives need to apply, in practice, when they support and assess students undertaking NMC approved programmes that lead to registration or a recordable qualification on the register, (NMC 2008).</p> <p>http://www.nmc-uk.org/Documents/Standards/nmcStandardstoSupportLearning%20AndAssessmentInPractice2008.pdf</p>
Sub-categories		<p>The product of further interpretation and analysis in which conceptual groups are combined to represent larger interrelated ideas in the data. An incremental step in grounded theory analysis.</p>
Subsequent Pass		<p>Passing an assessment which had previously been failed.</p>
United Kingdom Central Council For Nursing, Midwifery and Health Visiting	UKCC	<p>The regulatory body for Nursing, Midwifery and Health visiting from 1979 – 2002. "Its core functions were to maintain a register of UK nurses, midwives and health visitors, provide guidance to registrants, and handle professional misconduct complaints." (NMC 2014).</p> <p>http://www.nmc-uk.org/About-us/The-history-of-nursing-and-midwifery-regulation/</p>

Chapter 1

Introduction to the Study

1.1 INTRODUCTION

Birks and Mills (2011) suggest that people wishing to undertake doctoral study need to find a topic which inspires them. In my case, the topic found me long before I developed aspirations to undertake research. In 1995 I stood in the doorway of a neonatal intensive care unit and watched a newly registered nurse, who had been one of my students, participate in the resuscitation of a premature baby. She did not realise I was there. As I stood and watched, I thought to myself, 'I know how good you are on paper, but I have no idea if you can do this for real'. I suddenly, fully appreciated how important it was to ensure that nurses had not only been assessed as academically able, but also as competent to practice; it was my baby she was resuscitating.

It is important to say, at this point, that she could 'do it for real' and that my, now grown-up, child remains living proof of this. I, however, returned to my university lecturing post curious about the relationship between our theoretical and practical assessment results. During the following years my passion for effective practical assessment was noted and I became the practical assessments co-ordinator. Then, in 2003, Duffy published the first part of her seminal work 'Failing Students' (Duffy 2003), which confirmed that nurse mentors in Scotland were reluctant to fail underperforming student nurses in practical assessments. Her work raised the possibility that this was also happening in England. There was a lot of anecdotal evidence to support this, but little hard evidence. It was at this point that my manager suggested that I should investigate this issue.

1.2 BACKGROUND

Concerns about standards in nursing practice are not new, and Duffy was not the first to raise concerns about the assessment of students. Bendall (1976) reported, in 1976, that all was not well with the assessment of student nurses. She concluded that, in 84% of the 321 cases she investigated, there was a marked difference between what student nurses wrote they would do, and what they actually did in practice settings. This generated an on-going debate about how student nurses' practical abilities could be effectively assessed to ensure fitness to practice. At this time, students were assessed through written examinations and four practical assessments: aseptic technique; medicines management; total patient care; and ward management. These were one off tests, in which a senior nurse or a nurse teacher assessed the student's performance of nursing activities, in a practice environment. The assessments were often artificially contrived events in which patients and situations were handpicked. Yorke (2005:10) pointed out that the student was usually, "on their best behaviour", so such assessments were an inaccurate indicator of how well they functioned in unrehearsed and spontaneous practical nursing situations.

Up to this point, the preparation of nurses took place in hospitals. Training was based on an apprentice model of tuition: students were employees and spent the majority of their time in care settings. From the 1980s onwards UK education and assessment of student nurses underwent much change. Nursing moved, via colleges of nursing, into Higher Education. Nursing qualifications developed from certificated level, through diploma level, to all graduate programmes of study. The way in which nurses were assessed also changed. Multiple choice papers (MCP) were introduced alongside the written examinations and practical assessments. However, MCPs were abandoned within a few years because of criticism that they tended to assess lower cognitive levels (Dickinson 2011, Morrison and Walsh-Free 2001). Practical assessments, at this time, were undertaken by assessors who were senior nurses, and students were coached in preparation for assessments by more junior nurses. The advent of Project 2000 (UKCC 1986), initially, involved launching six pilot schemes to evaluate new models of nurse preparation. The outcome was the introduction of

continuous practical assessment of student nurses. Programmes of study were developed to prepare registered nurses, working in practice settings, to act as mentors, a role which now also incorporated an assessment element for the first time. However, concerns were already beginning to be raised about how effective practical assessment was, with Lankshear (1990:35) coining the phrase, 'failure to fail', when referring to the reluctance of practice-based assessors to tell students, face to face, that they had failed.

The new, university based, mode of nurse education valued and promoted increased academic achievement alongside nursing practice. The minimum qualification became a Diploma in Higher Education in one of four branches of nursing: Adult, Child, Mental Health or Learning Disabilities. In the 1990s several reports were published which evaluated the effectiveness of Project 2000 in preparing nurses for practice in the 21st century (Luker *et al.* 1996, May *et al.* 1997, May and Veitch 1998, Mcleod-Clark *et al.* 1996, UKCC 1999). These reports identified that newly qualified nurses no longer had the breadth of practical skills needed at the point of registration. This undermined their confidence, and impacted on care delivery. Project 2000 was discarded by nursing as the new millennium began.

In the early 2000s, nurse education focussed on competence and emphasised the importance of practice learning. Courses that gave equal weighting to both theoretical and practical components began to be introduced (UKCC 1999). Students were required to complete 2300 hours of practice time. This was spent in a variety of care environments, encompassing both community and hospital based settings, in the NHS and private sector. Whilst undertaking each practical placement, each student was allocated a named mentor who was responsible for both facilitating learning, and assessing the student's achievement (ENB 2000). Thus assessment of practice became a continuous process rather than a series of one-off events. Mentors were provided with varying levels of support by, for example, Practice Education Facilitators (PEFs) who were employed by the NHS in some areas, or by link lecturers from partner Higher Education Institutions (HEIs) in others. Further details of the UK nursing placements system can be found in Appendix 1.01.

Nevertheless, the difficulties identified by Bendall in 1976 remained (Bendall 2006), and Duffy's (2003) initial findings were reinforced by her thesis which confirmed that mentors were reluctant to fail unsafe student nurses in practical assessments (Duffy 2006). Bendall (2006) and Duffy (2006) raised serious concerns about whether practical assessment processes safeguarded the public. This raised the possibility that some registrants were unfit to practice and could potentially cause harm to patients. This concern reached new heights as referrals to the fitness to practice committee at the NMC reached record levels, with a backlog of 4,500 cases causing a financial crisis for the profession (NMC 2012, 2013). Coupled with this, the NMC was itself criticised for poor performance which may, in part, explain why concerns about practical assessment continued (Staines 2008, CHRE 2012).

Reluctance to fail is not, however, just a problem with which the nursing profession in the UK is grappling. Assessment of competence to practice is pivotal to the accountability and autonomy of all professions (Furlong 2001, Whiteford 2007). Other vocational professions have also become concerned about the reluctance of practice based assessors to fail students. Foremost amongst these is social work which has given much attention to this subject. Sharp and Danby (2000) found that social workers experienced tension between the nurturing and scrutiny dimensions of their role in both mentoring and assessing students. A number of high profile safeguarding cases (Laming 2009, Parliamentary Select Committee 2009, DCSF 2009) have further focussed attention on the preparation and practice of social workers. Finch (2009), Basnett and Sheffield (2010), Finch and Polletti (2013) and Finch and Taylor (2013) have continued to demonstrate parallel concerns between nursing and social work with regard to ensuring public safety through effective assessment of practical ability.

Other professions have also demonstrated concerns about mentors' reluctance to fail students in practical assessments. Hawe (2003) identified that assessors of teachers did not ground their judgements about practical competence on the formal assessment criteria they were provided with. Bowrey *et al.* (2007:cover) compared the difficulty of accountants monitoring the skills of novices to, 'foxes becoming gamekeepers', reflecting the difficulties inherent in being both a mentor and an

assessor. In medicine, Cleland *et al.* (2008) and Dudek *et al.* (2005) raised concerns about role conflicts encountered by assessors. Willis (2009) and Licari and Chambers (2008) recognised that dentists found it difficult to use competencies as practical assessment criteria. These examples show the relevance of this study for many practice based professions.

There is growing evidence that reluctance to fail students in practical assessments is an international issue which is affecting a number of professions. This has been identified in: Australia (Astin *et al.* 2005); Canada (Luhanga *et al.* 2008a, 2010, 2011, 2012); Italy (Finch and Poletti 2013); Ireland (Cassidy *et al.* 2012, McCarthy and Murphy 2008); Malaysia (Enrico and Chapman 2011); New Zealand (Whiteford 2007); Scandanavia (Jokelainen *et al.* 2013); Singapore (Jinks and Harron-Iqbal 2002) and the USA (Cangelosi *et al.* 2009). The main focus has been on the reluctance of mentors and assessors to fail students in practical assessments. There is less evidence regarding mentors who have failed students and the factors and processes which influence them in doing so. It is against such a backdrop that this study sought out mentors, who had failed student nurses in practical assessments, in order to explore what had helped them to overcome the prevailing reluctance to do this.

This study neither evaluated the decisions made by the mentors who participated in this study, nor did it attempt to discriminate between which participants were 'good' or 'bad' mentors. Professional judgements regarding practical assessment decisions were respected. What this study did do was to develop a grounded theory, based on participants' views, about what helped them during the challenging and difficult experience of failing a student nurse whom they judged to have underperformed in practice.

1.3 ORGANISATION OF THIS THESIS

This study was completed in two phases. Phase one was a comparison of theoretical and practical failure rates, on pre-registration nursing programmes, in England. This first phase of the study was undertaken in response to Duffy's (2003:82) recommendation that, "a national survey be conducted that establish the number of students who fail programmes on clinical grounds as opposed to academic grounds". Chapter 2 presents this first phase.

Chapter 3 presents subsequent literature reviews which were undertaken to inform the second phase of the investigation. These comprise a search of the literature which was undertaken, in line with methodological recommendations of Corbin and Strauss (2008), prior to commencing the grounded theory investigation and an overview of the more focussed body of knowledge around failing student nurses in practice, which has developed in the UK over the duration of this investigation.

Chapter 4 explores the methodological approach of the second stage of this study. The principles of grounded theory (Corbin and Strauss 2008) methodology are presented. An explanation of how these were implemented in the fieldwork phase of this study is reported. The aims of the study were to: investigate the factors that influenced the role and functions of those involved in failing student nurses in practice in England and formulate a proposition that would inform both the future preparation of mentors and the assessment of nursing practice.

Chapters 5 to 10 present the findings of the study. These are organised around the categories and central category which emerged from this investigation. Chapters 6, 7 and 8 present process focussed categories. These demonstrate the stages of decision-making that mentors who failed a student negotiated, examining how and why each step acted to secure and enable the mentor.

Chapters 5 and 9 present context focussed categories which explore the conditions and circumstances that sustained the mentor. A number of elements identified in the study intersected both process centred and context focussed categories. To avoid repetition each element has been

examined in detail in one category, and the relationship with other categories has been indicated at this point. Chapter 10 presents the central category, 'Standing Securely', and relates this to House's (1981) theory of 'Work Stress and Social Support'. Chapter 11 then goes on to critically evaluate the study, focus on the challenges that continue to face nursing and makes suggestions to address these.

1.4 CONCLUSION

This chapter has introduced the historical background against which this study was conceived and conducted. The structure of the thesis is explained, demonstrating the two phase approach which was undertaken. Chapter 2 will now present the first phase of the study.

Chapter 2

Phase One – Scoping the Population

2.1 INTRODUCTION TO CHAPTER 2

This chapter was originally presented as a report to Birmingham City University's Research Committee in accordance with an application to transfer from MPhil to PhD study. This application was approved in 2011 (Appendix 2.01) and later published (Hunt *et al.* 2012). This phase of the research was undertaken to assess the feasibility of the study as a whole by determining whether there were sufficient nurse mentors who had failed an underperforming student in practice. This first phase investigation was inspired by Duffy's (2003) recommendation that a comparison of national failure rates in theory and practice on nursing programmes be conducted to establish the extent of failure to fail in practice. The study reported here set out to generate a national picture of comparative failure rates in theory and practice in England in order to inform more detailed inquiry about practical assessment processes. This chapter presents an account of this first phase, which was conducted in 2009 and depicts the national picture in England between 2005 and 2008. This chapter is a complete report of the first phase of the study and includes the initial literature review, research design and implementation, findings, discussion, recommendations and dissemination strategy.

2.2 LITERATURE REVIEW – PHASE ONE

Practice is the core element of nursing, without it the activities of the profession have little meaning. NMC standards explicitly endorse the primacy of practice (NMC 2004, 2010a). In complying with

these standards, nurse education providers have always been responsible for ensuring that students develop into safe practitioners.

Passing theoretical assessments has always been an essential criterion for graduation from Higher Education Institution (HEI) programmes. Assessment of practical ability has been incorporated into HEI processes more recently as vocational professions have transferred to University settings. This has brought with it University responsibility to ensure public safety by ensuring those who graduate are fit to practice (Denton 2005). The literature review identified no studies which specifically set out to quantify a distinction between theoretical and practical failure rates in health care courses. All the studies which examined failure rates, such as the Non-Medical Education and Training Levy (National Audit Office 2001) and the Annual Quality Assurance Rating System (NHS London 2009), defined academic failure as failure of either or both the academic or clinical component of programmes and provided no specific data to compare theory and practice elements.

Studies at the time of this investigation focussed on attrition which in nursing varied from 3% to 65% between Universities (RCN 2006). In contrast 90.5% of students studying professions allied to health graduated (NAO 2007). None of these studies provided specific data about students who left courses as a result of failure in practical assessments.

NMC reports indicated that concerns about failure to fail were being taken seriously (NMC 2005, 2007a, b, c, 2008a). The Council attempted to engage mentors in the process of assessing students in practice by promoting awareness of roles, responsibilities and accountability. Despite this, neither the Council nor the Department of Health (DH) gathered data regarding failure rates in theory and practice (Long 2007, Corbett 2007). This was contrary to the guidance offered by the Chief Nursing Officer and denied the opportunity to measure failure to fail (DH–CNO 2010). This study was thus the first national survey to address this issue.

2.3 RESEARCH DESIGN AND IMPLEMENTATION

2.3.1 Aim

The aim of this first phase of the study was to establish the current situation regarding failure rates among students in nursing practice in England. The object was to gather data to compare failure rates in theoretical and practical assessments, across one cohort of students nationally, from as many Universities as possible.

2.3.2 Study Design

The study was based on positivist assumptions that identified variables could be measured to test theories and hypotheses (Comte 1865/2009). A quantitative research design was used because it allowed for the collection of data from across the whole country. It also facilitated interrogation of the data to analyse statistically the number of students referred or failing theoretical and practical assessments (Cresswell 2013). A retrospective survey method was chosen to gather cross-sectional data about theoretical and practical assessment results at an identified point in time (Bowling 2002, Jenkins 2009). Survey approaches are suitable where information is known to be available. In this case it was known that assessment records were routinely kept by HEIs (DAA 2009).

2.3.3 The Survey Instrument

The survey requested data from all 52 HEIs in England which offered pre-registration nursing programmes commencing in the autumn semester of 2005. This was the most recent student cohort to have completed a full 3 year programme at the time this study was undertaken. Final quality monitoring reports about these courses would have been completed just prior to circulation of the survey and so it was expected that data would be readily accessible.

No existing instrumentation was available. A survey tool was designed taking three factors into consideration (Appendix 2.02).

- i) The pre-registration nursing curriculum in each University in England is unique (Appendix 1.01), as are the number and type of theoretical and practical assessments undertaken. Gathering data per student, per academic year was thought likely to provide standardized data and enable description of the situation nationally (Galvez and Moya-Anegon 2007).
- ii) The variables to be compared and described and the hypotheses to be tested needed to be considered to ensure survey questions captured only relevant information (Punch 2005).
- iii) Terminology needed to be clear and unambiguous to enhance reliability and validity (Fink 2003). Closed questions which required numerical answers were designed to obtain quantitative data in line with the methodological requirements of the study design (Livesey 2010).

The following terms were used:

Refer - failure at the first attempt in an assessment.

Subsequent pass - passing an assessment which had previously been failed.

Withdrawn - failure at all permissible attempts in an assessment resulting in removal from the course.

Testing indicated that using only the word 'withdrawn' was ambiguous and could relate to students who had been removed from the course for reasons other than failure of an assessment, consequently the term 'fail' was used alongside 'withdrawn' to enhance clarity in two questions (Loughborough University 2009).

It was challenging to design a questionnaire to elicit the necessary 80 pieces of data, but concise and accessible enough not to deter would-be respondents. Ten questions were designed with answer grids which simplified the survey (Oppenheim 1992).

The 10 questions requested information about the:

- number of students enrolled for each academic year,

- theoretical assessment and practical assessment with regard to numbers of students who were referred, subsequently passed and, successfully completed programmes or were failed and withdrawn from the course.

All questions were subdivided to elicit figures for the full cohort, each branch of nursing and each academic year. Colour was used to discriminate between theoretical and practical assessment sections (Loughborough University 2009). This design was thought to be respondent friendly and most likely to promote a response (Appendix 2.02).

2.3.4 Administration

The survey was piloted and then administered via e-mail, together with participant information and an explanatory letter during May 2009 (Creative Research Systems 2007, Appendix 2.03). This method of administration has a higher response rate than postal surveys, offers immediacy of contact and confirmation of receipt (Loughborough University 2009). Follow-up occurred 3 weeks later. Further reminders were sent out on an individual basis by post (Edwards *et al.* 2002). There was a flexible approach to accepting data (Borque and Fielder 2003) and original time-scales were adapted as it became clear that some HEIs were keen to participate but that data retrieval was proving challenging. Data collection ceased at the end of 2009.

2.3.5 Reliability and Validity

The instrument was piloted to establish reliability and validity (Fink 2003). This was to ascertain if the instrument measured what was intended. It was only possible to test content and construct validity and not criterion validity since no other tools existed against which this could be compared (Twycross and Shields 2004a). The consistency, repeatability and stability of the data were also explored to ascertain reliability (Twycross and Shields 2004b). Four HEIs from Wales, Scotland and Northern Ireland were randomly selected and invited to participate in a pilot study to test the following: the ability of participants to provide precise, accurate data (reliability); fair and

comprehensive representation of the depth and breadth of issues under scrutiny (validity); and the feasibility of the study (Cohen *et al.* 2000). Three HEIs initially agreed to participate. One requested further ethical review and was excluded from the study to avoid a substantial delay. A second HEI reported that their examinations department was too busy to access the data. The pilot study highlighted that only HEIs with systems designed to gather specific data about practical assessment were likely to be able to respond fully. This was an uncontrollable factor that may impact on external validity and generalizability but Radhakrishna and Doamekpor (2008) suggest this is acceptable as long as it is acknowledged. One HEI pilot participant agreed to be interviewed by telephone to further test construct and content validity (Cohen *et al.* 2000). The respondent suggested minor modifications, but felt the questionnaire would reliably gather the data required (Fink 2003). In the full study data provided by all but one respondent gave numerical information sufficient to interrogate the data as planned.

2.3.6 Participants and Recruitment

All 52 HEIs which offered pre-registration nursing programmes in England from 2005 to 2008 were invited to participate. Contact details were obtained from the Universities and Colleges Admission Service (UCAS) web site, and senior managers were identified who could authorise the provision of relevant data for the study.

2.3.7 Analysis

Data were entered into Microsoft Excel (Microsoft 2007), rather than SPSS (IBM 2010), because they were too visually descriptive and complex for SPSS (Kupferman 2008). Excel afforded the facility of viewing comparative columns for theory and practice alongside each other in colour co-ordinated strings, which aided the reader in distinguishing between the 2 data sets. Individual HEI data were translated into percentages to assist in drawing comparisons because cohort numbers varied considerably (Galvez and Moya-Anegon 2007). The data were then merged to demonstrate national theoretical and practical assessments rates and organised to demonstrate measures of central

tendency in annual numbers. These were calculated in terms of rates of referral, subsequent pass and fail and withdrawal for full cohorts, by academic year and by branch of nursing (Clegg 1997).

An expert statistical advisor was consulted and recommended the test of two independent proportions (TIP) (Stats Direct 2000) as the most appropriate inferential statistical test. The VassarStats web site version was selected as it was user friendly (Lowry 2001). The TIP enabled the calculation of specific theoretical or practical assessment results for 2 branches of nursing to be compared in any given academic year. Proportions were independent because individual students were studying only one branch (Bourke and Daly 2000). However, it was only possible to perform this test where numbers of failures were large enough. Where frequencies were less than or equal to 5, proper comparisons could not be made. Probability values of less than 0.05 were taken to indicate statistical significance in two tailed tests (Armitage *et al.* 2002). It was not possible to ascertain whether individual students had failed both types of assessment so it was difficult to identify an inferential statistical test to analyse the difference between theoretical and practical assessment results. The statistician advised that the test of TIP should therefore be conducted with noted caution. Probability values of less than 0.05 were taken to indicate statistical significance in two tailed tests (Armitage *et al.* 2002).

2.3.8 Ethical Considerations

Indemnity insurance was obtained from Birmingham City University (Appendix 2.04). A favourable ethical opinion was issued by the Faculty of Health (FH), Ethics Committee, Birmingham City University (Appendix 2.05). The principles identified by Beauchamp and Childress (2013) are justice, respect for autonomy, non-maleficence, beneficence and fidelity. These principles and the research governance framework (DH 2005) were used to appraise ethical considerations at the time this study commenced.

The principle of justice required that participants were treated fairly, equitably and appropriately (Beauchamp and Childress 2013). This was regarded as the overarching principle which informed the

other principles. Respect for autonomy necessitated upholding each individual's right to make free decisions and choices (Beauchamp and Childress 2013). A senior manager in each HEI was contacted for permission for data to be provided. Non-maleficence required that individuals did not experience harm as a result of participating in the study (Beauchamp and Childress 2013). Requesting commercially sensitive data meant that it was essential to maintain confidentiality and anonymity and to gather only information pertinent to the study aims. Data were managed so that only the investigator could identify who had given particular responses and identifying data were securely stored to maintain confidentiality (Virginia Tech 2010). Anonymity was provided by allocating each HEI a random code (Polit and Beck 2004). Data will be destroyed 5 years after the study has been completed in accordance with University policy. Beneficence required that the study be worthwhile (Beauchamp and Childress 2013). Whilst individual HEIs would not benefit directly, it was anticipated that the findings would inform future assessment of theory and practice in nursing and possibly, other professions nationally and internationally. Fidelity required the researcher to act in good faith to all who were affected by the study. Whilst a duty exists to report the findings of this study, it is important that this is done objectively and sensitively to maintain public confidence (Morris 2008).

2.4 FINDINGS

2.4.1 Response Rate

Seventeen HEIs responded with data indicating that they assessed both theory and practice. Of these, one HEI provided data per assessment and not per student, but on request supplied information about the number of assessments conducted per academic year. An approximation of data per student was then calculated as the number of failed assessments per academic year = the number of students failed in each academic year. Two further HEIs could not provide data about individual branches of nursing but contributed usable composite data about cohorts (Chart 2.1). The remaining HEI could not separate theoretical and practical assessments and was excluded. This gave

a total of 16 useable responses, from HEIs in 6 of the 9 Strategic Health Authorities (SHA) in England in 2009.

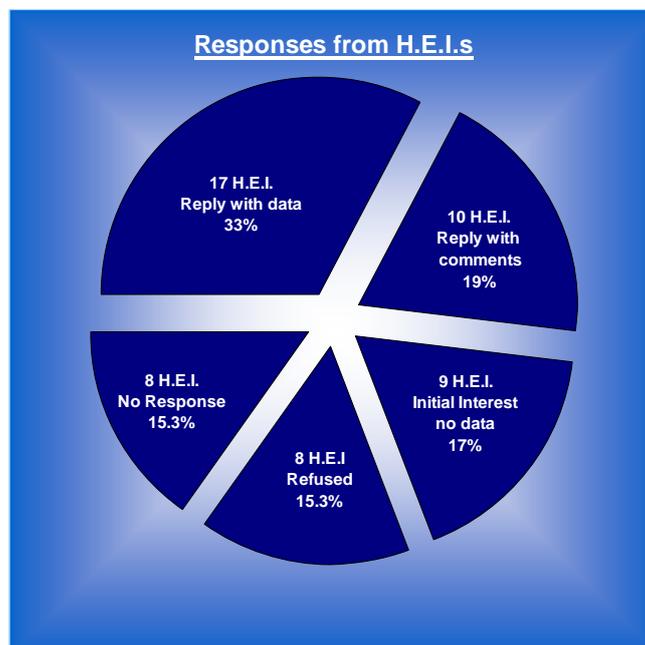


Chart 2.1 Response Rate

Twenty-seven other HEIs responded. Senior managers from 9 HEIs expressed interest and gave permission for data to be released but none were received. A further 10 explained why they could not extract the data requested. Eight refused with no reason being given and a further 8 HEIs did not respond (Chart 2.1).

HEI 31 returned a fully completed questionnaire in 90 minutes commenting that “the figures are based on those provided by information management for the annual report”. However, fourteen HEIs indicated that they did not routinely gather the information requested adding that, “*This took hours*” (HEI 42) and, “*it was difficult to tease out the data required*” (HEI 44). This suggests that quality monitoring processes may be influential in the provision of timely, comprehensive data.

2.4.2 The Sample

The 16 responses reflected the assessment results of 3725 student nurses; the median intake size was 202.5 students. The range of cohort sizes was 427, the smallest cohort being 20 students and the largest 447. A breakdown of the sample by branch of nursing is provided in Table 2.2.

	Total number of students in sample	Mean cohort size	Median cohort size	Range of cohort sizes		
				Largest intake	Smallest intake	Statistical Range
Total cohort	3725	248	202.5	447	20	427
Adult branch*	1691	120.8	114	271	14	257
Child branch*	246	24.6	21.5	64	9	54
Mental Health Branch*	511	42.6	34.5	75	20	55
Learning Dis. Branch*	146	18.2	17.5	34	4	30

* The sum of data relating to all 4 branches does not equate to full cohort data because 2 HEIs (HEI 42 and 44) did not identify which branch of nursing students had chosen to study.

Table 2.2 Summary of sample size, median and range of cohort sizes

Of the 14 HEIs providing specific data about the 4 branches of nursing, 8 offered all 4 branches (HEIs 4, 6, 9, 19, 31, 34, 36 and 48), 2 delivered adult, child and mental health branches (HEIs 25 and 28), 2 offered adult and mental health branches (HEIs 43 and 47) and 2 provided only adult branch (HEIs 45 and 50).

2.4.3 Comparison of Theoretical and Practical Assessment Results

Comparison of composite and branch specific data consistently demonstrated higher referral and failure rates for theory than practice (Chart 2.3). Comparisons were done using the inferential statistical test of two independent proportions**. Results of this test were interpreted with caution, as advised by a statistician, because it was not possible to be confident that the two groups contained completely different students.

There was a wide variance in referral rates between HEIs (Table 2.4). Data per HEI were calculated as percentages to give a standardised comparator despite variable cohort sizes. All HEIs referred students in theoretical and practical assessments and statistical ranges were 45.65% and 25.12% respectively. In 3 cases (HEIs 19, 47 and 50) the referral in practice concerned a single student.

**Tests for the statistical significance between two proportions drawn from independent samples. http://faculty.vassar.edu/lowry/propdiff_ind.html (Lowry 2001).

Combined data for the 3 academic years showed that 2185 (23%) students were referred in theoretical assessments and 533 (5.6%) in practice, indicating a ratio of 4 theory to 1 practice referral (Chart 2.3). Only 1 occurrence was found at individual HEI level where the referral rate for practice was higher than for theory. The test of TIP indicated a statistically significant difference in the number of students referred in theoretical assessments compared to practical assessments in each of the 3 academic years. In all instances the practical referral was lower (Chart 2.3). Academic year 2 demonstrated the highest mean referral rates for both theory and practice

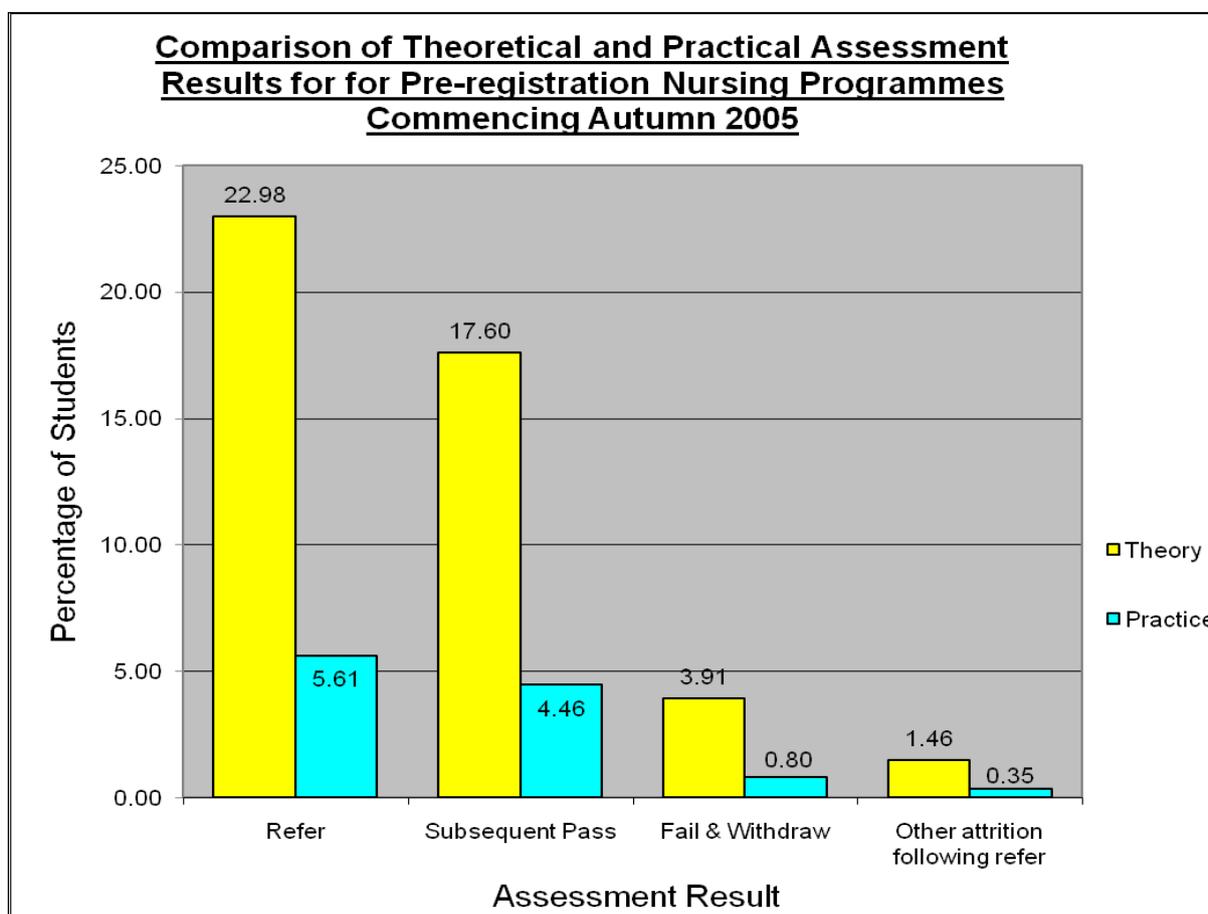


Chart 2.3 Comparison of Theoretical and Practical Assessment Results.

and year 3 demonstrated the lowest. This was consistent across all branches of nursing. The range of failure and withdrawal rates from programmes was 12.04% for theory and 4.25% for practice.

Fifteen HEIs (93%) withdrew students after failure in theoretical assessment but one did not (HEI 45). Twenty-five per cent of HEIs (HEIs 6, 19, 47 and 50) did not withdraw any students as a result of practical assessment (Table 2.5).

	Theoretical Assessment					Practical Assessment				
	Mean	Median	High	Low	Range	Mean	Median	High	Low	Range
Refer	22.98%	26.29%	41.89%	1.71%	45.65%	5.61%	4.5%	25.2%	0.09%	25.12%

Table 2.4 Range of Referral Results from Participating HEIs

	Theoretical Assessment					Practical Assessment				
	Mean	Median	High	Low	Range	Mean	Median	High	Low	Range
Fail & Withdraw	3.91%	2%	12.04%	0%	12.04%	0.8%	0.58%	4.25%	0%	4.25%

Table 2.5 Range of Fail & Withdraw results from participating HEIs

Combined data indicated that, across the 3 years of the course, 372 (4%) students were failed and withdrawn from programmes by HEIs based on theoretical assessments, compared with 76 (0.8%) who failed in practice, demonstrating a ratio of almost 5 theoretical fails to 1 practical fail (Chart 2.3). Only 2 occasions were identified in individual HEI data where the rate was higher for practice than theory. The test of TIP also suggested that, in each of the 3 academic years, there was a statistically significant difference in the number of students who were withdrawn from courses because they had failed theoretical assessments when compared with practical assessments, and this was consistently lower for practical assessment (Chart 2.3). Composite fail and withdrawal rates were highest in academic year 1 and lowest in year 3 but this did not apply consistently to all branches. The learning disabilities branch demonstrated a higher theoretical fail rate in year 3 and the child branch demonstrated a higher rate for both theory and practice in year 3.

Table 2.6 shows that a substantial number of HEIs in the sample did not fail and withdraw students based on the assessment of practical competence in each academic year. This was effectively demonstrated by the median fail and withdraw rate which was 0.26% in year 2 and diminished to 0% in years 1 and 3. Only 2 HEIs failed students in practice in all 3 academic years.

Academic Year	Number of HEIs which failed no students in practice	Percentage of HEIs which failed no students in practice
Year 1	8	53%
Year 2	7	47%
Year 3	11	73%

Table 2.6 Occurrence of HEIs Failing and Withdrawing No Students in Practical Assessments

2.4.4 Comparisons between Branches of Nursing

Branch-specific data demonstrated that referral and failure rates were consistently higher for theoretical assessment compared with practical assessment in all 4 branches of nursing (Chart 2.7).

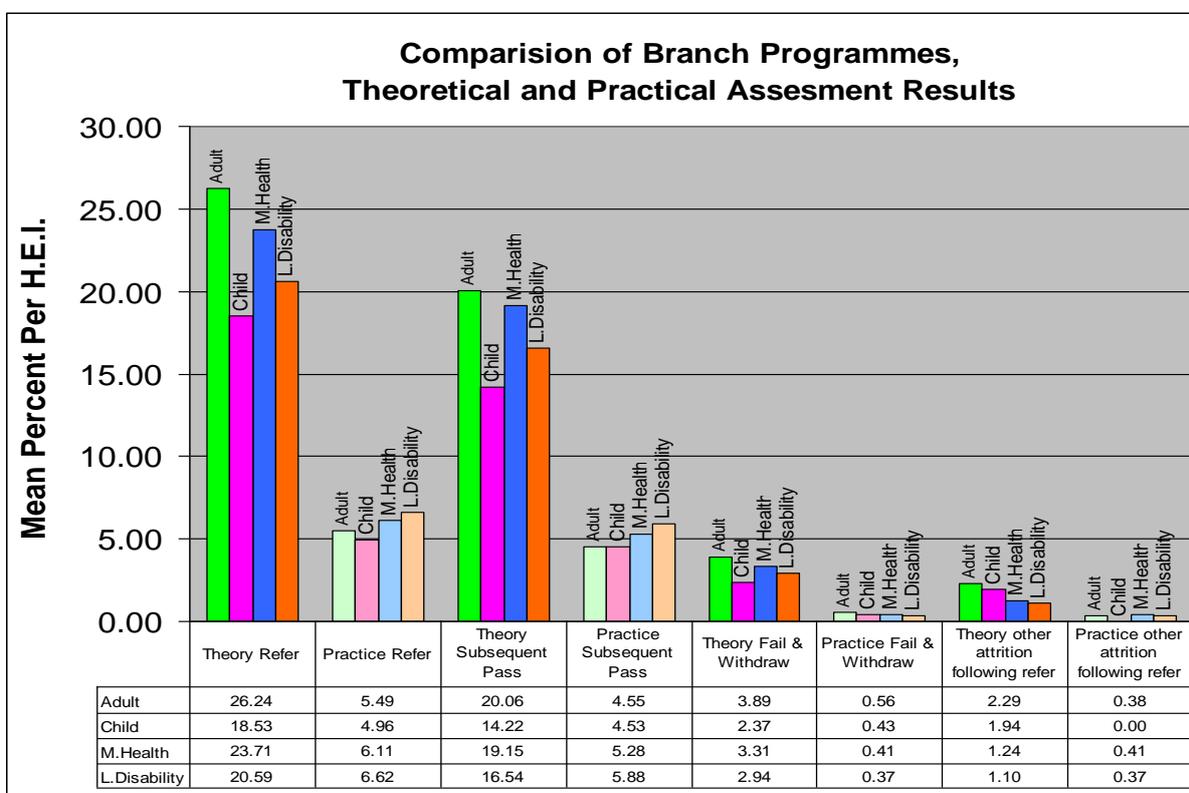


Chart 2.7 Comparison of Mean Branch Programme Results for Theoretical and Practical Assessment: All Academic Years Combined.

These data were compared using the test of TIP because students in each branch were different individuals.

Students were referred and failed and withdrawn from all 4 branches of nursing based on the assessment of practice but the proportion of students was generally so small that proper statistical comparisons could not be made and descriptive statistics were inconclusive (Chart 2.7). Where it

was possible to carry out the test of TIP no differences were identified. Therefore, the null hypotheses were accepted: there were no differences in practical assessment referral or fail and withdrawal rates between branches of nursing.

The adult branch demonstrated the highest mean referral rates for theoretical assessment and the child branch the lowest (Chart 2.7). The test of TIP indicated that the hypotheses in Table 2.8 should be accepted. All other comparisons between branches supported the null hypotheses. Comparison of theoretical failure rates indicated no differences between branches where proportions were large enough to test this and the null hypotheses were accepted.

There is a statistically significant difference in academic year 2 in the number of adult branch and child branch student nurses who are referred for theoretical assessment.
There is a statistically significant difference in academic year 3 in the number of adult branch and child branch student nurses who are referred for theoretical assessment.
There is a statistically significant difference in academic year 2 in the number of adult branch and mental health branch student nurses who are referred for theoretical assessment.
There is a statistically significant difference in academic year 3 in the number of child branch and mental health branch student nurses who are referred for theoretical assessment.

Table 2.8 Hypotheses Accepted

2.4.5 Subsequent Outcome for Students Who Were Referred

Chart 2.9 describes the later progression experience of students who were referred in assessments and demonstrates that proportions were similar for theory and practice. Comparisons of outcome following referral indicated that 76.6% of students who had been referred for theory and 79.5% of students who had been referred for practice, subsequently passed (Chart 2.9). The tenacity of most student nurses is noted here, most continued to reattempt assessments in which they had been referred.

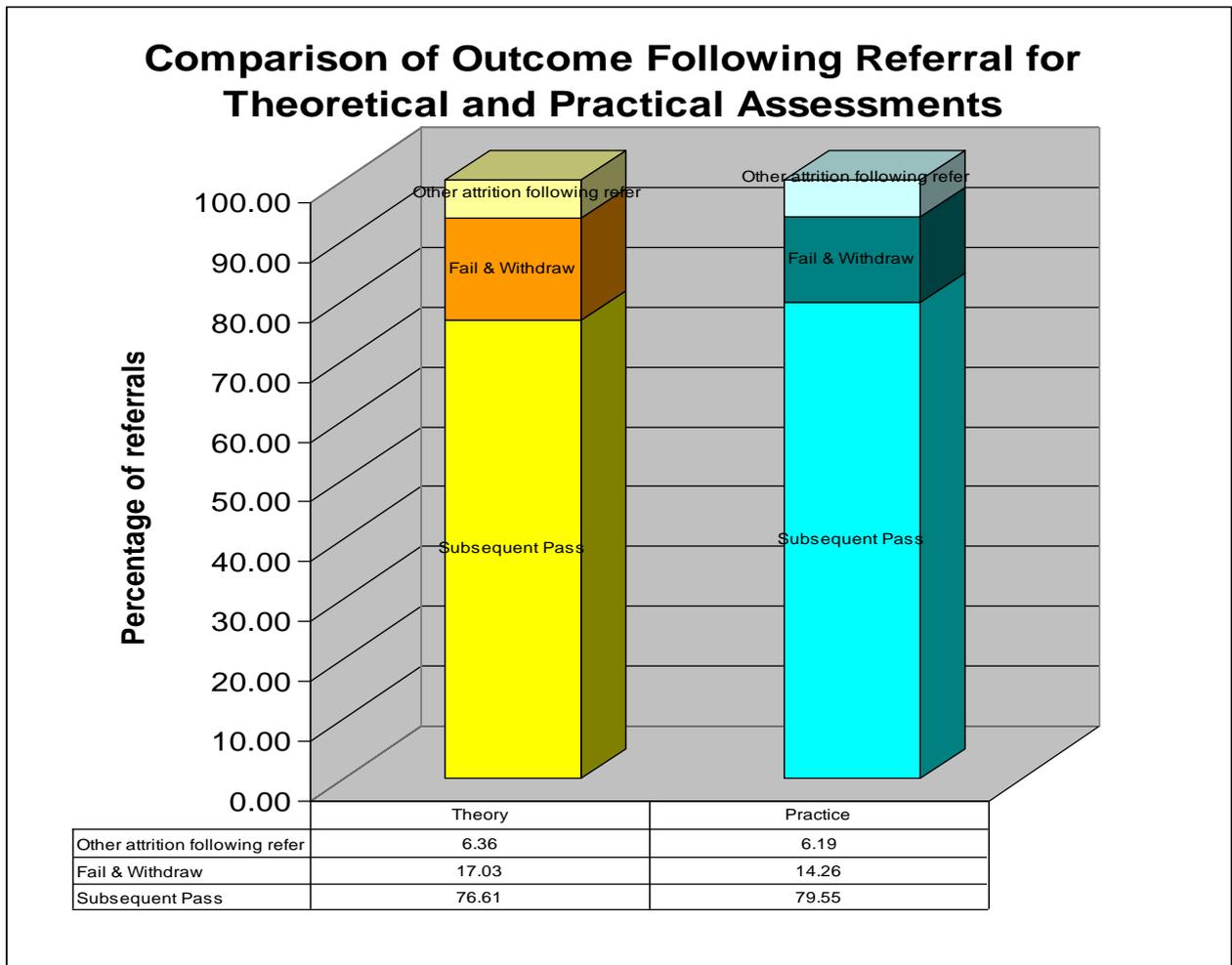


Chart 2.9 Comparison of Outcomes following Referral

Seventeen percent of students who had been referred for theory were withdrawn from courses because they failed further attempts, compared with 14.25% of students for practice (Chart 2.9). This equates to full course wastage attributable to theoretical failure of 10%, and practice 2%[▪]. Small proportions of students who had been referred left programmes before taking all the permitted reattempts these were similar for theory - 6.3% and practice - 6.2% (Chart 2.9). Whilst the study did not examine attrition rates, wastage rates from programmes following referral showed a 13.7% post referral attrition rate for theory (511 students) and a 2.9% post referral attrition rate for practice (109 students).

Calculations adapted from Glossop's (2001) formulae for calculating attrition.

▪ $\frac{\text{Number failing and withdrawing}}{\text{Number starting courses}}$

This compared with a mean attrition rate of 35% from the courses under scrutiny[■]. Attrition attributable to factors other than summative assessments was in the range of 18.9% to 21.8%.

This study set out to examine failure rates in theoretical and practical assessments in pre-registration nursing programmes. Data requested were not routinely gathered by 14 HEIs but comprehensive data could be provided quickly where a HEI used it for quality monitoring purposes. Findings showed that a very small proportion of attrition could be attributed to failure in practical assessments. Both referral and failure rates for theory outstripped practice by a ratio of more than 4 to 1. There was a wide variance in rates of referral and failure between HEIs for both theory and practice and 25% of HEIs did not fail and withdraw any students based on practical assessments. Students were most likely to be failed in year 1 and least likely in year 3. Comparison of specific branches of nursing demonstrated that child branch students were significantly less likely to be referred for theoretical assessments than students from other branches.

2.5 DISCUSSION

This section considers these findings in relation to the methodology used in this study and the implications for practical assessment of student nurses and HEI systems and practices.

2.5.1 The Methodology

The methodology facilitated the exploration of a hitherto unaddressed issue. The response rate to the questionnaire was 31%. This was low, but another 19% of HEIs also responded indicating that they did not gather this data and so could not complete the questionnaire. Hence an overall response rate of 50% was achieved although all responses did not yield data. The questionnaire was effective in gathering standardized data from HEIs (Galvez and Moya-Anegon 2007). The questionnaire was designed to enable participation by HEIs unable to provide branch specific data

Calculations adapted from Glossop's (2001) formulae for calculating attrition.

■
$$\frac{\text{Number failing and withdrawing} + \text{Number leaving following referral}}{\text{Number starting courses}}$$

and this successfully elicited composite information. Thirteen HEIs provided comprehensive data organised as requested. However, in one case a HEI provided data per assessment instead of per student. It may have been better to request data per assessment alongside the number of assessments performed as this may be more in keeping with the way that some HEIs store data. However, although this might have increased response rates, it would have necessitated approximations to be calculated rather than actual figures. This was felt to be an unacceptable reduction in accuracy.

Using e-mail and a postal survey proved efficient. E-mail facilitated one 90 minute response time and some HEIs returned hand written questionnaires (CRS 2007, Edwards *et al.* 2002). Using Excel (Microsoft 2007) to compare data sets was beneficial because colour coding significantly increased reader accuracy (Kupferman 2008). The questionnaire was reliable and provided a large amount of data which spread across a 16 page spreadsheet. Designing the spread-sheet and the questionnaire concurrently allowed optimal use of the columns available (Wilson 2003), prevented the quantity of information becoming overwhelming and facilitated a structured system whereby data could be easily accessed for cross-referencing purposes.

The test of TIP on the Vassar web site (Lowry 2001) was time-consuming but straightforward. The site gave clear results and provided reasons why some results could not be calculated. Findings to date have quantified the extent to which student nurses fail and are withdrawn from programmes as a result of practical assessment.

Overall the methodology was suitable. It highlighted that some HEIs are not collecting this data and could not answer the questions. Now that more is known about the availability of data, the ways it is stored and the progress HEIs are making in increasing the accessibility of information, it may be possible to undertake more detailed studies with a higher number of participants supplying data per student to support more detailed statistical analysis.

Subsequently requests have been made by other researchers to use this tool to replicate the study in other countries. Permission has been granted and the tool, in copyright format, has been released upon request with the proviso that the author is credited with its design. This may provide the opportunity to further scrutinise the criterion validity of the instrument (Twycross and Shields 2004a).

2.5.2 The Assessment of Student Nurses

Both referral and failure rates for theory outstripped practice by a ratio of more than 4 to 1. This seems to support Duffy's (2003) finding that mentors failed to fail student nurses. Alternative explanations include the possibility that failure rates in theory were too high or the design, execution and support of practical assessment for weak students were so effective that all students achieved pass grades. However, 25% of responding HEIs did not fail and withdraw any students as a result of practical assessment. This does not promote confidence that all nurses who qualify are fit to practice. It is ethically and professionally appropriate to have some level of attrition to maintain professional standards (Urwin *et al.* 2010). The disparity in results appears to support Yorke's (2005) view that some HEIs continue to be slow in accepting practical assessment as an important element of programmes.

The NMC's guiding principle that theoretical knowledge informs practical performance should be integral to the practical assessment of student nurses (NMC 2004, Denton 2005). As this survey demonstrated that students were more likely to fail theory than practice, the question arises as to how they pass practical assessments without a sufficient level of underpinning knowledge. The dilemmas that mentors face in defining and judging competence, have been recognised (Duffy 2006, Redfern *et al.* 2002). The NMC's Standards (NMC 2008a) specify that theoretical assessors must have developed their teaching and assessing skills to stage four whilst practical assessors (mentors) are required only to demonstrate development to stage two. This may contribute to the disparity noted between theoretical and practical assessment results.

Referral and fail rates varied between academic years. Students were more likely to pass practical assessments in year 3. This may be because clinical ability develops as experience is acquired (Fero *et al.* 2009). This finding also suggests that students whose practice was weak may have been identified during previous academic years. However Duffy's (2006) conclusion that many mentors admitted to failing to fail students in year 3 because they did not want to jeopardise the student's future so near to possible registration as a nurse, also offers a plausible rationale for lower rates in year 3.

Referral rates were consistently highest in year 2, which supports Duffy's (2006) conclusions that mentors tended to give students the benefit of the doubt in year one but felt previous colleagues had let them down when they were required to refer students at a later stage. Students may have been given the benefit of the doubt but, if referral did occur, students whose lack of competence was of concern in year one were more likely to be removed from programmes when they were reassessed than in other academic years. This indicates that some students whose practice was evidently weak were identified at an early stage and removed from programmes.

The profession continues to debate the optimum time to fail and withdraw students. Most mentors agree that the majority of students who lack competence should have been removed prior to year 3 (Black 2010). There is less consensus regarding years 1 and 2. Discussion has focussed on whether to identify and remove students whose clinical performance is poor at an early stage because this protects the public (Kevin 2006) or to give the benefit of the doubt in year one as some students need more time to accommodate and later develop competence (Luhanga 2008a&b).

There was wide variation in the rates of referral and failure between HEIs for both theory and practice. The issue of inter-University reliability with regard to standards of pre-registration nursing programmes is the remit of the NMC. If the NMC required data about failure rates there would be a far more comprehensive portrayal of the national situation. This could aid external examiners in their role as monitors of national standards and ensure parity between HEIs (Mott Macdonald 2010).

It is a challenge for the NMC to ensure a minimum national standard of competence. International discussion has been on-going regarding the merits of standardising curricula and assessment processes for nursing programmes (Wellard *et al.* 2007 and Lauder *et al.* 2008). The NMC has proposed that HEIs should write local outcomes for students to achieve in practice to provide scope for incorporating fitness for purpose requirements of individual employers (NMC 2010a).

The difficulty in writing concise and user-friendly practical assessment statements has been well documented (Hussey and Smith 2002, O'Donovan *et al.* 2004). Language becomes increasingly complex the more specific the outcome. Statements become practically unwieldy and incomprehensible to those who must apply them. It is time consuming to write employer-centred outcomes which are pertinent, manageable and robust enough to differentiate between competent and failing students in practice. Centrally constructed outcomes, as recommended in Scotland (Lauder *et al.* 2008), might assist external examiners in monitoring standards and ensuring parity between HEIs in order to reduce the wide variation in assessment results identified by this study.

Child branch students passed theoretical assessments more often than their counterparts, but were not more successful in practical assessments. This might indicate that academic ability does not necessarily translate into vocational aptitude (Hughes 2002), or that child branch mentors were less prone to failing to fail than their counterparts in other branches. Reliable practical assessment is more likely to take place when mentors are capable of reflecting with students so that meaning and background are captured when clinical episodes involving the student are assessed (Cassidy 2009b). This is seen to give mentors enhanced confidence in making judgements which might otherwise be disregarded as subjective.

2.5.3 Higher Education Systems and Practices

Fourteen HEIs did not routinely keep specific records of practical assessment results. Since neither the NMC nor SHAs request this data HEIs may view gathering it as a waste of resources. Education providers may prefer to emphasise theoretical achievements which are easier to verify rather than more complex competence based assessments (Zegward *et al.* 2003).

Discussion can only be speculative about why the NMC do not require HEIs to provide evidence of failure in practice rates during annual quality review and programme approval. There may be concern that public confidence would be damaged if a substantial problem was identified. Some HEIs have recognised the need for updated student record systems: three commented that student record systems had been updated recently, and that data would be easily accessible for future cohorts. The swiftness of HEI No.31's response indicated how quality monitoring can influence the design of data systems.

A mean attrition rate of 35.5% was identified, 2% of which was attributable to failure of practical assessments. Reducing attrition has become a key focus of DH policy since 2005 and attrition targets are now built into commissioning contracts as an indicator of value for money. The benchmark for attrition was set at 13% when this study was conducted but has since been lowered further.

Financial penalties continue to be imposed for missed targets (DH 2006). There has been a strong response from HEIs to reduce attrition, but this runs counter to NMC requirements regarding practical assessment which have the potential to increase rates. Increased attrition will be undesirable if it results in financial penalties. The DH (BBC 2008:web-page) notes that, "Universities... have a tangible incentive to keep students in their courses or lose funding" which supports lecturers' beliefs that the primary objective of HEIs is, "bums on seats" (Duffy 2006:251) and this contributes to failure to fail.

The national figure for HEI attrition in England is 15% which is one of the lowest in developed countries (Prymanchuck *et al.* 2009). The DH regards this situation as, "extremely good" (DH 2006:2). Incentives to reduce attrition on health professional training courses are heightened because course costs and bursaries are funded by the NHS (NHS Business Services Authority 2010). To set targets for nursing programmes of 13% or lower in this context is an ambitious aim, particularly when nursing not only makes academic demands but also requires a high level of emotional labour (O'Donnell 2009).

There are two facets to attrition (retention and failure) and their inter-relationship poses a challenge for HEIs and NHS England commissioning groups. “To try to equate retention rates with failure rates is to compare two things that don’t compare” (Swift 2008:web-page). Students choosing to leave nursing programmes are economically costly (BBC 2008) but allowing unsafe students to register as nurses has the potential to be an even greater drain on resources particularly when incompetence results in tragedies and ensuing law suites (Cantrill *et al.* 2010).

2.6 RECOMMENDATIONS

This study supports the argument that there is a failure to fail in practical assessment in the nursing profession and raises a number of questions about the influence of the systems and practices of NHS England Commissioning Groups, HEIs and the NMC have on failure to fail. Further study of the complexities of the relationship between theoretical and practical assessment would enhance current understanding. It is suggested that investigations might explore the following: the emphasis HEIs place on practical assessment and how those which currently fail students in practice are balancing this with the low attrition agenda; the extent to which mentors assess technical skills compared to higher level evidence-based decision-making skills; whether a mentor’s seniority or field of nursing affects willingness to fail; whether locally specified practical assessment outcomes affect assessment results and the points at which it is most appropriate to summatively assess practice.

A clearer picture of the progress being made in addressing failure to fail would be gained if relevant data were collected at national and local level. This would need to take account of the diversity of assessment processes in universities. Without effective measurement it is difficult to determine whether progress is being made in addressing mentors’ reluctance to fail underperforming students in practice. However, on a more optimistic note this study also supports Black’s (2010) findings that there are mentors who have failed students in practical assessments. Currently there has been little

investigation into the perspectives of such mentors particularly in terms of how they were enabled to do this.

2.7 DISSEMINATION OF THE FINDINGS OF PHASE ONE

National concerns regarding the quality of nurse education were being raised at the time this phase of the study was completed. Therefore ethical issues about dissemination needed to be considered. There was a responsibility to act in the best interests of the public and the profession. Since this was the only study which could provide quantitative evidence of the gap between theoretical and practical assessment results in nursing, the argument to contemporaneously share the findings and recommendations was compelling.

Coupled with this, in the same time frame, a nursing journal invited readers to participate in a national survey about assessment of practice. The researcher contacted the editor of the journal and agreed to provide a short statement about the findings to date and develop a full paper for publication in the journal. Unfortunately, the journal editor then made a freedom of information request to all HEIs requesting similar information to that gathered in this study. It was with dismay that e-mails were received asking "Is this you in disguise?" Questions of intellectual property were raised with the journal, and it became imperative to publish the findings of this study. Subsequently the nursing journal agreed to drop plans to conduct its own survey.

An executive summary of this study was disseminated immediately since both the ethical arguments and the necessity to further protect intellectual property were convincing (Appendix 2.06). This was circulated to all HEIs who had participated in the study, the Council of Deans, The Royal College of Nursing, the NMC and the Department of Health. The study was received positively and permission was given to the Chair of the Council of Deans to disseminate the report more widely. The Chief Executive of the NMC requested a copy of the full study so that it could be further considered by the Council. At the same time as the complete report was made available to the NMC it was also published by the University (Hunt *et al.* 2011) and lodged with the British Library in order to further

assert the intellectual property rights of the author. A paper reporting findings was accepted for publication by an international peer reviewed journal (Hunt *et al.* 2012, Appendix 2.07) and the findings later contributed to the Willis Commission (RCN 2012:52).

Some significant lessons were learnt from these incidents. These have now been presented in a vignette within a book (Hunt 2014, Appendix 2.08) which deals with the experiences of novice researchers. Through this medium the lessons learnt about dissemination of research findings were also disseminated.

2.8 SUMMARY OF CHAPTER 2

This chapter has presented the first phase of this study which was undertaken to determine whether there were sufficient nurse mentors who had failed an underperforming student in practice. Findings revealed disparities between the numbers of students who failed practical assessments and the numbers who failed academic assessments. Recommendations were made regarding the assessment of student nurses and the systems and practices of HEIs. Challenges were highlighted regarding both protecting intellectual property and disseminating the findings of this first phase of the study. Phase one of this study further demonstrated that there were mentors who had failed students in practical assessments and thus indicated that phase two of the study was feasible. The following chapters now present this second phase of the study.

Chapter 3

Phase Two - Literature Review

3.1 INTRODUCTION

This chapter principally focuses on the literature which was available at the commencement of this study. Grounded theory methodology suggests that the researcher should not undertake a formal review of the literature in the substantive area of the study until it is well underway. The aim of this is to keep the researcher open to emerging concepts, and reduce intrusion of preconceived ideas (Birks and Mills 2011). However, the author of this study was already immersed in this subject area as a result of her job. Therefore, to maintain transparency, it was felt appropriate to acknowledge what was known to the author about this phenomenon prior to commencing phase two of this study.

This chapter begins with an explanation of the strategy employed to search for relevant literature. This is followed by a thematic review of the UK and international literature, which focused on the experiences of those involved in assessing student nurses in practical placements. In particular, it concentrates on supportive arrangements which were identified as helpful to mentors prior to 2009. This incorporates the small volume of literature that specifically focused on supporting mentors who had failed students in clinical assessments. A short overview of the growing body of evidence that specifically focuses on failing students in practice, which emerged whilst this study was in progress, is then presented. This is examined in more detail in Chapters 5 - 9.

3.2 LITERATURE REVIEW STRATEGY

The primary database which was searched was the Cumulative Index to Nursing and Allied Health Literature (CINHAL); this includes the majority of healthcare related journals published in English over the last 35 years. In addition MEDLINE/PubMed, PsychINFO and the British Nursing Index (BNI) were accessed, but, produced no additional relevant material. The British Library Electronic Theses Online Service (EThOS) was accessed; several relevant theses were acquired via this route. The databases of the Department of Health (DH), Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN), and other profession related sites yielded further relevant studies and grey literature. These databases were searched for items published between 1985 and 2008. A further hand search was also undertaken.

The search began by focusing on UK literature because of the specific nature of the mentor's role in this country. However, it became clear that the subject of this study was of concern to professions around the world, and the search was then widened to include international papers which could be accessed in the English language. A secondary search of papers relating to other health and vocational professions was conducted as several other professions were investigating this phenomenon.

The search terms employed were:

- mentor*, assess*, precept*;
- nurs*, practic*, clinical*;
- support*, guid*, help*, assist*, promot*;
- competence, competent, competency, proficient, proficiency, ability, capability, fitness for practice;
- fail*, unsafe, incompetence, incompetent, underperform*, unsatisfactory, struggl*.

In order to refine the search these terms were combined, in various permutations, using the Boolean operators 'OR' and 'AND'.

The search terms and limits provided a variety of grey literature including: guidelines; reports; anecdotal accounts; letter; literature reviews; discussion papers; conference presentations; and a number of research studies, which focussed on the support of mentors in their assessment role. Abstracts were reviewed and full texts of relevant papers were either downloaded electronically, or obtained via inter-library and British Library requests, or by contacting authors directly. Further material of interest was then identified by conducting a review of the reference lists contained within the papers which had initially been acquired, and a hand search was also undertaken. During the study a total of 461 documents were identified, the abstracts from these were reviewed for relevance and the full text of 147 were obtained and reviewed. The Preferred Reporting Items for Systematic Review (PRISMA 2009) checklists was used to review trustworthiness, results and relevance. One hundred and two studies were found to be applicable to this study and a record of each is available in Appendix 3.1 (1985-2008) and Appendix 3.2 (2009 onwards).

3.3 DEFINING THE TERM 'MENTOR'

Generic definitions of mentoring refer to activities such as 'befriending', 'guiding' and 'advising' (Gopee 2011). Whilst the nursing profession acknowledges these as important elements of the role, NMC (2008a) interpretation of mentoring is more specific and incorporates a broader range of responsibilities. The NMC (2008a:45) define a mentor as a registrant, "who facilitates learning, and supervises and assesses students in practice settings". Nurse mentors must have one year post-registration experience, successfully complete an approved programme of preparation and demonstrate they have the knowledge, skills and competence required to meet the outcomes defined in the Standards to Support Learning and Assessment in Practice (SLAiP) (NMC 2008a). When these criteria are met the nurse is added to the local register of mentors held by the employer. To remain on this register the mentor must attend annual updating, and be reviewed every three years, to confirm that they remain competent to act as a mentor.

Each student nurse must have a named mentor when undertaking a clinical placement, this is a mandatory requirement. A mentor is normally allocated to a student; neither party has a choice in the matter. The mentor must spend at least 40% of the placement supervising the student directly or indirectly, overseeing the student's practice, and remaining accountable for care delivered to patients. At the end of the placement the mentor must then formally judge the student's practice, and is accountable for the assessment decision (RCN 2007). Hence, the professional obligations placed on the nurse mentor differ from those of the traditional mentor because, as well as being a trusted guide, they are also required to be an objective assessor (Cassey and Clarke 2011). Inherent tensions have been identified between the mentoring and assessing components of the nurse mentor role (Chandon and Watts 2012). It has been suggested that these are partly to blame for mentors' reluctance to fail underperforming students (Nettleton and Bray 2008).

3.4 LITERATURE REVIEW 1985 – 2008

There was a strong consensus in the literature that mentors in practice areas should be 'supported' (Lankshear 1990, Wilson-Barnett *et al.* 1995, Duffy 2000, Sharpe 2000, Pulsford *et al.* 2002, Duffy 2003, Rutkowski 2007, Nettleton and Bray 2008, Webb and Shakespeare 2008). However, identifying what this 'support' should consist of, and how it should be given, was less clear. This may be due to an assumption that there was shared, tacit understanding of this term. It seemed that 'support' was often used as a vague term, with no clear parameters or essential qualities being defined. Therefore, this literature review aimed to: tease out the current meaning of 'support'; clarify how and why mentor support was important; and to identify specific types of support which might assist mentors to fail underperforming students.

Thirty two studies provided some insight into various elements of ‘support’ for nurse mentors in the UK. These were organised into four themes which were sub-divided (see Figure 3.1). Examination of international nursing and inter-professional literature revealed sixteen more studies. These confirmed that similar elements of support were of relevance to a number of professions in various countries. This review of the literature is organised around the four themes identified in the 48 studies, published from 1985 to 2008, which were reviewed.

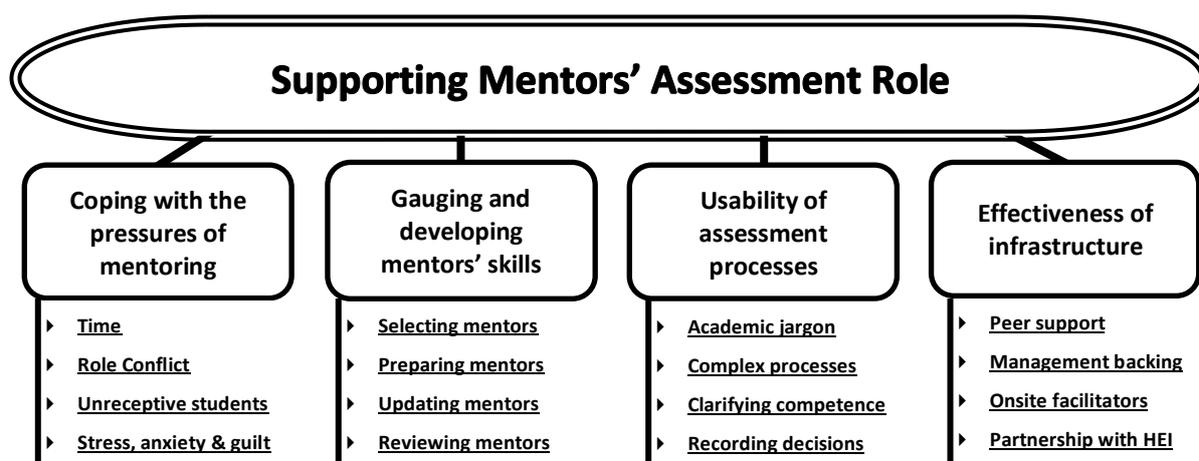


Figure 3.1 Themes identified in the review of the literature 1986-2008

3.4.1 Coping with the Pressures of Mentoring

3.4.1.1 Time

Time was repeatedly identified as a major barrier to effective mentoring and assessment practices. Most mentors believed they had inadequate time to prepare, supervise, guide and assess students (Atkins and Williams 1995). This is a longstanding issue; lack of time for mentoring was ranked as a particular problem by occupational therapists in 1996 (Illot 1996). Forty-three per-cent of the 237 nurses in Watson’s (2000) study also reported that they had insufficient time to mentor and assess students effectively. Neary (1997:6) suggested that this was because the mentoring role had been, “tagged on” to the registered nurse’s job as, “just another activity”. This placed an unrealistic workload on nurses which they could not manage. Inadequate time has been identified, more

recently, as a universal constraint amongst most professions which deliver both clinical and educational services (Cleland *et al.* 2008).

Clinical workload was a significant barrier to fulfilling the mentor role (Hurley and Snowden 2008). The “competing expectations” of patient care and mentoring caused difficulties, especially when dealing with a failing student (Wilkes 2006:45). Staff shortages (Edmond 2001) and inadequate staff to student ratios (Hutchings *et al.* 2005) both impacted on the time a mentor had to make an appropriate assessment of a student. Further difficulties arose in brief placements where the mid-point, formative, assessment might need to be conducted after, as little as, two weeks (Lankshear 1990). The difficulties outlined here could result in mentors being unable to complete assessments on time. This, in turn, compromised both university processes, and the time available for students to demonstrate improvement (Duffy 2003 and 2006).

Mentors recognised that the limited time they had available to teach impacted upon students’ learning (Myall *et al.* 2008). Rutkowski (2007) noted that lack of time undermined the process of assessment; only limited observation of the students’ competence was possible leading to a compromised judgement (Webb and Shakespeare 2008). It has been recommended that priority should be given to addressing the lack of allocated time for mentoring activities (Nettleton and Bray 2008).

Mentors and students views varied about what constituted an adequate amount of time spent together (Pulsford *et al.* 2002). Students felt quality time with mentors was essential (Myall *et al.* 2008), and recognized how dedicated and willing mentors were to spend their own time undertaking this role (Dolan 2003). A number of studies demonstrated that nurses often undertook mentoring duties in their own time (Atkins and Williams 1995, Phillips *et al.* 1996, Pulsford *et al.* 2002, Myall *et al.* 2008), including meeting with students in their own home, and completing assessment paperwork out of hours (Dolan 2003).

The optimal amount of time required for mentoring activity has not been identified. However, Atkins and Williams (1995) recommended that time for mentoring should be factored into the working day. Fade (2006) recommended that an estimate of the time needed to do this should be built in to financial models, and this should be taken into account as part of workforce planning, across all health related professions. Pulsford *et al.* (2002) and Webb and Shakespeare (2008) supported this view. This demonstrates that these issues have prevailed for a considerable amount of time and the nursing profession has, so far, not addressed them successfully.

3.4.1.2 Role conflict

The studies reviewed demonstrated that use of the term 'mentor' did not lend clarity to the role (Wilson-Barnett *et al.* 1995, Pulsford *et al.* 2002, Myall *et al.* 2008). Consensus regarding the meaning attached to the term mentor was elusive (Hagerty 1986, Marle 1990, Phillips *et al.* 1996). The variety of interchangeable labels used within nursing and across other professions, confused the issue further. The terms: 'mentor'; 'assessor'; 'preceptor'; 'facilitator'; 'supervisor'; and 'co-ordinator', were all used (Bray and Nettleton 2007). Enduring definitions of mentoring speak of a nurturing, guiding and enabling role; they do not refer to judgement and appraisal. These elements have been annexed to the mentor role more recently by the ENB (2001) and NMC (2004, 2006 and 2008a).

Studies demonstrated that the activities of mentors have become more complex, and the competing elements of the role have been given differing emphasis since the 1980s. As a result, mentors reported being unsure about their responsibilities and struggled with the perceived mismatch between the 'supporter' and 'assessor' role (Bray and Nettleton 2007). Neary (1997) reported that 56% of the 155 mentors in her study found it difficult to be objective, when assessing performance, because of the close relationship they had developed with students. Ninety-one of the 155 student participants, in this same study, were reluctant to be assessed by their mentor (Neary 1997).

Conversely, Cameron-Jones and O'Hara (1996) found that, whilst mentors regarded their role as

primarily supportive, students expected them to evaluate their performance. Wilson-Barnett *et al.* (1995) identified very few examples in which practitioners had lone responsibility for either the supportive or judgemental role. Role duality has been noted to generate conflict of interests (Bray and Nettleton 2007). Bayley *et al.* (2004) recommend that the assessment function of mentoring should be retracted. However, community nurses considered they were able to fulfil both roles and made little distinction between them (Jinks and Williams 1994). Nevertheless, they were concerned at being a source of stress to students when they took on a more appraisal focused role (Twinn and Johnson 1992).

Mentors experienced further role tension between their responsibilities to patients and students. This was shown to trouble nurses working in hospital settings more than those working in primary health care (Atkins and Williams 1995). More pressing commitments relegated mentoring to a low priority (Phillips *et al.* 2000, Jinks 2002, Dolan 2003, Rutkowski 2007) because nurses gave precedence to patients' needs (Lauder *et al.* 2008). Mentors reported feeling that they, "served two masters" (Lambert and Glacken 2004:180) which generated, "role strain, conflict, ambiguity, overload and burn-out".

Additional dissonance for mentors surrounded what being a 'good mentor' entailed. Hrobsky and Kersbergen (2002) noted that mentors' memories of being a student led them to believe that a good mentor was a moral and caring person. This interfered with the gatekeeping role they also acknowledged they should undertake. Luhanga's (2006) findings supported this view; mentors in her study were reluctant to fail underperforming students because they saw this as a reflection of their own incompetence, or feared being labelled a bad person. Hawe (2003) also reported that awarding a fail grade gave a tacit negative commentary about a mentor's qualities. In such circumstances mentors sought the support of their peers, to check that it was not just they who judged the student to be failing. Andrews and Chilton (2000) noted that, when students passed their practical assessments, they rated mentors more highly than the mentors rated themselves; this was not the case when students failed.

3.4.1.3 Unreceptive students

Evidence suggests that the majority of students expected to pass practical assessments. They often responded with shock, anger and frustration if they received feedback about aspects of their practice which required development (Burgess *et al.* 1998, Duffy 2003, Luhanga 2006). Sharpe's (2000) findings suggested that this was partly due to students dealing with unexpected emotions related to loss and grief. Nonetheless, students could behave destructively and manipulatively at such times.

Mentors were frustrated by students who were unreceptive to feedback and found them difficult to manage (Lankshear 1990, Duffy 2003). Overconfidence and lack of insight were identified as contributing to students' unreceptiveness (Luhanga 2006). This was compounded by a reduced ability to reflect on, and question, their own practices, or learn when errors were made (Rittman and Osburn 1995, Gutman *et al.* 1998, Hrobsky and Kersbergen 2002). Such students experienced difficulty in developing an accurate view of their practice. They required precise and frequent feedback (Luhanga 2006), but this was rarely interpreted as supportive (Duffy 2006). Negative working environments often ensued and such students unsettled the placement team (Rutkowski 2007).

American and Canadian studies, in particular, demonstrated students' increasing tendency to instigate appeals and litigation regarding mentors' decisions (Orchard 1994, Luhanga 2006). Dudek *et al.* (2005) noted that some mentors rescinded fail decisions because they either felt intimidated by medical students' threats of legal action or because the amount of time required to structure a counter-defence was prohibitive. Neary (2000) noted that student nurses were quick to learn how to exploit assessment documents to their benefit, using variations in the way assessment processes were applied to their advantage. This was identified as a concern by tutors and mentors, but not by students (Dolan 2003).

Another defensive behaviour noted was that students blamed inadequate mentors, inappropriate placements or lack of academic input for their underachievement (Duffy 2006). It has been posited that this sometimes occurred because students were too dependent on staff (Beeman 2001), had unrealistic expectations of what to expect in clinical practice (Duffy and Watson 2001), and found it difficult to step out of roles such as 'parent', 'partner' or 'friend' which inhibited them from taking on the role of nurse (McCarthy and Murphy 2008). Students who were receptive to feedback were often easier to help, whilst defensive and unreceptive students were difficult to engage. Mentors in several studies indicated that they needed support and protection (Duffy and Watson 2001, Sharpe 2000, Dudek *et al.* 2005). They suggested that independent student counselling and improved assistance from line-managers might be helpful.

3.4.1.4 Stress, anxiety and guilt

Mentors reported experiencing stress when working with underperforming students because they needed to employ extra vigilance to keep patients safe (Fade 2006, Luhanga 2006). Practitioners recounted feeling exposed, isolated, and vulnerable in such situations (Burgess *et al.* 1998). Watson (2000) identified that such feelings were associated with high levels of sickness and low retention rates. Luhanga's (2006) study linked this to mentor burn-out. Wilson-Barnet *et al.* (1995:1153) recommended that, "restorative support should be provided to stressed mentors working with distressed students"; the components of such support were not explicitly identified. There has been speculation that regular breaks (Atkins and Williams 1995), and critical incident stress debriefing (Duffy 2006) might assist mentors to cope.

Providing face to face feedback to students about negative aspects of their practice was shown to be a particularly stressful experience for mentors (Lankshear 1990, Dolan 2003, Bray and Nettleton 2007). Consequently they reported reluctance to do this (Duffy 2003, Luhanga 2006). Moseley and Davies (2008) revealed that mentors found the cognitive aspects of their role, such as assessing and giving critical feedback, challenging. They often experience guilt (Webb and Shakespeare 2008) and

tended to blame themselves if the student did not pass. Guilt centred on their own self-perceived inadequacy as a mentor, as well as the distress and hardship that they would cause the student. Guilt was particularly strong if the student was withdrawn from the programme as a result of failing (Ritman and Osburn 1995, Watson and Harris 1999, Duffy 2006). Practitioners also reported being reluctant to award fail grades when no remedial back-up was available to help students improve (Dudek *et al.* 2005). Stress was heightened by lack of support from the mentor's employer and the university (Watson 2000). Those who did fail students identified themselves as brave (Luhanga 2008b) because they had to work counter to the social, psychological and systematic norms of vocational professions (Lambert and Glacken 2004, Dudek *et al.* 2005). Fade (2006:225) suggested that training in, "supportive dialogue techniques" could assist mentors to provide constructive feedback to students. This would promote sound assessment governance, by overcoming mentors tendency to either avoid or rush assessment interviews, when concerns needed to be raised with students.

3.4.2 Gauging and Developing Mentors' Skills

3.4.2.1 Selecting mentors

A small number of studies were identified which considered how those most suited to the mentoring role could be selected (Clifford 1994, Philips *et al.* 1996, Sharpe 2000, Luhanga 2006). Becoming a mentor was considered mandatory for any nurse seeking promotion to a higher grade. This meant that junior staff were required to attend mentor preparation programmes without vetting (Philips *et al.* 1996). Nettleton and Bray (2008:211) argued that, "unsuspecting and unsuitable individuals" could sometimes find themselves in the position of mentor, without the experience, aptitude, or motivation to undertake this role. Further concerns were raised, by Clifford (1994), that the biggest contribution to practical assessment was often made by those with the least experience of evaluating clinical skills.

Some selection criteria have been proposed. Nurses should be able to clarify their understanding of the functions and implications of mentoring (Philips *et al.* 1996), and demonstrate an appreciation of the importance of the gatekeeping role (Bray and Nettleton 2007). Luhanga (2006) advised that the ability to establish and maintain professional boundaries was an essential quality. Sharpe (2000) recommended that the most experienced and able mentors should be chosen to work with students on their first practical experience because, at this point, the potential risk the student presented was unknown, and the demands of failing a neophyte student were onerous.

3.4.2.2 Preparing mentors

Formal preparation has been, repeatedly, identified as a critical factor in developing mentors skills to recognise, and fail, underperforming students (Jinks and Williams 1994, Wilson-Barnett *et al.* 1995, Neary 1997, Philips *et al.* 1996, Jinks 2002, Duffy 2003, Luhanga 2006, Fade 2006, Kneafsey 2007, Myall *et al.* 2008, Bray and Nettleton 2008, Webb and Shakespeare 2008, McCarthy and Murphy 2008). Many recommendations about the duration of such programmes have been made; the standard now being set at five days protected learning time (NMC 2006 & 2008a). However, mentors who received one week of formal training considered this insufficient (Jinks and Williams 1994), with many feeling that they still lacked confidence (Duffy 2000).

The content of mentor preparation programmes has also attracted attention. Studies have made a variety of recommendations about course components which could help mentors to fail underperforming students. Proposals have included incorporating topics such as: adult learning techniques; sharing expectations; “the how and not just the what to assess” (Neary 1997:6); supervisory and coaching practices; report writing (Phillips *et al.* 1996); the use of powerful questioning techniques and critical debate (Fade 2006); delivering constructive feedback (Duffy 2000); using reflective skills; identifying unsafe skills (Kneafsey 2007); conflict resolution (Luhanga 2006); using assessment documents effectively (Bray and Nettleton 2007); and gatekeeping

responsibilities (Duffy 2006). The NMC (2008) Standards to Support Learning and Assessment in Practice (SLAiP) set out the current competencies which mentors must meet.

3.4.2.3 Updating mentors

The NMC SLAiP Standards (2008a) require mentors to update annually, and places responsibility for provision with the employer. Studies have demonstrated that mentor updating is a neglected mandatory obligation. Practitioners identified barriers to attending updates such as: substantial clinical commitments; lack of managerial support; and scant information about scheduled updates (Duffy 2000). Wilson-Barnett *et al.* (1995) recommended that staff should be provided with continuing opportunities to update their mentoring knowledge and practice to maintain their role. Jinks (2002) suggested that this might be achieved through the introduction of a peer support programme. Webb and Shakespeare (2008) agreed, suggesting that this would help to manage mentor burn-out.

3.4.2.4 Reviewing mentors

Several studies indicated that support mechanisms did not meet mentors' needs. Lack of feedback on mentoring performance was highlighted as a particular issue (Duffy 2000, Jinks 2002). Mentors felt frustrated by this, many indicated that they never received feedback from academic staff following the conclusion of a student's placement. This caused particular difficulties for mentors who had failed a student because they felt disregarded and of low status (Duffy 2003). Burgess *et al.* (1998) recommended that all clinicians should be debriefed following the experience of failing a student, and suggested that this would enhance the retention of mentors. Duffy's (2003 and 2006) findings supported this, and suggested that critical incident debriefing should become de-rigueur for mentors. McCarthy and Murphy (2008) reiterated this recommendation, pointing out that many mentors still did not fully understand assessment processes and, therefore, could not implement stipulated procedures effectively; this offered students the opportunity to appeal against decisions. It was suggested that helping mentors to understand the final outcome decisions for each student,

once appeals had been heard, would result in less mentor frustration and facilitate improved assessment practices.

A significant number of studies demonstrated a consensus that feeling valued was important to mentors (Lankshear 1990, Dilbert and Goldenberg 1995, Yonge *et al.* 1995, Burgess *et al.* 1998, Sharpe 2000, Watson 2000, Dolan 2003, Duffy 2003, Devis and Butler 2004, Luhanga 2006, Nettleton and Bray 2008). A number of facets were identified which promoted feeling valued including: receiving feedback following university panels (Burgess *et al.* 1998); the introduction of staff development strategies by employers (Watson 2000); encouragement and reassurance from Practice Education Facilitators (PEF) (Lankshear 1990, Luhanga 2006); formal credit via letters of acknowledgement (Sharpe 2000, Dolan 2003); assurance of faculty support; and being given, “legitimate authority to assign a fail grade” (Luhanga 2008a:136). These measures demonstrated to mentors that they were valued and respected. They promoted confidence and job satisfaction because mentors saw that their work mattered, and that their status matched that of academic assessors.

3.4.3 Usability of Assessment Processes

3.4.3.1 Academic jargon

The complex language in which practical assessment documents (PAD) were written acted as a barrier to effective mentoring. Mentors reported difficulty in understanding academic jargon which they regarded as ambiguous and obscure (Duffy and Watson 2001). They devised their own mechanisms to cope with this obstacle, but this led to inconsistencies in assessment (Dolan 2003). In Bray and Nettleton’s (2007) study participants (n = 110) indicated that they devised their own learning outcomes because they could not link students’ performance to the formal assessment criteria in PADs. Some mentors reported using a team approach to decode assessment requirements (Neary 2000) using a, “deconstruction and reconstruction” approach (Scholes *et al.* 2004, Webb and

Shakespeare 2008:504). May *et al.* (1997) noted that PEFs often undertook a crucial role as interpreters of PAD jargon.

Some studies demonstrated that work had been done to improve accessibility of PAD language. Additional guidelines which had been written to help mentors understand PADs were identified in Jinks and Williams' (1994) study. Some HEIs had reworked documents to simplify language and find terms with shared meaning (Scholes and Albara 2005). Further recommendations to improve this situation included: involving mentors in developing PADs (Duffy 2000); aiming for brevity and clarity of terms (Watson 2000); and reduction of the number of competencies (Dolan 2003).

3.4.3.2 Complex processes

Mentors also struggled with the complexity of practical assessment processes, finding them excessive, tedious, long winded and confusing (Rittman and Osburn 1995, Twinn and Davies 1996, Duffy 2000). Kneafsey (2007:366) observed that, "continuous assessment is not achieved without difficulty". Complexity of process was shown to be a particular problem when a mentor needed to fail a student. In such circumstances, strict adherence to processes was required, but the complexity of procedures hindered this (Calman *et al.* 2002). This led to inadvertent deviations from due process, which resulted in students being offered further assessment attempts, despite failing. Mentors criticised ambiguous, confusing, over-complex protocols (Myall *et al.* 2008). Several studies demonstrated that clearer, more user-friendly practical assessment procedures were required (Pulsford *et al.* 2002, Duffy 2003, Luhanga 2006, Dawson 2006) which, "sewed up the loops hopes a student could get at you through" (Lankshear 1990:37).

3.4.3.3 Clarifying competence

Writing criteria which clearly expressed competence, in practical assessment documents, was noted to be difficult. This was the focus of several academically led studies (Ashworth and Morrison 1991, Dolan 2003) which reported that more detailed clarification would assist mentors in assessing

students. However, mentors rarely examined the detail of assessment criteria (Neary 2000), perceiving it to be, “estranged from clinical practice”, and noting that it, “had the potential to unwittingly interfere with assessment of clinical performance” (Brown 2000:408-9).

Articulating how and what mentors should assess received particular attention in several studies (Watson 2000, Fade 2006, Dawson 2006, McCarthy and Murphy 2008). Debate has been intense regarding the use of competencies to assess student nurses. Some findings suggest that this approach is reductionist and diminishes the profession’s activities to a tick box list (Dolan 2003, Dawson 2006). Other studies refer to the need for valid and reliable assessment tools which are transparent and fair (Norman *et al.* 2002).

Those studies which explored the reality of how mentors assessed students found that they used pragmatic, yet sophisticated, techniques which examined both qualitative and quantitative aspects of being a nurse (Dawson 2006). This provided scope to assess unforeseen (Lambert and Glacken 2004), complex, multi-faceted, dynamic aspects of practice (Duffy 2006), without being constrained by predetermined, “micro-level criteria” (Fade 2006:366). Initially mentors were found to focus on personal attributes, psychosocial abilities, and emotional intelligence, in judging whether students had mastered the art of nursing (Dudek *et al.* 2005, Wilson and Carryer 2008, Webb and Shakespeare 2008). However, when it came to justifying a fail decision, they articulated this through reference to unsafe practical skills and knowledge deficits because these were easier to substantiate. Hence, fail decision were usually verified through criteria related to the science of nursing (Hrobsky and Kersbergen 2002).

3.4.3.4 Recording decisions

Producing documentary evidence of a student’s ability, or inability, to demonstrate competence was regarded as a time consuming, tedious process. However, it was considered necessary in a culture where mentors needed to be able to defend their decisions. Dawson’s (2006) study strongly rejected the tick-box structure for recording competency achievement, and found that mentors preferred a

narrative approach when portraying students' practical aptitude. This provided a more authentic assessment of nursing activities, and reduced the feeling of having to fit student accomplishments into predetermined performance criteria. Brown's (2000) earlier work alluded to similar principles, suggesting that mentors became much more dynamic and unfettered when they were not constrained by categorising students' abilities. Neary (2000) suggested that learning outcomes and competencies fitted best with development planning rather than assessment processes. She recommended implementing a, "responsive assessment scheme" (Neary 2000:8), which evaluated students' personal growth. She suggested that this better tallied with the fluctuating levels of performance it was reasonable to expect of students, in placements of varying complexity. Investigations concerned with the legal issues indicated the necessity for documentation to be factual, specific, and non-judgemental (Smith *et al.* 2001), if it was to stand up to intensive and repeated scrutiny (Dudek *et al.* 2005).

3.4.4 Effectiveness of Infrastructure

3.4.4.1 Peer support

A number of studies identified co-workers as a valued source of support (Atkins and Williams 1995, Phillips *et al.* 1996, Twinn and Davies 1996, Neary 1997/2001, Burgess *et al.* 1998, Duffy 2000, Watson 2000, Sharpe 2000, Pulsford *et al.* 2002, Dudek 2005, Fade 2006, Luhanga 2006, Cleland *et al.* 2008). Buddy systems (Sharpe 2000) and team mentoring helped to reduce feelings of isolation (Neary 1997), assisted in workload management and were useful when composing written reports (Neary 2000). Peer support groups were identified as helpful in exchanging ideas and gaining reassurance (Atkins and Williams 1995). Mentors reported that having a second opinion about a student's level of competence was a major source of support (Burgess *et al.* 1998). Mentors who did not obtain confirmation from colleagues about their concerns were unlikely to fail students (Dudek *et al.* 2005).

More experienced colleagues facilitated the development of new mentors. They did this by discussing how competence might be demonstrated in the practice environment and offering insight into the cultural norms of assessment in particular practice settings (Fade 2006, Cleland *et al.* 2008). Experienced mentors could help by sharing their experiences, suggesting strategies and providing moral and emotional support (Skingley *et al.* 2007). Whilst mentors expressed gratitude to colleagues they also expected more formal support (Duffy 2000).

3.4.4.2 Management backing

Brenan and Hutt (2001) argued that student nurse education and assessment should be embedded in clinical staffing infrastructures. Duffy (2006) found only one mentor who felt she had received sufficient support from her line manager when failing a student. Pulsford *et al.* (2002) also identified a lack of managerial support for mentors. Cameron-Jones and O'Hara (1996) recognised that the mentoring role was demanding, and that staff who undertook this function needed a considerate manager who was aware of the challenges. However, Sharpe (2000:17) noted that, "such management required a shift in the organisational culture towards a learning environment", and this necessitated an organisational will to equip managers with such expertise. Fade's (2006) study recommended broader departmental ownership of assessment systems which would demonstrate organisational commitment to mentoring. Furthermore, this would improve preparation of the future workforce and ultimately enhance patient care, which is the primary purpose of the nurse.

3.4.4.3 Onsite facilitators

The role of clinical link nurses emerged after schools of nursing moved into higher education (Williamson and Webb 2001). Titles varied (Lambert and Glacken 2004) and there was no consensus about the nature of the role. Nevertheless, clinical link nurses were regarded by mentors as invaluable sources of advice, moral support, and mediation skills (Duffy and Watson 2001). The more frequently clinical link nurses visited or telephoned mentors, the more helpful mentors perceived them to be (Watson 2000).

Where organisations invested in clinical link nurses, mentors were more comfortable in their role (Luhanga 2006), and felt reassured by their help (Myrick and Yonge 2005). Dudek *et al.* (2005) identified the components of the clinical link nurses role which practitioners found helpful when faced with an underperforming student: being a point of contact; clarifying steps in the assessment process; advising on how to break bad news; putting information into a cohesive written format; keeping students who challenged decisions in check; and handling appeals processes. When the person fulfilling the link role was consistent, strong relationships were built, and maintained, which underpinned mentors' sense of support. (Cahill 1997, Myall *et al.* 2008).

3.4.4.4 Partnership with Universities

Although practice constitutes up to 50% of health care students' preparation (NMC 2004), Ilott (1996) found that it only took up only 11% of academic resources. Hawe (2003) noted that lecturers viewed practical assessments as serving an encouraging and affirming purpose, rather than a gatekeeping function. More recent studies reaffirmed the low standing which practice was accorded and recommend that higher status should be given to practical assessment, with less emphasis being placed on academic achievement (Luhanga 2006, McCarthy and Murphy 2008).

Strong links between practice and HEIs have been shown to bolster mentors' confidence in their assessment ability (Hrobsky and Kersenberg 2002, Dudek *et al.* 2005). Universities which facilitated a consistent flow of information (McCarthy and Murphy 2008) between placements increased the ability of mentors to identify, "consistency of performance" in students (Orchard 1994:325, Burgess *et al.* 1998, Duffy 2003). This improved collegial relationships between clinical and educational staff (Myall *et al.* 2008). However, this support has been shown to be patchy. Duffy *et al.* (2000:37) noted that mentors reported, "rarely seeing any staff from university". She advised that progress needed to be made in identifying and developing the role of the nurse teacher in practice (Duffy and Watson 2001) so that the information, support and feedback, that mentors indicated they needed, could be provided (Pulsford *et al.* 2002).

Grievance and appeals hearings were also seen to undermine effective partnership working. HEIs were often found to alter or overturn mentors' judgements (Orchard 1994, Hawe 2003, Scholes and Albarra 2005, Skingley *et al.* 2007). When this happened, mentors felt compromised and worried that unsafe professionals had been allowed to register despite their efforts (Rittman and Osburn 1995). Disregarding feedback from mentors was observed to be the norm, rather than an exceptional circumstance, which, "constituted evasion of professional responsibility" by universities (Hrobsky and Kersbergen 2002:552). This undermined the trust mentors had in university support mechanisms (Twinn and Davies 1996), even when these were delivered with good intentions (Phillips *et al.* 1996).

Amendments to appeals and grievance procedures may improve practitioners' confidence in university processes. Recommendations include: eliminating overlap of personnel on panels at each ascending level of the appeal process; the provision of guidelines to everyone involved in the appeal process, rather than just students (Orchard 1994); and formal feedback to practitioners on the outcome of appeals (Duffy 2006). However, Beeman (2001) emphasised that the power dynamic between HEIs and practice would have to change if mentors were to be convinced that they were genuinely regarded as a credible part of the pre-registration nursing assessment process.

3.5 LITERATURE FROM 2009 ONWARDS

Recent evidence suggested that, despite Duffy's (2003, 2006) work being widely disseminated, discussed and acted upon by the NMC (2006, 2008a), mentors continued to be reluctant to fail students. This demonstrates that establishing a problem exists is not enough. Duffy (2014) has endorsed Hunt *et al.*'s (2012: 354) view that, "continued development of processes which support assessors to fail underperforming students is essential to promote public confidence". Gainsbury (2010) reported that 37% of 1945 mentors surveyed would not fail a student, even if they had doubts about their competence. Mead (2011) noted that 10% of the 94 mentors who participated in

her study felt the same way. Brown *et al.* (2012) identified that 18% of 1790 mentors admitted that they had passed underperforming students. Mentors' reasons for doing this included: lack of support; lack of confidence; struggling to demonstrate that concerns were valid; and anxiety that their decisions would be overturned. Recent studies have recommended development of support processes. In particular, Jervis and Tilki (2011) noted the need to enhance mentors' confidence and skills in: delivering difficult messages; maintaining empathy, respect, sensitivity and dignity when giving negative feedback; and encouraging mentors to reflect on their own values, beliefs and preconceptions. The National Nursing Research Unit has produced papers about the mentoring role (Chandan and Watts 2012, Robinson *et al.* 2012) which reflect some of the concerns and recommendations which have already been discussed in section 3.4. Robinson *et al.* (2012) also asked some challenging questions about the future direction of mentoring in the UK (Table 3.2).

- Should all nurses be mentors, or should this be developed as a specialist pathway?
- Should senior mentoring posts be created for the sole purpose of assessing students?
- How can PEF roles best be financially supported?
- How can joint working practices between HEIs and PEFs best be developed?
- How might support approaches best be developed to meet the needs of independent sector placement providers?
- How can the time intensive nature of mentoring be best managed during a period of increased financial pressures?
- Does one year post registration experience give mentors sufficient time to develop adequately to take on the mentoring role?
- Are on-line mentor programmes an effective way to prepare mentors?

Table 3.2 Debating and deciding on the future directions of mentorship (Robinson *et al.* 2012)

Duffy (2014) has recommended that these questions should be debated widely. NHS Education for Scotland (2013) has also advocated implementing processes to: identify and select mentors; develop a common understanding of the supervisory role of mentors; and guide the continuing professional development of mentors.

The international debate surrounding the difficulties of assessing student nurses' practical abilities has also grown over the last six years. Much of this has focused on the emotional challenges of mentoring underperforming students. The most prolifically published researcher in this area is Luhanga, who has undertaken a number of studies in Canada (Luhanga 2006, 2008a, 2008b, 2010a,

2010b, 2011, 2012, Laroque and Luhanga 2013). Her most recent work focuses on the emotional support needed by mentors, and the organisational interventions which can facilitate this. Schaffer (2013) has reported on mentor burnout in the USA. Other vocational professions have also continued to investigate the practical assessment of students. Social workers, in the UK, have been particularly focussed on identifying solutions to the challenges this offers (Finch 2009, Matthews *et al.* 2010, Basnett and Sheffield 2010, Parker 2010, Finch and Polletti 2013, Finch *et al.* 2013, Poletti and Anka 2013, Rawles 2013, Robertson 2013, Schaub and Dalrymple 2013, Simpson and Murr 2013). Finch (2009) observed the consequences of becoming emotionally caught up in the fail situation, and noted that mentors who remained objective were able to cope more effectively. Basnett and Sheffield (2010) reported on the physical and psychological impact of being isolated when mentoring a failing student and also recommended further support for mentors.

Finch (2009) also noted the difficulty of using a competency model to assess, and questioned if it was possible to itemise social work practices into discreet constituents. Cassidy's (2009a:3 and 2013) on-going investigation examines this in nursing; his preliminary findings indicated that, "valid subjectivity" is a practical assessment mechanism worthy of further exploration (Black *et al.* 2013b). This might help mentors to balance the objectivity of competency based assessment with intuitive recognition of unsafe students (Cassidy 2009b).

The public enquiry into events at the Mid Staffordshire NHS Foundation Trust (DH 2013a) and the subsequent review of 14 other NHS Trusts (DH 2013b) have added to this debate. The rising number of fitness for practice referrals made to the NMC about recently registered nurses and the findings of the Willis report (RCN 2012) have also contributed to this discourse. Therefore, as this study reaches its conclusion, a body of evidence has evolved regarding the experiences of those failing student nurses in practice. This newer evidence has been reviewed, compared and themed around the categories which have emerged from this study, and is explored and discussed more fully within these categories, which are presented in later chapters.

3.6 CHAPTER 3 SUMMARY

This chapter has presented the strategy employed to search for literature relevant to phase two of this study. It incorporated a thematic review of the literature available up to 2008 which specifically focused on supporting mentors who had failed students in clinical assessments. The review incorporated international evidence from nursing and other vocational professions. A short overview of the growing body of evidence that specifically focused on failing students in practice, which emerged whilst this study progressed (2009 onwards), was then presented and will be examined further in later chapters.

Chapter 4

Phase 2 - Methodology, Method and Model

4.1 INTRODUCTION

This chapter presents the methodology selected for phase two of the study - Grounded Theory (GT) (Corbin and Strauss 2008). It explains how this qualitative approach was interpreted into a method which was employed in the field. The chapter concludes with a brief overview of the substantive theory, 'Standing Securely'. Reflective commentary is interspersed throughout this chapter, identified by the use of the first person in the narrative.

This second phase of the study set out to explore the factors that enabled mentors to fail underperforming student nurses in practical assessments. Phase one of this study showed that this was far less likely to happen than failing a student in a theoretical assessment (Hunt *et al.* 2011). The purpose of phase 2 of this study was to:

1. Investigate the factors that influenced the role and function of those involved in failing student nurses in practice in England.
2. Formulate a proposition that would inform both the future preparation of assessors and the assessment of nursing practice.

4.2 CHOOSING GROUNDED THEORY METHODOLOGY

4.2.1 The Development and Divergence of Grounded Theory

Grounded theory is informed by the disciplinary traditions of American pragmatism (Mead 1934) and symbolic interactionism (Blumer 1969). Locke (2001) suggests that symbolic interactionism is best thought of as a way of working through the American pragmatist view of the world. The word pragmatic denotes action. The pragmatist view is that debating ideas and beliefs has merit if it produces practical answers about the actions to be taken next (Stern and Porr 2011). Hence, the meaning of an idea or belief is dependent on what people do because of it.

Symbolic Interactionism explores how people develop, use and interact with an intricate range of symbols to make meaning, communicate and share experiences (Plummer 2000). Symbols are considered to be anything that a person may encounter in the world and so covers diverse entities such as: words, gestures, roles, rules, objects, institutions, people, ideals, and virtues (Stern and Porr 2011). Researchers should therefore endeavour to understand the world in the way that the participants make sense of it, by focussing on how people create meaning through the symbols that shape and represent their world (Blumer 1969).

Anselm Strauss and Barney Glaser are considered the founding fathers of GT (Morse *et al.* 2009, Bryant and Charmaz 2007). The purpose of GT is to generate new theory rather than test existing theory. The emergence of GT resulted from collaborative work between Strauss and Glaser in a study about dying (Bryant and Charmaz 2007). Both had personal interest in this area through their unsatisfactory experiences of a relative dying (Stern 2009). Glaser drew from the quantitative tradition and Strauss from qualitative epistemologies. Blending their different research traditions, they devised a new research approach which used social processes and field work (Stern 2009). One of the cornerstones of the methodology is the use of constant comparison to link theory generation closely and continuously to the raw data. This provides an internal check and challenge to the trustworthiness of the researcher's interpretation and analysis (Birks and Mills 2011).

There are diverse explanations about the essence and conduct of GT and this can make it difficult for novice researchers to design a rigorous study, but there is a consensus about some key principles that characterise a GT study. These include: initial coding and categorization of data; concurrent data generation and analysis; memo writing; theoretical sampling; constant comparative analysis using inductive and abductive logic; theoretical sensitivity; intermediate coding; identifying a central category; theoretical saturation; and theoretical integration (Morse *et al.* 2009). All these characteristics guided the design of this study.

4.2.2 Rationale for Choosing Grounded Theory Methodology

A number of things were taken into consideration when selecting a suitable methodology. Firstly, I reflected on my own assumptions and beliefs and then attempted to identify a research philosophy which matched with these. Various approaches were considered and practical considerations were also taken into account about the appropriateness of the research method to the area being investigated.

4.2.2.1 Selection of Grounded Theory

At the outset of this study little was known about the factors which influenced the roles and functions of mentors who had failed student nurses in practical assessments. An approach which gave meaning to, rather than measurement of, key actors' views about what had helped them to do this was considered most appropriate, and so a qualitative approach was chosen (Holloway and Wheeler 2009). Qualitative approaches are concerned with understanding behaviour/experience and investigating the meanings people give to these (Holloway 2008). The five qualitative approaches described by Cresswell (2013) were considered. The selection process used is demonstrated in Table 4.1.

QUALITATIVE APPROACH	INVESTIGATES	AIMS TO	APPROPRIATE FOR	SUITABILITY TO THIS STUDY
Grounded Theory	Shared meaning and actions. (Holloway 2008)	Explore “What’s going on”. (Glaser 1992:41)	Investigating an area where little is known. Offering explanations. (Corbin and Strauss 2008)	Allows an explanatory framework to be developed. Produces theories which offer practical actions and consequences. DECISION: ACCEPT
Narrative	Individual identities and experiences. (Clandinin and Connelly 2000)	Co-construct stories, identify turning points specific to a time and location. (Denzin 1989)	Studying the detailed experience of an individual. (Riessman 2008)	Concerned with one individual. Does not generate an explanation of necessary actions. DECISION: REJECT
Phenomenology	The essence of a person’s experiences as they exist within the individual’s consciousness. (Husserl 1913)	Uncover patterns, relationships and meaning related to a particular experience. (Moustakas 1994)	Exposing deep issues. Challenging taken-for-granted meanings. Enhancing understanding of experiences. (Cresswell 2013)	Could enhance understanding of the mentor experience but not explain it. DECISION: REJECT
Ethnography	Culture sharing of a particular group in their natural surroundings. (Harris 1968)	Study group norms, values and behaviours from the group’s perspective. (Wolcott 2008)	Explaining common social processes in a cohesive group. (Fetterman 2010)	Participants could not be considered a cohesive cultural group. Failing not a common occurrence. DECISION: REJECT
Case Study	A particular unit within a culture. (Yin 2009)	Study norms, values and behaviours from the perspective of the chosen case. (Cresswell 2013)	Studying particular cases thought to be of specific interest. (Stake 1995)	Currently unclear which participants may be of particular interest. DECISION: REJECT

Table 4.1 Selection of Qualitative Approach

Until the time this study commenced, research in this area had predominantly focussed upon mentors' reluctance to fail students, rather than on factors helping mentors to fail an underachieving student. GT was appealing as a methodology because it offered scope to explore, "what [was] going on" (Glaser 1992:41) and was a recommended approach when investigating a little researched area. GT also has the capacity to offer explanations (Holloway and Todres 2009). Its grounding in symbolic interactionism fostered generation of meaning by examining the interpretations people gave to their experiences and exploring how they interacted with each other (Holloway 2008). GT was ultimately selected because it appeared most likely to support the research aim: to explore the actions and circumstances which had satisfactorily enabled mentors to fail an underperforming student nurse. Moreover, it had the potential to produce theories about practical actions related to nursing education and practice (McDermid 2006). As Corbin (2009:25) suggests, I wanted to develop theory that would be, "useful", and which might help to, "make the world a better place".

4.2.2.2 Positioning Oneself in the Study

Corbin and Strauss (2008:32) argue that, "objectivity in research is a myth". Past experiences, knowledge and biases all become drawn into the research process, but rather than objecting, they recommend using this to enhance sensitivity (Denzin and Lincoln 2011). From this perspective having insight into the area to be studied, through my experiences as a service user and a practical assessment co-ordinator, gave me an advantage because my mind was already tuned in (Dey 1999). This could enhance my sensitivity to issues and problems from the participants' perspective. Openly acknowledging my own pre-existing knowledge, beliefs and biases helped me to avoid forcing preconceived ideas upon data, whilst also giving transparency to the study. This could assist readers in judging my ability to tune in to and interpret participants' voices. At the commencement of the study I reflected on my own preconceptions. I noted these so that they could be reviewed later in the study to evaluate their intrusion into the research process.

The methodological principles set out by Corbin and Strauss (2008) were chosen as the principal text to guide this grounded theory study, with Birks and Mills (2011) text acting in a supporting role.

4.2.3 Essential Components of Grounded Theory

Myers (2013:35% e-book) defines GT as, “a qualitative research method that seeks to develop theory that is grounded in data systematically gathered and analysed”. This research method has a specific approach in which there is continuous interplay between data collection and analysis. The iterative nature of GT method requires the researcher to follow a procedure in which a number of elements of the process interact as the study spirals towards theory development, processes do not occur chronologically, and several are often occurring simultaneously (Corbin and Strauss 2008). The theory generated may be either substantive or formal. A substantive theory is specific to the people, group and place studied. A formal theory is more abstract and generalisable to a wider population (Glaser 2007). The ten hallmarks of grounded theory methodology will now be explained.

4.2.3.1 Initial or Open Coding and Categorisation of Data

(See glossary for full definitions of codes, groups and categories referred to in this section).

Corbin and Strauss (2008:195) refer to the initial phase of coding as, “open coding” (see Table 4.2). Open coding involves line by line examination of data, identifying words and phrases which seem significant and assigning labels to these. As the interpretive phase proceeds, and links are drawn between them, open codes are then grouped into conceptual groups, and then on into sub-categories and a label is ascribed to each (Myers 2013). These can be seen as building blocks which continue to be clustered as relationships between them become apparent (Urquhart 2013). From this process, macro-categories eventually emerge which encompass several related groups; see Figure 4.5 on page 81 for an example from this study. Data collection continues until no new codes are emerging from the data.

Type of Coding	Conceptual Level	Procedure	Purpose
Open or initial coding	Descriptive	Line by line coding of data examining 'what it is telling you' (Corbin and Strauss 2008: 33). Asking questions of the data to discover: What? Who? How? When? Why? Summarizing text with concise code names. (Myers 2013).	Development of basic conceptual constructs.
Intermediate coding	Interpretive	Identifying relationships between codes and incrementally grouping these together to form categories (Corbin and Strauss 2008). Categories should demonstrate characteristics, variations, properties and dimensions (Birks and Mills 2011). Consideration of the nature of relationships between categories (Myers 2013). Identification of central category and the relationship of categories to it (selective coding).	Refining and relating conceptual constructs.
Theoretical or advanced coding	Theory Formulation	Identifying causal and/or correlational links between categories. Drawing inferences from this which offers explanations. Engagement of the emerging theory with existing literature (Corbin and Strauss 2008).	Generation of theory which emphasises key relevant aspects and makes prediction possible.

Table 4.2 Phases of coding in grounded theory

4.2.3.2 Concurrent Data Generation and Analysis

Once the first data has been analysed, further data is collected and analysed. This continuing analysis involves both coding the new data and comparing it to previous data and codes. In this way categories develop as dimensions and properties are uncovered. This process continues in an iterative spiral as the grounded theory begins to emerge. This is the key characteristic that differentiates GT from other research designs (Birks and Mills 2011).

4.2.3.3 Memo Writing

Memos are written as an on-going process from the planning stage of the study onwards (Glaser 1992). These have been described as conversations with the self and provide an audit trail of thinking as analysis progresses. Researchers are advised to capture thoughts as they occur and not

to be overly concerned about eloquence and composition since these can be refined later (Corbin and Strauss 2008).

4.2.3.4 Theoretical Sampling

As open codes are merged and begin to form into categories the researcher makes strategic decisions about where to sample next (Corbin 2009). This is driven by the search for more information to explain the properties and dimensions of categories and the relationships between categories. This helps to feed the constant comparison technique (See 4.2.3.5). Memos, at this stage, make explicit the decision processes around selecting information rich sources (Birks and Mills 2011).

4.2.3.5 Constant Comparative Analysis

Constantly comparing data is crucial in GT methodology. All incoming data is compared with that already collected to check for similarities and differences. This includes absence as well as presence of data (Corbin and Strauss 2008). The codes and categories generated are grounded in the data. In this way the breadth, depth and nuances of concepts emerge to offer a deeper interpretation (Myers 2013). Both inductive and abductive analysis drives decision making when constantly comparing data (Birks and Mills 2011). In inductive reasoning, a probable conclusion is drawn by generalising from a set of premises, and a cogent argument is offered based on the available evidence (Urquhart 2013). Abductive reasoning requires a creative leap, in which the best available evidence is used, to generate the likeliest explanation (Bryant and Charmaz 2007). Constant comparative analysis is used continually to test and refine the conclusions from both types of reasoning (Corbin and Strauss 2008).

4.2.3.6 Theoretical Sensitivity

Theoretical sensitivity relates both to the researcher's personal life-experiences and the empirical theories which they have absorbed (Birks and Mills 2011). As a grounded theory develops it must

continue to resonate with the data from which it is emerging. The researcher must become immersed in the data to increase their capacity to: recognise possible meanings, understand and interpret these, and to isolate what is pertinent (Otkay 2012). Awareness of subjectivity drives a reflexive process of continuous challenge for the researcher. This provides an on-going internal checking process to help maintain internal validity and reliability, thus supporting a rigorous process that is trustworthy and reliable. This helps the researcher to move away from personal biases and assumptions which may force the data into preconceived expectations (Morse et al 2009). The data can then be viewed in new and more creative ways which can help to reveal the previously unseen essence of a phenomenon (Urquhart 2013).

4.2.3.7 Intermediate or Axial Coding

In their earlier iterations of GT Strauss and Corbin (1998:123) referred to the intermediate phase of coding as, “axial coding” (see Table 4.2). By 2008, they had concluded that differentiating open and axial coding was artificial, both went, “hand in hand” (Corbin and Strauss 2008:198). However, intermediate coding cannot begin to occur until some open coding has taken place. As the study progresses, and iterative processes develop, coding might take place on several levels simultaneously. Hence, whilst it is useful to differentiate between phases of coding for explanatory purposes, it is difficult to separate them during analytic processes (Corbin and Strauss 2008).

4.2.3.8 Identifying a Central Category

A central category is identified which encapsulates the grounded theory as a whole. It should encompass and explain all subsidiary categories by drawing them together and appear often in the data (Corbin and Strauss 2008). It must fit closely with the original data and be an accurate, yet abstracted, representation of participants’ voices. This category should develop increasing explanatory power as the other categories are related to it (Birks and Mills 2011).

4.2.3.9 Theoretical Saturation

Theoretical saturation is closely linked to theoretical sampling. It involves continuing to theoretically sample until no new insights are emerging from the data. Corbin and Strauss (2008:149) advise that categories should be developed to a point where they offer, “considerable depth and breadth of understanding about a phenomenon and relationships to other categories have been made clear”. Birks and Mills (2011) suggest that this abstract notion can be judged to have occurred when a central pattern or theme has emerged, which makes sense to the researcher, and nothing further is being contributed to this by additional data. Theoretical sampling should only halt when this is judged to have been achieved.

4.2.3.10 Theoretical Integration

Achieving theoretical integration involves identifying causal and/or correlational links between categories (Myers 2013) (see Table 4.2). Inferences should be drawn from these links to present a comprehensive explanation which addresses variation in the data. A storyline technique is often employed to integrate and present the theory in an accessible format (Corbin and Strauss 2008). This provides a narrative about the central category, and its relationship to all other categories, which has two purposes. Firstly, it helps to refine the coherence and continuity of the theory, and secondly, it helps to convey the theory to the reader in an accessible format. The theory should emphasise key relevant aspects and make prediction possible (Myers 2013).

Theoretical codes derived from existing theories may be used at this point to help position the study within the existing body of knowledge (Urquhart 2013). A framework which demonstrates the relationship between the depth of conceptual analysis and the scope of the theory produced is suggested by Urquhart *et al.* (2010) (see Chart 4.3). Myers (2013:36% e-book) suggests that researchers should try, “to move up along the left axis of the figure as much as they can and as far right as possible”. Hence, the greater the depth of analysis the greater the scope of the theory developed, the widest form being formal theory. Glaser (2007) points out that most novice

researchers produce a substantive theory rather than formal theory. The grounded theory presented here is a substantive theory. It focuses on an applied professional field, “remains close to the real world situation”, and provides a working theory of action related to that context (Darkenwald 1980:67). It may, therefore, be considered transferable to other contexts with similar characteristics, but is not generalizable to the wider population.

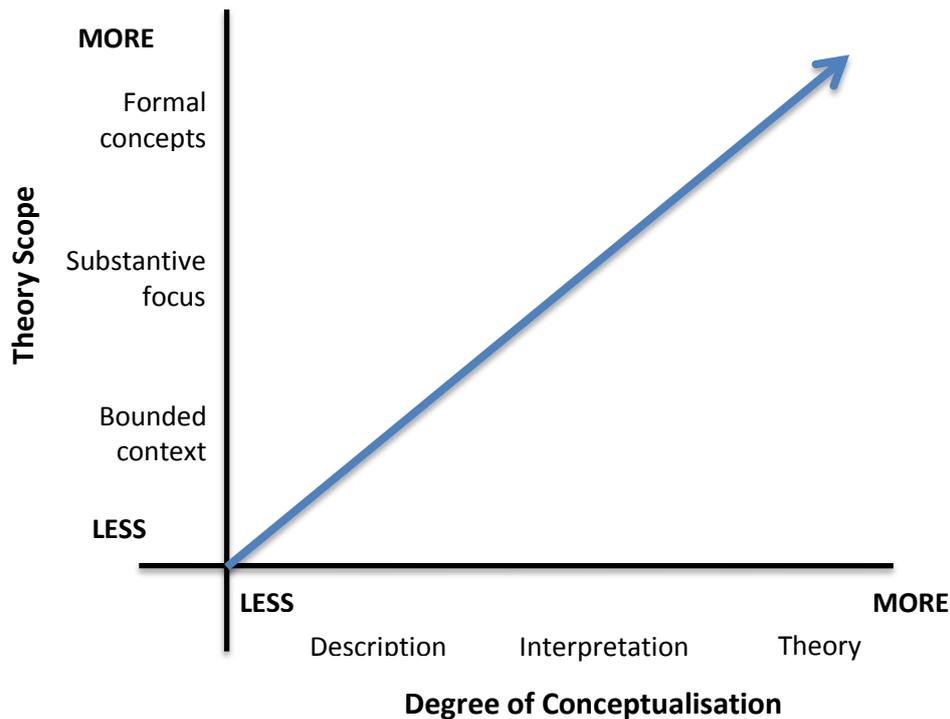


Chart 4.3 A Framework for theorising in grounded theory studies (Urquhart *et al.* 2010)

4.2.4 Criticism of Grounded Theory

This section offers a brief overview of some of the common debates which have occurred around GT methodology and considers how these might inform the design of a GT study. Burrell and Morgan (1979) note the debate which surrounds the quality and rigour of GT. They argue that this arises because positivist and interpretivist paradigms do not share common language or values. Lincoln and Guba (2000) maintain that the notion of validity cannot be used to judge qualitative research, and the criterion for evaluation should be trustworthiness. In an attempt to bridge the differences, Gasson (2004) maps the four traditional quality measures of positivist research; objectivity,

reliability, internal validity and external validity, to the interpretivist alternatives; confirmability, auditability, authenticity and transferability. All four measures should be clearly in evidence for any claim of rigour to be made.

As Glaser and Strauss' work on GT diverged, differences between the two were made public. Melia (1996) remains unclear as to whether there are critical differences between the two positions, or whether Glaser and Strauss' ideas were the same notions put in different ways. This also seems to be the conclusion of more recent debate (Morse *et al.* 2009). Birks and Mills (2011:5) suggest that because gaps exist in seminal texts about GT, researchers have been left to "figure out what was... 'going on' ontologically and epistemologically". Because the methodological gaps have only recently been filled, second generation GT researchers had to develop their own methodological positions. This has led to the variety of GT methodologies which exist today. Both Corbin (2009) and Birks and Mills (2011) further advise that it is counterproductive to argue for one genre of grounded theory against another. However, an essential set of methods must be in evidence, in the design of a study, for it to be considered grounded theory methodology.

4.2.5 Evaluating the Quality of a Grounded Theory Study

Glaser and Strauss (1967) argue that the most effective test of quality in a GT study is how useful it is in practice. Nevertheless, the researcher must aim for quality at all stages of the process. Corbin and Strauss (2008) recommend using Charmaz's (2006) criteria to evaluating grounded theory studies because they are comprehensive, and include both scientific and creative benchmarks. They are elements are arranged into four groups: credibility, originality, resonance and usefulness. This study will, later, be evaluated using these criteria (Chapter 11).

4.3 ETHICAL CONSIDERATIONS

In any research study there is a necessity to meet standards for ethical conduct. There is a responsibility to consider potential harm to participants. The study must be designed to mediate against this (Oktaý 2012). Olesen (2007) notes the lack of direction in GT literature regarding ethical considerations. Both Olesen and Oktaý attribute this to the era in which the seminal texts were authored, suggesting that, in the intervening years, concern and awareness regarding the way in which research is conducted has developed. Glaser (1994) and Strauss (1987) both offer only one page of guidance regarding ethical considerations in GT. Therefore, the principles identified by Beauchamp and Childress (2013) and the research framework (DH 2005) provided further structure for ethical considerations.

Justice required that all participants in this study were treated fairly, equitably and appropriately. This was regarded as the overarching principle which informed the other principles.

Respect for autonomy ensured that individuals had the right to make decisions and choices free from pressure or coercion. All potential participants were provided with information about the study on which to base their decision regarding whether or not to participate (Appendices 4.01). This included information about how the results were to be used, an undertaking to preserve anonymity, and an assurance of the right to withdraw at any time. Consent was sought in writing and a cooling off period was built in. Permission was sought from participants to voice-record, transcribe and use extracts from their data in the final thesis and other reports about the study (Appendix 4.02). No participants were identified in any way.

Nonmaleficence obliged the researcher to ensure that, as far as reasonably possible, individuals did not suffer harm as a result of participating in this study (Beauchamp and Childress 2013). A risk assessment was conducted (Appendix 4.03) in preparation for the ethical review and supportive arrangements were prepared for participants, including a resource detailing appropriate sources of help (Appendices 4.04). All data were kept in a secure environment and not stored on the hard drive

of a computer. External hard drives and USB memory sticks were password protected. Anonymity was maintained by labelling recordings and transcripts of interviews with a code, to protect confidentiality. Audio recordings and transcripts were stored in a locked safe, in the researcher's home. Consent forms and personal information were also locked away in a secondary safe, in a different location, in the researcher's home (Polit and Beck 2004). It is intended that data will be destroyed five years after the study has been completed, as directed by Birmingham City University, Faculty of Health policy.

A transcription service (TS) was used to process audio recordings. The company held a formal contract with the Faculty of Health at Birmingham City University, so quality standards were well defined. The TS web site provided a 256BIT encryption certificate and was 'hack tested' on a regular basis; servers had software and hardware firewalls. Audio recordings were uploaded via this web site for transcription. The TS provided e-mail notification when each transcription was complete and each was then securely downloaded. The terms and conditions of the transcription service included full data protection. A further nondisclosure agreement between the two parties was also set up which incorporated a confidentiality undertaking .

Fidelity required the researcher to act in good faith. Trustworthiness and dependability of data was achieved through maintenance of a reflexive diary, field notes, memos and on-going comparisons. In this way, the researcher aimed to provide an explicit decision trail, which readers of the study could use, to decide if the research was rigorous.

Beneficence necessitated ensuring, as far as reasonably possible, a positive outcome for participants. It was anticipated that being interviewed might be of benefit to individual participants as it offered a unique debriefing opportunity, which might not have, ordinarily, been provided. One of the aims of this study was to provide an explanation about how mentors could be supported in their decisions to fail underperforming students in practical assessments. For nursing, this is expected to make a

positive contribution to the maintenance of professional standards and to public protection. There may also be wider applications to assessment within other professional fields.

Sponsorship and ethical approval for the study were provided by the Faculty of Health, Birmingham City University. Further ethical approval was sought from HEIs and NHS Trusts as the study progressed. A wide variation in requirements was noted when seeking approval from HEIs. Some were satisfied with the approval granted by Birmingham City University, others required partial or full approval by their institutions' own ethics committees. Ethical approval was obtained from 7 further HEIs. Approval was gained from NRES Committee, West Midlands – Solihull, and 7 further governance approvals were obtained from various care organisations. Some participants contacted the researcher directly, having heard about the study from colleagues or friends, and requested to be interviewed outside their work environment, in their own time. These cases were considered to be safeguarded by the original sponsorship and ethical approval obtained from Birmingham City University. The participant's employer was not approached in these cases (Appendix 4.05, 4.06).

4.4 GROUNDED THEORY METHOD

Stern and Porr (2011) advise that whilst a GT study can tentatively be planned in advance the researcher should not pre-construct the path the research will take. The trajectory of the study will be governed by such decisions as where to sample next and which codes and categories to pursue. This section, therefore, describes the 'fine-tuning' and adjustments which were made, to the planned method, whilst working in the field.

4.4.1 The Sample

An initial sample was identified using purposive sampling (Section 4.4.1.2), and then, as the study progressed, theoretical sampling (Section 4.4.1.3) was directed by the categories that emerged.

Sampling stopped when categories were well developed and saturation (Section 4.4.1.4) had been achieved.

4.4.1.1 Recruitment

Recruitment of participants was initiated using links that had been established with HEIs across England during phase one of this study. Each University was, again, invited to participate in phase two of the investigation. Those which responded positively were asked to circulate a recruitment poster, usually via e-mail, but sometimes also by hand (Appendix 4.07). The governance departments of NHS and private sector organisations, who expressed an interest in the study, were approached for approval. Individuals who wished to participate directly self-referred and were recruited as appropriate, in line with the focus of purposive and theoretical sampling (Section 4.4.1.2 and 4.4.1.3).

4.4.1.2 Purposive Sampling

Mentors, lecturers and practice education facilitators are all involved in the practical assessment of student nurses. Purposive sampling was used to recruit the first participants from all three of these groups. The criteria for selection were:

- that participants had experience of failing a student nurse in a practical assessment,
- that this had happened in England,
- informed consent was given.

Volunteers from three separate organisations, representing three fields of nursing, were initially recruited.

4.4.1.3 Theoretical Sampling

Theoretical sampling commenced after the first interviews had been undertaken. Participants who could provide information about areas of interest were sought. For example, support from a mentor's mentor seemed to emerge early in the interviews as an important factor, so theoretical

sampling sought clarification of the scope and function of this role. Theoretical sampling also required looking for disconfirmatory data, or participants whose experience might vary from the purposive sample; for example, in this study, lone nurses in care homes and practice nurses who might have difficulty accessing a formal practice education facilitator. Information rich cases were selected to assist in the development of categories; this guided the trajectory of the study (Morse 2007).

At times, I felt emotionally challenged, because participants whom I had interviewed expressed gratitude about having access to a concerned listener, and said it had been helpful to talk about such a difficult situation. On numerous occasions I was asked to return to talk with their colleagues, who had also failed students, because of the beneficial impact of being able to 'off load' and 'vent'. I found it hard to resist the temptation to offer personal help to these mentors and manage the researcher/colleague boundary. The supportive resource (Appendix 4.04), which had been developed for such situations, was some help in dealing with the guilt I experienced. At these times I also reminded myself of the long term aim of the study, to benefit those who needed help. In order to achieve this, I reaffirmed the need to manage these tensions effectively. Strategies to accomplish this included personal reflection and candid discussion with my director of studies and supervisors.

4.4.1.4. Achieving Saturation

Corbin and Strauss (2008) state that the aim of theoretical sampling is to reach a point where saturation has been achieved; this is generally defined as occurring when interviews are providing no new data to develop categories further (Stern 2007). It was challenging to identify the point of saturation. As a novice researcher, I was anxious that I might prematurely halt data collection and miss something important. Birks and Mills (2011) suggest that saturation is an abstract notion which is probably never fully achieved. Data collection stopped when categories were deemed to be well developed and related to each other, and no major new concepts were emerging which informed

the core category. Further personal reflection, regarding achievement of saturation, is included in Chapter 11.

4.4.1.5 Details of the Sample

A total of 31 participants took part in the study; fifteen assessors, eight practice education facilitators (PEF) and eight university lecturers, who had links with practice areas (see Table 4.4). It became clear, early on, that, although each had been grouped according to their current role, most recalled being a mentor who had failed a student, and reflected on this. Hence, the group formally identified as mentors numbered fifteen, but the number of participants who gave accounts of their mentoring experience was twenty-seven. The roles and boundaries of lecturers and PEFs were also blurred; they often undertook similar roles. Lecturers also recounted memories of working as PEFs. The sample was recruited nationally and was geographically spread across 340 miles, incorporating seven universities, eight NHS Trusts and three private sector organisations. Participants from all 4 fields of nursing were recruited to the study. The sample comprised seven male and twenty-three female participants, who had been engaged in the assessment of student nurses from between six months, to thirty two years. Their year of registration ranged from 1975 to 2009.

Field of Nursing	Mentors	Practice Education Facilitators	Lecturers	Total
Adult	6	5	6	17
Child	3	2	1	6
Mental Health	4	1	1	6
Learning Disability	2	0	0	2
Total	15	8	8	31

Table 4.4 Participants field of nursing and role

I decided not to disclose any further details about participants to protect their anonymity. This was because, as preliminary findings from this study were presented, audiences were very curious and enquired where various events had occurred. The professional and ethical importance of protecting participants from such intrusion has remained important to the integrity of this study.

4.4.2 Data Generation

Semi-structured interviews were the selected method of data collection. Alongside this, field notes, memos and diagrams supplemented analysis as part of the confirmatory process of GT (Corbin and Strauss 2008, Corbin 2009).

4.4.2.1 Interviewing

A check-list and interview guide was devised based on findings from the first phase of this study and the preliminary literature review (see appendix 4.08 and 4.09). This was used to facilitate smooth running of interviews and to assist in collecting uncompromised data (Duffy 2006). The interview schedule was expanded, as the study progressed, to incorporate probes about ideas identified in previous interviews. Consistency of interviews was ensured by retaining all original questions (Birks and Mills 2011).

Since I had not previously conducted qualitative interviews, my preparation involved attending a two day seminar on qualitative interview techniques, at the University of Oxford (Ryan and Griffiths 2010). Feedback was also obtained from colleagues who agreed to participate in mock interviews. This helped me to refine questioning, probing and listening skills. Interviews were voice-recorded and a transcription service was used to produce verbatim, written accounts. Transcripts were returned to participants for checking, amendment and addition of any further thoughts.

Standard questions were included in all interviews but participants were encouraged to talk freely and interruptions were kept to a minimum. I noted key words which required further probing and periodically checked the interview schedule for questions which had not been covered (Corbin and Strauss 2008). Open questions sometimes needed to be formed, without prior preparation, to probe further. I advanced this skill by reflecting on each interview, evaluating my questioning technique, and rehearsing different ways to elicit information (Birks and Mills 2011).

Whilst effective questioning skills were important, setting the climate for open and transparent dialogue was equally essential. This involved engaging participants from the outset and using the skills of attentive listening (Stern and Porr 2011). I aimed to engage participants by endeavouring to generate a friendly and relaxed atmosphere, expressing genuine interest in each volunteer, appreciating that they had taken the time to share their experiences and indicating how valuable their accounts were (Gray 1994). I remained mindful of the need to gauge this for each participant as it could be perceived as patronising. The skills of attentive listening were sitting as still as possible whilst maintaining eye contact, leaning slightly forwards, maintaining an open posture, offering para-verbal and non-verbal encouragement, acknowledging feelings and trying not to distract the speaker when writing brief notes or checking the voice recorder (Stern and Porr 2011). Listening was important, not only to encourage participants to talk, but also to clarifying meaning and note non-verbal cues, which indicated where probing might be useful (Gordon 1997). I found both silence and paraphrase effective at different times, if used with non-verbal signals to indicate that I was interested and listening.

Ryan and Griffiths (2010) advise that the duration of an interview needs to be carefully gauged. Practical issues needed to be considered, including peoples' reluctance to participate in lengthy interviews and the time taken to transcribe these (Glaser 1992). I considered the optimal length of an interview to be one hour; this gave enough time to establish rapport and elicit in-depth data. The length of actual interviews ranged from 32 minutes to 1 hour 22 minutes with the mean length being 56 minutes.

Interviews were arranged to accommodate venues and times convenient to participants; they were geographically wide ranging. On several occasions, when I arrived, I found venues were less than ideal and sometimes challenging. For example, on one occasion the room the participant had helpfully booked was no longer available and instead she had arranged a table and chairs in a large store cupboard to accommodate the interview. However, coping with these snags elicited a level of

camaraderie between me and interviewees which broke the ice and seemed to encourage participants to offer very candid accounts of their experiences.

Because of the long distances travelled, it was sometimes expedient to conduct more than one interview in a day. In these instances participants had been involved in the same fail scenario. This provided a useful illumination of the same event from the different perspectives of a mentor, PEF and link lecturer. I found this immediacy useful as more normally in a GT study, several days would elapse between each round of data generation to allow for transcription, analysis and consideration of theoretical sampling. Birks and Mills (2011) acknowledge that at times there are logistical reasons why there may be reduced opportunities to analyse data in between interviews. They suggest reviewing the voice recording and undertaking preliminary analysis in between interviews. A headset was therefore used to listen to interviews to reduce the possibility of content being overheard while undertaking preliminary coding from the audio file. An up-to-date set of codes derived from previous interviews was used as a comparative checklist and notes made of those which recurred. Attention was also paid to new themes which emerged and these were noted. The interview schedule was annotated as a reminder of areas to probe in the following interview. Birks and Mills (2011:71) suggest that this type of analysis is, "in fact likely to be more effective when undertaken within a short time frame". I found it important to be organised so that sufficient time was allowed in between interviews to undertake this preliminary analysis. I also found that three interviews were the maximum which could realistically be undertaken in a day using this process.

4.4.2.2 Transcription

Oliver *et al.* (2005) note that transcription practices tend to be given superficial attention in GT studies, and neither Strauss nor Glaser advocated transcribing interviews at all (Covan 2007). Stern and Porr (2011:58) suggest that there is no necessity to, "painstakingly ensure that every single word, tone of expression, pause and sigh is accurately recorded". However Corbin and Strauss'

(2008) methodology required initial detailed line by line analysis; it was difficult to envisage a way of undertaking this if a transcript was not available.

A transcription service was used which produced word-processed transcripts within 24 hours of uploading audio-recordings. This service allowed me to provide the transcriber with a simple rubric of how para-verbal utterances and pauses in the dialogue should be recorded (Appendix 4.10). Further detail of speech patterns was not included since it was found distracting. Oliver *et al.* (2005) recommend this method of transcription in GT because it does not focus on the mechanics of speech, but on individual's meaning.

My preferred method of working with transcripts was to study a word-processed version whilst simultaneously listening to the audio recording. This helped to capture emotion and intonation authentically, which assisted in drawing out meaning. This system was advantageous because coding could then take place whilst the interview was still fresh in my mind and it helped me to represent the participants meaning as authentically as possible. However, one of the main disadvantages was that transcribers were not familiar with some of the technical terms participants used which resulted in transcription errors. I amended these errors on the word-processed versions of transcripts. Using a transcription service also allowed me to return transcripts to participants expediently for checking, amendments and additions (see section 4.3). Only two participants requested that small portions of material were not quoted in the final study following sight of their transcript.

4.4.2.3 Field Notes

Field notes were used to record the venue and conditions, as well as particular events including interruptions, requests for the recording to be paused and specific gestures used by interviewees. They also served as an aide memoire regarding participants' responses during pre and post interview episodes, when the recording device was not switched on. As the study progressed, they were used to note relationships with other participants, for example, when it became likely that a student who had been referred to by a previous participant was being discussed again. I also noted my own

responses to, and impressions of, the information and situations which were disclosed. These records were used as material for later, more in depth, reflection and to aid comparison of data (See Appendix 4.11 and Chapter 5.2.3).

4.4.2.4 Memos as Data

I thought of early memos as building blocks which would be reanalysed as data in the later stages of the study (Appendix 4.11). My initial memos were simple and sometimes quite vague, but as the study progressed I wrote memos with more clarity, as complex issues came into focus (Corbin and Strauss 2008). I started writing memos during the planning stage and followed Glaser's (1978:83), "prime rule" that when an idea was sparked I should stop what I was doing and write it down immediately. Hence, I usually had a paper and pen with me, and was unconcerned by the eloquence of each memo, the prime objective being to capture the thought. Memos were noted on all manner of things, such as tickets, receipts and other detritus to be found in a messy handbag. Storage of these was managed by scanning and storing them as electronic copies, the original hard copies were filed. It was reassuring to read Juliette Corbin's anecdotes about similar experiences during her research investigations (Corbin and Strauss 2008).

4.4.3 Concurrent Analysis

Once the first data had been transcribed concurrent analysis began. Open codes were ascribed to each element, within the transcript, which seemed relevant to the research aims. An early attempt to group some codes was made. I did not want to produce an unmanageable volume of codes which might make higher level analysis unduly difficult and result in analytic paralysis (Clark 2005). This is consistent with Corbin and Strauss' (2008) view that open and axial coding go hand in hand. Data generation and comparative analysis continued in an iterative spiral. This meant that each transcript was considered in the light of codes generated previously. Similarities, differences, relationships and context were noted and the breadth and depth of categories began to develop. The interview schedule was reviewed periodically, during the iterative cycle, and updated when necessary.

I regarded it as important to continue returning to the data and checking that the concepts which were emerging remained authentic to participants' accounts. This reinforced the process of constant comparison and helped to retain the focus of the study. It was also helpful to hear the voices of participants regularly, via the voice recordings; this was a strong reminder that I was interpreting their perceptions and not mine.

4.4.3.1. Coding and Categorising

The actual name ascribed to a code seemed important. I wanted these descriptors to encapsulate what was going on in the data in a compelling way, whilst always retaining the participants' meaning. Use of a thesaurus helped with this process. Two forms of coding were used, gerunds and in vivo codes. Gerunds are verbs which have been turned into nouns by adding *ing* (Charmaz 2006). These help to identify process and action in the data. In vivo codes use, "the actual words of research participants" (Corbin and Strauss 2008:65) which helps to preserve participants' meanings. I felt it was important to capture the action in participants' accounts, this would indicate the interventions and enterprises needed to reduce reluctance to fail. I used a reflexive approach to mediate against application of "pet codes" from my own subconscious (Birks and Mills 2011:96). I used the analytic techniques advised by Corbin and Strauss (2008) to aid this (see section 4.4.3.2), particularly "waving the red flag".

Line by line coding of data was useful in the early stages of analysis, however, progression to an overview approach developed as conceptual control of the data was gained. I began noting conceptual group labels (see Figure. 4.5), rather than individual open codes, against sections of new transcripts where they compared to previous data and only coding fresh concepts which emerged.

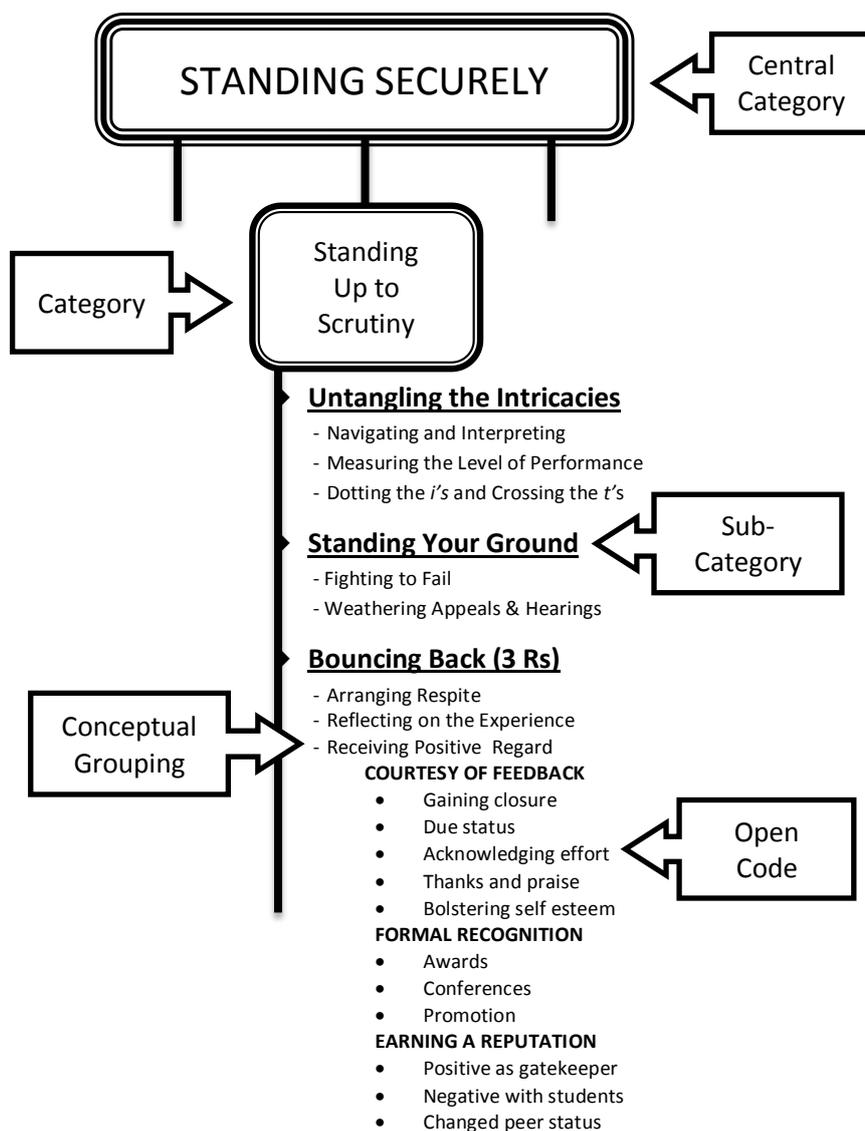


Figure 4.5 Analytical processes - Generating the central category from open codes

Timing this move was important. Glaser (1978) advises caution about prematurely abandoning detailed coding because this increases the risk of missing important elements. However Clarke and Friese (2007) advise that holding on to this method for too long can overcomplicate the process. I took stock when the process began to feel very repetitive and noted that the same open-codes were frequently re-emerging. I concluded that I was being over cautious and this might be inhibiting higher levels of analysis. This reflection helped me develop confidence in identifying relationships and categories then began to emerge. The characteristics and variations of each category were reviewed to ensure they fully reflected the properties and dimensions. Constant comparison

remained a key principle at the intermediate stage of coding and helped to identify gaps in categories, theoretical sampling was then directed towards investigating these gaps.

Diagram 4.5 demonstrates the incremental process of building categories from open codes. This diagram appears simple, but the process was not. Trial and error played a significant part in organising the data into abstract, yet coherent, categories which remained authentic to the original data. The structure of the process is most easily explained backwards, Gutteridge (2003) uses the metaphor of a tree to explain this. The tree trunk represents the central category, several categories branch from this, sub-categories branch again from these as large twigs, conceptual groups branch once more to small twigs, groups of leaves (open codes) are attached to these. However, in GT one begins with the leaves (open codes) and concludes with the tree trunk (central category).

4.4.3.2 Analytic Tools and Ways of Thinking in GT

The tools used to analyse the data were based on those recommended by Corbin and Strauss (2008). Whilst undertaking constant comparative analysis, questions were asked of the data such as what, when, why, how and with what results or consequences? Corbin and Strauss' (2008) coding paradigm also assisted with this. It encouraged me to consider the relationships between elements through examining conditions, circumstances, interactions, emotions, and consequences within the data. Where these were not already explicit, the original data was re-examined. If relevant data were identified these were coded. Where no answers were available, the interview schedule was adjusted to explore this with future participants. Identification of gaps in the data also informed theoretical sampling. As the process evolved, I was able to group codes to develop explanations of increasing depth. Eventually these converged into categories. I continued to compare incoming data to develop variance, dimensions, properties and relationships within the emerging theory.

Examples of how some of these tools were used are now presented.

Thinking about various meanings of a word aided understanding about what participants might mean by the term (see Table 4.6). For example, mentors often explained that failing a student was 'hard'. Teasing out what 'hard' meant to each mentor gave a wide range of meanings. Corbin and Strauss (2008) recommend eliminating all but the most relevant meanings. However, in this instance, the word hard was found to have meaning on a number of levels. This provided insight into various categories which were emerging. Hence, most of the meanings were retained, to develop various dimensions, within emerging categories.

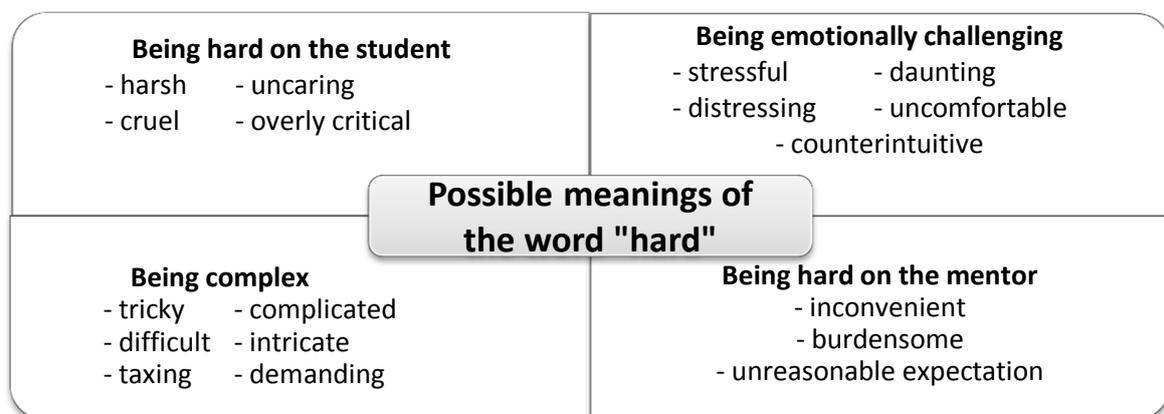


Table 4.6 Example demonstrating thinking about possible meanings of a word.

The **flip flop technique** helped to examine the extremes of concepts (Myers 2013). Again, using the word 'hard' as an example, I began to explore if there were situations in which mentors found the other extreme; that it was 'easy' or 'easier' to fail a student. The interview schedule was adjusted to reflect this query. Actions and situations that made things easier then began to emerge during interviews.

Waving the red flag was also used as to reduce the intrusion of my own biases, assumptions and beliefs (Corbin and Strauss 2008). This involved trying not to take meanings for granted and clarifying them, where possible, during interviews. An effective technique for doing this was reflecting the word back to the interviewee and waiting for further elaboration. This practice reduced the likelihood of any connotations being put onto a term by me which the interviewee might then collude with. For example exploring what mentors meant by intuition:

MA09: *"I don't know what it is but sometimes I get this intuition that ... that sometimes things are just not right."*

Interviewer: *"This intuition ..."*

MA09: *"Yeah. I don't know. I don't know what it is. I just get ... yeah. It's just an intuition. Well I suppose I do have my standards. I suppose every nurse has her standards and you know, I know how I work ... how I would expect a newly qualified to work. Umh ... and there are lots of students who when they come into their third year ... Some students have got it and some students haven't."*

Seeking out negative cases was an element of theoretical sampling which helped to identify if exceptions were in evidence. The process for seeking out such cases is described in section 4.4.1.3. These helped to explore alternative explanations and expand the dimensions and properties of categories (Myers 2013).

Looking at language was helpful in two ways. Firstly, language could offer insight into situations and how they were perceived by mentors (Corbin and Strauss 2008). For example, mentors used terms such as 'my student', 'her student' or 'your student' which seemed to indicate that mentors perceived they had ownership of the student. Further investigation could then be undertaken to explore what such ownership meant and whether this hindered or helped mentors to fail students. Secondly, language also indicated the ways in which participants conceptualised their experiences (Corbin and Strauss 2008). For example one mentor talked about how difficult it was to fail a student and that she felt that she had to put up a fight to fail the student. The in vivo code 'fighting to fail' emerged from this.

Asking so what? This was not a question directed at participants, but one directed at the data. This technique complimented a number of the strategies already discussed above. It helped to deepen my analysis of seemingly obvious statements and ensure that I explained concepts fully, did not take things for granted, considered alternative explanations and probed these in later interviews.

Corbin and Strauss (2008) suggest that theoretical sensitivity can be further developed by **engaging with relevant literature**. It transpired that it was necessary to engage with a much wider scope of literature than could have been anticipated before the study began (Norton 2008). This included

decision making models from mathematics (Kahneman 2011), sociological concepts of fear (Furedi 2006), strategies for coping with feelings of lay-off guilt from management/human resources perspective (Noer 2009) and mechanisms of recognition from ornithology (Dooley 2005). This widened the scope of the study, beyond that directly related to mentoring and assessing, to other varied, yet relevant, theories.

4.4.3.3 Memos in Analysis

Memos provided an audit trail which demonstrated the analytic thinking that took place. This helped to ensure quality in both the processes and product of the study (Birks and Mills 2011), and provided a record of how the data were interpreted (see Chapter 11 for further discussion of quality). Memos often took the form of reflective writing, in which I questioned myself and the data, and explored and critiqued how analytic techniques had been used. Thought processes could be made explicit and rationale for grouping of concepts was recorded. Using memos helped me step-back from the data to think conceptually (Corbin and Strauss 2008). It enhanced my awareness of gaps in the evolving theoretical explanation.

I developed a system to keep track of memos which enabled me to cross reference them. Most GT theorists now recommend computer software to do this (Birks and Mills 2011, Corbin and Strauss 2008). However, paper based systems are also considered acceptable and this was the method I employed. Only a limited number of memos could be viewed in full at the same time on a computer screen, whereas a paper system was limited only by the logistics of space. I often spread memos, codes and categories across the floor and sat in the middle thinking and organising them into clusters. I then wrote further memos explaining why these were being grouped and added this to the cluster of papers. It is suggested that novice researchers can become overwhelmed by the quantity of data and that analytic paralysis sets in (Clarke 2005). However, I felt more constrained and frustrated by the spatial limitations of a computer screen. Once I had accepted that low technology was best for me I began to make headway, because then data was physically and visually

mobile. Literally being immersed in the data enhanced my ability to see connections and relationships, this aided abductive reasoning. Memos were scanned and stored electronically and paper versions of grouped data, including memos, were stored in labelled, plastic folders.

4.4.4 Theoretical Integration

Theoretical integration is regarded as the final phase of theory building; this cannot occur unless both open and axial coding have been undertaken. However, the process of achieving theoretical integration was also part of the iterative cycle, and occurred concurrently with these other types of coding (Corbin and Strauss 2008). Constant comparison continued to be the analytic cornerstone of the method. The theory was continuously refined as it was compared with previous and incoming data. Corbin and Strauss (2008) offer the analogy of an umbrella to describe this process, they suggest that spokes alone do not make an umbrella, in the same way that concepts alone do not make a theory; both require an overarching canopy for the whole to converge into a coherent construct. The next subsection explains the processes undertaken to achieve theoretical integration.

4.4.4.1 Identifying a Central Category

The first step of theoretical integration was distinguishing a central category which met five criteria (Table 4.7).

- | |
|---|
| <ol style="list-style-type: none">1. All major categories can be related to it and placed under it.2. Appears frequently in the data.3. Logical and consistent with the data. No forcing of data.4. Sufficiently abstract to facilitate further research.5. Grows in explanatory power as each category is related to it. |
|---|

Table 4.7 Five Criteria Required of the Central Category (Corbin and Strauss 2008)

Moving beyond the level of description, to formulate theory, was the most challenging stage of GT for me. The responsibility of ensuring that the interpretation was genuine, and did justice to

participants' accounts, became overwhelming at this point. For a time, it impeded me in making the final analytic leap.

Committing to a central category was aided by several techniques. Diagrams, which I thought of as visual memos, helped depict relationships and were a helpful way of recording my deliberations about conceptual relationships. Generating integrative diagrams helped thinking about data in "lean ways" (Corbin and Strauss 2008:125) and gave me scope as a visual thinker (Appendix 4.12). Many diagrams, of wide-ranging complexity, were generated over the course of the study and illustrated how the theory evolved. Both matrix and network diagrams were used. Matrices were used to examine the dimensions, properties and relationships of concepts. Network diagrams facilitated representation of the final theory because they, "recreate[d] the plot of events over time as well as explaining the complex interaction of variables" inherent in this theory (Miles *et al.* 2014:239). Storing diagrams in a ring binder, in chronological order, helped to illustrate the progress of analysis. I found this an efficient way of recording the progression of thoughts, developing alternative explanations, and further expanding categories. Cataloguing diagrams helped to recreate my intellectual journey and provided a visual audit trail (Birks and Mills 2011).

Re-reading interview transcripts for general sense, coupled with the question, "What keeps striking me over and over when I read these?" (Corbin and Straus 2008:107) helped me to focus on the central message from participants, whilst maintaining the iterative process. A storyboard was generated by producing a set of diagrams which pictorially presented the explanatory framework. Writing some short descriptive sentences, about each sequential diagram, helped the story to emerge further, and brought focus to the central category. This facilitated articulation of the theoretical explanation and ensured major themes were incorporated around the central category. Memoing and diagramming are often neglected aspects of GT (Strauss and Corbin 1998), but in this study they were the methodological elements which enabled theory to coalesce; they were at the heart of my analytic process.

4.4.4.2 Refining the Central Theory

Once the central category had been identified, refinement and adjustment of the theory commenced. The internal consistency of the substantive theoretical framework was reviewed, gaps and poorly developed categories were identified and elaborated, over-elaboration was removed, and coherence between the central category and the source data was checked (Birks and Mills 2011).

The logic and flow of the theory were reviewed for internal consistency. In particular, I wanted to ensure that, although the theory was abstract, participant's perspectives were represented (Corbin and Strauss 2008). Refining the theory meant pruning the data to that which was most pertinent to the purpose of the study. This element of the analytic process was challenging, particularly after such effort had been put in to ensuring theoretical saturation had been achieved. Deciding to condense, omit or eliminate certain ideas, which had been pursued rigorously earlier in the study, felt incongruous. However, Myers (2013) advises that it is important to keep the theory lean, whilst retaining the most important elements. I resolved my reluctance by setting aside some findings that seemed peripheral for later publication.

4.4.4.3 Validating the Scheme

Checking that the substantive theory was representative of the original data was the final stage of analysis (Corbin and Strauss 2008). This was undertaken to establish the trustworthiness of the scheme (Holloway 2008). Several methods were used to do this. Firstly, the original data was re-visited and compared with the theoretical abstraction, checking that it explained the cases studied. This involved re-listening to original audio-recordings of all interviews and reflecting on whether the explanatory framework reflected each participants account, noting if there were omissions or overemphases, and that variations were accounted for. Secondly, some early analysis was shown to participants for them to comment on (See Chapter 11). Their feedback indicated that the finding resonated strongly with them. Later, tentative findings were also presented at conferences (See

Chapter 11 and Appendix 11.01). Positive feedback was received from audiences which included some participants from the study, further mentors, some of whom had failed students, PEFs, LLs and other researchers studying this field (Appendix 11.02).

Birks and Mills (2011) advise that researchers should only return to the research literature in the substantive area when their own theory has been developed. This helps to avoid forcing the new theory to fit with that which already exists. Once the substantive theory had become distinct in this study, existing theories and literature were examined. One reference appeared a number of times (House 1981). This theoretical piece offered a snug fit with the core concept and both studies reciprocally, “augmented, supported and validated” each other (Birks and Mills 2011:125). Thus, the study reported on here is situated within theories of work-stress and social support which have developed from House’s (1981) work. Lastly, this grounded theory of ‘Standing Securely’ can be viewed as valid because it offers insights into what can be done practically to help mentors. Hence, it is useful, this being the primary purpose of developing a grounded theory (Corbin and Strauss 2008).

4.5 INTRODUCTION TO THE SUBSTANTIVE THEORY – STANDING SECURELY

A brief summary of the substantive theory is presented here and is discussed in more detail in subsequent chapters. The central category which emerged from this study was that mentors needed to feel secure to fail underperforming students in practice based assessments. Mentor security could be undermined in a number of ways which resulted in reluctance to fail. Where mechanisms existed to promote mentor security it became more likely that mentors would fail underperforming students. These various elements, which can support or undermine mentor security, will be explored in the next section of the thesis.

4.6 SUMMARY OF CHAPTER 4

This chapter presented the methodology chosen for phase two of the study - Grounded Theory (GT) (Corbin and Strauss 2008). It explored how this qualitative approach was interpreted into the method which was employed in the field. A brief overview of the central category, Standing Securely, was then presented. The following chapters present more detailed exploration of the five categories which underpin the central category. These are then drawn together in chapter 10, where the central category is elaborated on.

Chapter 5

Phase Two - Findings Category A: Braving the Assessment Vortex

5.1 INTRODUCTION TO CHAPTER 5

This chapter introduces the category “Braving the Assessment Vortex” which has two subcategories and seven conceptual groups which are illustrated in Figure 5.1. This category crosscuts with three other categories and the connections between these are demonstrated in Figure 5.2. The relationship between this category, its subcategories and conceptual groups is presented, and considered in the light of current literature. The chapter concludes with a discussion of the findings related to this category.

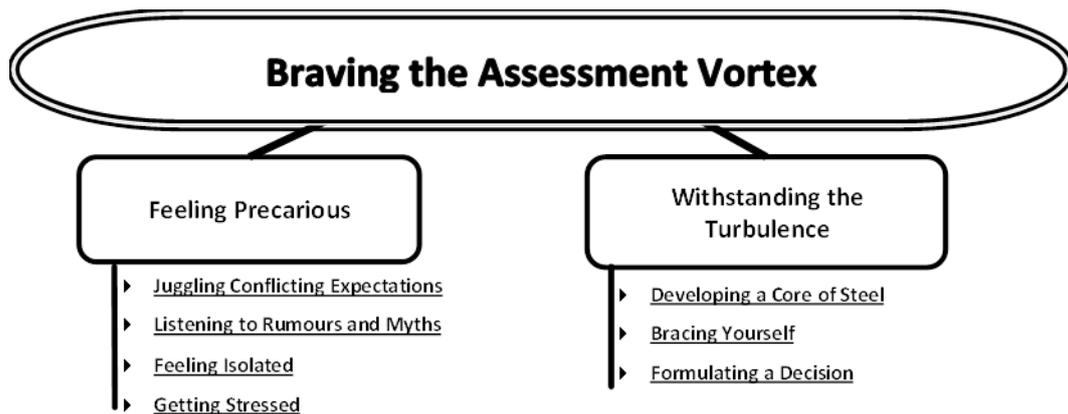


Figure 5.1 The Relationship of Subcategories and Conceptual Groups to Category A.

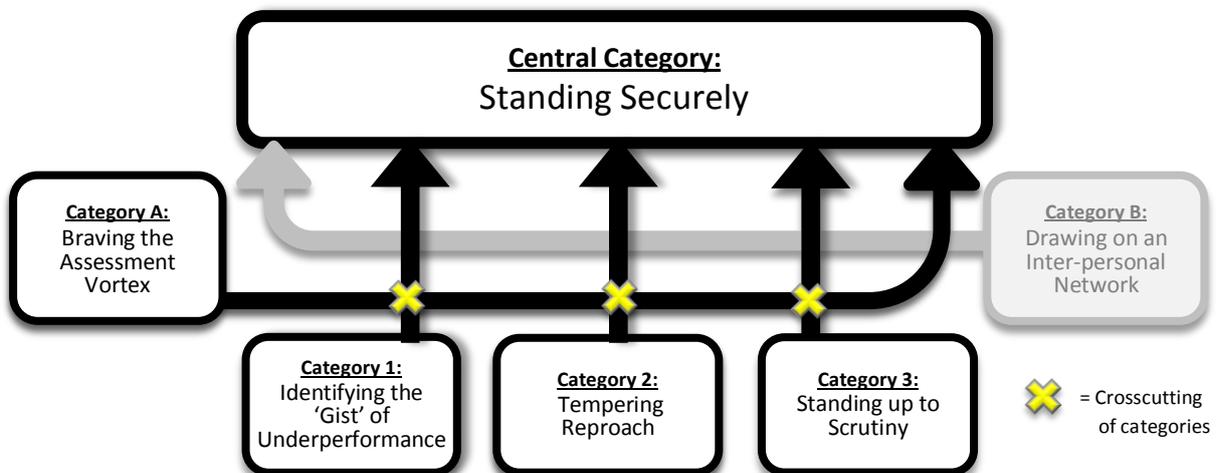


Figure 5.2 The Crosscutting of Category A with other Categories

5.2 FEELING PRECARIOUS

Managing a student's underperformance in practice is taxing for mentors and can cause high levels of stress, particularly when a positive outcome is not possible. Cassidy (2009a) recognises the heightened fragility of the mentor/mentee relationship under such circumstances, and both Duffy (2006) and Black (2011) note that mentors' experience emotional dissonance and anxiety. The findings of this study support these views. Mentors reported that various groups and individuals had contradictory expectations of them. This generated uncertainty and made them feel they were in a fluctuating situation. Mentors who went on to fail students outlined strategies and support which helped them to manage the tensions experienced.

5.2.1 Juggling Conflicting Expectations

This current study found that differing expectations came from a variety of sources. These include: the self; the student; patients; the general public; colleagues; the nursing profession; the employing organisation; the university; and the media. Mentors perceived a mismatch of needs and found it challenging to satisfy all parties. Mentors reported that they had to manage substantial internal-conflict whilst deciding whether or not to address the student's weaknesses. A number of studies support these findings, both Rooke (2014:46) and Carr and Gidman (2012:25) found that nurse mentors performed a, "juggling act" when balancing the requirements placed upon them, as did social workers (Rawles 2013:7). Middleton and Duffy (2009) and Woodcock (2009) noted the onerous task mentors faced in fulfilling a complex array of demands, and Robinson *et al.* (2012:6) reported mentors, "under considerable pressure and facing a diverse range of challenges".

Mentors in this study indicated that, initially, they transferred the nurturing values employed in nursing to their mentoring role. An assumption was made that being a 'good' mentor was commensurate with enabling the student to pass the practical placement. This view did not change whilst mentors only encountered able students. Turbulence built where a student persistently underperformed. In common with the mentors in Black's (2011) study, participants reported that

their belief in themselves as 'good' mentors was challenged, and they blamed themselves for the student's lack of progress.

"Nurses by their very nature are kind people and they want things to be alright and so if it's not, you're very much questioning have I missed something or have I been judgemental."

(LT06)

A range of emotions were expressed at this point, including: disappointment; frustration; dismay; indignation; discouragement; confusion; and dejection. Mentors reported that it felt counterintuitive to fail students. Practice Education Facilitators (PEF) identified that this was often exacerbated by students who expected to be the mentor's primary focus; a view intensified by universities' emphasis on the student experience. Mentors reported that some students struggled with patients' needs being given primacy over theirs and felt their 'rights' were being disregarded. The Francis Report (DH 2013a) has emphasised that such care workers, who do not place the patient at the forefront of their attention, are a major contributor to healthcare failings. Mentors believed that it was rare for students to fail practical assessments and perceived that it created an implicit psychological contract (Rousseau 1989). If the mentor failed the student, the student felt mistreated, believing the mentor had breached the psychological contract. Mentors were concerned that students felt entitled to challenge their assessment decision.

"The student has the right to appeal about everything and they've got the impression now that simply turning up on a course is enough to become a nurse." **(LT06)**

Mentors reported that students challenged their decisions in a number of ways: criticising their lack of attention to assessment processes, accusing mentors of neglect, bullying, harassment or being prejudiced in a variety of ways, for example, being sexist, racist or ageist.

"If they take a dislike to you they go back to university and the university picks this up and says well yeah what you've experienced there is a form of bullying or discrimination. You know, even if you know you haven't done it. It could be quite detrimental to you." **(MA05)**

Similarly, Jervis and Tilki (2011) noted that mentors' feared negative criticism from both students and universities. This concurs with Finch *et al's* (2013:9) findings that social workers felt that students could, "beat them down" with such accusations. Accounts of students making threats of physical intimidation and, at times, carrying these out are further explored in Chapter 7.

Further tensions were noted between keeping patients safe from an underperforming student, and keeping the student nurse content whilst, potentially, exposing patients to increased risk. This has also been identified as a concern in studies of Canadian, American and Australian nurses (Killam *et al.* 2010, Luhanga *et al.* 2010, Schaffer 2013, O'Brien *et al.* 2014), which noted that students' "inability to follow instructions, overconfidence or defensive behaviour" (Killam *et al.* 2010:2), jeopardised patient safety. Mentors in the current study reported struggling to promote the well-being of both student and patient since one was often detrimental to the other. However, it was considered inevitable that patients' well-being would be compromised, to some degree, if the student was to be failed. This was a time-consuming process, which reduced capacity to deliver care, and mentors expressed concern that they were consciously exposing patients to potential incompetence.

Participants noted that employers' quality monitoring processes emphasised promoting patient's well-being, and rarely expressed organisational expectations about preparing the future workforce. This concern was also noted by the Willis Commission (RCN 2012). Consequently, mentors were anxious that they would be reprimanded for giving attention to mentoring, rather than fulfilling their primary role. Mentors working in private sector organisations were particularly anxious about the amount of extra time failing a student required.

Interviewer: *"You said if your manager knew how much time failing the student took ..."*

MA02: *"... he would not be very happy because he's paying me. Basically he's paying me a lot of money to run a home and while I'm failing the students and spending hour, after hour, after hour doing that I'm not doing the job he's actually paying me to do."*

Mentors were concerned that their employer would refuse to offer further placements to students if they discovered how much time it took to fail an underperforming student. They explained how precarious the provision of placements in the private sector was whilst assessment processes were so time consuming. Both Rawles (2013) and Matthews *et al.* (2010) have noted similar concerns, regarding private sector placements, for social work students in the UK.

Mentors felt that acting as both a mentor and an assessor caused role-conflict. Whilst mentoring involved the emotional elements of nurturing and comforting, acting as an assessor required a more objective and detached approach.

“Well is there space for two relationships? You know with the nurturing and more like a ...you know a different role really, whereas the other person is the one that’s doing the assessment, the actual assessment. Because it feels that students might need that supportive and nurturing side of a relationship with a mentor, but then the mentor might be the one who suddenly is having to have these difficult conversations.” (PE06)

“You can’t be a mentor and an assessor at the same time because you’ve got conflicting interests haven’t you?” (MA12)

This duality of role has also been identified as a concern for Belgian mentors (Huybrecht *et al.* 2011).

Despite this tension, some mentors in this current study expressed reluctance to separate the functions, both for logistical and self-protective reasons. Mentors whose job involved lone-working struggled to see how the roles could be separated, whilst some participants who worked in teams, were hesitant to have colleagues assess ‘their’ student, and wanted to keep control of the whole process. This suggests that some mentors would prefer to continue experiencing the tension of being both nurturer and assessor, rather than feel that they were a ‘poor’ mentor if a colleague failed ‘their student’.

Mentors, PEFs and Link Lecturers (LL) often expressed a common view of what they called ‘*The University*’; an indomitable entity which held the balance of power. None of the participants recognised themselves or their counterparts as being part of ‘*The University*’ which was considered a higher authority, dissociated from, and often in conflict with them.

“‘The University’, you see, we talk about ‘The University’ and imbue it with this sort of personality.” (PE03)

‘*The University*’ was often regarded as an obstructive agency, which discounted the risk underperforming students could present to the public. Neither participants employed in practice nor those employed by universities regarded the LLs who supported practice placements as part of ‘*The University*’. Rather, they were seen as fellow professionals who shared nursing values and beliefs about protecting the public. Rawle’s (2013) study demonstrated that social workers held a similar

view of LLs, the focus of their dissatisfaction was also *'The University'*. In the current study, HEIs were regarded as having a differing value set to nurses. *'The University's'* prime objectives were to retain fee paying students, and avoid bad publicity and litigation.

"I think they are concerned about their attrition rates." (MA07)

"I know there is a bit of tension between attrition and quality." (PE06)

Hence, it was often regarded as being unsupportive of mentors, PEFs and LLs, when students failed practical assessments, as this ran counter to *'The University's'* objectives.

"The official line [from 'The University'] is that we all should be working collaboratively to fail students. But then when you're actually faced with the reality, the response that you get, unless you are particularly tenacious and confident, I think it's really ... the message is don't fail people." (MA07)

In some situations attempts had been made to persuade mentors to change a fail to a pass. Mentors felt that in the majority of such situations *'The University'* was attempting to coerce them into passing an underperforming student for its own ends, such as protecting its reputation, attrition rate or financial position.

"It's two fold, it's going to make bad headlines for 'The University', on the other hand it's don't fail people unless you're really sure because we're going to lose money." (LT04)

The views expressed by nurses in this study are consistent with international social work studies which have highlighted concerns about the negative effects the market economies of universities have on mentors' attempts to fail students (Robertson 2013, Eno and Kerr 2013). The Health Foundation (2011) notes that, as health care organisations push for a more open culture of safety, they are likely to come into increasing conflict with HEIs who are reluctant to fail students based on poor practice.

Most PEFs and LLs noted that they seldom encountered a mentor whose expectations of a student were unreasonable.

*"I can say absolutely, with my hand on my heart, I have never encountered a student in the whole time that I have been working here, never encountered a student who has failed in practice who did **not** deserve to fail in practice. They might have had a material error claim because some poor rushed assessor didn't do the midway review at the correct time, or didn't give them a clear enough action plan, or didn't write the action plan on the correct bit of*

*paper. But **always**, you can track it back to the fact that there **was** something about that student's practice that was sub-standard." (PE02)*

PEFs and LLs indicated that, in their opinion, mentors were usually too lenient. In such circumstances they reported challenging the mentor's view of what constituted a 'good mentor', by suggesting that a 'good mentor' would fail a weak student. This fuelled the mentors' uncertainty about what a 'good' mentor was which was compounded by listening to local rumours and myths.

5.2.2 Listening to Rumours and Myths

Mentors trusted co-workers' reports about what had happened to mentors who had failed students because they conveyed convincing messages, which made sense of the situation.

"The power of your colleagues who are your mates, who you trust who you listen to are more. I had good relationships with the wards on the whole but it didn't matter. I didn't work with them on an everyday basis. It was really their kind of personal relationships that seemed to make a massive difference." (PE08)

However, factual accounts could degenerate into myths and stories, with little foundation in reality, which became an obstacle to the robust assessment of students.

"It's an urban myth ... I don't know where these rumours start but they just keep rolling it over from generation to generation." (MA13)

Distorted information was often persuasive because it seemed plausible and, the more negative information the story contained, the more convincing it became. This engendered fear, particularly where the scenario seemed to have happened close by.

"Mentors are frightened to fail students, they believe there'll be an investigation, that their practice will be looked at, that they will be held ... held accountable for the fact that this person does not know what they should know." (MA13)

These scenarios may have little basis in fact and, when questioned, no first-hand witness accounts of such occurrences were available.

Interviewer: *"Have you seen any mentors who have been audited as a result of failing a student?"*

MA13: *"No. No I've never seen a mentor audited as a result of failing a student."*

Absorbing such rumours had a powerful effect on mentors and they became insecure about their own professional standards, questioned their own abilities, and worried that they might not have met others' expectations. This generated apprehension about being performance managed or disciplined. Mentors debated how to uphold their professional values whilst, "*staying out of trouble*" **(MA15)**. This contributed another facet to the culture of fear which the Francis Report (DH 2013a) identified as being prevalent in the NHS. Schaub and Dalrymple (2013:88) also identified a, "*perception of surveillance*" amongst social workers that impeded conversations which would enhance feelings of safety. Bilton and Cayton (2013) suggest that rumours and myths can be a consequence of the multitudinous sources of guidance and advice available in health and social care; these are impossible to absorb in entirety, leading to anxiety that one has missed something important.

Awareness of the attention being paid to the nursing profession by the media compounded this unease. Conflicting media messages about nurses, simultaneously lauding them as 'angels' and criticising lapses in standards of care, created an unstable and shifting base of expectations from which to work. Avoiding media attention was an important consideration.

"It's very much entwined with their own fear of being criticised bearing in mind that the whole culture of health care is to make scapegoats of whatever profession and there's an awful lot of bad media and that all fits into the psyche of the profession." **(LT05)**

Mentors wanted to be seen as professional and they were keen not to provide material for the media. They believed that a complaint could seriously impair their professional reputation, and this was a recurring source of anxiety when supervising a student who delivered sub-standard care. This anxiety increased further when mentors followed this line of reasoning to a point where they might eventually appear in a court of law or a professional misconduct hearing.

"It wouldn't stand up in a court of law and you know, if somebody was to die, that's ... it's important to have everything correct." **(MA06)**

"You do realise it's your PIN number now that they can take away from you." **(MA05)**

The potential loss of registration as a nurse and, consequently, loss of employment, generated a powerful image.

5.2.3 Feeling Isolated

Mentors reported that, whilst they were supporting a satisfactory student, they felt they were working in partnership with colleagues. However, when a student's performance gave cause for concern, colleagues could distance themselves, indicating that it was the mentor's responsibility to deal with the student's poor practice because they were the named supervisor.

“ ‘Cor your student's bad!’ And the reference to ‘Your student’. It's almost like they belong to you and you feel responsible because they're your student. So then there's also this added burden from your colleagues as well about making sure your student is up to scratch.” (LT08)

It was further noted that mentors often took possession of the student through the use of terms such as, ‘*my student*’. This had the effect of attaching the mentor to the student, making them feel individually responsible for finding a solution to the student's poor performance.

Where extreme problems occurred, mentors reported that university staff could either be readily available or dissociate themselves from dealing with the issue. These extremes are illustrated in the following excerpts:

“This student would not leave the ward, he would just not leave even though we told him he was dismissed. A senior lecturer from the university had to come. She came within an hour and removed him.” (MA01)

“We just got this phone call out of the blue to say we needed to escort him out of the building. Well we can't do that I need to know why and that's when she reluctantly said ‘He's already been struck off.’” (MA04)

In such circumstances, mentors felt they were left isolated and unsupported in a threatening situation which further reduced the trust they placed in ‘*The University*’. Luhanga *et al.* (2010) have, similarly, reported lack of support from Canadian universities.

As a student's inability became more evident, co-workers could become increasingly averse to working with them and withdraw. The mentor's role could become a solitary one in which they felt alone, closely supervising the student and taking all necessary precautions to ensure no mishaps

occurred. Both Gurling (2011) and Wisdom (2011) reported the isolation nurse mentors experience at such times, particularly in geographically remote areas. Social workers have reported comparable feelings of isolation (Basnett and Sheffield 2010, and Finch *et al.* 2013). Mentors in the current study reported that being left unaided increased both workload and anxiety, sometimes to intolerable levels.

“It’s a very lonely and traumatic business really.” (PE04)

Some participants suggested that it was the NMC’s (2004 and 2008a) requirement, for students to be nominated a named mentor, which resulted in this position. Whilst they were disappointed by colleagues who withdrew, they were also tolerant of this behaviour accepting that, as a named mentor, they carried ultimate responsibility.

Being undermined by colleagues could also isolate mentors. This occurred when students were befriended by co-workers who thought the mentor was being too severe. Conflict increased and, in the worst cases, teams broke down.

“I have seen personal conflicts impact on learning experiences. I’ve had to manage a number of situations where the student was splitting the team.” (MA07)

Mentors noted how the reduction in trust and goodwill could have long term effects on working relationships. This concurs with findings in social work where team harmony could also be disrupted (Basnett and Sheffield 2010). This could be particularly apparent when the mentor held a junior status within the work environment. PEFs noted the unusually high levels of responsibility placed on junior colleagues.

“The role of a mentor is hugely complicated. It is incredibly important and it requires a level of skill we wouldn’t necessarily expect of our junior nurses. Because you are not only working with somebody in practice, you are overseeing what they’re doing. You are assessing and managing risk. You are critically appraising someone’s performance against standards which you may not have long achieved yourself. You are taking theoretical knowledge taught in University and putting it into practice in an unpredictable environment. You are having to give critical feedback. This is the kind of job we don’t give to anyone who is lower than a band 6. So we are giving the most complicated jobs to the most junior part of our workforce.” (PE08)

PEFs and LLs empathised with the tensions that mentors experienced in failing a student and agreed that contemplating such an action could be quite momentous. Mentors experienced a significant transformation in their perception of the role they were expected to fulfil if this was the first time they had failed a student. PEFs and LL were aware of how, “wretched” (PE03) and alone this could make mentors feel. Conversely, in some situations, considerable expectations were placed on mentors by academic staff, frustrated by the vulnerability mentors exhibited in such circumstances. Here, the view was that mentors were professionals who should be able to independently manage challenging students. Some academic staff were perturbed, by mentors who considered it the lecturer’s role to facilitate interviews in which feedback, on poor performance, was to be given to students. Lecturers suggested and that mentors would “call upon [them] for this service” (PE02).

“After the voice recording stopped the lecturer took my arm, turning me to a group of mentors in an update, and said ‘Look at them, they’re all professionals but they expect me to do their dirty work for them when it comes to failing students’.” (Field Note G.2)

Under such circumstances the lecturers felt they were expected to undertake the task for the mentor, who achieved the desired result, but avoided leading the uncomfortable conversation. Academics felt that this diminished the mentor’s professionalism which some mentors sensed. This made them feel ineffective which exacerbated their reluctance to seek help and consequently increased feelings of isolation. Hence mentors further questioned their own judgement and abilities and became increasingly indecisive and stressed by the situation. This is explored further in Chapter seven.

5.2.4 Getting Stressed

Mentors described feeling bewildered and confused. They wavered in deciding where their loyalty lay and vacillated between actions which were least likely to cause harm to themselves or the many. They sought a solution which could satisfactorily resolve all conflicting elements. Insecurity was increased by assessment procedures and professional standards. These were perceived to be a dense array of complex and confusing details and language, which caused mentors to feel perplexed.

“She couldn’t piece the bits of information together and she was all of a bit flummoxed by the whole thing.” (LT01)

The increasing tension caused some mentors to experience symptoms of anxiety and stress. These included: being unable to sleep; nausea; tremors; palpitations; heightened emotions and agitation.

“I was feeling sick, I was feeling stressed, I was feeling anxious, I was feeling ... well I wasn’t sleeping very well to be honest. It did affect me quite a lot, the pressure.” (MA06)

Such responses have been well documented internationally, in a variety of professions, when mentors managed underperforming students (Duffy 2003, 2006, 2013a, Black 2011, Black *et al.* 2014, Finch 2009, Basnett and Sheffield 2010, Schaffer 2013). As they became increasingly unsettled by the tensions, mentors acknowledged that they might capitulate if they did not find a way to compose themselves. It was possible to reach an intolerable point where taking sick leave was seen as the only option. Further discussion regarding mentor burnout can be found in Chapter 8.

5.3 WITHSTANDING THE TURBULENCE

Mentors indicated that they needed support to manage the conflicting feelings involved in failing a student. Dissonance was evident and contradictions, in terms of which action to take, made mentors feel they were in a no-win situation. They sought for some control over the situation and used considerable personal reserves to manage the challenges.

5.3.1 Developing a Core of Steel

Mentors worried about whether they were strong enough to take on this challenge. Duffy (2006:1) points out that mentors ‘weigh the balance’ in deciding whether or not to fail a student. In this current study mentors likened their internal journey to bracing oneself to, *“grasp that nettle”* (PE02); an act which could potentially be painful, but which if done with assurance would be less so. This supports Black’s (2011) findings that mentors needed courage to fail a student.

“You have to have a core of steel.” (MA04)

Mentors who possessed this “core of steel” shared certain characteristics (Chart 5.3).

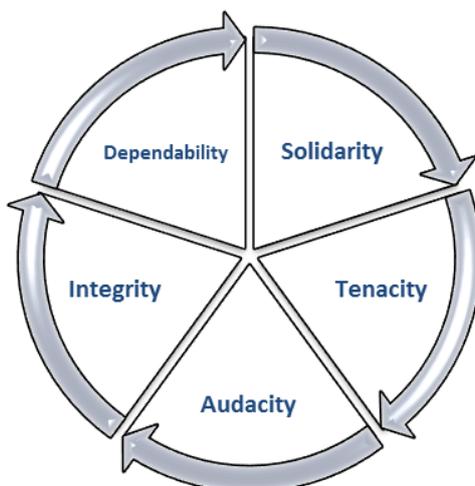


Chart 5.3 Composition of the Mentor's Core of Steel

5.3.1.1 Solidarity

Participants expressed a sense of interconnectedness with fellow professionals and the general public, and a willingness to uphold shared standards. Mentors who demonstrated a ‘core of steel’ emphasised their role as a gatekeeper of the profession, and were also concerned that patients received high quality care. They were committed to preserving the interests of these groups, and felt a strong and cohesive responsibility towards them.

“I’m failing you because I don’t think you’re up to joining my profession. It’s not because I don’t like you and it’s not because I don’t have time to spend with you and it’s not because of this, that or the other. There’s only that reason and we’ve tried and we can’t put it right.” (MA12)

Several studies support the view that mentors who assess effectively have a strong sense of professional unity (Rooke 2014), and moral duty (Black 2011). Basnett and Sheffield (2010:2127) suggest that, in social work, this reduces stress by offering an, “emotionally focused response” which gives a wider perspective and reduces emphasis on the individual student. It is possible that this is the same for nurse mentors.

5.3.1.2 Tenacity

Mentors identified their determination and focussed persistence in challenging situations. They persevered even when they knew this would be a difficult process. They did not stop when they encountered difficulty, or when others tried to persuade them to change their mind.

“The official line [from the University] is that we all should be working collaboratively to fail students. But then when you’re actually faced with the reality, the response that you get, unless you are particularly tenacious and confident, is don’t fail people.” (MA07)

Similar qualities were noted in those healthcare workers who contributed to the Francis Report (DH 2013a).

5.3.1.3 Audacity

Mentors who had failed students expressed a willingness to be bold and courageous. They were prepared to challenge convention and were unlikely to give in to intimidation. They faced opposition assertively and were undaunted when threatened.

“they said ‘Will you change your mind Sister?’ And I said ‘No, I will not! I will not change my mind’.” (MA12)

This further supports Black *et al*'s (2014:10) finding that, “it takes courage to stand up to the norms of a particular organisation or culture”.

5.3.1.4 Integrity

Participants involved in failing students presented themselves as having strong moral principles, and being consistent in their decision making. They indicated that they would remain focussed on what was right despite the personal cost, work according to a clear set of principles, and that their expectations of students did not fluctuate.

“You’ve got to have strong values to fail someone and say these are your issues.” (MA03)

Schaffer (2013) reported that, mentors in the USA emphasised scrupulousness when assessing their protégées, whether or not they passed.

5.3.1.5 Dependability

Mentors recognised that they needed composure and commitment at times of tension. They were loyal to their obligations, could be relied upon to follow procedures, and made their meaning clear and unambiguous.

“There’s no point in mincing your words, I’m not prepared to put you in a situation where you are going to lose your PIN because that’s not fair.” (MA02)

Such qualities seemed to foster internal stability, enhancing mentors' capacity to withstand conflicting demands and confront difficult situations. Mentors with previous experience of failing a student were aware of what to expect and this aided their resolve.

Interviewer: *"So your previous experiences ..."*

MA04: *"... have bolstered me I think for this so I've got no hesitation in doing it again if I have to."*

Rooke (2014) suggests that this quality is most likely to be present in those who chose to undertake the mentoring role. Mentors were at their most confident in failing a student if their previous experience of doing so had been tolerable. However, in spite of this, they noted how difficult it was to cope with such pressure alone.

5.3.2 Bracing Yourself

Even those mentors whom PEFs identified as having 'a core of steel' indicated that failing a student was not an activity which should be undertaken single-handedly.

"It is the people that help, yeah. And I ... as much as I come across as a confident person I still ... I think we all still always need that support." (MA09)

Mentors wanted to speak to another person, rather than access written guidance, when they had difficulty because it relieved some of the tension of feeling isolated, and allowed them to explain the particular details of their situation in a timely way, as each situation was unique.

"We seek out help when there's a problem. We don't go and converse about things when things are all hunky-dory and lovely and maybe that's the crux of the matter."(LT02)

Access to supportive people was identified as the fundamental reinforcement that enabled mentors, PEFs and LLs to steady themselves for the challenges of working with, and potentially failing, an underperforming student. Robinson *et al.* (2012:5) suggests that, "multi-stranded working relationships" are the glue which holds such systems together. The reciprocal social support mechanisms which the current study found assisted mentors are explored further in Chapter 9.

5.3.3 Formulating a decision

When assessment turbulence was offset, mentors reported gaining composure which allowed them to consider how to make a sound assessment decision. Bilton and Cayton (2013) have also suggested that easing cognitive overload, stress and moral confusion reduces the risk of distorted professional judgement. In this study the decision process was found to involve three questions. When combined, the answers needed to produce a result which established an acceptable level of security for the mentor, and was compelling enough to fail the student. The most convincing case is demonstrated in Figure 5.4:

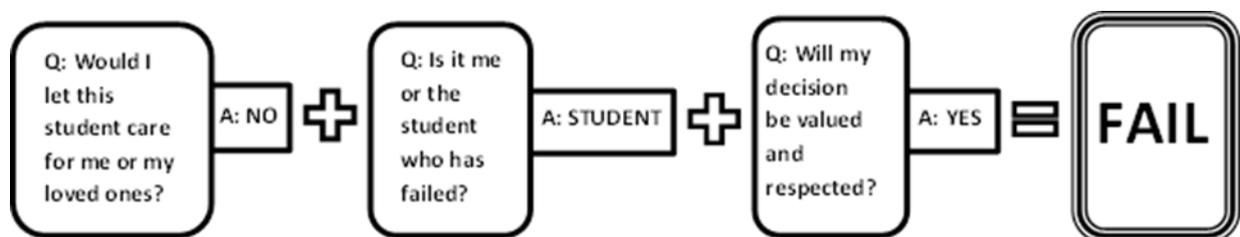


Figure 5.4 Formulating a Fail Decision

The processes and decision making which surround these criteria are explored in the next three chapters. Question one is considered in Chapter 6, which deals with safeguarding security as an end user. Question two is explored in Chapter 7, which examines establishing security as a mentor, and question 3 is discussed in Chapter 8, which explores how security as an assessor is determined.

5.4 DISCUSSION

5.4.1 Cultural Deterrents

The findings of this category indicate that mentors struggled with the role conflicts they faced, but more than this, mentors seemed to have an overriding anxiety about being found inadequate and punished for it. In health and social care settings performance is perceived as being constantly monitored, and a culture of surveillance has developed to streamline the ability to attach blame. The

Francis Report (DH 2013a) has called for a reduction in blame culture whilst also emphasising the contradictory needs for increased scrutiny and whistleblowing. Fostering a culture which incorporates all these factors will be challenging and further debate is needed to clarify how this can be achieved for mentors. Schuab and Dalrymple (2013) suggest that the extensive monitoring mechanisms now in place can lead to docility in mentors. One interpretation of mentors' reluctance to fail might be that they are being cautious in a risk adverse culture.

Further external surveillance by the media has also intensified anxiety. Between 1994 and 2000 a 900% increase in newspapers use of the word "risk" has been noted in relation to life in general (Reuters 1994-2000). Furedi (2006) argues that this has fostered an accompanying culture of fear, and he particularly notes this in healthcare workers. A significant number of mentors in this current study were worried that they, or the student, would attract negative media attention. It is worthy of note that the UK tabloid press has strongly criticised the culture of blame and fear within the NHS whilst rarely examining how it has contributed to this (Castille 2014). What became evident in this study was that nurses' concerns about negative television and newspaper coverage extended to their mentoring role. It is suggested that whilst mentors feel they are being constantly monitored for the purposes of blame and condemnation they are unlikely to feel secure.

It has been suggested that mentors who are able to tolerate uncertainty about what the final outcome of the assessment will be, are better able to cope. Mason (1993) suggests that this involves achieving a position of safe uncertainty. This requires giving attention to an unfolding situation, whilst tolerating the ambiguity of not being able to predict the outcome. Shohet (2012;you-tube) observes that this is not often tolerated in the NHS where a, "short-term fix" and, "tick-box" culture prevails. However, he maintains that tolerating uncertainty allows space for the situation to develop and is one of the most effective supervision mechanisms. Safety is not then necessarily found in the outcome of the assessment, but in the mechanisms through which the assessment process evolves, because a period of uncertainty is accepted as a secure element of a fair assessment.

A Western culture of entitlement has also developed alongside the culture of fear (Twenge and Campbell 2009) and this is particularly evident in the young who are four times as likely to show narcissistic personality traits as those over 65 (Stinson *et al.* 2008). Overindulgent parenting and self-esteem focussed education systems are recognised as contributing to this (Twenge *et al.* 2012). In the UK the National Student Survey (NSS 2014), a key league table which universities are judged against, may contribute to this culture of entitlement (Canning 2014). This survey puts students' opinions about whether programmes have met their expectations at the heart of the university economy. Universities are motivated to ensure they obtain high ratings in the NSS to improve their attractiveness to potential new students.

Paying close attention to what students want might be reasonable when the student is the customer; however, student nurses in the UK do not pay for their preparation as professionals, the NHS does. It therefore seems reasonable for student nurses to give attention to what the NHS, and its end users, patients, require. Student nurses who focus on their own needs, rather than the professional attributes that patients and healthcare services need, pose a, "potential risk for unethical actions and behaviours towards patients" (Alves 2012:1). They can also cause significant difficulty for mentors. Student entitlement is, therefore, one element of university ethos which it may be appropriate to moderate for those studying health and social care disciplines. The current move towards focussing on healthcare students' level of engagement in their programme (Austin 2013), rather than their expectations of the programme, might be of benefit to both patients and mentors.

5.4.2 Playing 'Games'

A number of dynamics were noted in this category which could be interpreted as dysfunctional interactions. These are now considered in relation to Berne's (1961) theory of transactional analysis and Karpman's (2007) drama triangles. Transactions are defined as, "the fundamental unit of social intercourse" (Berne 1964:6% e-book). When communication takes place between individuals, one

person initiates the first interaction, another person then responds with a further transaction, and so on until the transaction is complete. Each individual response is termed a stroke. Strokes will be directed by one of three ego states: Parent, Adult and Child. The most straightforward transactions take place between Adult ego states. However, various permutations of transactions exist which operate between different ego states. Some of these are termed dysfunctional transactions or, “the games people play” (Berne 1964:title). Such games have an ulterior or hidden purpose; and there is a pay-off or gain. Karpman (1968 and 2007) demonstrates how these games work using drama triangles. A drama triangle exists when people consciously, or unconsciously, take up particular roles as victim, persecutor and rescuer. Each role is diagrammatically represented by one corner of the drama triangle; the sides of the triangle represent the transactions which occur (see Figure 5.5).

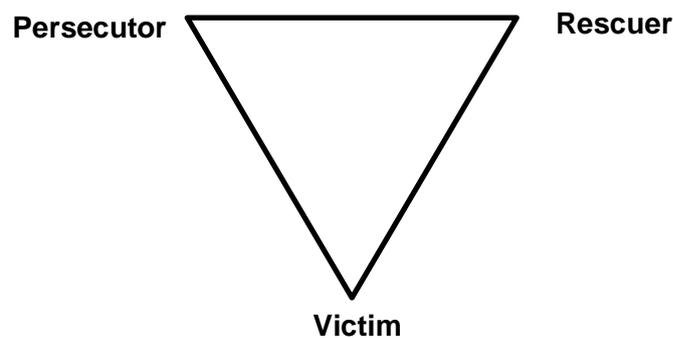


Fig. 5.5 Drama Triangle (Karpman 1968 and 2007)

Four of the dynamics which have been noted in this chapter are now discussed:

Conflicts between mentors and co-workers: This drama triangle occurred when a student took on the role of victim, viewing the mentor who had raised concerns about their poor practice as their persecutor. The student then sought out a co-worker, who was of the opinion that their practice was satisfactory, to act as their rescuer. The student’s ulterior purpose being that the co-worker (rescuer) would chastise the mentor (persecutor) and possibly persuade them to change their mind. The pay-off for the student was that this might alter their assessment result to a pass whilst they also avoided a personal dispute with their mentor.

Mentor's perception of their role as protector of the NHS: In this drama triangle the mentor seemed to feel obligated to rescue their organisation (victim) from the underperforming student (persecutor). The ulterior purpose being to demonstrate that they were a valuable asset to their organisation, the pay-off being that it increased their sense of job security. This may have been a particular concern whilst an economic downturn was in progress.

Mentors' anxiety about being reported on by the media: This drama triangle appeared to exist when the mentor portrayed themselves, and the underperforming student, as the potential victims of negative news reports. The media were, in this case, cast as persecutors. If the student was also prepared to take on the role of rescuer they accepted being failed because this protected both them and their mentor from negative press reports. The mentor's ulterior purpose was to suggest that the press were responsible for the fail grade which was awarded. The pay-off was that the student was less likely to object to the fail grade which reduced the mentor's feelings of guilt.

Academics frustration with mentors who expect them to deliver the 'fail' message to the student: Some situations were identified where academics felt they were expected to rescue the mentor (victim), from the duty of telling the student (potential persecutor) that they were not at the required standard. The mentor's ulterior purpose was to involve a third party in the interview because they were anxious about the student's response and wanted a witness to be present. The pay-off was that the mentor avoided leading an uncomfortable conversation which they did not feel confident to conduct. However in these situations some academics seemed conscious that they were being expected to act as rescuer and did this reluctantly.

Eliminating drama triangles requires that either: the rescuer stops undertaking the rescuer role; or the victim stops transacting in the victim role (Karpman 2007). Instead both should transact from the Adult ego state, which means making autonomous, objective appraisals and stating these in a non-prejudicial way (Berne 1964). Mentors who exhibited a core of steel, particularly those who emphasised the importance of acting with integrity, appeared most able to avoid becoming involved

in drama triangles. This links with Finch *et al.*'s (2013) argument that mentors who are conscious of ego defensive stances: subconscious mechanisms to reduce anxiety and shame (AllPsych 2011), will be more able to manage the uncomfortable feelings that can inhibit them from failing a student.

5.4.3 Regulating the 'Assessor' Role

The current NMC (2008a) SLAiP standards require that mentors undertake both nurturing and assessing roles. This present study demonstrates that the qualities a nurse needs to be a rigorous assessor are not necessarily those associated with 'good' mentoring as portrayed in the nursing press. Such reports most often focus on the student's perspective, not the mentor's, and concentrate on the nurturing and teaching aspects of the role rather than the assessment element (Schaub and Dalrymple 2013). Nettleton and Bray (2008) have advocated separating the mentor and assessor roles to crystallise the functions of each. This fits with the 'hawk and dove' model proposed by McManus *et al.* (2006). Those with 'dove' tendencies were influenced to boost grades in face to face assessment scenarios and may be better suited to the nurturing role of the mentor. Those with 'hawk' attributes were less influenced by the inter-personal nature of practical assessment and were more demanding in their expectations. Black (2011) also identifies courage and awareness of professional gatekeeping responsibilities as essential assessor qualities. Tunstall (2001) and Morgan *et al.* (2002) have also identified discrete traits which lend themselves to either the mentoring or assessing role. Together these findings point to a group of essential qualities required in assessors and identified by mentors in this current study as, "the core of steel" (section 5.3.1). It seems possible that some of these criteria could be used as benchmarks for selecting practice based assessors. Accentuating the qualities of a 'good' assessor (Table 5.6) may be an important step in addressing the imbalance between focus on the mentor and assessor roles.

Study	Attributes of Rigorous Assessors
Hunt (Current study)	The 'Core of Steel': <ul style="list-style-type: none"> ▪ Solidarity, ▪ Tenacity, ▪ Integrity, ▪ Audacity, ▪ Dependability.
Black (2012)	<ul style="list-style-type: none"> ▪ Courage, ▪ Awareness of gatekeeping role.
Nettleton and Bray (2007)	<ul style="list-style-type: none"> ▪ Awareness of gatekeeping role.
McManus <i>et al.</i> (2006) Hawk and Dove Model	'Hawk' tendencies: <ul style="list-style-type: none"> ▪ Demanding expectations, ▪ Not influenced by face to face nature of assessment, ▪ Both male and female, ▪ Experienced in assessment, ▪ Nationalities outside the UK.
Luhanga (2006)	<ul style="list-style-type: none"> ▪ Ability to establish and maintain professional boundaries with students.
Morgan <i>et al.</i> (2002) Examiner /Advisor - advocate Model (adapted)	Examiner approach: <ul style="list-style-type: none"> ▪ Explicitly referring to official and/or personal criteria, ▪ Orientated towards demonstration of professional role, ▪ Drawing on what is absent from the student's practice.
Tunstall (2001) Growth or Mastery	Testing Mastery: <ul style="list-style-type: none"> ▪ Reviews <i>achievement</i> of elements (rather than <i>progression</i> towards).
Phillips <i>et al.</i> (1996)	<ul style="list-style-type: none"> ▪ An understanding of the functions and implications of mentoring.

Table 5.6 Attributes of Rigorous Assessors

Determined efforts should be made to deal with the isolation mentors experience when managing underperforming students. The NMC standards for pre-registration nursing currently require that each student is allocated a named mentor (NMC 2010a). This standard would benefit from further consideration. A team orientated approach to mentoring such as that recommended by Carr and Gidman (2012) may be a more enabling for both student and mentor. Whilst it is acknowledged that a team approach can lead to, "dilution of responsibility" (Huybrecht *et al.* 2011:275), it is argued here that isolation can also lead to assessment paralysis when mentoring an underperforming student. Placing the responsibility for assessment outside the remit of the mentoring team might enable mentors to tolerate the uncertainty which exists as the student's abilities develop.

5.4.4 “The University”

The solidarity of many link lecturers with their practice colleagues was a marked finding of this study. Mentors, PEFs and LLs usually remained united and did not identify themselves or each other as being part of “The University”. The market forces of the corporate entity, “The University”, were seen as outside the values and purpose of the nursing profession. It was apparent that academics, who maintained strong links with practice placements, still saw themselves primarily as nurses. They were keen to maintain their professional integrity before meeting the requirements of their employer. LLs appeared to be adhering to the sentiments espoused by Rolfe (2012:736) by trying to make a difference and not, “succumb[ing] to the corporate goals” of the university.

However, there were other academics who had begun to absorb university culture, they expressed impatience with mentors who struggled with challenging students. Once removed from the everyday business of nursing, it seemed that some nurse academics forgot the reality in which mentors had to function (Neal-Boylan 2013). Academics could underestimate the difficulty of working alongside a student for most of the day and then being expected to give candid face to face feedback. Academics were relatively sheltered through the distancing of internet feedback and scheduled appointments with students. These practices were not available to mentors. The theory practice gap continues to exist whilst nurse lecturers comply with corporate agendas rather than putting patients first. It seems necessary for the NMC to enforce the requirement that all nurse academics engage in the reality of nursing practice to help them to, “re-establish their core values as nurses” (Timmins 2014:286) otherwise they are restricted in what they can teach students. The current NMC consultation regarding periodic revalidation of nurses and midwives (NMC 2014b) offers the profession an opportunity to address this.

Francis (DH 2013a) has stressed that nurses have a duty of candour and the Chief Nurse has emphasised ‘courage’ as one of the six cornerstones of nursing (Cummings 2012). If nurse academics lack the courage to be candid with their university employers about how business

approaches are undermining professional values and patient safety, it is unsurprising that individual mentors feel insecure in their attempts to fail underperforming students in practice. Nurse academics taking a courageous and candid approach should be the first step in enabling mentors to fail underperforming students in practical assessments.

5.5 SUMMARY OF CHAPTER 5

This chapter has presented the category “Braving the Assessment Vortex”. It has demonstrated the challenges and difficulties that mentors encounter when deciding whether or not to pursue the action of failing a student. The position mentors find themselves in is likened to a maelstrom from which they need to extricate themselves if they are to attend to their gatekeeping role. This has been considered in relation to the culture of fear (Furedi 2006) prevalent in health and social care and the culture of entitlement (Twenge and Campbell 2009) which is prevalent in society as a whole. Interactions between mentors, students and others have been explored through Berne’s (1961) theory of transactional analysis. The personal traits of mentors who tackle the challenges of failing an underperforming student have been presented. The processes to be undertaken in building a secure fail decision which have been introduced here will be elaborated on in subsequent chapters.

Chapter 6

Phase Two Findings - Category 1: Identifying the ‘Gist’ of Underperformance

6.1 INTRODUCTION TO CHAPTER 6

This chapter introduces the category “Identifying the ‘Gist’ of Underperformance” which has three subcategories and eight conceptual groups which are illustrated in Figure 6.1. This category crosscuts with two other categories and the connections between these are demonstrated in Figure 6.2. The relationship between this category and its subcategories and conceptual groups is presented, and considered in the light of current literature. The chapter concludes with a summary of the findings related to this category.

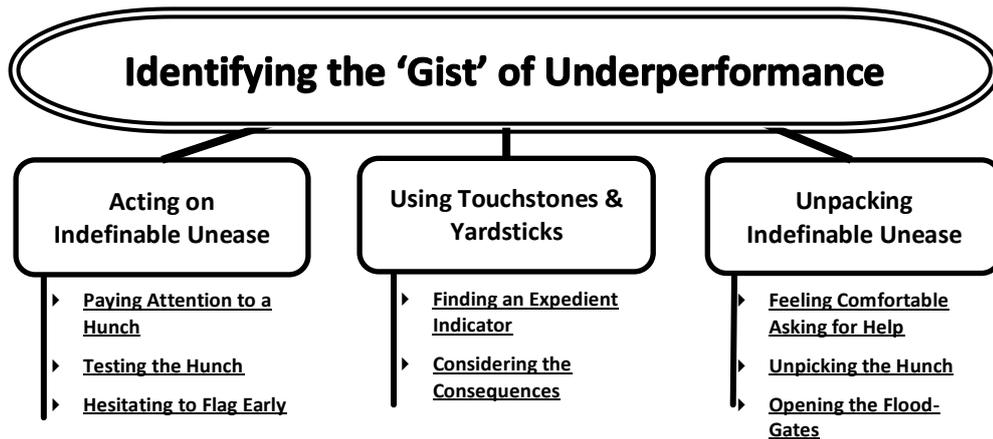


Figure 6.1 The Relationship of Subcategories and Conceptual Groups to Category 1.

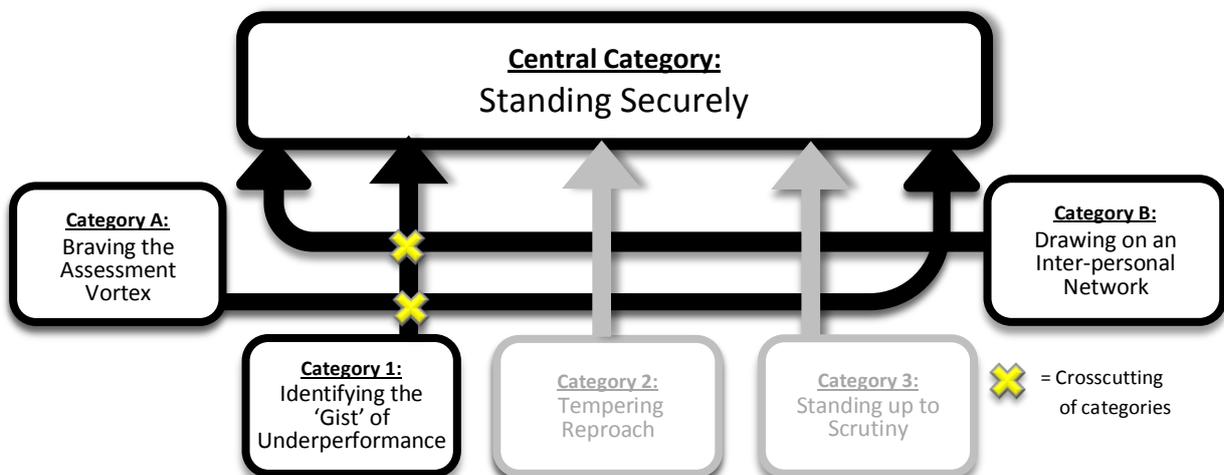


Figure 6.2 The Crosscutting of Category 1 with Category A and Category B

6.2 ACTING ON INDEFINABLE UNEASE

This subcategory examines how mentors rapidly sensed a student was underperforming and why they sought the views of others to substantiate this.

6.2.1 Paying Attention to a Hunch

All participants, without exception, reported experiencing an indefinable unease early on in their relationship with an underperforming student. They described this in various ways:

“Initially it was a hunch.” (MA02)

“Your gut instinct is that he’s saying these bizarre things.” (MA03)

“You just have that sense don’t you? And you know that they’re not going to …” (MA06)

“Sometimes I get this intuition that ... that sometimes things are just not right.” (MA09)

“She just rung my alarm bells and I thought I just don’t think that you should pass.” (MA14)

“I just got this thing in my stomach.” (MA15)

All had actively noted this and considered it worthy of attention, but had struggled to express it in a tangible way. During interviews mentors’ explanations faltered and trailed off into intense hand gestures and facial expressions. When pressed, some described an intuitive impression of something being amiss, coupled with an impalpable sense of discomfort.

“It’s that thing you can’t touch, but you feel and you see and you learn, and we can’t put it in a jar and put a label on it.” (MA12)

Others noted how quickly it had occurred, sometimes in the first few minutes or days of the practical placement.

“You do develop this kind of judgement and it’s automatic and people will say that it’s wrong or it’s unprofessional but it’s a lie because it’s human and you do develop this judgement within five minutes [clicks fingers] like that and you do and you just have it.” (MA15)

This finding is supported by several studies which have noted that mentors rely on, “early intuitive feelings” when concerned about a student’s capabilities (Black 2011:148, Gigerenzer 2007, Cassidy 2009b, Jervis and Tilki’s 2011, Duffy 2013a, Robertson 2013, Debrew 2014). Black *et al.* (2013:slide) refer to these as, “red flags”, a term drawn from the earlier work of Hrobsky and Kersbergen (2002).

Emphasis has been placed on the importance of supervisors noting their own emotional responses when they sense dangerousness in a student (Rittman and Osburn 1995, Poletti and Anka 2013). In this current study mentors reported that they were reluctant to trust their intuitive feelings so early in the placement. However, those who had gone on to fail the student had believed it was worthy of further scrutiny.

6.2.2 Testing the Hunch

Mentors used a variety of strategies to clarify their unease. Some undertook additional observation of the student.

“Okay, well let’s give her the benefit of the doubt. Let’s watch the student and see what they do and if it’s still right and it confirms what you thought then you were still right before.”

(MA15)

“Then I want to validate what I think, right? I might think it. I might be wrong. But I’ve got to see it for myself.” **(MA12)**

“Instinct in the first week isn’t enough. If you’ve got something that backs that up at any level then you think right I am definitely onto something here.” **(MA02)**

This is consistent with Duffy’s (2006) findings that mentors attempt to give the student the benefit of the doubt. Mentors found it easier to confirm or disprove their initial impression when this related to a psychomotor skill and the parameters of acceptable performance were quantifiable.

“I think there were that many issues, to be honest that we actually focussed on the ones that were measurable.” **(MA02)**

More difficulty was reported with ‘softer’ elements such as empathy, professionalism, consideration and courtesy. The following is an example of the complexity of articulating underperformance about one of these elements:

“We’ve gone onto a hospital ward visiting, god knows I’ve done it too many times this last few weeks, and you walk up to reception. You stand there, and you know that they know that you’re there. And you know that they know that you know that they know you’re there. Nobody looks up. They just sit there, don’t they, and they carry on writing. Now I know that you’re busy, but just an ‘Are you alright?’ That’s all I need. Because then I know that you know that I’m still there. Now that for me is unacceptable. And if I have a student doing that then I’ll be failing her.” **(MA12)**

Some mentors sought the opinions of colleagues informally, particularly about 'softer' elements. Mentors suggested that an implicit professional consensus existed about the qualities and abilities a student nurse should have. Their views about the student were bolstered when colleagues agreed with them, even if they too were unable to convey their unease explicitly.

"I'm asking them 'What's your gut instinct?' [and they say] 'Well it's about their familiarity or something and I can't....it's not something that I'm.....I've not been able to say that's inappropriate but I've just got this knot.'" (MA14)

Mentors also sought ways to explore the service user perspective. Some discussed their feelings with family and friends:

"I'll talk to my daughter about it and things like that and my son, he is very much like me. He'd say 'Mother! Well if that's what you think, then that's what should happen' so that's it really, it's just asking them....." (MA09)

and others sought patients' views about the student:

"You've got to involve the patient at some point and say 'How did that feel for you?' Because the bottom line is we are looking after people. And if they find that approach acceptable then it's Okay. If they don't find the approach acceptable then it's not Okay." (MA12)

Mentors used such people to check that their expectations were not unreasonable. Where patients endorsed their view, mentors were encouraged to follow up the hunch. Cassidy (2009b) suggests that using such strategies acts to validate subjectivity; it demonstrates multiple sources have been used to triangulate the judgement, and provides a decision-making trail. Basnett and Sheffield (2010) noted that confirmation from colleagues offered emotional support to supervisors of social work students. However, mentors in this present study noted that employing any of these confirmatory strategies delayed concerns being raised as early as they might have been.

6.2.3 Hesitating to Flag Early

Mentors and support staff stressed the importance of raising concerns as early as possible so that the situation could be well managed.

"You've got to identify pretty quickly if there's anything that's major. And like I said, in a few weeks placement you can be on to your midterm interview if you're not careful." (MA02)

However, mentors reported heightened reluctance to raise concerns promptly when this was founded solely on an indefinable sense of something being wrong. Being unable to articulate the problem made them feel foolish or incompetent which challenged their security. Mentors did not want those who they contacted to think they had made an impulsive decision. Their concern was that support staff would not take them seriously, belittle them, or be critical of their mentoring ability. This heightened insecurity.

“She’s reporting it to the lecturer and then if she’s obviously got to speak to him about how (the student) is performing she was worried about the backlash.” (MA03)

Gainsbury (2010) reported that mentors often felt negatively judged by academic staff, a view shared by Cassidy (2009a:310) who noted that mentors could feel “stupid” for raising concerns. Brown *et al.* (2012) found that mentors were only willing to contact the university as a last resort. Mentors in this current study recognised that their negative expectations about contacting support staff made them reluctant to highlight the situation, even though they knew that early intervention was important. Resolution to this conflict was found through two mechanisms: ‘Using Touchstones and Yardsticks’ and ‘Feeling Comfortable Asking for Help’ which both accelerated the process.

6.3 USING TOUCHSTONES AND YARDSTICKS

This subcategory explores how and why mentors used short cuts to test their initial impression of the student’s underperformance, and to check if their unease had foundation.

6.3.1 Finding an Expedient Indicator

Mentors sought an incisive and convenient way of testing their hunches. Their aim was to measure the magnitude of their hunch promptly, and generate confidence that this had a rational foundation. Using such indicators reduced the need to test their impression out in the more time consuming ways described previously and facilitated concerns being raised at a very early stage.

“I noticed that we use it as a yardstick. As in would you want this particular student looking after a member of their family or themselves? And we use that as a yardstick.” (PE01)

Touchstones and yardsticks were considered convenient reference points against which the student could be assessed. They were viewed as simple tests to indicate that doubts were sufficiently strong to prompt flagging them early. It was recognised that such mechanisms were imperfect and did not mean there was definitely something wrong. However, they helped mentors to view themselves and others as end users, experiencing the student’s practice from various perspectives. Each of these standpoints will now be examined.

6.3.2 Considering the consequences

6.3.2.1 Considering the personal consequences as a patient

The most commonly cited touchstone used by mentors was: ‘Would I let this student look after me or mine?’

“Yeah. Yeah, it’s the one.....it’s the measure...you know? Would I want this person looking after my relative?” (MA13)

This was seen as a powerful way of seeing beyond the immediate situation and helped to organise priorities. Mentors explained that, if the answer to this question produced a scenario in which they could foresee a threat to themselves or a loved one, this galvanised them into taking action. It offered a way of over-riding anxiety about being viewed as irrational, unreasonable or unfair.

Mentors then generalised the predicted personal implications to any service user. Defending one’s own self-interest was rationalised by re-framing the action as advocating for the public. Malihi-Shoja *et al.* (2013:14) point out that, “from a user point of view [this] is the most and, indeed, the only consideration necessary”. The Francis Report (DH 2013a) also emphasises the virtue of this approach, insisting that all health care staff should consider the implications for patients first, at all times. In the present study mentors used this ethical stance to support their judgement, noting it was the most compelling way to justify acting on a hunch.

6.3.2.2 Considering the personal consequences as a nurse

Another frequently cited touchstone was used to consider the student as a colleague. Mentors asked:

“If you acted like that as a qualified nurse to another qualified nurse what would happen to you?” (MA05)

“Could I employ them as a nurse? Would I be happy to have that person turn up on Monday morning give them the drug keys and with the same support that I would give anyone else run a shift? And if I wouldn’t let that person run a shift because I feared for the safety of my service users it’s pretty negligent of me to be signing them off.” (MA02)

Mentors expressed a professional pride in the standard of care in their work area. They did not want to experience the potentially dangerous consequences of having an incompetent registered nurse as their colleague. Raising their concern became even more pressing when the mentor also considered what could happen to them if it was identified that they had sanctioned an incompetent nurse joining their team. When mentors recognised that their employer expected them to comply with the duty of candour recommended by Francis (DH 2013a), and that this extended to their mentoring role, they were more likely to raise concerns. One ward manager emphasised this expectation of her staff saying:

“If one of my mentors wasn’t dealing with it, I would be dealing with them not dealing with it.” (MA07)

When organisations gave preparation of the future workforce a prominent place in their quality metrics, mentors reported feeling empowered as assessors. This reflects Carr and Gidman’s (2012) findings that mentors functioned more effectively when they felt their employer valued the worth of the role.

“You have to be in an organisation where those things are important and where it’s seen that they’re important.” (PE03)

Hence, knowing the expectations of their own organisation gave mentors confidence to raise concerns early.

6.3.2.3 Considering the wider consequences

The final yardstick mentors used was thinking about the potential consequences of the student being employed elsewhere. Mentors asked, 'Would I be happy to pass this student on to anyone else?'. One participant described the uncomfortable experience of taking a phone call from an external organisation which had subsequently employed an incompetent student:

"And she took a job up north, and within eight weeks they were on the phone, and I took the call, and they wanted to know who on earth had signed her off because she was horrendous. Now that's not fair on the people she's looking after. It's not fair to the employer." (MA02)

Mentors considered such events challenged their own personal integrity. Those who had personally encountered this were aware that every mentor was accountable to others within the profession.

Mentors who had failed students were mindful of the level of responsibility inherent in the gatekeeping role.

"You do realise it's your PIN number now? That they can take that away from you? And you need to be making sure that the care you're giving is.....a hundred, you know, 110% really." (MA05)

Such mentors were likely to take action when they encountered an underperforming student. This is consistent with findings from Black's (2011) study.

Some participants reported that they used the acronym NIMBY as yardstick, modifying it to NIMPBY: 'Not in my profession's back-yard'. Hence, considering if the student would be a good ambassador for the profession, the organisation and the university was used as a touchstone.

"As you can see [crying, wipes eyes].....you can probably tell, I feel quite passionate about it because I think.... I think that nursing is so important. We can't let people through unless they're right. I didn't think I was so passionate about it. But, you know, I really do feel that." (LT04)

"I think it's about improving us as a profession and being able to be seen as a profession. That's why I won't take any rubbish from students." (MA14)

Chapter 5.2.1 reported on some of the consequences mentors feared as a result of negative media attention. In the context of this category mentors also suggested that they were protecting the

student from becoming the subject of a professional misconduct hearing which might be reported in the press.

“At the moment, if I passed you, you’re going to be on News at Ten by the end of the month because you really are that unsafe.” (MA02)

“You saw him as being one of those people being on the front of the Nursing Times and the media in maybe five to ten years’ time.” (MA04)

Several mentors described checking the NMC web site regularly because of concerns that certain students, whom they had failed but who had subsequently passed, would be struck off. The motivations for this action were conflicted. They came partly from both wanting reassurance that such nurses had not gone on to do further harm, and also in seeking vindication that it had been right to raise concerns.

“We are going to see them on the NMC ‘role of honour’. When you go on and look at what the conduct things are you know it’s mortifying.” (LT03)

“She resigned very quickly and was gone, I’ve looked for her on the NMC cases to see if she was ever referred.” (MA08)

Focussing on the wider adverse implications could help the mentor to raise the problem early. Being unable to clearly articulate the problem was an opposing inhibitor. To override this inhibition mentors needed to have confidence in the person whom they approached to help them unpack their unease.

6.4 UNPACKING PERCEPTIONS OF UNEASE

This subcategory explores how and why mentors overcame their reluctance to raise concerns based on indefinable unease. It then goes on to examine how this uneasiness was deconstructed and reframed into a rational format.

6.4.1 Feeling Comfortable Asking for Help

Another factor that encouraged mentors to flag concerns early was feeling at ease seeking assistance. Mentors reported seeking out a trusted guide, with whom they felt secure discussing the situation. Usually this was a dependable friend, relative, colleague or manager who was considered as *“the mentor’s mentor”* (MA12). Passmore and Chenery-Morris (2014) noted how much midwives valued a responsive PEF at such times. Mentors in the current study felt most at ease exploring concerns with someone familiar and insightful whose judgment they valued. They were hesitant to approach people they had not met; a finding supported by Brown *et al.* (2012).

MA03: *“I think if you know the lecturer you can phone up and say, ‘Well you know, I don’t want anything but I’m just saying I’ve got this gut instinct about someone and I don’t know what it is, she hasn’t done anything wrong but I’ve just got a gut instinct.’ And it could be just like a friendly chat rather than if you phoned someone up and they’re probably – ‘Who does she think she is?’ She’s got a gut instinct to me is just.....I don’t know.”*

Interviewer: *“So it makes it easier to flag issues earlier, knowing them?”*

MA03: *“Yeah.”*

Interviewer: *“And then what if it ends up being nothing?”*

MA03: *“Well then it isn’t it, you know yourself if you raise something with another professional they would expect....you can’t go round saying ‘It’s my gut instinct’, you’ve got to have evidence.”*

Interviewer: *“But your instinct was right?”*

MA03: *“Yeah it was. But obviously, I still needed, you know, specific information which obviously we got. But it was easier to speak to someone that you actually can face to face, that you’ve met, that you know than a lecturer on the other end of a phone that you’ve never met. You know yourself, if you’ve never met someone and then you’re trying to work alongside them it’s harder because, you know, they think ‘Who does she think she is?’ Whereas if they’d met me they might take my opinion a bit more of value.”*

The ‘mentor’s mentor’ (MM) could be a formal or informal role. The term was used to describe a person who was external to the situation, easy to talk to, listened thoughtfully and provided advice willingly without devaluing the mentor or dismissing the hunch. This helped mentors to relax and speak candidly about the situation. Where a concern had been raised MMs considered it worthy of deliberation whether or not it eventually proved to be accurate. Where PEFs and LLs had high visibility, mentors were more likely to seek help early and more likely to fail weak students (Robinson *et al.* 2012, Brown *et al.* 2012). Parker (2010) noted that social workers also valued a MM

when managing placement difficulties. The good practice of raising the concern early, rather than waiting for firmer examples to emerge, was emphasised by MMs.

“Go with your gut instinct because that’s usually what protects you.” (LT03)

“My advice and encouragement was if your gut instinct is saying that he’s saying these bizarre things, then obviously we need to report it.” (MA03)

They confirmed that it was reasonable to pay attention to the hunch at this point, whilst still being cautious about its reliability. This enabled mentors to live more comfortably with the ambiguity that their unease roused, and to allow evidence to emerge. Mentors became aware that they did not have to be certain to be safe and felt better equipped to tolerate the exploratory discomfort which might allow indicators of the student’s ability to surface. In such circumstances mentors were likely to raise concerns at a much earlier point in the assessment process and gain expedient help in scrutinising them.

6.4.2 Unpicking the Hunch

When a ‘familiar face’ was called upon early the MM could facilitate unpacking the mentor’s hunch whilst recall was fresh. Those with a designated role in supporting mentoring and assessment processes were extremely useful at this point. They were able to reassure the mentor by portraying this imprecise phase of the assessment process as a reasonable initial step.

Mentors were keen to be seen as being fair and felt more confident when they had clear examples of poor practice to demonstrate their concerns because they could use these to support their judgement.

“Intuition’s alright, but if you are going to fail a person, you’ve got to be factual about it. You can’t say ‘I feel that this person’s attitude is poor.’ What do you mean by that? So assessing this sort of thing is really, really difficult.” (MA12)

It was appreciated that ‘intuition’ could be rapid recognition of previous experience, several warning indicators being assembled subconsciously and raising alarm prior to deeper analysis of the situation taking place.

“Intuition is different because it has got its basis in fact. Although you think it’s just a gut feeling, it’s not. It’s based on all that’s come before hand and what your mind puts together. Although you might not do it as a jig-saw, it’s done already up there [points to head].” (MA12)

MA12: *“Unpick it. So what’s this feeling you’ve got because it can’t just be a gut feeling. I think they might describe it as a gut feeling because they can’t explain it any other way but there must be something else.”*

Interviewer: *“So who will help to unpick it?”*

MA12: *“Well probably [the mentor’s] mentor.”*

PEFs and LLs also recognised their role in assisting mentors to unpack a hunch.

“Because when they know you, they have confidence in you, in the fact that if they come to you with a problem, something will be done about it. Their primary focus is actually their patients and they’re not always able to unpick what the student is doing that means they’re not achieving the required standard.” (PE02)

“Part of [the mentor’s] initial gambit was always I can’t give you an example, which was always really funny. Because then I’d go on and say ‘Well we’re going to have to come up with an example. Let’s think about when it is you first felt like that.’ But it would sometimes take them a really long time to get there.” (PE08)

Unpacking ‘intuitive feelings’ was time consuming and impeded care delivery. Gainsbury (2010)

revealed the difficulty mentors experienced in supporting their concerns with solid evidence.

Simpson and Muir (2013) suggested that this was because a practice narrative required a common sense approach which did not fit well with academic processes and competency models of assessment (Knight and Page 2007). This is explored further in chapters 7 and 8.

Mentors also noted that they rarely had to fail a student and hence this was a process they were unfamiliar with. They recognised that PEFs and LLs were more experienced in failing students and had more sophisticated skills and techniques at their disposal to restructure instinctive feelings into tangible indicators. PEFs acknowledged that helping mentors to unpack their sense of unease was one of their key functions and required a large amount of exploratory enquiry.

“It was just always very specific questions like tell me what is the problem? What is it that makes you feel uneasy? What is it that stops you giving that student that patient to look after? What were you doing at that time? Anything that... There’d be something in what they’d said that you’d normally be able to pick up on and drill down that little bit more and ask them some probing questions.” (PE08)

Mentors were able to uncover examples and patterns more easily if they had sufficient thinking time. However, this was not feasible during working hours when thought processes were monopolised by care decisions. Insight was more likely to occur outside working hours.

“I don’t have time to sit here and think for an hour so. I have a 45 minute drive to and from work, so I use that time when I’m sitting in the car to think.” (MA08)

An authentic reason to withdraw from direct care delivery and explore the situation was provided by a PEF visiting the work area. This clearly demonstrated a valid reason for the mentor’s pause in nursing activity to colleagues, and offered some guilt-free work-time in which to consider the ‘hunch’. “Safe discursive space” has been identified as an essential requirement for social work supervisors who are managing underperforming students (Ruch 2007, Finch *et al.* 2013:12, Schaub and Dalrymple 2013). Basnett and Sheffield (2010) have also noted the need to have space to ruminate and manage intrusive thoughts about students whom they found challenging.

Psychomotor examples of incompetence were easier to extract than psychosocial ones. However, in retrospect, mentors could give examples of how both types of incompetence had been broken down and articulated plainly.

“Tasks are really easy to assess, giving injections, writing a report....but the soft things, the things that really, really matter, they are the ones you have difficulty with. Their manners, the way they dress, the way they present themselves to the public and to their colleagues, things like that.” (MA12)

“When you see a student playing with their phone, looking out of the window, fiddling with their coat buttons and looking completely disinterested.” (MA13)

Once they began to extract examples and patterns of behaviour, mentors became calmer because they could present these in a rational and defensible way, which shielded them from challenges by the student or university panels.

“Actually the relief was quite palpable, because all of a sudden, they could then really articulate what the problems were and then they felt justified. Actually I have got five examples which all justify why I’m feeling uneasy, and they felt better because it was something solid, concrete, that nobody could argue with. That had happened, they’d observed it, they were prepared to document it. So it was just the point at which they started to feel more confident.” (PE08)

PEFs noted that mentors might not link their examples with the formal outcomes in practical assessment documents. This was the last stage of unpicking indefinable unease and one which support staff were often directly involved in.

“Think about what it is in your heart of hearts you think they’re struggling with. Then get the practice document in front of you and think about how what you’ve observed fits. Whatever it is find the outcome it relates to.” (PE05)

The help of PEFs in relating real life situations to academic outcomes reinforced to mentors that they were not alone. As feelings of isolation began to diminish, mentors began to feel calmer because they had resources to depend on, validation of their ‘gut instinct’ from others and official sanction all of which provided stabilising forces. A sense of gaining control began to emerge which reduced feelings of insecurity. Mentors reported that, as their composure built and their anxiety lessened, they became better able to articulate examples which supported their assessment of the student.

6.4.3 Opening the Flood Gates

Mentors gathered momentum when requirements had been demystified and they realised that they were expected to provide plain, everyday examples. At this point PEFs reported that “the flood gates opened” (PE08) and mentors would begin generating examples more quickly and easily.

“And sometimes it would be an hours conversation before they’d suddenly get down to a, ‘Actually they charted the observations wrong’, or ‘Their fluid balance calculations are always inaccurate’. They would suddenly come up with that one example. But it was also amazing that once they’d identified that one example, it opened the flood gates and all of a sudden, that’s when all the information would come out. But it would take a really long time to get there.” (PE08)

Mentors felt they needed to provide plenty of examples as, individually, each scenario often sounded petty and unreasonable. At this stage they recognised the tendency to “throw in the kitchen sink” (PE08) to emphasise the extent of the student’s inability. Mentors’ regained their equilibrium when they could provide a number of examples especially if some of these were quantifiable rather than ‘softer’ elements of practice.

Generating rational evidence from indefinable unease increased mentors' sense of security about their decision but it also intensified their concern about causing the student distress. Managing this anxiety is the focus of the next category.

6.5 DISCUSSION OF CATEGORY 1

6.5.1 The 'Gist' of a Nurse

The findings of this category demonstrate that mentors quickly experienced an indefinable sense of unease that a student was underperforming. They liken this to the fast instinctive recognition they experienced when there was a change in a patient's condition. Benner (2001) calls this understanding without rationale. She explains it as an intuitive grasp of a patient's altered state without knowing how a concern has been identified. In mentoring, Black *et al.* (2013) equates this to sensing that something is missing in the student's performance.

Mentors noted that they had an overall sense of the student's underperformance which they could not initially breakdown. This suggests that Gestalt theory may have some relevance in explaining how mentors assess students (Ehrenfels 1890, Wertheimer 1938). The difficulties which mentors experienced in separating the individual factors which had initially raised their concerns, suggests that a complex recognition process occurred subconsciously. Mentors' discomfort was generated by the absence, in the student, of some of the indicators which represented the whole characteristic configuration of "nurse". Eno and Kerr (2013) liken this to mentors using a matrix approach to identify gaps.

Similar responses are well recognised in ornithology (Dooley 2005, Gladwell 2005). Birdwatchers are able to note the vibe of a bird from its few seconds in flight, and through this to identify its family and genus. This is referred to as seeing the 'gist' of a bird; a term thought to come from the word 'gestalt'. Facial recognition systems employed in computer technology also use a gestalt type of

detection. Here algorithms of facial landmarks offer a compressed representation of the whole which provides fast detection of faces in a visual scene (NSTC 2006).

This explanation offers some insight into the speed with which mentors first sense a student is underperforming. This system has some obvious complications which mentors noted; it is unhelpful to the student as it offers them no explanation of what the concerns are, or how to modify their performance. However, when this element of decision making is considered in relation to Kahneman's (2011) model of "thinking, fast and slow", an explanatory framework for the whole process described in this category can be offered.

6.5.2 Recognition Primed Decision Making

Recognition primed decision making is a theoretical framework posited by Kahneman (2011), Klein (1999) and Gladwell (2005). It suggests that humans have two modes of thinking. Generally people are governed by the faster thinking system 1 which does most of its work subconsciously at speed. System 2 is a much slower and more conscious mechanism which acts to critique and modify the fast thinking of system 1. Hence, the terms 'fast' and 'slow' thinking are employed. This mechanism fits with Jervis and Tilki's (2011) recommendation that objectivity and intuition should be used in balance during practical assessment processes.

The gestalt recognition discussed in the previous subsection can be interpreted in this model, as the 'fast thinking' of system 1. This 'fast thinking' is often augmented by 'rules of thumb' called heuristics. These are defined as "simple procedures that help find adequate, though often imperfect, answers to difficult questions" (Kahneman 2011:98). In terms of the findings of this present study the "touchstones and yardsticks" which mentors described using (section 6.3.2) can be seen as heuristics. Heuristics are criticised because they may be susceptible to bias and this is one reason why system 2 thinking is also necessary to moderate system 1. However Klein (1999) demonstrates that heuristic devices are an accurate and essential element of decision making when used by experienced professionals. Here they are seen as 'the acid test', a conclusive and decisive test to

judge the essence of something. The participants in this study, who were experienced professionals, used heuristics as the fundamental criteria by which they judged the essence of the student.

Mentors found it more reassuring to make the decision based on heuristics rather than by using the behaviourist focussed, competence model of assessment, contained in practical assessment documents.

Nevertheless, mentors also deemed it fair and transparent to use the slow thinking system 2 methods, set out in assessment documents, to make explicit to the student and 'The University' how the student was underperforming. At this point mentors requested the assistance of a PEF or LL to help them unpackage their perceived 'gist' of the student. The painstaking nature of this unpacking process, as described by PEFs, illustrates how deeply embedded the 'gist' of a nurse was in mentors' subconscious, and reveals the skilled practice of PEFs in extracting the component parts. Cassidy (2009b:33) considers this to be the vital element of, "substantiated intuitive judgement". This process though had a disadvantage; as the component parts were drawn out, each individual item sounded trivial and the sense of the whole was lost. This may be why, at this point, 'throwing in the kitchen sink' occurred and mentors generated more and more discrete elements to try and recapture the whole essence of the student's performance. This offers some insight into why the tensions exist between the professional judgement of nurses and the behaviourally-based outcomes favoured by academics (Simpson and Murr 2013). It also demonstrates why portfolios may be an ineffective practical assessment method because the 'gist' of the student's capability is lost when performance is broken down to fit competency statements.

It is acknowledged here that the most recent iteration of the Standards for Pre-registration Nursing (NMC 2010a) goes some way to producing heuristics. These present four key domains which students should be judged against. These NMC Standards were being implemented in year one of some pre-registration nursing programmes when this current study was conducted, but were not embedded in all courses. Future evaluation may indicate how useful these four domains have been in acting as heuristics for mentors.

6.5.3 Formulating a Decision: Step 1

Ascertaining that their judgement of the underperforming student was sound did not mean that the mentor would necessarily award a fail outcome. Consideration of the student's practical ability comprised only the first element of a more complex decision-making process, which involved other external factors. However, deciding that the student would not be allowed to care for them or their loved ones was the first step mentors took in formulating a decision (Fig 6.1). Making this initial decision led the mentor on to consider further influencing factors which will be explored in chapters 7 and 8.

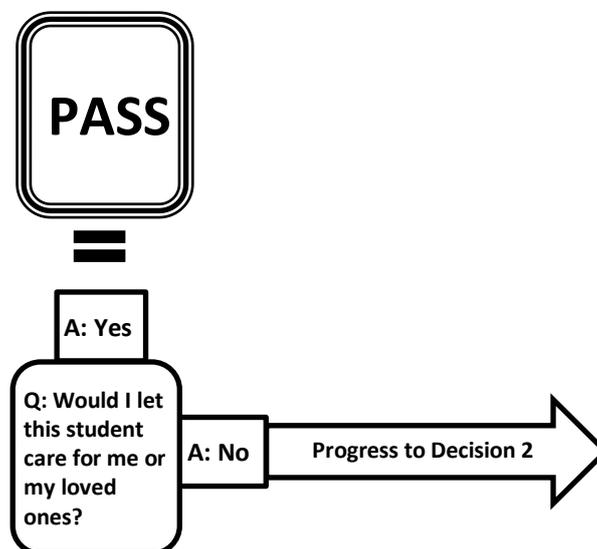


Fig 6.3 Step one of decision formulation.

6.6 SUMMARY OF CHAPTER 6

This chapter has presented the category “Identifying the ‘Gist’ of Underperformance”. It demonstrated how mentors rapidly sensed that a student was underperforming, used short cuts to test this and went on to deconstruct the intuitive unease they experienced and reframe it into a rational format. This process has been considered with regard to Gestalt psychology (Wertheimer 1938) and also in relation to rapid cognition theory and recognition primed decision making theory (Kahaneman 2011, Klein 1999, Gigerenzer 2007 and Gladwell 2005). The second step mentors undertook in formulating a fail decision, “Tempering Reproach”, is considered in the next chapter.

Chapter 7

Phase Two Findings – Category 2: Tempering Reproach

7.1 INTRODUCTION TO CHAPTER 7

This chapter introduces the category “Tempering Reproach” which has three subcategories and eight conceptual groups which are illustrated in Figure 7.1. This category crosscuts with two other categories and the connections between these are demonstrated in Figure 7.2. The relationship between this category, and its subcategories, and conceptual groups are presented and considered in the light of current literature. The chapter concludes with a summary of the main findings related to this category.

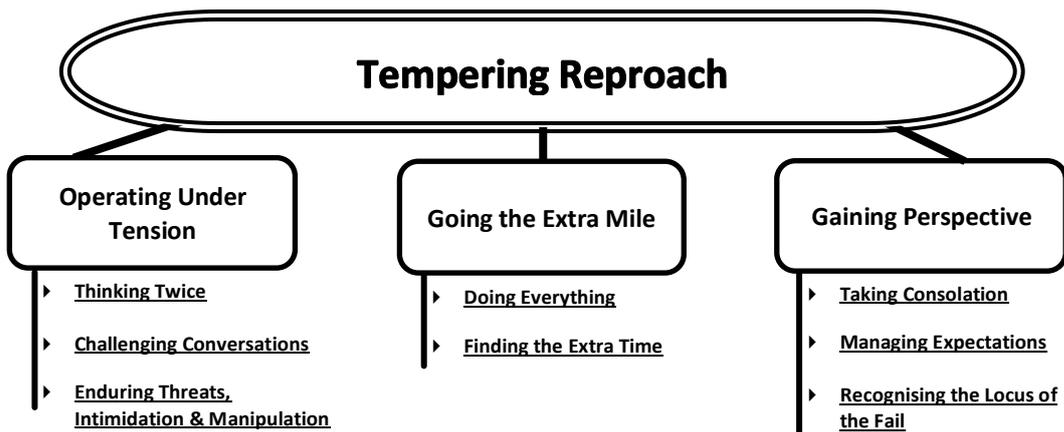


Figure 7.1 The Relationship of Subcategories and Conceptual Groups to Category 2.

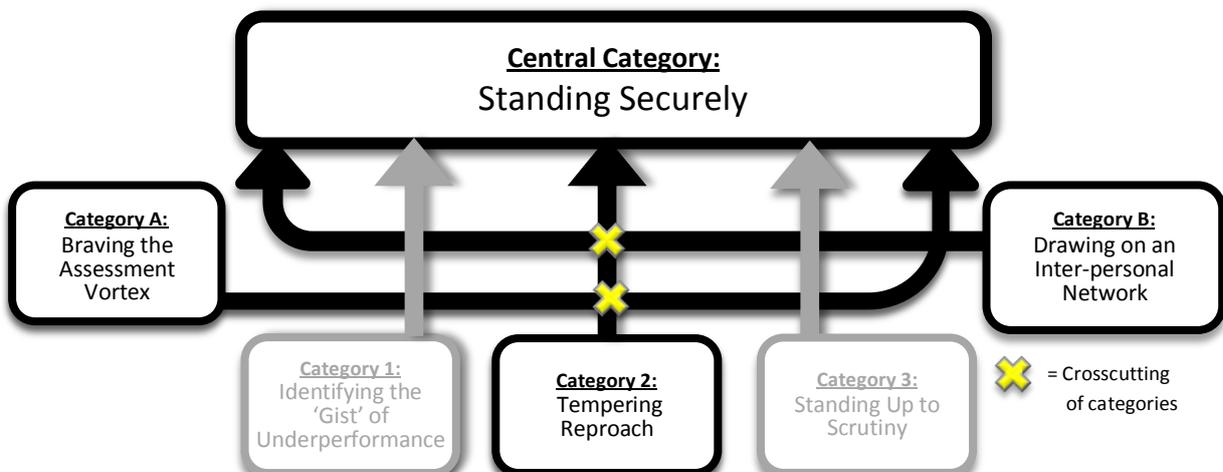


Figure 7.2 The Crosscutting of Category 2 with Categories A and B

7.2 OPERATING UNDER TENSION

Mentors realised that, once they had identified what was generating their unease, it was possible to communicate a set of examples to the student. However, they felt responsible for the negative feedback and worried about the student's response. This caused tension which made it difficult to initiate dialogue.

7.2.1 Thinking Twice

Participants reported experiencing a second wave of hesitation, because causing a student anxiety ran counter to the usual intent of nurses. Discomfort was exacerbated when negative feedback came from a team because this could be construed as ganging up against the student. Mentors questioned if they were the 'good' person they had thought because they saw themselves as the source of the student's misery, hence internal conflict began to re-emerge.

"You never with a patient or client say 'You've failed.' And then suddenly, we're expected to be able to do that in the student and their mentor role. And we expect them to do something that is actually professionally a bit counterintuitive. And I think, I might sometimes say to people it is a bit counterintuitive to the rest of your role where you're trying to be upbeat and positive and optimistic. And you'd never be in a position to say 'You've not met the standard.' But that is exactly what you're expecting mentors to do really." (PE05)

Most research in this area recognises the, "emotional loading" (Eno and Kerr 2013:136) which accompanies the recognition of an underperforming student (Duffy 2006, Finch 2009, Basnett and Sheffield 2010, Black 2011). Vacillation between two equally unpalatable alternatives follows. Finch *et al.* (2013b) suggest that this is because mentors are vicariously experiencing the student's burden as well as coping with their own feelings, which Basnett and Sheffield (2010) associate with grief and loss. These feelings can be so strong that they paralyse mentors (Finch and Poletti 2013).

Mentors in this current study were eager to be viewed as fair, and reported seeking alternative reasons for the student's poor performance. If these could be found, the mentor felt absolved of the need to fail the student, could switch back to helping mode, and their self-perception remained intact.

Mentors explained that they did not come to work to deliberately make someone's life miserable and preferred nurturing to judging students.

"One of the things I'm very clear on is that we have to treat students how we'd treat ourselves and if a student is ill, if a student has problems at home we need to know about it and we need to be able to protect them from what's happening on the ward." (MA14)

A maternal instinct was evident in both female and male participants.

"You feel like you're hatching an egg and you want to see it, you want to take them under your wing." (MA15)

"It's like having a child isn't it, or you're rearing something. I suppose it's because you want them to succeed." (MA06)

Mentors expressed genuine anxiety about the wider psychosocial consequences that failing could have for the student. Wisdom (2011) and Luhanga *et al.* (2010) have both identified similar maternal concerns in mentors. Hence assessing a junior workmate generated moral dilemmas and distress for mentors (Huybrecht *et al.* 2011).

If no alternative reasons for the student's poor performance could be found, mentors often blamed themselves. This is consistent with the findings of a number of studies (Duffy 2006, Finch 2009, Black 2011, Basnett and Sheffield 2010). Feelings of self-reproach emerged and mentors searched for ways to put things right for everyone. Guilt was lessened when mentors knew that, if they raised concerns early, they could give the student the opportunity to improve which provided hope. This aided delivering honest feedback at an early stage. However such challenging interactions were outside mentors' parameters of comfort, and resolve could waver. Anxiety remained high about how to deliver the message and this could delay feedback.

7.2.2 Challenging Conversations

Mentors found broaching concerns with students difficult. They worried about how the student would react and dwelt on negative accounts from colleagues (see Chapter 5.2.2). The level of unease with which mentors approached interviews is illustrated by one PE:

“As she was talking to the student, bless her, her hands were shaking and she was trying, you know, to tick off on a little list. And bless her, the lass was shaking, so I knew she felt anxious, I knew she was under a lot of pressure.” (LT03)

Anxiety focussed around several elements: the seriousness of the consequences for the student and for patients: the discord which could arise between the mentor and the student; and the potential for emotions to run high. When students reacted negatively to feedback this exacerbated mentors' guilt and made on-going relations difficult. Students who were receptive to feedback made it easier to maintain a nurturing relationship in which the mentor could help them to develop.

PEFs noted conversations could be handled badly because mentors wanted to get them over with quickly and withdraw from potential conflict. In such instances mentors could deliver the message quickly and bluntly.

“The most horrifying experiences have been when I've been called on to sit in on a final interview because the student's failing and the mentor seemed to think that it's alright to simply hand over a placement document and say 'Well, I can't pass you on this placement.' And there's this sort of silence.” (PE02)

This might be interpreted as the hesitant behaviour of an insecure mentor, or that the mentor did not have the right words that were understandable and meaningful to the student. The negative emotions this could engender in the student were also observed. Where the message had been delivered in a clumsy way it was usually inevitable that the student/mentor relationship degenerated.

PEFs noted that having a person to witness, facilitate and arbitrate the conversation enhanced mentor confidence, but that self-belief could be boosted further when mentors believed that they could lead the interview productively themselves. Mentors used the term “challenging conversations” (MA01) to describe such interactions and this had two meanings. Firstly, undertaking such conversations challenged mentors' skills and abilities. Secondly, the purpose was to challenge and scrutinise students, questioning their poor performance and examining ways to tackle this. Duffy (2013b) has also noted that mentors need help to undertake challenging conversations.

“They are mentoring students really well because they are challenging the student and I think they find that difficult.” (PE06)

“Those mentors knew what they wanted to do it was just a case of - how do we do it in a reasonable manner?” (LT03)

Having a colleague or PEF at hand helped mentors prepare for the conversation, making them feel better equipped to conduct the discussion. Cassidy (2009b:307) suggested that this also helped students to see that mentors were, “investing in a learning dialogue”. This required structuring the conversation around explicit factors, which participants identified as:

- being clear about the student’s shortcomings without becoming emotive,
- focussing on enabling the student to improve,
- noting the needs of all parties involved,
- remaining mindful of the standard to be achieved.

This is congruent with Jervis and Tilki’s (2011) recommendation that emphasis should be placed on helping mentors to deliver sensitive but explicit messages. This ensured that the feedback given to the student and the University was consistent (Fitzgerald *et al.* 2010), and mentors did not later dwell on what might have been said in the conversation but was not (Schaub and Dalrymple 2013). Rooke (2014:45) noted that an, “honest and open” dialogue was thus promoted. However, it was observed by participants in this current study that conducting a focused conversation did not always result in a positive response. There was a tendency for students to externalise the reasons for their shortcomings, often blaming the mentor. Mentors did not underestimate the effect that a student who rejected and disputed their feedback could have upon them, but where they felt adept in conducting challenging conversations they were capable of enduring this. This is consistent with Staykova *et al.*’s (2014) findings that mentors viewed conflict resolution strategies as important.

7.2.3 Enduring Threats, Intimidation and Manipulation

Once feedback had been provided, students would either endeavour to improve their performance or reject the criticism and attempt to sway the assessment outcome by manipulating the mentor.

Where students expected frank feedback, recognised that patients' needs superseded theirs, and knew that they should take responsibility for their own performance, they responded constructively.

"[The student] has learnt a massive amount from the way she tackled it and realising some of the issues were of her own making and it has definitely altered the way she puts herself across because of it." (LT01)

"[The student] said, 'You haven't nagged me, what you've done is kicked my backside, so it's made me realise how much work I've needed to do.'" (MA05)

In such circumstances mentors were able to work productively to improve student performance, rather than defensively to protect themselves. This was considered a win/win situation in which both parties benefitted because a successful outcome was more likely for the student and it reaffirmed that the mentor was 'good'.

However, in some situations participants reported that students' behaviour became manipulative, a point also noted by Gainsbury (2010). As discussed in chapter 5, strategies ranged from gentle persuasion to malevolent coercion. Four types of coercive students were identified by participants:

- Ingratiators
- Diverters
- Disparagers
- Aggressors

Each type intensified mentors' guilt and fear to differing levels. This is illustrated in Chart 7.3

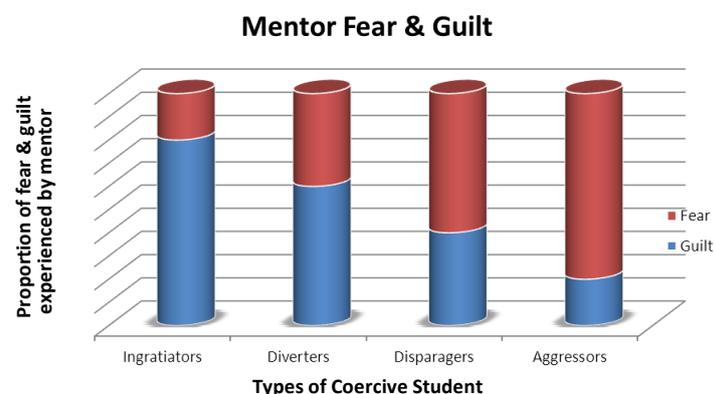


Chart 7.3. The effect of coercive student behaviour on mentors' fear and guilt.

The four types of coercive students which participants identified and the strategies they employed to manage these are now explored further.

7.2.3.1 Ingratiators

Ingratiators were characterised as students who bought themselves favour with their mentor by deliberate efforts such as being charming, obliging, indulging or emotionally exploitative. Mentors were susceptible to high levels of guilt and low levels of fear when students employed these tactics. Such students often had likeable personalities and worked to sway mentors by doing supplementary things to please them such as bringing in cakes and making cups of tea, running extraneous errands, offering compliments and flattery, or using persuasive emotional tactics like begging to be passed or overt demonstrations of emotion such as hugging or crying.

“This very sweet person, which also made the thing difficult, this was a very sweet apparently very biddable and very pleasant little creature that they were saying ‘No’ to.” (PE03)

“The student will either try to be tearful, you know start crying or why, why, why have you got to fail me? And sometime the student will pile on the pressure.” (PE01)

Such actions tested mentors' views of themselves as 'good' people who avoided causing harm, and open displays of emotion and distress particularly exploited their disposition to comfort and nurture. This further played on the mentor's guilt because they saw that they were causing harm to a pleasant person, who was not menacing them, and this made them feel worse about themselves.

7.2.3.2 Diverters

Diverters were depicted as students who attempted to distract and redirect the mentor's focus. Such students played on factors which were unconnected to the area of underperformance and could incorporate such elements as illness, personal circumstances, disability or on-going university proceedings.

“His personal problems, he'd already been told they shouldn't be impacting on his placement. For example, his washing machine had flooded, well that's got nothing to do with us. It was like my car broke down, I had to get a bus and taxi to work. So it was all irrelevant things that he knew shouldn't have an effect, he blew them out of all proportion.” (MA04)

“Students can bring a lot of baggage with them as well and this lassie, she was quite good at eliciting concern and making people feel that really this was her background and where she’s come from and her situation, she wasn’t averse to leaning on people to let them to think she would get better with time. I think mentors need to have support to resist all of that baggage.”
(PE03)

Mentors often described the help which they had offered, but noted diverters were keen to remain on placement rather than take advantage of the alternative solutions they had been offered.

“All of us collectively kept saying to her ‘Look I think you should take a break and then come back to nursing, concentrate on this now.’ and so we all said it but she didn’t want to, she wanted to carry on.” **(MA06)**

It was sometimes difficult for mentors to separate the relevant from the irrelevant in such circumstances. For example, a student who was seen spitting in the ward sinks, emphasised that she had reduced hearing **(MA08)**. Even where mentors were able to discriminate, disabilities or difficult personal circumstances could burden their conscience and this increased guilt.

However, mentors were also concerned that they might inadvertently have been unreasonable in their management and assessment of the student, and so anxiety also began to manifest itself more clearly alongside the guilt.

“They’ll take student’s problems on that they shouldn’t be taking on. And I think sometimes we need to remind mentors that their main job as a mentor is, yes it’s to be supportive, but the bottom line is for them as mentors to objectively assess whether a student is passing their objectives, and if they’re not they’ve got to fail them.” **(PE06)**

Mentors coped with both ingratators and diverters by revisiting the touchstones and yardsticks they had used during the intuitive phase of the initial assessment (See Chapter 6.3). If a threat of harm to a loved one could be foreseen it counteracted the guilt of causing harm to the student.

7.2.3.3 Disparagers

Disparagers were described as students who challenged their mentor in belittling, denigrating or professionally harmful ways. The student could employ two methods. First, they might question the mentor’s reasonableness and competence, or second, accuse the mentor of harassment, bullying or discriminatory behaviour. Mentors recognised that students had a right to raise these concerns, but

noted that such counter claims could be used to distract attention away from the student's under-performance.

"They've got the right to appeal against us if they think we've been unjust towards them."
(MA04)

Where such strategies were used, mentors' levels of fear increased as they became anxious that they would be identified as having shortcoming and would be in trouble.

"It's quite difficult because they fear that a student will turn around and say 'Well you haven't helped me.'" (LT05)

Mentors envisioned an ensuing investigation which might focus on their competence as a nurse and any weaknesses in their own practice, any failings in the way they had supported the student, or professional misconduct in terms of prejudice or intimidation.

In some instances guilt prompted mentors to question themselves deeply about their motives for raising concerns with the student. In such cases mentors preferred to blame themselves.

"As soon as the student starts to kick back they'll back off and say 'Oh you know it must have been me as a mentor'." (PE06)

The touchstones and yardsticks used during the intuitive phase of the decision bolstered mentors' interpretations of themselves as patient advocates and rigorous gatekeepers. Hence they could justify that they had acted in an altruistic way because least harm had been done, the wider-ranging outcome was positive, and this tallied with a nurse's usual self-perception. Mentors felt further protected when they were aware of the availability of official administrative mechanisms to support and advise them in such circumstances. These will be further explored in Chapter 9.

Accusations of bullying and harassment were problematic for mentors because they had difficulty in discriminating between what might be considered thorough and conscientious feedback, and what could be seen as bullying and harassment. They felt that students were seldom exposed to frank critiques and so were not accustomed to this; consequently they were ill-prepared for criticism of their practice. Hence a culture of expectation led students to believe they were entitled to succeed (see also Chapter 5.4.1 for discussion about the culture of entitlement). This, coupled with the

previously discussed belief that a 'good' mentor could help any student to pass a practice based assessment, could result in students reacting defensively or counter-attacking to refute the criticism being levelled at them.

"This student refused to sign any paperwork. She refused to acknowledge the meeting had taken place. Very aggressive to the mentor, finger pointing, hostile; so much so that on one visit I had to stop her and say 'Look this behaviour will not be tolerated, it's unacceptable, it's aggressive, it's bullying and it's harassment and it has to stop.'" (LT06)

This behaviour occurred when the student believed the mentor had broken faith with them. It could lead to the mentor feeling they were being bullied and harassed by the student. Positions of resentment could arise, it became increasingly difficult to maintain a functional mentor/student partnership, and this often meant that the relationship broke down.

7.2.3.4 Aggressors

Aggressors were viewed as students who engaged in open hostility towards their mentor after negative feedback. Such students might threaten the mentor psychologically or physically and do this directly or via a third party.

"I don't live locally and I came downstairs one day to find a hand written note on my doorstep, actually inside the porch from this student." (MA08)

"We had a student's boyfriend come and threaten the mentor because they'd said they were going to fail them....They were quite frightened because the student in question had said what a bad temper this individual had and that they were a martial arts expert and nightclub doorman. They were quite concerned for their safety and for several weeks afterwards we made sure they never left the building on their own....Especially when the partner came into the car park and threatened [the mentor] and he was supported, he was never left to go out of the building on his own, even in the day someone went to his car with him. " (MA13)

In such situations mentors experienced heightened fear but only limited guilt. These were the most extreme situations described by mentors. Physical support from colleagues and intervention by security staff and the police helped mentors to cope. In these cases mentors were deeply affected by the lengths to which students and their families/friends would go. When threats reached the front door of their home, mentors recognised the tenacity and courage they needed to see through the assessment of the student to its rightful conclusion. However, they also noted that their feelings

of guilt subsided because the student's behaviour was so severe that the mentor's judgement of them was vindicated.

"If the student is belligerent that makes life a bit easier." (LT02)

In such cases students were usually removed from the placement area and fitness to practice proceedings were instigated. However, in some situations mentors reported that they had continued to persevere with mentoring such students.

Much has been written about toxic mentors, detailing their negative attributes and obstructive approaches to student learning in practice placements (Darling 1984, 1986). However, PEFs and LLs who participated in this current study indicated that mentors who failed students did not have the characteristics of the 'toxic' profile. Rather, mentors who had failed a student were identified as motivated, 'good' mentors, who were prepared to 'go the extra mile' for their student before deciding to award a fail grade.

This study indicates that coercive students exist who exert improper influence over their mentor's assessment decisions. Ann Keen in her keynote speech to the RCN Congress in 2009 warned students not to do mentors a disservice (Kendall Raynor 2009) and service users have raised concerns that weak students "work the system" if they think they are going to fail (Malihi-Shoja *et al.* 2013:10). These views are consistent with Passmore and Chenery-Morris's (2014) observations that midwifery students exert pressure on their assessors, and concerns expressed by Canadian nurses that students conceal damaging evidence about their performance (Luhanga *et al.* 2010). In social work this has been attributed to students' difficulty in objectively critiquing their own performance (Schaub and Dalrymple 2013) and the tendency to blame external forces (Poletti and Anka 2013). Furness (2011) noted that male social work students particularly adopted a defensive stance. The question of how to suitably manage such students is one which deserves further study.

7.3 GOING THE EXTRA MILE

A key strategy used by mentors to cope with these circumstances was 'going the extra mile'. This meant making every effort to help the student succeed by going beyond what could reasonably be expected or required of a mentor. This necessitated mentors dipping into their physical and psychological reserves to provide additional resources of time, materials, and emotional investment.

7.3.1 Doing Everything

Mentors felt it was important that they were seen as wanting the student to pass, and doing everything they could to accomplish this. This fitted with their expectation of a 'good' mentor. Mentors' motives were identified as preserving self-image, reducing guilt, and defence against external criticism and threats. Mentors felt they needed to do everything they could to help the student so that they did not reproach themselves later. They wanted to be seen as reasonable and not viewed as mistreating the student. This might be seen as insecurity, or stemming from both the nurturing tendencies authentic mentors possess, and participants' individual concepts of themselves as intrinsically supportive people. Mentors' own expectations of themselves were often unrealistic in such situations. They felt they must be seen to be exerting full effort and advocating for their student so that they were above reproach. This could bring about a situation in which the mentor's approach of doing everything for the student became paternalistic and the student passively accepted this, expecting the mentor to be the one who overcame the obstacles for them, and both parties colluding to reinforce the myth that a 'good' mentor can ensure every student passes.

"I wasn't here to fail him, I was here to get him through." (MA04)

This belief resulted in mentors taking their efforts to extremes and exhausting themselves.

"You've put so much effort into somebody over several weeks. I mean I've done...I've gone...I've stayed after they've gone. I've been doing homework for them at home, doing questions, just writing it out at home, bringing it in for them, coming in early, on your late shift spent time with them." (MA01)

PEFs noted that mentors surrendered their own well-being to be seen to be doing a scrupulous job. They generated a device which could physically and psychologically deplete them, whilst not necessarily enhancing the students' performance. Rather than putting in additional effort, students could exploit the mentor's endeavours. This finding is consistent with other studies which have noted that one-to-one mentoring relationships can result in excessively dependent students (Brennan and Williams 1993, Budgeon and Gamroth 2008, Luhnaga *et al.* 2010).

However, for mentors, knowing they had undertaken these extended activities made it easier to fail the student. If they could reassure themselves that they had done everything possible, this appeased feelings of guilt and reduced concern that they could be blamed for the students continued poor practice.

"I think it is very important for mentors to feel that they have done everything that they can to ensure that the student could succeed, and that if the student doesn't succeed at the end it's because the student couldn't make the practice. That was almost an organic thing, but I did realise over the years, as I became involved in supporting mentors in their day to day decisions, that that was really important to them, to feel that they had given [the student] every opportunity because it's quite a hard thing, and the student's stance will be that 'You didn't help me.' " (PE03)

Some mentors recognised that they were acting defensively but felt this was inevitable given the demanding expectations of students and the university.

"I do think we've gone too far down this human rights and the student rights route. At the expense of practice and care I think, and safety. Because the student has the right to appeal about everything and they've got the impression now that simply turning up on a course is enough to become a nurse. Sitting in a classroom and being spoon fed every day is enough to be a nurse." (LT06)

It was noted that much of the extra work mentors undertook was based on goodwill and that often no extra time was provided to facilitate this. Hence mentors were much more likely to fail an underperforming student where they had been willing to use their own personal resources to create the extra time.

7.3.2 Finding the Extra Time

Rawles (2013) and Burgess *et al.* (1998) have both questioned why it takes so much more time to fail a student than pass them. In this current study participants suggested this was due to the mentor's tendency to leave no stone unturned and because of the need to follow exacting assessment processes flawlessly. Mentors were not generally allocated any extra time to accommodate this. They identified the need to be both committed and resourceful in generating this additional time if they were to see the job through to a suitable conclusion, whilst also maintaining a reasonable standard of care for patients. Lack of time is a recurrent theme which continues to be raised in almost all of the most recent studies about mentoring in health and social care (see for examples, Finch 2009, Luhanga *et al.* 2010, Teatheridge 2010, Black 2011, Huybrecht *et al.* 2011, Carr and Gidman 2012, Cassidy *et al.* 2012, Robinson *et al.* 2012, Willis-RCN 2012, Veeramah 2012, Duffy 2013a, Jokelainen *et al.* 2013, Kendall-Raynor 2013, Rawles 2013, Rooke 2014, Hutchinson and Cochrane 2014). This well documented difficulty was summed up by Lord Willis, the chair of the commission on nursing education, who reported that, "the greatest source of heartache" for him was mentors telling him how they struggled to make time for students (Kendall-Raynor 2013:13).

The extra hours could be found in three ways. Time could be generated within working hours, personal time adjacent to working hours could be put aside or private time away from work could be used.

"They come in early and you know even if the student's coming in at 9 and the student is working until 5, for the nurses to catch up on their bits they haven't done they're coming in at eight and they are still there at six and seven. And one nurse only two weeks ago, I had to go in at the weekend. I went in and he's working in the office on a Saturday and I said 'What are you doing?' and he said 'I've got a student with me and I'm having to catch up.'" (MA13)

Generally this time was provided through the goodwill of the mentor or their colleagues. These three time clusters will now be examined in further detail.

Generating extra time within working hours caused mentors two concerns. Firstly, that the underperforming student's additional needs were being met to the detriment of patients and

secondly, that colleagues might think they were workshy. Certain mentoring activities did have to be undertaken during this time frame; these usually related to presenting the student with extra practical learning opportunities. In most cases the time to facilitate this was found through prioritisation, time management, cutting corners or through negotiation with colleagues to take up the slack.

Interviewer: *"So how do you get this extra time that you need with a failing student?"*

MA15: *"You don't, you make time."*

Interviewer: *"How?"*

MA15: *"You either rush jobs safely. You cut corners, safely. You delegate other tasks, long tasks to other girls, you say 'I really need to sit down with this student and I really need you to do this for me.' You talk to your manager and go if you're on an early, 'Look I'm having to hand these patients over at two so I can have an hour with her'."*

This caused an increased workload which had to be squeezed into insufficient space and could result in short cuts being taken. In only one case was an organisational structure identified which provided additional time to mentor students.

Interviewer: *"Who facilitates that time for you?"*

MA07: *"I do."*

Interviewer: *"How?"*

MA07: *"By moving other things or doing it after hours."*

Interviewer: *"What about the mentors, do they do the same?"*

MA07: *"No, they have allocated time. I allocate for my colleagues and they have half a session per week which is four hours just solely for their mentoring role."*

In this team, the mentoring role was given high priority. This gave staff confidence to take a pause from direct patient care and include mentoring functions during their working day. Hence they were freed from the guilt and anxiety of either putting patients at risk or colleagues under extra pressure.

Using personal time which bordered work time was another strategy. This involved giving up lunch and coffee breaks, arriving before working hours or staying behind after shifts. Time generated in this way could be put to several uses. Firstly, if the student was also willing to give up personal time this could be used for extra practical learning opportunities, meetings and interviews. Secondly, the mentor could catch up with nursing duties, such as delivering elements of care and completing patient records, which they had not been able to fulfil whilst undertaking intensive mentoring activity. Thirdly, the time could be used to organise and produce extra learning activities and

resources. Fourthly, to liaise with colleagues, PEFs and LLs regarding the student, or lastly to negotiate and complete the complex paperwork involved in managing an underperforming student. Using this method to generate the extra time alleviated mentors' anxieties about standards of care being compromised and not doing their share of the work. However, it meant mentors worked above their contracted hours, potentially compromising their own well-being by forgoing breaks and meals to fulfil their mentoring duties. Carr and Gidman's (2012) study noted how this could impact on the mentor's work-life balance.

Giving up personal time outside working hours was another approach. This involved undertaking work during days off, annual leave and sleeping time if working nights. Time generated in this way was used to catch up with paperwork, produce extra learning resources and make contact with and meet PEFs and LLs. Here the disconnection between the 9-5 working hours of education staff and the 24/7 nature of care work became striking. This is consistent with Schaffer's (2013) findings that mentors' variable shift-patterns limited the support available during working hours. Mentors generally made the concessions, giving up their personal time to accommodate hours when education staff were available to support them.

MA15: *"Oh that was when I got home, I was staying awake after a night shift. I got home about 9.30 and I was on the phone to the Uni for support when I got home so I didn't go to bed until about 11 o'clock in the morning and that was when we were on night shifts."*

Interviewer: *"So it takes extra time when you've got a failing student?"*

MA15: *"Oh god yeah! Absolutely! Oh much more time! I think the last girl I had by comparison hardly needed me at all."*

PEFs were concerned by the amount of extra time mentors committed to an underperforming student. They noticed mentors were motivated to do this by a combination of professional pride and integrity mixed with fear and guilt.

"It's much easier to fail them and not feel so bad when you know you've done god knows how many hours, I think it's much easier." (MA01)

"If I felt that I'd been so busy on placement that I wasn't giving the student 100% then I'd be very reluctant to fail them." (MA08)

All participants were clear that they would not consider failing a student until they were satisfied that they had been an exceptional mentor who could have done no more to help the student. Such intent suggests that participants in this study were unlikely to be toxic mentors (Darling 1986). This is consistent with Robinson *et al.*'s (2012:6) view that such mentors were, "doing a good job."

7.4 GAINING PERSPECTIVE

Identifying that they could not have done more did not make the mentor feel guiltless about failing students. Participants described feeling emotionally burdened because there was no possible outcome in which everyone flourished. They described experiences of distress, frustration, dread, disbelief, indignation and pressure which left them "*feeling horrible*" (MA05) and "*like a baddie*" (MA09) which impeded clear thinking. Three practices helped the mentor to gain perspective on the situation, which were: taking consolation; managing expectations; and recognising the locus of the fail.

7.4.1 Taking Consolation

Participants identified that gaining consolation comprised discharging frustration, checking personal motives, and being shown kindness and understanding. Mentors were exasperated by both the student's lack of progress and their own inability to improve the situation. Duffy (2013a) has also noted mentor anger directed at both previous colleagues and 'The University' for neglecting to deal with the student at an early stage. These feelings could overwhelm mentors who needed to release frustration so they could see beyond it. In each case this involved venting feelings to a willing listener.

"She [PEF] was someone we could go to and rant and rave at." (MA04)

"You take it out on your husband. My husband has to hear most of it and he just sits and listens but you've got to explode at someone." (MA09)

This cathartic release helped mentors to restore composure and view the situation more coherently.

Whilst wrestling with their emotions, mentors repeatedly verified they were doing the right thing with others. No choice seemed to be wholly right, and the decision was actually about doing the least harm. Mentors reflected on their motives for failing the student to ensure they were not being mischievous, malicious or overly severe. PEFs and LLs also noted their own need for reassurance and this was described as 'the ascending question' which all levels of staff asked of each other. It seemed that everyone sought out others to obtain reassurance that doing such an unpleasant thing to a student nurse was the best overall outcome. It cannot be overemphasised how much checking of this point was undertaken, and how widely this was done before a consensus was reached. A collegiate response was generated which demonstrated strong moderation of the decision through ascending tiers of the nurse education system. This collective response gave participants the determination to follow the decision through, despite the fact that it would cause both them and the student distress.

PE03: *"At the end of all of that actually I had to go home and my poor husband got it all night because I'd found this entire business traumatic as well and I think that sometimes that's the issue. It's that quis custodiet sort of thing; it's not who guards the guardians but who looks after them as well."*

Interviewer: *"So who looks after the [PEFs] then?"*

PE03: *"Well exactly. I guess the whole thing was that, what we do was to look after each other, we had a sort of monthly meeting and I've got to say that we asked the same question 'I did the right thing, didn't I?'"*

Interviewer: *"And you went back and asked your colleagues?"*

PE03: *"Yeah absolutely, absolutely. I do think that in the whole thing, that's the one issue if you like, that comes out, that that's what people need to know."*

Interviewer: *"So if this question is spiralling up the chain who at the end of it says 'Yes, you've made the right decision?'"*

PE03: *"Where does it stop? D'you know I don't think there is a single individual, but I do think a collegiate response does come. You do feel a sort of corporate responsibility that says 'Yep absolutely this is what needs to happen.' But maybe there is some Senior Nurse somewhere who goes home and says to somebody else 'I did the right thing didn't I?'"*

Discussing students outside the working environment raises questions about how student information was handled and protected. Participants were usually keen to point out that they did not disclose personal information through which the student could be identified. However, this does raise some concerns about how nurses are applying the six principles of information governance in

the NHS: the “Cauldicott principles” (DH 1997 and 2013c:5), in their mentoring role. This is an area which would benefit from further study.

Alongside ‘letting off steam’ and ‘checking this was the right thing to do’, mentors also recognised the need to receive sympathy, support and encouragement because they needed their own distress to be acknowledged. Showing mentors fellow feeling and kindness helped them to feel they had some mutual support.

“So [colleagues] are there you know, they can have a bawl of their eyes out and I’ve seen them do it, if we can do it in front of each other then we’re not doing so bad are we?” (MA12)

Nurturing responses reduced mentor insecurity, affirmed the reasonableness of such feelings, and acknowledged the unfortunateness of the situation. Knowing that they were not the only person to feel like this also helped mentors to regain their composure and consider constructively what they should do next.

A variety of people took on the consoling role, but most often a PEF fulfilled this function (see Chapter 9.3). Participants noted how essential this role was in enabling them to marshal their emotions and calm their thought processes, so that they could return their focus to the shortcomings they had identified in the student’s performance.

7.4.2 Managing Expectations

Where students’ and mentors’ expectations were managed there was less surprise when students sometimes failed practical assessments. This reduced tension because failing became an accepted possibility. In such cases the student had a clear understanding that the mentor’s role incorporated aspects of both nurturing and judgement, and that they were required to fail any student whose performance was below the required standard. The following factors, when coupled with this, reduced student recoil: concerns being identified early, so that the student understood the corrections they needed to make; adequate time being provided to improve; and importance being attached to the consequences of not fulfilling requirements. Jokelainen *et al.* (2013) have highlighted

the importance of preparing student nurses for the expectations of practical assessment. In Australia O'Brien *et al.* (2014:23) found that managing student expectations, “pre-empted some of the less satisfying aspects” of mentoring. Robinson *et al.* (2012) suggest that this is something which PEFs and LLs should target. However, it was noted by participants in this current study that this adjustment of expectations was difficult to achieve given the culture of entitlement in which students were immersed.

“We’ve got a society that can’t seem to accept things. ‘I want it! That’s why I’m having it!’ No, you can’t say ‘No!’ because they have a tantrum – Oooooffff!....You have to find a different way to say no. We’ve got a very childish, selfish society and that is now impacting on what is coming out into jobs and it frightens me.” (LT03)

Mentors expectations of themselves also required adjustment. They felt there was a need to redefine what failure and success meant in terms of mentoring. This meant re-examining the belief that a mentor could help any student to pass a practical assessment, and reviewing what the mentor’s key responsibilities were. It was felt by some that the title ‘mentor’ was counterproductive since it spoke of the gentler end of the spectrum of virtues they were required to have, and did not reflect the harsher judgemental qualities required to assess. Nettleton and Bray (2008) have previously noted this concern and suggested that mentor and assessor roles be separated (see Chapter 5.4.3).

Despite all of these factors coalescing, mentors could still report feeling guilty. In some instances they exploited a loop-hole which enabled them to meet the professional expectation to fail the student, whilst also colluding with the norm that ‘good’ mentors did not fail students. The strategy was to fail the student whilst pointing out the errors which they, the mentor, had made in the assessment process. They then encouraged the student to appeal, so that their fail decision was nullified, and the student was given a fresh attempt. This could be viewed as either the mentor choosing to compromise their own reputation for the benefit of the student, or a safe way to meet all the conflicting expectations being placed upon them. Either way, this might be a new manifestation of how mentors balance all the conflicting expectations of managing a failing student.

However, it indicates that not all mentors proceeded ethically or acted with integrity (see Chapter 5.3.1). It also suggests and that in a few instances 'game-playing' (Berne 1961) and 'drama triangles' (Karpman 2007) were again being employed to achieve an ulterior purpose or obtain a pay-off (see Chapter 5.4.2). This strategy has consequences for patients' safety and protracts the assessment process.

7.4.3 Recognising the Locus of the Fail

Having experienced such emotional conflict, mentors who reached a point where they recognised that the student had failed by their own hand were the ones who felt the most secure. This was achieved through ensuring everything had been done to help the student and recognising both the student's responsibility within the assessment process and the reasonable expectations they, the mentor, should have of both the student and themselves. Mentors asked themselves whether they had failed the student or the student had failed themselves. Where they saw that they could have done no more, and that the student's fate was in their own hands the onus shifted and self-reproach eased.

"It's not down to the mentor, it's actually down to the student that they failed. You've done more because you're working beyond and over really aren't you because you're trying your best to pass them." (MA01)

Both Killam *et al.* (2010) and Cassidy (2009b) point out that this can shift the blame for failing onto the student. They suggest that terms such as 'not yet ready to progress' might reduce the culture of blame. However, participants in the current study felt that if the mentor had kept their side of the contract, the failing student should accept that it was their own contribution that had not met requirements. Adjusting to this perspective absolved the mentor of much of the guilt they had experienced and increased their resilience to manipulative students. This freed mentors to focus on the complexities of the assessment process itself.

7.5 DISCUSSION OF CATEGORY 2

7.5.1 Psychological Contracts

The findings of this category suggest that both mentors and students have to negotiate a complex array of conflicting psychological contracts (Rousseau 1989). A psychological contract (PC) is a tacit reciprocal agreement between an individual and another party which is built on an individual's perceptions of the promises and obligations they expect the other party to fulfil (Zagenczyk *et al.* 2009). The PC has two facets, transactional expectations which are usually explicitly expressed, and relational expectations which are more often implicit and so open to individual interpretation (Chaudhry *et al.* 2010).

Although the term psychological contract has traditionally been used to explore the employer/employee relationship, it has more recently also been applied to both the professional/profession relationship (George 2009) and the mentor/mentee relationship (Haggard and Turban 2012). In this study the central PC exists between the student and the mentor. However this is also influenced by a number of other PCs which exist between various parties including: the student; the university; the mentor; the healthcare organisation; and the overseeing professional body.

The evidence from this study strongly suggests that a significant component of the psychological contract which exists between the student and the mentor centres on a shared agreement that a 'good' mentor should be able to help every student pass their practical assessments. Initially both parties seem to share the same perception. However, when a student consistently underperforms and is given this feedback by their mentor the psychological contract is perceived to have been broken and this has a number of resultant effects.

7.5.1.1 The Student's Perception of the Psychological Contract

There are indications in this study that the student's previous socialisation into university culture influenced the assumptions they made on entering the practice environment. If the student had developed an explicit (transactional) psychological contract with the university in which they were encouraged to believe that they were the customer, then their education was the principal aim and their satisfaction took priority. Students expected mentors to uphold this contract. When the mentor drew the student's attention to unsatisfactory performance the student felt that the mentor had violated the contract. George (2009) notes that anger and frustration can then surface, Rodwell and Guylas (2013) report that nurses are particularly prone to taking breaches of PCs personally, and St Pierre and Holmes (2010:1169) recognise that nurses who feel they have been subjected to organisational injustice used, "various means to punish the source of the injustice". These studies offer possible explanations for some of the student responses identified in section 7.2.4. Elements of communicating from a Child ego state and acting in the role of victim role, drawn from theories of transactional analysis (Berne 1961, Karpman 2007), are also useful in interpreting this behaviour (see Chapter 5.4.2).

Two papers from the USA have recently been published which report on growing concerns about the incivility of student nurses towards staff in academic settings (Gallo 2012, Shanta and Ellason 2014). The concerns raised in both papers indicate that the difficulties lecturers experience are similar to those identified by mentors in this current study. Shanta and Ellason (2014) propose applying Worrell *et al.*'s (1996) empowerment model to help manage such situations in classroom settings. This involves using specific elements of communication, collegiality, autonomy and accountability to change the outcomes of uncivil behaviour. Being equipped with such strategies would promote transacting from an Adult ego state (Berne 1961) and could also help mentors manage uncivil students in practice settings.

Austen (2013) suggests that using a student engagement model could also help mentors to assert themselves. This approach involves placing student commitment rather than student expectations at the heart of healthcare education programmes. This principle needs to be applied equitably in both academic and practice settings for mentors to benefit. Current guidance on professional conduct for nursing and midwifery students is set out by the NMC (2010b), and this does clearly demonstrate the requirements the profession expects of students. In order for these to be enforced effectively in practice settings mentors need to be confident that Universities will support them. As explained in Chapter 5 this is not always the case. Further discussion around the sub-category of “singing from the same song sheet” can be found in Chapter 9.

Currently the majority of publications which address the subject of mentoring focus on the student’s perspective (Black 2013). Schaub and Dalrymple (2013) report that mentoring is considered from the protégés focus in 80% of research papers. Only 30% of papers offer a mentor perspective which supports the view that currently student entitlement prevails over mentor authority. Much of the literature focuses on students’ expectations of mentors and criticism about their performance. Mentors have been accused of ‘bullying’ (Topa *et al.* 2014, Hakojarvi *et al.* 2014), “eating their young” (Sauer 2013:43) and being ‘toxic’ (Darling 1986:title). The current study provides evidence that manipulative and harmful students also exist who can have damaging effects on mentors. Empowering mentors with strategies to recognise and handle such students would equip them with a realistic foundation from which to function, particularly where the student is failing. This present study demonstrates that, when mentors were aware that students were attempting to manipulate or threaten them and felt able to voice this, students were more effectively managed and mentors felt secure.

7.5.1.2 The Mentor’s Perception of the Psychological Contract

The perception that a ‘good’ mentor could get a student through was often shared by mentors when they first encountered an underperforming student. However, when the mentor had ‘gone the extra

mile' and the student continued to underperform, they initially experienced dissonance (Festinger 1957) because they had to accommodate two conflicting beliefs; that they were a 'good' mentor and that they could not improve the student's performance. Alongside this, mentors reported feeling guilty that they were causing distress and hardship for a student. Both dissonance and guilt will now be explored.

In order to ease the dissonance, mentors who went on to fail students undertook three activities as they sought to re-establish internal consistency. Firstly, mentors sought to confirm their belief that they were a 'good' mentor by going the extra mile to help the student pass, thus adding new parameters to the PC. Secondly, the experience was reframed as the student not meeting their obligation to improve, and hence breaching the PC. Thirdly, the mentor began to emphasise the psychological contract they perceived existed between them and their profession. Their concept of a 'good' mentor was realigned with that of professional gatekeeper acting to safeguard the public. Mentors then justified that they had met their obligations of their explicit professional psychological contract.

Mentors, both in this study and others, reported feeling guilty when they failed a student. Guilt was felt particularly strongly when the student would be withdrawn from the programme as a result of failing in practice, and would not become a nurse. Under such circumstances the feelings mentors experienced seemed to have some similarities with those observed in middle-managers who had been required, by their superiors, to make employees redundant (Noer 2009).

Both Noer (2009) and Heathfield (2014) note that in redundancy situations, organisations usually focus formal resources on helping those who have lost their position, whilst those who remain are taken for granted and expected to be productive. Noer (2009) reports that those left behind suffer negative feelings which persist and are not resolved without support, making the residual workforce less productive. This is analogous to the mentor/student situation in a fail and withdraw scenario. Students who fail are invested in post-failure and can ultimately become the survivors moving on to

other courses of study whilst mentors continue to experience negative emotions, because little is invested in their post failure needs (this will be explored in Chapter 9).

The “going the extra mile” behaviour of mentors noted in this chapter can be explained through this theory. Mentors undertake every action they can to appease the negative emotions they anticipate feeling if they need to fail a student. It is suggested that human resource strategies (Heathfield 2014) can be applied to help mentors manage their guilt and reduce burn-out. One such strategy is demonstrated in Table 7.4. This present study demonstrates that when a supportive person, usually the PEF, undertook some or all of the activities noted in Fig 7.4, mentors were better able to cope with the emotional burden which surrounds failing a student nurse. This is supported by Zagenczyk *et al.* (2009) who identified that supervisor support could reduce feelings of guilt in managers who perceived they had breached a psychological contract.

<u>Tips for Coping When You have Failed a Student</u>
◇ Recognise that your emotions are legitimate
◇ Experience and work through each phase of loss (Kubler-Ross 1969)
◇ Seek advice from your LEM or PEF
◇ Recreate your daily working patterns
◇ Treat yourself with kindness
◇ Talk about your feelings
◇ Pay attention to the student’s needs
◇ Value other students and mentors
◇ If feelings of guilt persist seek professional help from(name/dept contacts)

Table 7.4 Managing ‘Mentor Guilt’ (adapted from Heathfield 2014)

In subsequent mentoring encounters, mentors tended to maintain a more transactional dimension to the psychological contract in which they made expectations and obligations more explicit to students, and reduced the emotional element of the PC. This was counterintuitive and was not indicative of the traditional mentoring role which is characterised by a high level of emotional commitment. However, where this approach was adopted, students seemed better able to deal effectively with negative feedback and responded by endeavouring to meet their obligation to

develop their performance. This indicates that more explicit, transactional psychological contracts help mentors to feel secure when failing underperforming students.

Cassidy (2009a) queries if it is helpful to shift the blame for the fail onto the student. However, this current study identifies that mentors were often ready to blame themselves for the student's failure, and students could be willing to let them. Actions which encouraged students to take responsibility for their own performance were identified as aiding mentors to make a fail decision. It is suggested that this area would benefit from further investigation.

7.5.2 Emotional Intelligence (EI)

Findings from this study indicate that both mentors and students could have difficulty in discriminating robust feedback from bullying and harassment. Jackson *et al.* (2002) have reported that nurses express more concern about perceived aggressive responses from colleagues than they do from patients. Providing negative feedback to students has been demonstrated to affect mentoring relationships adversely, sometimes to the point where they break down, and emotional abuse can be perceived to be occurring on both sides.

Emotional intelligence exists where an individual has the capacity to discriminate between their own emotions and those of others (Grewal and Salovey 2005). This study has demonstrated that, where mentors were able to conduct challenging conversations with students in an enabling way, the likelihood of an effective outcome was increased. This possibility also increased if the student responded receptively to the feedback (Merlevede and Bridoux 2004). This required both parties to respond to the situation using emotionally intelligent strategies. This ability is based on the capacity to be both self-aware and perceive emotions in others (Hutchinson and Hurley 2013). Emotionally intelligent transactions are characterised by reflexive thinking, non-judgemental interpretation, and accurate understanding of emotional signals (Beasley 1987). Emotional intelligence facilitates effective management of human interactions to accomplish objectives (Goleman 1995). It has been suggested that assessment of EI is helpful in selecting students for health professions' programmes

(Libbrecht *et al.* 2014). Gorgens-Ekermans and Brand (2012) suggest that incorporating EI into nursing curricula may increase individuals' emotional coping resources and reduce stress during periods in which accomplishments are being brought into question. Wagner and Martin (2012) also report that EI prompted experienced professionals to undertake pre-incident planning, which lessened the emotional content during difficult situations. It is possible that this is a transferable skill and could be adapted from intense nursing situations to demanding mentoring episodes. However, this study suggests that mentors require guidance on how to further develop and apply the skills of emotional intelligence to this new area of focus.

7.5.3 Protected Spaces

Mentors in this study indicated that they needed space to both think and talk, neither of which have priority in a task orientated culture. Chapter 6 identified one mentor who used her journey home to contemplate her student's needs and the mentoring activity she would employ. Another pointed out that the only effective way to obtain legitimate work time to reflect on mentoring was when a PEF visited to discuss a student's performance. DeBrew and Lewallen (2014) emphasise the importance of thinking space when considering whether not to pass a student, to ensure that a sound decision is made, and to plan how to approach such conversations. Well planned interviews could curb mentors' tendency to deliver 'fail' messages and then retreat quickly from interviews, which was identified by some PEFs in this current study. It could also reduce the tendency noted by Schuab and Dalrymple (2013) for mentors to express 'I should have said x, y or z' feelings after impromptu meetings, and also address the mismatches between mentor feedback to students and written feedback to HEIs, which was identified by Fitzgerald *et al.* (2010). Alleviating these issues was seen to be a proactive way to lessen antagonism between mentors, students and 'the University'.

Mentors in the present study, particularly those who worked in ward environments, often noted that private space for staff communication was limited. Finding areas where they would not be overheard or constantly interrupted was problematic, particularly since they were unlikely to be

granted time away from the ward area. This severely limited possibilities to hold safe conversations with both students and PEFs. Providing such spaces might reduce some of the tensions inherent in holding challenging conversation. Morath and Leary (2004) noted that providing such psychological and physical spaces emphasised a work culture of open disclosure, facilitated re-examination of situations, and promoted trust rather than blame. Where mentor and student could hold a frank discussion in a protected venue it is possible that both might be more willing to listen and explore difficult messages openly, without feeling that private matters were being raised in a public place. This could assist in engendering a productive and less antagonist mentor/student relationship at times when a student's performance is not at the required standard.

This chapter has demonstrated that justifying thinking time, in a job that is primarily action focussed, is challenging. Alongside this, the tendency to claim insufficient time is one that has lost its resonance in a profession which has historically claimed there is never enough time to do everything. However, placing mentoring as a higher priority among nursing actions might legitimise some opportunities to reflect and plan, particularly if venues were also available for mentoring activity. Combined with this, PEFs and LLs using their visible presence to legitimise and secure mentor activity around reflection and feedback, increases possibilities for this to occur.

7.5.4 Formulating a Decision: Step 2

The second step in formulating a decision to fail focussed on the mentor asking 'Is it me who has failed or the student?' If the mentor decided that they had done everything they could to help the student pass, and that the locus of the fail resided with the student, this increased the potential that the mentor might go on to award a fail grade (Figure 7.5). The third element necessary for a fail outcome to coalesce will be explored in chapter 8.

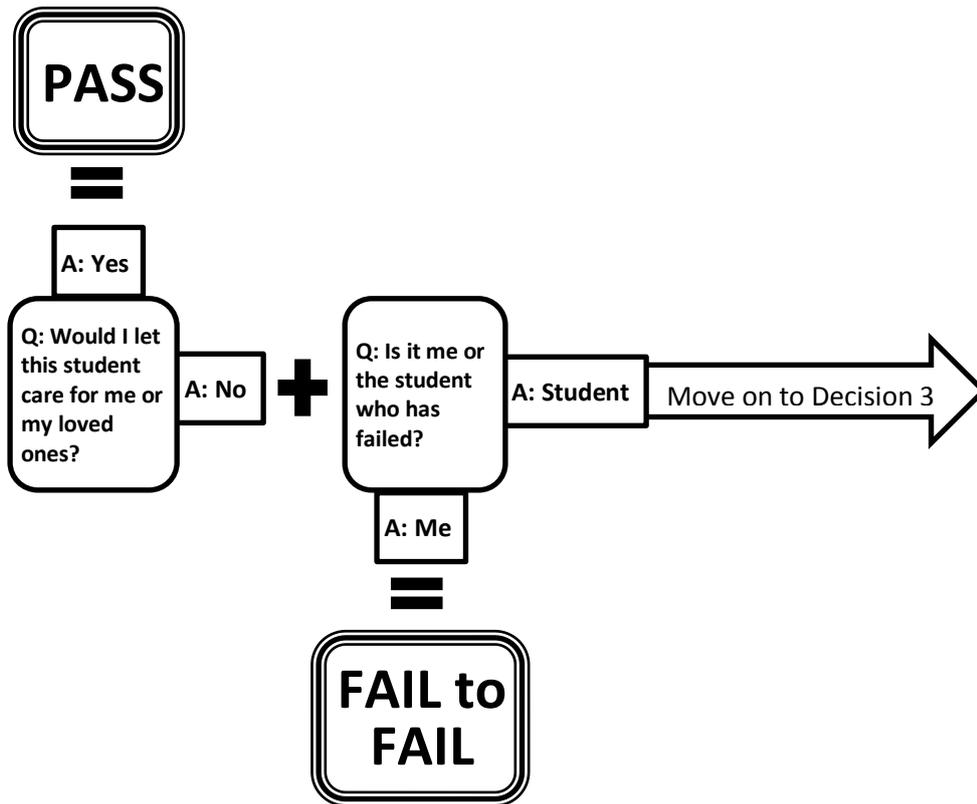


Figure 7.5 Steps one and two of decision formulation.

7.6 SUMMARY OF CHAPTER 7

This chapter presented the category “Tempering Reproach”. It demonstrated how mentors coped with the emotional challenges inherent in failing a student in a practical assessment and the resources they drew upon to do this. It explored why most of these resources were provided through the goodwill of nurses who were prepared to draw on their own personal reserves, and via the collegiate responses which stabilised and steadied assessment decisions. The emotional responses identified within the mentor/mentee relationship have been considered in relation to psychological contracts (Rousseau 1989), emotional intelligence (Goleman 1995), and redundancy guilt (Noer 2009). The final step mentors took to formulate a fail decision is explored in the next chapter “Standing up to Scrutiny”.

Chapter 8

Phase Two Findings – Category 3: Standing Up To Scrutiny

8.1 INTRODUCTION TO CHAPTER 8

This chapter introduces the category “Standing Up To Scrutiny” which has three subcategories and eight conceptual groups which are illustrated in Figure 8.1. This category crosscuts with two other categories and the connection between these is demonstrated in Figure 8.2. The relationship between this category and its subcategories and conceptual groups are presented and considered in the light of current literature. The chapter concludes with a summary of the main findings related to this category.

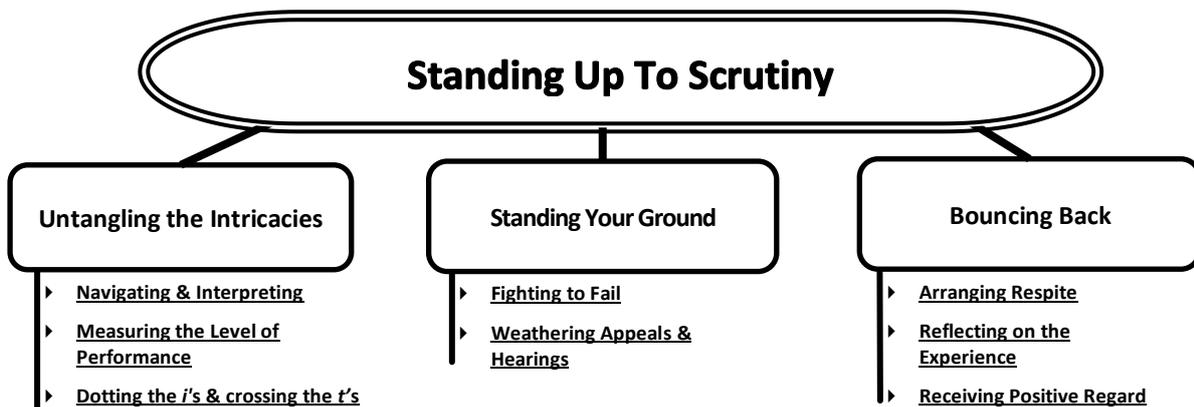


Figure 8.1 The Relationship of Subcategories and Conceptual Groups to Category 3

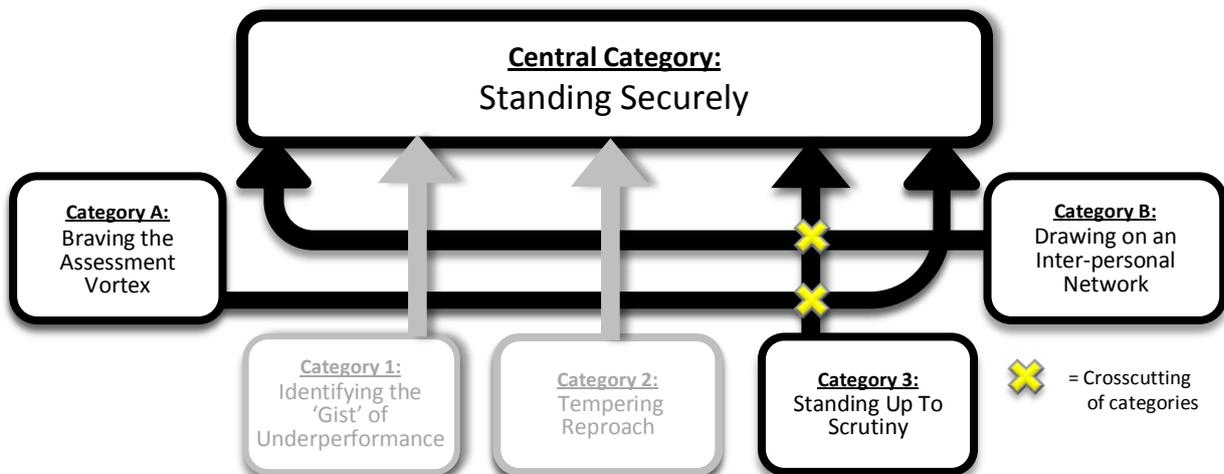


Figure 8.2 The Crosscutting of Category 3 with Categories A and B

8.2 UNTANGLING THE INTRICACIES

As discussed in Chapter 6.4 it was not until mentors needed to use assessment documents to manage an underperforming student that they paid detailed attention to them. This was because when students were performing satisfactorily, errors in procedure were overlooked.

Interviewer: *“So if you’ve got a student that’s performing to the required standard how much do mentors use the practical assessment documents?”*

PE08: *“Very little because they just know the student is passing and they have no qualms. You hear them say ‘I’ll sign you off it doesn’t matter what the document says, you’ll be signed off at the end.’ Because there’s nothing they’ve seen that gives them cause for concern. It’s when the student’s failing they need something to justify against.”*

Participants could not recall any incidents in which either a student who had passed a practical assessment had raised concerns, or where a University had subsequently overturned a pass result.

As the majority of students performed satisfactorily mentors generally had no reason to be concerned about implementing practical assessment processes meticulously. Hence, they were unpractised in the finer details, and recall of such procedures was vague, even though most had attended mentor updates.

“I’ve only had to fail two or three students in ten years.” (MA08)

Even those who considered themselves to be experienced mentors acknowledged that their recall of how to follow practical assessment procedures was limited. Nevertheless much attention became focussed on compliance with due process when a student was underperforming.

8.2.1 Navigating and Interpreting

The sudden necessity to follow procedures precisely worried mentors. This was partly caused by anxiety about the unfamiliar, but also because processes for failing a student were reputed to be tortuous, with many opportunities to take a wrong turn and derail the process. One mentor illustrated the volume of requirements as follows:

“Have you done your interviews? Have you documented it? Have you discussed this with the student because she’s the one that’s most involved? Have you told X and Y? Have you asked the clinical lead for support? Have you done any of that? And then let’s document it,

document, document, document. And we'll bring the University in, the personal tutor and programme director duo. We'll bring in the practice educators for support and guidance. Oh and do they have core action plans?...” (MA08)

Many procedures which caused difficulty and hesitation were identified, in particular:

- Ensuring all interviews were administered correctly and on time,
- Developing timely action plans which were specific enough,
- Making appropriate and timely contact with a range of people both within the organisation and at the university.

The process could be undermined if deadlines were overlooked because of competing nursing commitments. Interviews could be postponed, or students could neglect to present their practical assessment documents. Both delayed assessments and gave grounds for appeal. Assessment time frames and deadlines did not acknowledge the unscripted and changeable nature of nursing workloads, little slippage was allowed, even when emergencies occurred. From a practice perspective this is unreasonable and adds to the stress.

Mentors found contacting PEFs and LLs difficult because their working hours did not necessarily coincide, and access to electronic resources was not always readily available in practice settings. Web-sites were often regarded as difficult to navigate, and were protected with passwords which might not be easily recalled since mentors rarely attempted to access them. This corresponds with Robinson *et al.*'s (2012) observation that on-line resources were unhelpful in managing failing students.

“We have tons of guidance but it's all on this website that is so difficult to navigate and I find it hard to navigate so goodness knows what they must think out there, and they have a website that I can't get into.” (LT05)

Participants made it clear that written guidance documents were second best to having the support of a human being. The more policies, procedures, role descriptors, websites, handbooks and toolkits mentors were provided with, the more they became intimidated, confused and overwhelmed. This is consistent with Bilton and Cayton's (2013:9) view that that healthcare professionals exist in, “a haze of demands, orders and contradictions” which cause inefficiency, delay, and threaten patient safety.

Hence mentors reported that pinpointing the exact answer they needed was often not feasible in the limited time frame they had.

"I mean, obviously there's tools out there like ... toolkits. There's all the stuff on the website and all that kind of stuff. And even though I was part of all the people that did it, d'you know what? Take it all off-line now, burn it all on a big bonfire, and it's still the people. They don't use it... It's all about people and face to face contact." (PE08)

In line with Hybrecht *et al.*'s (2011) findings, mentors in this study sought a guide who knew the assessment processes intimately, had experience of where hidden problems could arise, and understood how to avoid these.

"We use [our PEF] as a Google and interpreter." (MA07)

In addition, some PEFs created an alternative guidance document to explain assessment processes in a more accessible way.

MA09: *"They [assessment documents] can be complicated but I have a little book that breaks it down for me."*

Interviewer: *"Where did the book come from?"*

MA09: *"The practice educator gave it to me. We only generally bring it in if we have problem students so that we can break it down for them, and for myself actually."*

As this had been written by the local PEF, mentors working in this Trust felt secure taking this course of action until their guide was next available. The Department of Health (2014:21), in its response to the Francis Report, conceded the need to cut back on, "burdensome bureaucracy" in healthcare. In this current study, consistent guidance from a key individual helped to make the system more predictable, provided the mentor with the most advisable route through procedures, kept them focussed, and reduced oversights to a minimum. Often the mentor seemed to be dependent on their PEF in the same way as a driver might rely upon a 'sat nav'.

Interpreting what was required was complicated by the structure and language of assessment documents. A number of studies have found that the jargon laden nature of practice documents confused nurses (Yonge and Myrick 2004, Hanley and Higgins 2005, Luhanga *et al.* 2010, Cassidy *et al.* 2012).

“Too complicated, language completely undecipherable. Flowery, NMC language that doesn’t really translate into reality.” (LT07)

Interviewer: *“Do practice documents help you to fail a student?”*

MA06: *“Yyyyy...uummmhhhh...well...kind of. They’re a bit confusing to be honest. There’s a lot that’s repeated and some of the language is difficult to understand and grasp.”*

Participants in this present study noted that complex academic jargon could intimidate mentors and in some instances they had relied on others providing them with a translation. Mentors were frustrated by how to apply generalised terms to their particular area of practice. Participants noted that if assessment documents were simplified, written concisely in plain English, and could be easily contextualised to their work area this could make their role more straightforward.

Interviewer: *“So what would help mentors in terms of books?”*

PE02: *“Simplifying them, making them less repetitive, plain English please.”*

Some participants suggested that practical assessment documents could be eliminated and replaced with a system more in keeping with the way a mentor works, as illustrated by this PEF:

Interviewer: *“Your facial expression is telling me it’s extremely tempting, the idea of not having a practical assessment document...”*

PE08: *“Massively. The only thing that’s holding me back is because I can’t think what would replace it. It is massively tempting because the job is practical and so are nurses, their kind of natural abilities are around practical things rather than assessment type documents. So if there was something that could be almost more in line with how a nurse works, almost more intuitive, it potentially could be far easier for mentors to make those decisions.”*

The view of such participants was that practical assessment documents were of little use. Mentors either used supplementary resources developed within their own work area, or relied on a PEF to translate, this being the most expedient way to negotiate the intricacies when time and resources were limited.

8.2.2 Measuring the level of performance

Participants valued guidance about the standard a student should be achieving in each academic year. This helped them to view the student’s performance holistically. Clearly articulated statements about the overall level of performance a student should reach by each milestone in the programme were felt to offer a workable assessment system.

“With my own Trust we’ve come up with a set of expectations for first, second and third year students, which has gone to all of the ward areas and we gave them out at their mentor updates.” (PE01)

“What mentors need to know very clearly is what is the progression? What is it like? Are you really expecting somebody in the first year to be able to do the same sort of things that you’re expecting somebody in their third year to be able to do.” (PE03)

Mentors could relate criteria for the standard of performance in each year to any activity the student might be undertaking in a particular care environment and this reduced concern about which explicit skills a student must have performed. This reduced focus on ‘the book’ as the object of assessment, redirecting focus to the students nursing actions and applied knowledge.

Contextualising performance to any care environment became simpler, and mentors felt they grasped assessment requirements more easily when they were less constrained by them.

“We know what we need to see for each student that comes in through whichever progression point they are in the course. So if we feel that they are substandard we can say ‘Well this is where you need to be.’ I think they do help.” (MA11)

Some participants identified Bondy levels as an effective tool (Bondy 1983). This refers to a skills escalator structure, which identifies the level of performance that students should be achieving in practice at given points in the programme. This approach provided some flexibility, to accommodate the differing levels of independence it was reasonable for students to demonstrate in a diverse range of care environments.

“I think Bondy levels help the mentors to separate out what they’re expecting from students depending on what year they are at and what level you are expecting.” (PE07)

Where levels of performance were used in conjunction with examples to demonstrate underperformance, there was a reduced tendency for students to fixate on specific events. Instead, they were more able to understand how the examples being used reflected their overall operation as a nurse.

“You should be providing support for what you did or demonstrating a different way of thinking... and when I went through that, where I would expect her to be, the weighting of words and the extra analysis she said ‘Oh that’s never been told to us, that makes sense’.” (MA14)

When students grasped the holistic nature of the assessment and did not compartmentalise it, they were more likely to work with mentors to resolve shortcomings. Even if they did not improve, students had more insight, and were less likely to blame the mentor.

The findings reported in this category are supported by a number of other studies which have suggested that a competency focussed approach fragmented assessment (Watson *et al.* 2002, McCarthy and Murphy 2008, Butler *et al.* 2009, O'Connor *et al.* 2009, Cassidy *et al.* 2012, Chambers and LeBarre 2014). Mentors preferred a more integrated approach in which practice was considered, "an aggregation of skills into methods of working" (Eno and Kerr 2013:141). The student's engagement was assessed holistically (Austen 2013), and the focus of the assessment was the students' actual responses in practice, rather than how they recorded them in practical assessment documents (Simpson and Muir 2013). These findings tally with recommendation 185 of the Francis Report (DH 2013a) - that nurse education should be more focused on the practical requirements of care delivery.

8.2.3 Dotting the *i*'s and crossing the *t*'s

Mentors reported that they could unwittingly breach assessment processes if meticulous records had not been kept. The principal advice to colleagues was 'document everything'.

"It was one of our senior staff nurses, she said how horrific it was having to go to appeals and to make sure I'd written down everything because she hadn't done that and she's learnt that lesson. So thankfully I did write up everything and I had it to hand." (MA04)

Participants felt that when documents were returned to the University they would be scrutinised to identify errors or omissions, which students could use to appeal. Some mentors were frustrated that, even though they had done everything possible to help the student, their fail decision was quashed because this was recorded only briefly, or a particular detail was omitted. This generated their perception that failing a student was hampered by bureaucratic University procedures.

Mentors often referred to the need to 'dot every *i* and cross every *t*' when recording their activities with an underperforming student.

“You need to cross the t’s and dot the i’s anyway to make sure that what you’ve done you’ve got evidence to prove why. You’ve got everything backed up.” (MA10)

This meant creating a meticulous paper trail which clearly and accurately recorded every detail of assessment activities and communications. This was regarded as defensive, but necessary to preserve mentors’ integrity, in a situation which could become antagonistic. Several reports and studies have noted that mentors struggle with the volume and complexity of assessment paperwork (Cassidy 2009b, Fitzgerald *et al.* 2010, Gainsbury 2010, Veeramah 2012). Mentors in the current study felt that excessive procedures often provided the student with another assessment opportunity, rather than the mentor’s judgement being wrong.

“They [the student] might have had a material error claim because some poor rushed assessor didn’t do the midway review at the correct time, or didn’t give them a clear enough action plan, or didn’t write the action plan on the correct bit of paper. But always you can track it back to the fact that there was something about the student’s practice that was substandard.” (PE02)

Participants expressed exasperation that this was the reason patients were being exposed to repetitious encounters with unsafe students.

Mentors in this study felt that practical assessment processes focussed on paper driven procedures. Verbal communication was diminished by geographical dislocation from universities, and much of the message mentors were trying to convey to ‘the University’ was lost when written down. This view was shared by mentors in Gainsbury’s (2010) survey. Expressing their concerns verbally to a member of university staff, who could either act as their spokesperson or contact them if extra information was required, was regarded as a more effective way of communicating the totality of the student’s underperformance. The Francis Report (DH 2013a:23) has emphasised the need to, “develop better ways of turning data into intelligence to help identify situations where patient safety may be at risk” and for, “greater attention to be paid to narratives” (DH 2013a:90). Considering innovative, less paper intensive methods for recording mentors concerns about unsafe students might contribute to this culture of change.

The necessity to defend their professional judgement so vociferously frustrated mentors, particularly when they considered the additional time and effort they had invested. This resulted in some mentors refusing to be rebuffed; this will be explored further in the next subcategory.

8.3 STANDING YOUR GROUND

This subcategory focuses on situations in which participants felt they were in direct conflict with 'the University' about the outcome of a failed assessment, either because the student had made an appeal, or because 'the University' had decided not to ratify the fail decision. Middleton and Duffy (2010) have previously suggested this is an area which requires further study.

8.3.1 Fighting to Fail

Practitioners felt that, at this point, the process could become overtly confrontational and that they were contending with the whole University system. Mentors' negative feelings, and a loss of trust in Universities at such times have been noted in several studies (Basnett and Sheffield 2010, Jervis and Tilki 2011, Finch and Poletti 2103, Laroque and Luhanga 2013, Rawles 2013, Schaffer 2013). The literature suggests that universities can create an impenetrable system which makes practitioners feel that they are being undermined and humiliated (Parker 2010, Eno and Kerr 2013).

"We want to be involved right from the beginning and feel that it's 50/50, we're minded of that but sometimes it doesn't feel as though it is. It's only when it matters to the University that it's partnership working." (PE07)

In most cases LLs identified more affinity with practitioners than with their own employers; all becoming increasingly frustrated with a system which seemed determined to keep students, no matter what implications this had for the safety of the public, or the quality and employability of the Universities' own end products. Some lecturers expressed anger towards their own University, feeling that their role was being undermined by an unnecessarily pedantic, academically driven process which had lost sight of its purpose and was overriding their professional judgement.

"I was so cross when I heard that he could go back, I thought 'Don't make us do all of that and then send him back again.' It gives him mixed messages, it's incredibly undermining to the staff and to me because it's hard you know making sure you've done everything to get them off the course." (LT05)

Realising that some LLs shared their frustration supported and emboldened mentors. Where such resolve was engendered, the term "*fighting to fail*" (MA01) was used. This referred to the determination to persevere, even when this required standing up to the might of 'the University'. Black (2012) identified that mentors who fail students possess courage, and this was again demonstrated here. However, it was also noted that mentors emotional strength and morale was bolstered by the number of people who were supporting them (see Chapter 9). Where they felt the full weight of their own employer was behind them mentors and PEFs were at their most willing to press for the fail decision to be upheld.

"Actually the most important support was always [my own] organisation." (PE08)

This is reflected in Kendall-Raynor's (2009) identification of one NHS trust, which was so alarmed by a University's stance that it had set up its own fitness for practice panel to consider whether to offer further placements to students about whom mentors voiced serious concerns.

In order to "fight" effectively mentors needed to feel prepared. Having an irrefutable case was the first part of this strategy, acting as proof of their actions and justification for their decision. This needed to be a formal record, which demonstrated how their activities and judgement were wholly aligned with official assessment procedures. The next strategy was having witnesses to verify their account and agree with their judgement, which helped to demonstrate that they were acting reasonably and justifiably. Thirdly, mentors reported seeking corroboration from PEFs and LLs who could act as an expert witness. Where all three elements were in place mentors were most likely to continue 'fighting to fail'. This finding concurs with those of Parker (2010), who noted that social work practice educators became increasingly empowered when they felt part of a collective, fighting against a university system which they felt was trying to marginalise them. However Higgins

(2014:62) points out that PEFs have to be skilled diplomats when acting as a bridge between the “conflicting and competing” cultures of practice and education.

8.3.2 Weathering Appeals and Hearings

Two types of university governance procedures were identified when there was disagreement or concern about a student’s practical ability. The first was the appeal system, in which the student could challenge the conduct of the practical assessment process. The second was a fitness for practice referral. This process was instigated when there were serious concerns that the student’s behaviour could put them or others at risk. Universities differed in the processes implemented to manage both appeals and fitness for practice hearings. In some cases a review of the assessment paperwork was conducted and the decision made solely as a paper-based exercise. In other instances face to face interviews were conducted or panels convened, at which the student could make representation. Both systems were felt to have advantages and disadvantages.

Where Universities reviewed documentary evidence, mentors were spared verbal challenges and provocation but missed the opportunity to elaborate on, or clarify ambiguities. Face to face meetings, on the other hand, allowed mentors to have their say, but could be intimidating, overwhelming and confrontational, making some mentors feel as though they were under siege. Descriptions of feeling “*hauled up in front of the university*” (PE05) were expressed by some participants.

“We’re looking at the practical side of it and it’s like you feel as if they are questioning your judgement, basically that it’s your practice that’s wrong.” (MA10)

It was further noted that some mentors confused appeals and fitness to practice hearings and were unclear about the different purposes of each. In such circumstances mentors held inaccurate beliefs about the level of scrutiny they would face. Where the different purposes were understood, mentors appreciated why fitness for practice hearings were so rigorous. The composition of such panels could elicit opposition from practitioners. Opposition was particularly likely where panels comprised members from other Faculties within the University whose programmes did not have a

vocational component. Mentors felt that such people had little insight into the safeguarding and professional behaviour requisites of nursing, and focussed only on academic convention, which paid little heed to protection of the public.

“You have to be able to weigh up what’s acceptable from a student within a university and what are the academic mores and things like that but you also have to understand that much is being asked of these health students because it’s not only all of that . Not only do they not have to plagiarise and not only do they have to be respectful of University property but they also have to have that really professional persona where things are asked of them and they have to be honest above any question of doubt where they have to put peoples safety first and foremost and I guess it’s that extra element that’s required with health professionals. It seems to me that if you are a geographer you only have to keep the university’s rules. But if you’re training to be a nurse you not only have to meet all the university’s, but you have to meet the professional regulator’s requirements and you need somebody [on the panel] that understands that because it makes a difference.” (PE03)

“You’ve got to have somebody leading [the panel] who knows what they’re doing and you would never have a director of nursing without a nursing qualification.” (LT06)

Interviewer: *“What about the Dean of Engineering chairing the panel?”*

PE04: *“It makes no professional sense to have somebody outside of nursing judging whether or not somebody is capable of nursing. It’s got to be said.”*

Interviewer: *“Why not?”*

PE04: *“Because it’s a profession and we know what our profession requires and that’s that really. I mean there are people on the NMC who aren’t nurses but they’ve got a lot of insight into what we’re doing. That’s a different matter altogether.”*

Even where mentors understood the purpose of panels and agreed with their composition, they could still view them as employing inequitable processes which strongly favoured the student. This PEF illustrates how rarely a student’s appeal is turned down:

“On this one occasion the appeal was not upheld, which was quite a spectacular result, and the Trust were very happy.” (PE03)

Larocque and Luhanga (2013) and Rawles (2013) note universities are hesitant to uphold mentors judgements because they fear that students will take legal action. Simpson and Murr (2013) observed that in such cases power battles could ensue between academic and practice organisations. As illustrated by the NHS Trust which had set up its own progression board for students because it was so concerned about University procedures (Kendall-Raynor 2011). The Willis Commission (RCN 2012:2) is however clear that, “universities should fully value nursing as a practice

discipline” and that Vice Chancellors needed to work with nursing Dean’s to demonstrate commitment to the values of the professions.

Mentors felt ‘The University’ gave great attention to the vulnerability of the student, whilst not recognising that the mentor might also feel insecure. Mentors explained that they were challenging a university which they remembered as a place of intimidating higher authority from their own days as a student. Participants identified several ways that Universities could make events less daunting.

These included:

- implementing equitable processes which recognised the vulnerability of both student and mentor;
- clarifying how processes and hearings would be conducted so that mentors knew what to expect;
- providing mentors with a copy of the records they had made about the student’s performance in the practical assessment document since NMC standards do not permit mentors to retain a copy (NMC 2007c);
- giving mentors the same level of respect as they did academic colleagues, which indicated that theoretical and practical assessors held equitable status.

These strategies provided participants with the credibility and confidence to state their case without the need to feel subservient or defensive. Where they were able to do this they felt they had weathered the hearing, no matter what the outcome was.

“I was by then confident to sit in meetings in front of numerous university representatives and, not argue my case, present the case. And there’s a full stop at the end of the sentence, as in the decision has been made. It’s not for discussion. As harsh as that might sound there were one or two situations where I had to take that approach. As in I’m not here to discuss this, I’m here to explain and walk away.” (PE08)

Nevertheless, it could still be disappointing when the appeal or hearing found in favour of the student, and participants noted the disheartening effect of this experience. The final section of this chapter explores how mentor resilience can be fostered in such circumstances.

8.4 BOUNCING BACK

Participants found it particularly difficult when their assessment decision was later overturned. On mentor preparation programmes they had been encouraged to fail underperforming students, but identified that Universities did not always endorse their decision when they adhered to this guidance. This inconsistency led some to feel despondent and either resolve to pass all future students or refuse to take any more.

“We’ve gone through all this. We’ve done what you asked us to do and this is the outcome. No thank you. We’re not having any more.” (LT06)

Several recent studies have noted an increasing number of mentors withdrawing from the role in such circumstances (Laroque and Luhanga 2013, Rawles 2013, Schaffer 2013). Mentors in the current study who had gone on to fail further underperforming students identified three key countermeasures that bolstered their resilience (Figure 8.3). These requisites - respite, reflection and regard will now be presented.

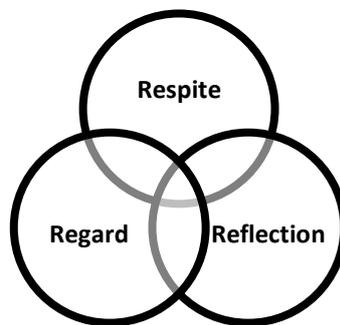


Figure 8.3 Measures which Enhance Mentor Resilience

8.4.1 Arranging Respite

In the aftermath of failing a student, participants expressed the need for a break to recover from the ill effects (see Chapter 5).

“It’s absolutely mentally draining. You feel that you can’t...at the end of it you just can’t give anymore.” (MA10)

“It did make me feel quite sick actually.” (MA09)

Mentors managed the need for respite in a variety of ways. Some had taken sick leave or annual leave. In supportive environments the nurse responsible for allocating students had taken this need into consideration when allocating subsequent students; here respite was considered essential to prevent burn out, which could occur if mentors took a series of difficult students close together. Mentors who felt confident in the strength of their support network were more likely to be proactive in requesting a break.

Interviewer: *"Some mentors have said to me they need some time off from students...."*

MA11: *"From students, yeah! Oh Yeah!"*

Interviewer: *"And what do you think about that?"*

MA11: *"Yeah, I agree. And I keep a list of who were students...even if they failed or the good past students, and so I know when people have sort of... been hammered a bit for want of a better phrase, with students, just so they get a bit of a rest."*

Interviewer: *"So they get a rest afterwards?"*

MA11: *"Yeah."*

Interviewer: *"What do you think would happen if you didn't do that?"*

MA11: *"Get burn out with...with...with mentoring. I think so. Yeah, definitely."*

As well as re-establishing their health and well-being mentors noted the need to catch up with outstanding work, rebuild normality in the work area, and restore family relationships all of which might have been disrupted.

"I did say at the end of it actually to [PEF] 'For heaven's sake if you've got another one that you think is about to fail don't send them me yet I need to get some of my work done.'" (MA02)

Mentors working in the private sector were particularly anxious to catch up with overdue work (see Chapter 5).

The effects on relationships with partners and family were particularly noted by female mentors.

"The personal cost? I nearly had a divorce...and you've got that at the back of your mind and you do take things home with you, you do...luckily I've still got a husband." (MA09)

"Your life at home feeds on how you go by your nursing, so if you've got a student as well..." (MA11)

Mentors recognised the extra strain which their personal relationships had been placed under during this episode. Some reported that family members had been adversely affected. Mentors wanted to nurture their own loved ones before embarking on mentoring again. Hence, they

attached significance to a period of respite to re-establish a stable base from which to assess subsequent students.

It has been well documented that nurses have limited time to care for themselves (Bright 1997, McGee 2006) and a number of NHS Trusts now recognise that employees need time to implement strategies which help them to recover fully from challenging experiences (Trueland 2013). It is suggested here that mentor resilience is a precarious commodity which requires regular replenishment if mentors are not to become despondent and revert to failing to fail.

8.4.2 Reflecting on the Experience

Mentors reported that even after the assessment was complete, they continued to question themselves about whether they had done the right thing. Talking about the experience was valued as it offered an unburdening mechanism and allowed exploration of troublesome issues. Some mentors needed to vent their shock, frustration and indignation; others needed physical comfort and reassurance. All saw this as a cathartic exercise which helped them to relieve emotional tension. Talking strategies varied from formal debriefings to informal chats. Peer supervision was highlighted by some as being helpful whilst others sought a PEF with whom they were comfortable to talk. Practice Education Facilitators and LLs recognised that talking also helped them to make sense of the experience.

Mentors often referred to the personal costs of the episode in terms of both the extra financial outlay (additional travel, phone calls, resource production) and lost personal time.

“I just couldn’t get her out of my mind, again feeling guilty that I’d let her down...and I was on holiday in a way that I should have been enjoying myself, but I was absolutely shattered. Mentally exhausted, I really was.” (MA10)

“I got calls on my annual leave and I was like ‘Oh for god’s sake.’” (MA15)

During this reflective process mentors considered if the personal cost to them and their family had been worth it, which is consistent with Duffy’s (2006:266) view that mentors, “weigh the balance”.

The process of reflection helped participants to compare their expectations with the reality of the experience, and to reorganise their perspective taking this into account. Most participants identified that this reduced the tendency to dwell on events when the outcome did not tally with what they had been taught to expect on mentor preparation programmes.

Wallbank (2012) points out that nurses need somewhere to unburden themselves and because their work is unpredictable they do not have well-ordered breaks in which peer debriefing can occur.

Wisdom (2011) has recommended that mentors should be debriefed after each cohort of students and Basnett and Sheffield (2010) have suggested that social workers need to use dialogue to find closure after failing a student. Laroque and Luhanga (2013) suggest that emotional support is important for mentors post failure, and Rawles (2013) states that debriefing also helps when things go right in a fail situation; this can enable the mentors to offer subsequent support to colleagues.

Social support has long been recognised as an essential factor in managing work stressors (House 1981). Mentors need formal provision to debrief with colleagues and facilitators. This restores their cache of resilience and enables them to continue assessing students robustly.

8.4.3 Receiving Positive Regard

It has been reported that usually mentors only receive feedback when there has been a problem (Simpson 2009). In the present study mentors emphasised that key factors in bolstering their esteem and resilience were: acknowledgement of their effort, and being given thanks and praise.

Interviewer: *“So when you say (PEF) boosted you, how did he do that?”*

MA06: *“He would look at all the positive things that I’ve done and... you know... give you praise and things like that because that’s important, so you know you’re doing a good job.”*

Appreciation was always welcomed, but was particularly effective when it came from a senior member of Faculty. Formal recognition also sustained mentors and could be provided through mentor awards, mentor conferences and invitations to take on more senior mentoring roles, a finding which is corroborated by Schaffer (2013). Mentors were also aware that such accolades might earn them a reputation. These polarised into the stigma of being a harsh assessor and the

esteem of being a rigorous professional gatekeeper. Both had drawbacks. Firstly, students could arrive feeling anxious which might inhibit them from performing at their best.

“You’re the one that fails everybody or ‘I haven’t got her as a mentor have I? She’s going to fail me’.” (MA06)

Secondly, further challenging students could be allocated to such mentors because they would assess them diligently. Mentors then worried that they attracted those who were demanding to mentor which resonates with the findings of Black’s (2013) study.

“(PEF) are actually sending students to us now that have been failing in the Trust, because they know that if they come to us, and they’re not at that level we’re not afraid of failing students.” (MA05)

Mentors also recognised their status changed with their peers who began approaching them for advice about problematic students. This finding is at odds with Rooke’s (2014) study which reported that mentors felt that their experience was not recognised by colleagues. PEFs in the current study noted the impact of peer guidance; mentors had faith in each other’s advice about how to approach situations, which increased role confidence and security.

“Speaking to other mentors, like [name] who was on the ward opposite to me, that helps because obviously she’d failed a student before. So it’s like a big family.” (MA10)

However, mentors often noted that after the failure they might receive no further feedback on developments from partner Universities.

“We never got a full explanation, we tried. We never really got one” (MA03)

This is consistent with findings from other studies. Basnett and Sheffield (2011) have previously recommended that social workers should be informed of the final outcome for the student. Simpson (2009) however noted that nurse mentors were usually only given negative feedback. In such circumstances mentors in the current study felt discarded, unsettled and in limbo; they needed to gain closure to relieve the pressure of uncertainty.

“If you didn’t get that feedback from the University...that leaves you sort of very much almost on edge.” (MA02)

It was considered a matter of courtesy to be provided with feedback and where this happened it demonstrated to mentors that they were held in regard as equal partners with academic staff. Feedback provided a broader over-view of the situation and feelings of embitterment at seeing the student in practice again were reduced if they had been prepared in advance. Mentors who received on-going communication felt they were accorded due status as an important part of the overall assessment process.

Mentors who were willing to continue failing underperforming students most often prevailed where a collegiate matrix of supportive mentoring existed, which met the need for respite, reflection and regard. Mentors in such environments expressed willingness to continue robustly assessing all students.

“And you can just draw a line underneath it and move on. Because you know what you did was the right thing then you just move on to the next student.” (MA02)

8.5 DISCUSSION OF CATEGORY 3

8.5.1 Credibility of the Mentor Voice

Yorke (2005) and Hunt *et al.* (2012) noted that Universities struggled to embrace the concept that practical assessment should have equal status with academic scrutiny. Mentors' experiences in this study indicate that they continue to feel that they are not afforded the same protections and safeguards as their academic colleagues when it comes to failing students. Mentors felt their integrity was undermined when their core professional values were ignored or dismissed by central University processes and students were allowed to remain on programmes posing potential on-going risks to patients. In the wake of the Francis Report (DH 2013a) this could be interpreted as a further situation in which reports of substandard practice are rebuffed, particularly when assessors perceive they do not merit the courtesy of feedback regarding the details of the decision.

It should be of concern that the mentor voice is heard so little in the literature relating to practice based learning and assessment; 80% of current studies reflect the student view (Schaub and Dalrymple 2013). Those undertaking future studies might redress this balance by ensuring that mentors at least have parity with students in how much weight is given to their experiences and views. In situations where disagreement about the standard of the student's performance arises between mentor and student this study indicates that the mentor voice should carry more credibility. If mentors are to be given the same authority as academic assessors their professional judgement needs to be given pre-eminence over students' self-assessment. This is not to argue that the student voice should be ignored but to position it so that it does not dominate the needs of the nursing profession and patient safety.

Fitness for practice panels generate strong feelings in mentors and ways of resolving this need to be found. Simpson and Murr (2013) suggest that universities take up a defensive position in such situations. The conflict of interests re-emerges. Further examination of the structure and function of fitness for practice mechanisms for pre-registrants is needed since in the view of a number of participants in this study this does not currently seem to have credibility with practitioners. The potential for unfit nurses to register seems probable within current process and this is another area which may benefit from a consistent national process.

8.5.2 Tightening the grip on practical assessment processes

The circuitous problems of producing comprehensive, concise, user-friendly practical assessment documents which this current study has identified were neatly summed up by a colleague. He drew on a quote from the Star Wars film saga – “The more you tighten your grip, the more star systems will slip through your fingers.” (Lucas 1977). Whilst this analogy might seem flippant, it is an effective example of how everyday life can sometimes offer insight into a situation. Changing this quote to ‘The more you tighten your grip, the more practical assessment processes will slip through your

fingers' encapsulates the point that strategies to refine and further clarify assessment practices can make them more inaccessible. This is demonstrated in Figure 8.4 and is discussed below.

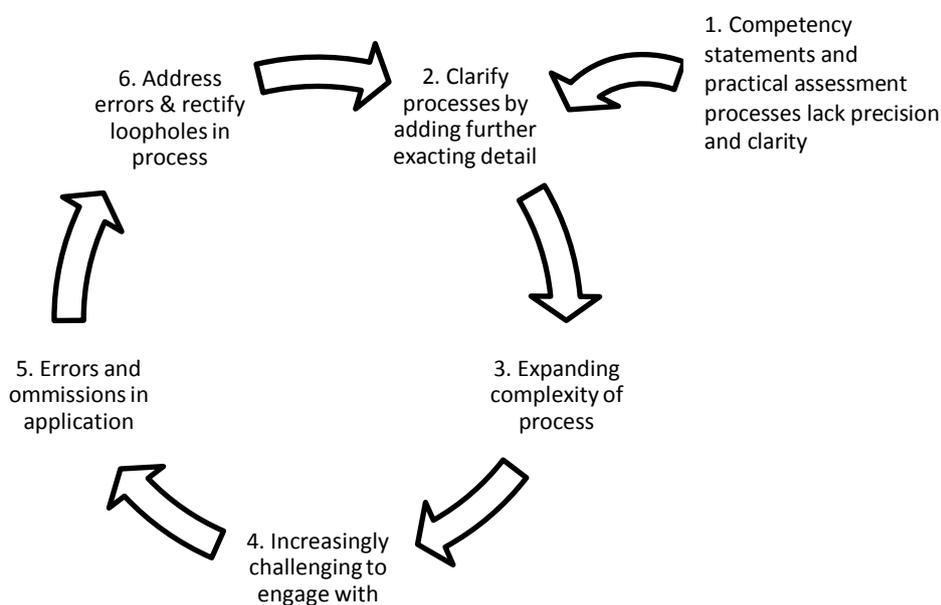


Figure 8.4 The problems of 'tightening the grip' on practical assessment

Step 1 of the above diagram denotes competency statements and assessment processes, which were originally written with the intent of comprehensively capturing what a student nurse needed to do to be deemed competent (UKCC 1999). However, as established in Chapter 6, 'the whole [of a competent nurse] is other than the sum of its parts'. The original competencies did not capture 'the whole' and additional caveats were added in an attempt to rectify this (step 2). The documents continued increasing in detail, with language becoming more precise in an attempt to close loopholes and clarify processes (step 3), thus assessment standards grew more extensive, intimidating and challenging to engage with (step 4). Time pressured mentors were even less able to absorb the expanding requirements and hence could make errors or omit essential elements (step 5). Further elaboration was undertaken to address errors and loop-holes making the documents even more extensive (step 6). The expanding sphere of processes and competency statements, intended to clarify, instead spiralling to produce a system so complex that mentors were unable to fully engage with it, and an underperforming, yet resourceful, students could find loop-holes to exploit.

This scenario is exemplified by the expansion of the Standards for pre-registration nursing produced by the professional bodies of nursing. The 2001 UKCC version was 23 pages long, the 2004 NMC version had extended to 48 pages and the 2010a NMC iteration, including annexes, ran to 150 pages. This demonstrates Bilton and Cayton's (2013) observation of the health professionals' preoccupation with writing guidelines and protocols; by 2011 seventeen sets of guidelines had been published which offered guidelines about how to write guidelines for healthcare (Carthy *et al.* 2011). Dawson (2006) described the difficulty for mentors in following the myriad of assessment guidelines and protocols and recommended that mentors should use a narrative approach to justify their assessment decision. Advances in voice recording and electronic transcription services might also aid this approach and could significantly reduce the time intensive element of statement writing.

Mentors preferred to use criteria, such as those published by Bondy (1983) and Stuart (2013), to identify the target benchmark a student should attain in each year of the programme. Prior to 2010 no formal progression criteria were available for the second year of the programme. The 2010 NMC standards make reference to progression requirements at the end of year two, stipulating that the student is "required to work more independently with less supervision" (NMC 2010:102). This brevity and vagueness contrasts markedly with the rest of the standards which are detailed and exacting. This is one element of the pre-registration nursing standards where mentors and academics would benefit from more detail.

The merits of grading students' practice have been debated in the literature for some time (Andre 2000, Scammel *et al.* 2007, Heaslip and Scammel 2012). This current study argues that the profession should first focus on defining pass and fail grading criteria for each year of the programme, before attempting anything more complicated. Mentors in this study indicated pass/fail grading criteria were the most helpful written resource which they had, but that these were most often produced in-house rather than by 'The University'. It is further suggested that addressing the neglect of year two in the NMC standards (NMC 2010a) would reduce mentors tendency to, "pass the buck" (Edinburgh Napier University 2012:15) because they would have more clarity about the

standard of performance they were judging a second year student nurse against. This may also reduce some of the pressure on sign off mentors who make the final decision about students' suitability to become registrants, at the end of the third year (Black 2012).

Austen (2013:webpage) recommends assessing students' engagement as an effective way of addressing the culture of entitlement. Austen defines engagement as "The mental state of operation in which a person performing an activity is fully immersed in a feeling of energised focus, full involvement, and enjoyment in the process of activity". Whilst this has merit in assessing expectant or overly dependent students who lack initiative, caution is needed in overemphasising this element of assessment. Mentors in this current study pointed out that some underperforming students were highly motivated, pleasant and keen but were unable to apply nursing knowledge in a rational and consistent way to care delivery and/or lacked insight into the harm they might do to patients. Such unsafe students could pass practical assessments if engagement alone was the criterion to pass.

The challenge for the nursing profession is creating a practical assessment process which strikes the balance between all these requirements. Since this is identified as such a complex undertaking it seems profligate to continue to expect the 56 English universities which currently offer nursing programmes to invest in each developing their own practical assessments. Some regions have collaborated locally to begin addressing this process (MMU, UoM, USM 2012). However, it would seem even more cost effective to adopt the 'All-Wales Approach' (NLIAH 2011) and generate one national system. This would provide a consistent approach across England which would also simplify quality monitoring and reduce replication of academic effort. It would also reduce the difficulties for mentors who assess students from more than one HEI.

8.5.3 Obfuscation

The findings of this category suggest that professional bodies and universities can sometime employ elaborate educational jargon and convoluted protocols in practical assessment documents. Mentors viewed this as obfuscation: an activity which caused bewilderment through the use of obscure,

unclear and unintelligible communication. One possible explanation for this is that academics are unintentionally exploiting interpersonal capital in negative ways. Bourdieu (1984, 1986, 1992) argues that people can use the trappings of their social station to elevate themselves above those they regard as inferior. Mentors in this study indicated that obfuscation made them feel inferior to academics and positioned them as a less powerful underclass (Gauntlett 2011). This suggests that professional bodies and academic systems might be influenced by subtle, covert values when producing practical assessment protocols. If this were the case it would be discouraging, since it would point to a misuse of power and authority, a loss of professionalism, and a disregard for patient safety.

Academics should have the capacity to convey complex ideas in unpretentious, easily accessible ways (Zukav 1979, Enstien 1971, Heisenberg 1958, Schrodinger 1951). Where this is evidence it demonstrates a genuine will to communicate productively with mentors and enable them to function effectively. Kingston University's Snapshot assessment project (Tolley *et al.* 2010, Tolley *et al.* 2011) reports a pilot scheme to develop simple and accessible practical assessment processes for mentors and students. This is one example of nurse academics demonstrating enabling intentions.

Both professional bodies and academics need to be aware that the practical assessment processes they linguistically and procedurally construct often intimidate and undermine mentors, whether or not this is intentional. This reflects the criticism to which Governments have been subjected regarding use of opaque language to hide meaning (Orwell 1950). Such activity is exemplified by Sir Humphrey Appleby, a master of obfuscation, in the BBC situation comedy 'Yes Minister' (BBC 1980). Mechanisms such as the SMOG calculator (Simplified Measure of Goggledygook, McLaughlin 1969), which grades the readability of text to measure its accessibility to the target audience and enlisting the expertise of the Plain English Campaign (PEC 2014) could be helpful as an initial step in reducing such barriers to shared understanding.

8.5.4 Learned Helplessness

The theory of learned helplessness (Seligman 1975) offers a further possible explanation for the sense of disempowerment mentors reported. This suggests mentors perceived that they lacked control over an on-going, adverse situation. Mentors may learn to be helpless as a result of either, their own negative experiences of failing a student, or by modelling from other mentors encounters and responses (Bandura 1986). Peterson *et al.* (1995) posit that this leads to passivity, hostility and feelings of worthlessness, and can result in difficulty in problem solving. This may explain why mentors express reluctance to fail, and why they reverted to 'failing to fail' after a fail decision had been overturned. This also offers an explanation of why mentors who did continue to fail students noted they had a core of steel (Chapter 5.3.1) and were prepared to 'fight to fail'. Such mentors continued to believe they could have some control over the situation (Maier and Watkins 2005).

8.5.5 Burnout

A number of environmental and organisational factors have been identified which are associated with mentor burnout. These are summarised by Schaffner (2013:13) as "lack of equity (Van Dierendonck *et al.* 1998), perception of lack of fairness (Maslach and Lieter 2008), perceived organizational support (Peterson *et al.* 2008), decision latitude (Rafferty *et al.* 2001), and job control (Sundin *et al.* 2007)." These factors resonate with those reported by mentors in the current study whose fail decision had been rebuffed by 'The University'.

Burnout is linked to diminished commitment (Maslach *et al.* 2001) and as can be seen in this study mentors whose experiences reflected those criteria listed above were unwilling to engage in the process of rigorous assessment again. Mentors who had been willing to undertake the challenges of failing an underperforming student could revert to failing to fail because their attempts had been thwarted and they were disillusioned by the system. Mentors perception of their disempowerment should be of significant concern to the nursing profession which has invested substantial effort in emboldening mentors to fail underperforming students. It is recommended that strategies which

mentors identified supported them after they had failed a student – respite, reflection and regard need to become standard practice to curtail mentor disillusionment and disengagement with the practical assessment process.

8.5.6 Attrition

Attrition has already been discussed in phase one of this study (Chapter 2). However, it is suggested that further refinement of the commissioning contracts between universities and Local Education and Training Boards (LETB) with regard to attrition targets would do much to enhance the relationship between practitioners and 'The University'. The second phase of this study identified that participants felt strongly that HEIs were reluctant to remove students from programmes when their practical performance was substandard. The speculative reasons for this were identified as:

- avoiding financial penalties by going over attrition targets,
- concerns about projecting a good image in the national student survey to attract new candidates,
- averting litigation, fines and compensation.

This study did not seek out the views of senior university managers about this, and it is acknowledged that their voice is lacking from this debate. However, whether or not this is the intention, it should be of concern to HEIs that this is how their practice partners view them.

It is suggested that the concept of positive attrition (ASLLC 2012) be considered when education contracts are negotiated between HEIs and LETBs. This would distinguish between students who left programmes because they were unhappy or dissatisfied (Orton 2011) from those who were failed and withdrawn from programmes because they did not have the necessary attributes and abilities to become a nurse. Penalties could then be applied to HEIs for high attrition in the former group but not the latter. This would put in place some safeguards for patients and some reassurance for practitioners.

8.5.7 Virtual Support

Provision of support via virtual media has proliferated over the last decade and Professional bodies and Universities have invested heavily in IT resources to support mentors. However, participants in this study noted that these online resources were generally unhelpful; one participant went as far as suggesting setting fire to them all (**PE08**). This is in some ways a surprising finding given the proliferation of online social networking available at present. Putnam (2001) and Gauntlett (2011) suggest that technological resources can be used to build social capital but that this needs to be interactive and visual. The problem with most of the electronic resources available to mentors in this current study was that their function was to impart information and replace the human contact which mentors needed (RCN 2007). Mentors were treated as passive recipients of information with no opportunity for dynamic dialogue and problem solving. Virtual resources might be seen as more useful in supporting mentors if they increased the possibility of bringing together practitioners and academics who are geographically separated. It could also resolve some of difficulties in accessing support, which mentors working unsocial hours currently experience.

8.5.8 Formulating a Decision: Step 3

Ascertaining that their decision would be valued and respected was the final element of formulating a decision. This decision when integrated with those of steps one and two of the process synthesised a compelling judgment which convinced mentors that the fail decision was secure for the student, patients and themselves. This was the final step in formulating a decision (Figure 8.5). Together, steps one two and three, demonstrate the procedure participants in this study used to develop the conviction to fail an underperforming student.

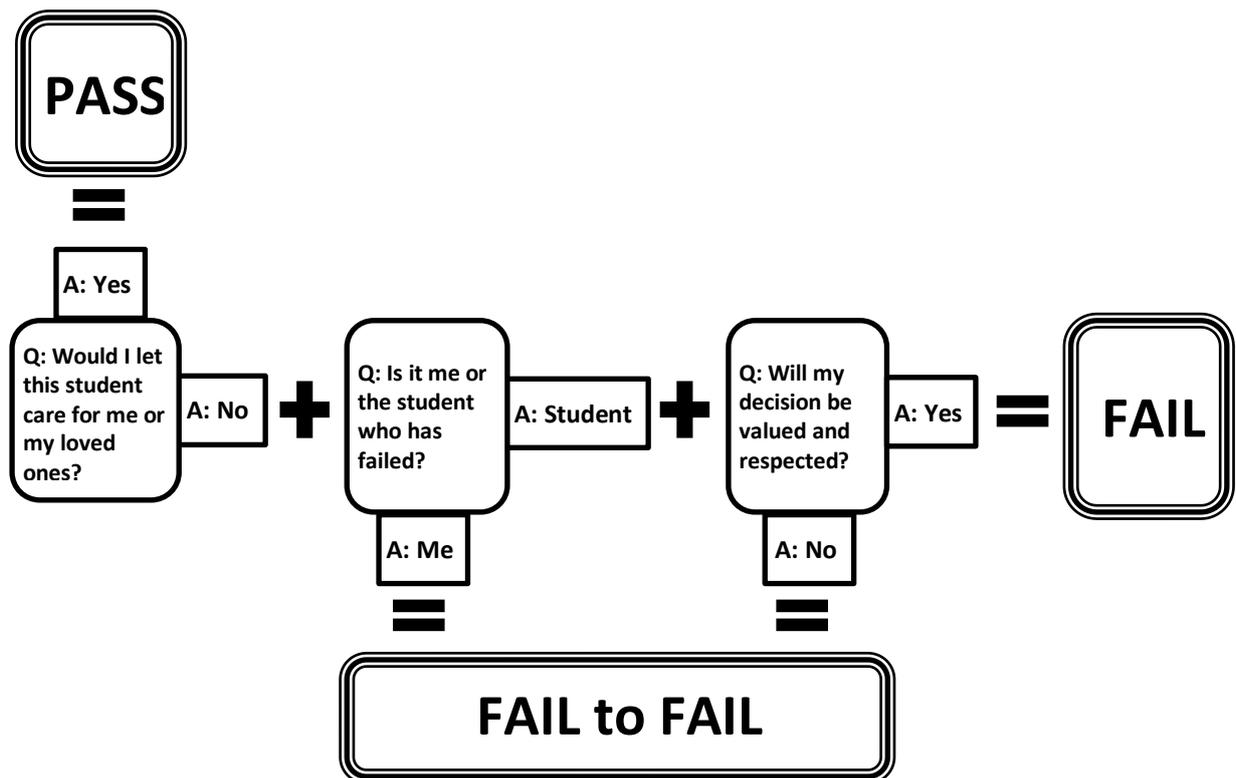


Figure 8.5 Steps one, two and three of decision formulation.

It is notable that only one third of decision formulation relates to judging the student's ability. The dynamics of the mentor role within the healthcare organisation and the relationship between practice and academic establishments take up the other two thirds of the decision process. These deal with emotional and social elements of being an assessor and the choices mentors make in relation to these. It seems that where both the mentor's employer and the academic partner organisation have in place strategies to support and enable the mentor, the mentor needs to invest less time in making the decisions necessary in steps 2 and 3 and can instead focus on mentoring and assessing activities. Chapter 9 now explores support structures which enhance mentor security.

8.6 SUMMARY OF CHAPTER 8

This chapter has presented the category “Standing up to Scrutiny”. It has examined why mentors were unpractised in the finer details of practical assessment procedures and how a human ‘sat nav’ was used to navigate processes. The necessity for mentors to be steadfast in defending a fail decision when facing university opposition was explored and three key countermeasures that bolster mentor resilience when their decision has been overturned were presented. The mechanisms participants employed to stand up to scrutiny have been considered in relation to Schaffer’s (2103) work on mentor burnout. The social capital which mentors reported drawing on to support them in formulating a fail decision will be explored further in the next chapter.

Chapter 9

Phase Two - Category B: Drawing on an Interpersonal Network

9.1 INTRODUCTION TO CHAPTER 9

This chapter introduces the category “Drawing on an Interpersonal Network” which has three subcategories and six conceptual groups which are illustrated in Figure 9.1. This category crosscuts with all other categories and the connections between these are demonstrated in Figure 9.2. The relationship between this category, and its subcategories, and conceptual groups are presented and considered in the light of current literature. The chapter concludes with a summary of the main findings related to this category.

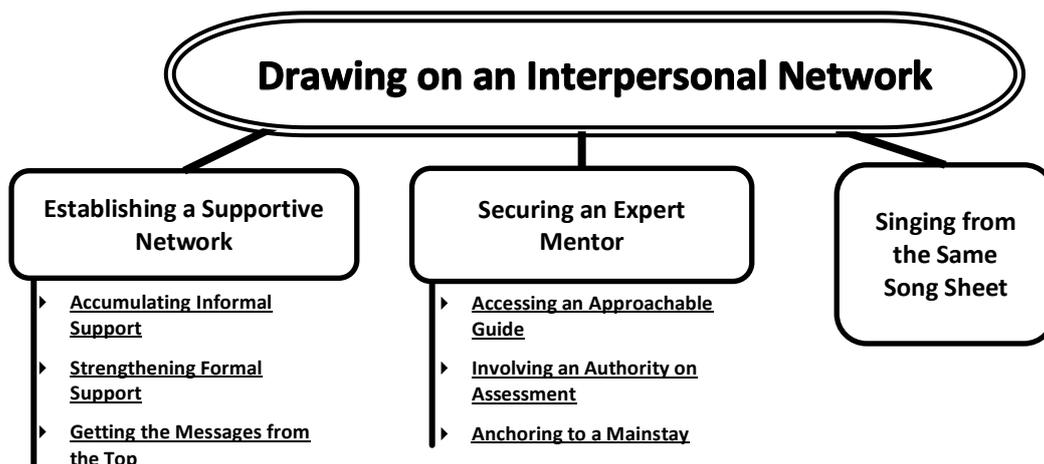


Figure 9.1 – The Relationship of Subcategories and Conceptual Groups to Category B.

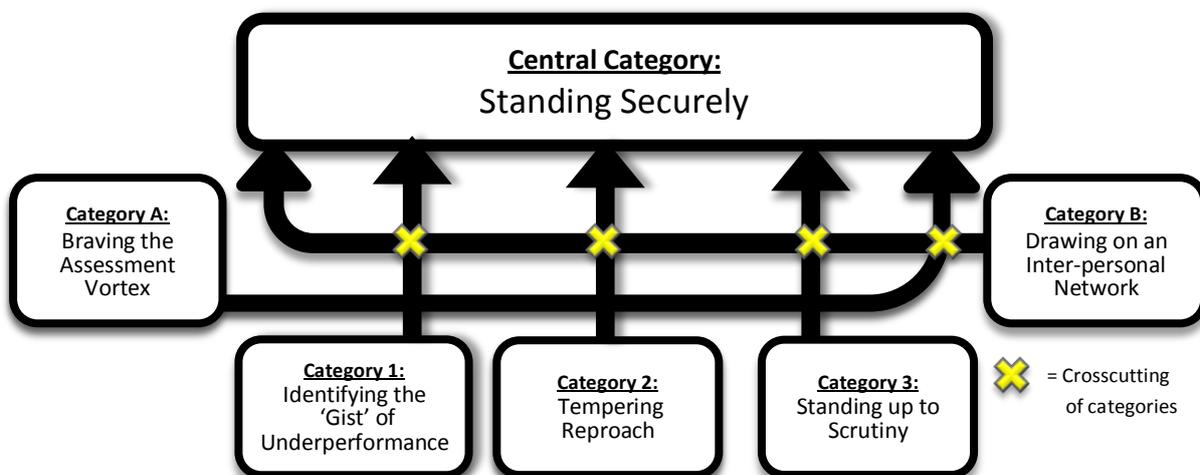


Figure 9.2 – The Crosscutting of Category B with Categories A, 1, 2 and 3

9.2 ESTABLISHING A SUPPORTIVE NETWORK

In order to feel secure enough to fail an underperforming student, mentors noted that above all else, they needed to be able to engage with a network of people for support. Such networks can be viewed as 'Social Capital': the benefits obtained from social ties between individuals and groups of people (Putnam 2001). This was valued far beyond any paper-based or technological resources. When asked what had helped them to fail the student, the invariable answer was that people had been their most effective resource.

"People are much more supportive than a piece of paper here, much more supportive, definitely." (MA05)

"Nothing is as good as a person." (MA04)

"It's the people, just the people." (MA06)

A strong interpersonal network provided practical and emotional support during this demanding experience. Participants who could draw on a robust and dependable network of people felt sufficiently sustained to see the process through. Without this support, the resolve to fail an underperforming student diminished significantly, even for mentors with 'a core of steel'.

Interviewer: *"If you hadn't got (PEFs)....."*

MA09: *(Audible gasp)*

Interviewer: *".....and you hadn't got those colleagues that come and tell you about the students when they are not performing, and you hadn't got your husband..."*

MA09: *(Audible gasp) "Ohhh No!"*

Interviewer: *".....and son and daughter to talk to....."*

MA09: *(Audible gasp) "Hhmmmm!"*

Interviewer: *".....and you had that student...."*

MA09: *"Phew!....Dear!.....Ummhh!.....My decision wouldn't change. It wouldn't change....umh.....I think I'd still do.....what my intentions and what my intuition was telling me. Maybe I'd have gone off work for quite a few weeks [laughs] with stress uhm...and I think it would have been unbearable. It was unbearable at the time. I think it would have been more unbearable..... I don't think I could have done it to be honest..... No, I wouldn't!"*

It was notable that informal support provided much of this crucial interpersonal support. Also that mentors had established their personal network through their own endeavour. Formal support tended to be dislocated from the mentor by both distance and hours of work. Nevertheless, where

systems had been put in place, such assistance also contributed considerably to the mentor's persistence. The structure and function of these formal and informal networks is now explored.

9.2.1 Appreciating Informal Support

In most situations mentors had developed their own informal support network, which they felt comfortable to access. Two distinct types of informal support networks were identified in this research: internal and external to the mentors working environment.

9.2.1.1 External Informal Support

Informal support mechanisms, external to the work environment comprised a wide variety of associates from the mentor's personal life. These are illustrated in Figure 9.3:

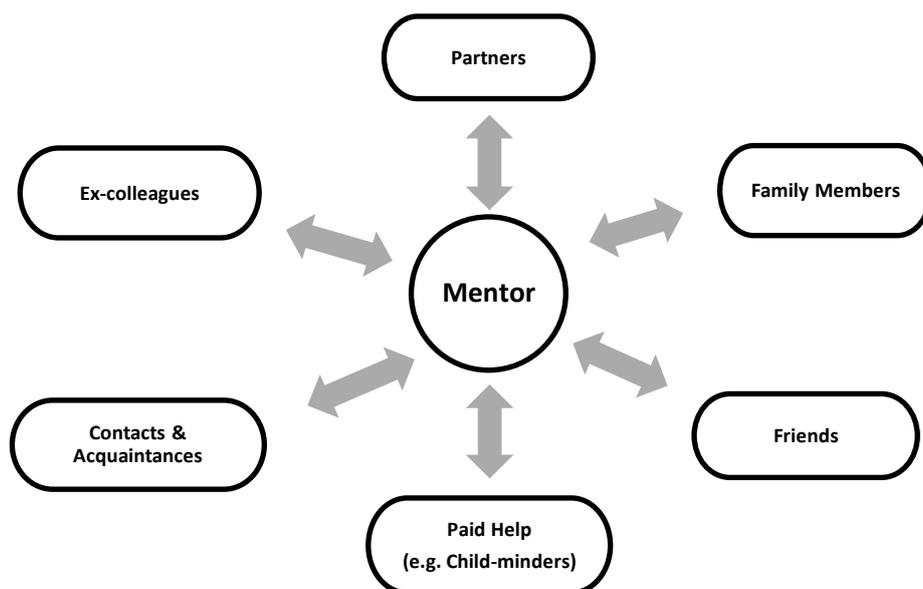


Fig 9.3 Sources of Informal Support External to the Work Environment

Mentors who failed students appeared to have rich sources of social contact in their personal lives. They acknowledged the value of this in sustaining them through a difficult time. However, most of this was a home-grown arrangement with no formality. Supporters were under no obligation, and the help they gave was based on goodwill. Even when the support of paid helpers was drawn on, such as child-minders, they often also provided favours to mentors at short notice, and offered the

mentor an opportunity to vent their feelings. Mentors were aware that if they relied on any of these informal arrangements too heavily they might disintegrate. They also recognised the toll providing this support took upon those who were willing to offer it.

Mentors reported taking guidance from trusted people whose opinion they valued. They sought out people whom they identified as experienced and knowledgeable on a professional level; these were often ex-colleagues.

"We meet actually so we can talk about things like that as well, so that helps a lot, because obviously she's out of it, she's not working in that role now, so it's nice just to be able to have a chat with her about it. She'll say, "Oh, ring me up, you know if you're having a problem"."

(MA10)

Where formal support structures could seem distant and daunting, informal mechanisms were usually comforting and sustaining. No situations were identified where an informal supporter dismissed or diminished the mentors' concern. Mentors explained that there was less need to feel foolish about asking what seemed trivial questions, or embarrassed at becoming distressed around such people. External informal support structures helped mentors cope emotionally by validating the way they felt, offering practical solutions, endorsing their feelings about the student's behaviour, and combatting feelings of isolation.

"The power of your mates, who you trust, who you listen to are more." **(PE08)**

However, the accuracy of the guidance and advice provided informally, particularly when it pertained to formal processes, could be questionable since it did not necessarily arise from an official source. In this way the unfounded myths and rumours, discussed in chapter 5, could be perpetuated, which increased the mentor's anxiety unnecessarily.

Confidentiality was also a consideration. Mentors felt that it was acceptable to seek help and advice about an underperforming student from others outside work, providing they did not identify the student by name. Chapter 7.4.1 points out the potential risk of a confidentiality breach when discussing students. Mentors indicated that they recognised the ethical considerations involved, and generally indicated that they proceeded with caution. This suggests that mentors had some

awareness of the 'Cauldicott Principles' (DH 1997 and 2013c:5), and the relevance of these to their mentoring actions. However, in the absence of accessible formal support, mentors noted that using informal support networks was inevitable, if a proper assessment decision was to be reached.

Finding the extra time to manage an underperforming student (Chapter 7.3) could be difficult, particularly if the mentor had to create the time outside working hours. Home life could be substantially disrupted when a mentor was trying to manage an underperforming student; personal relationships could suffer as a result (Chapter 7.3). Mentors needed to find somebody to take over their domestic obligations and other responsibilities outside work.

"She wouldn't [otherwise] have been able to give that time out of hours because she had got children to pick up." (MA10)

This either fell to understanding partners, family members and friends or, if this support was not available, paid help, such as child-minders were called in to cover home commitments. Mentors recognised the favours people had done for them, but felt frustrated by the student's lack of awareness of the effects their dependency and expectations had on a wider circle of people.

"You know what, I've spent a lot of time with you and I've got four kids that need things now and you're gonna have to not want me every second of the day." (MA15)

9.2.1.2 Internal Informal Support

Internal informal support mechanisms comprised a wide variety of associates from the mentor's working environment. These are illustrated in Figure 9.4. The importance that mentors attach to informal support from colleagues has been recognised in other recent studies (Carr and Gidman 2012, Jokelainen *et al* 2013, Schaffer 2013). Mentors, in this present study, explained that the advantage of this type of social capital was that colleagues often shared first-hand experience of the student. In these cases the mentor did not need to explain the situation so extensively, but sought moderation of their views to ensure they were being fair and reasonable. Basnett and Sheffield (2010) noted that this type of social support was also valued by practice educators in social work.

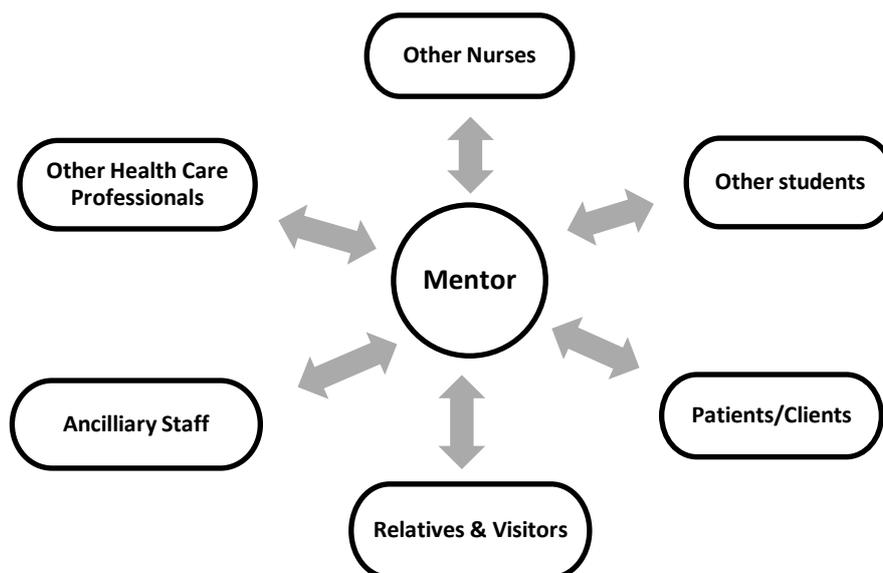


Figure 9.4 Sources of Informal Support Internal to the Work Environment

Participants in this current study reported that practical and emotional support was available in an immediate way from colleagues, who could see a mentor needed assistance with the student and would step in, either offering to take over, or providing moral support.

“Another colleague went to intervene and I stepped back so they could just take over and cool it down.... The student was crying and then after he’d gone home a colleague calmed me down which was quite nice.” (MA01)

This was not necessarily provided just by other nurses. A range of different people were identified as proffering support within working hours.

“When you say peer support people think well it should be somebody of your own profession but it doesn’t necessarily need to be... you know...it can be anybody, can’t it really...but somebody, obviously who’s in a position to understand what you’re going through.” (MA12)

Other students nurses on the placement could offer the mentor moral support by reassuring them that they were a ‘good’ mentor.

“Another student said to ‘thank you, I learned stuff from you and you pushed me.’ And then I thought well no it’s not me, I’ve been doing my job the way I should be.” (MA04)

The most irrefutable evidence was provided by patients who commented that they were unhappy with the student. The University might question a mentor’s judgement, but were less able to be repressive when patients’ views were submitted as evidence.

Participants in this study suggested that when formal internal support networks were distant or lacking, and mentors did not have a strong informal network to draw on, it could be more difficult to fail a student. This study revealed some formal support networks which effectively relieved pressure on informal support networks. These are discussed below.

9.2.2 Strengthening Formal Support

In the most supportive environments, formal assistance was close at hand, structured and nurturing. These support frameworks went beyond the mandatory requirements of the NMC (2008a), being more detailed and refined in responsiveness to both mentor and student needs. This is consistent with findings reported by Elcock and Sharples (2011) and Rooke (2014).

9.2.2.1 Internal Formal Support

Internal formal support was configured as a matrix of interlinking people within the work environment, who offered mutual support which was accessible 24 hours per day 365 days of the year. This research demonstrated that such structures were not always clearly evident, but where mentors reported they worked well, they were organised along the lines illustrated in Figure 9.5.

Support structures, from the mentor's perspective, began at team level where they were not considered an isolated person mentoring a specific student. Instead, a team approach was evident, in which the named mentor took the lead, but responsibility was shared. All participants embraced the philosophy that it was their business to help the student learn, and to feed into the assessment process. Hence both the student and mentor felt supported, and the relationship between them became less confined, both could have a break without the student feeling abandoned or the mentor being concerned that the student was not being sufficiently supervised. This structure provided communal resources to measure progress, reducing feelings of isolation and uncertainty.

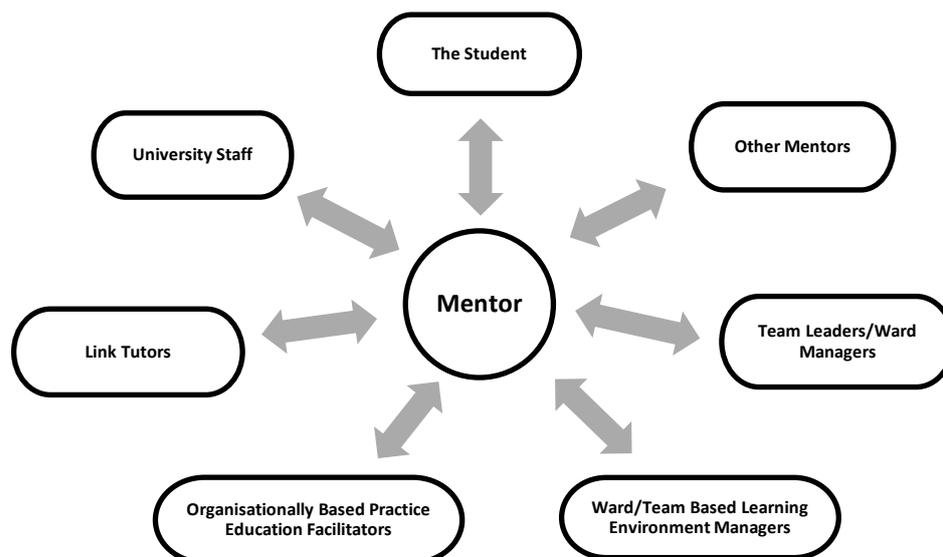


Figure 9.5 Sources of Formal Support at Team/Ward Level within the Working Environment

This promoted a cohesive and moderated assessment of the student's performance. Where such communities of practice have been found, they have been reported as effective in both nursing (Carr and Gidman 2012), and social work (Schaub and Dalrymple 2013).

In this present study these types of structures were found to be supported by a learning environment manager (LEM). The LEM was usually a more senior nurse working within the ward or team, who had a special interest in mentoring. Where LEMs existed their role was seen as fundamental in helping mentors feel secure when failing an underperforming student. Congdon *et al's* (2013:139) findings support this view, identifying the LEMs role as, "pivotal in supporting mentors on a day to day basis", and that mentors valued having close contact with a guide in their own practice area. Organisations which invested in LEMs provided them with designated time and resources to carry out the role. This included gatherings where LEMs got to know each other, shared experiences, discussed organisational standards and values in preparing the future workforce, and developed links. Thus, when they were faced with difficult situations they drew on a matrix of peer level organisational contacts, with whom they were familiar and confident.

"[Having someone] in each ward set up who was confident of the process and able to provide reassurance that there was a support structure, was really helpful." (MA14)

Reinforcing the matrix of LEMs were a group of more senior nurses, known by a variety of titles such as Practice Placement Managers or Practice Education Facilitators (PEF), whose role was to support pre-registration learning and assessment in practice. Gurling (2011) found that PEFs disseminated information, raised the profile of mentoring, and developed confidence in mentors. This view was supported by the findings of this current study. In some situations LLs from the local university fulfilled this role; they were often regarded as part of the placement team rather than 'The University'. A diagrammatic representation of such a structure can be seen in Figure 9.6.

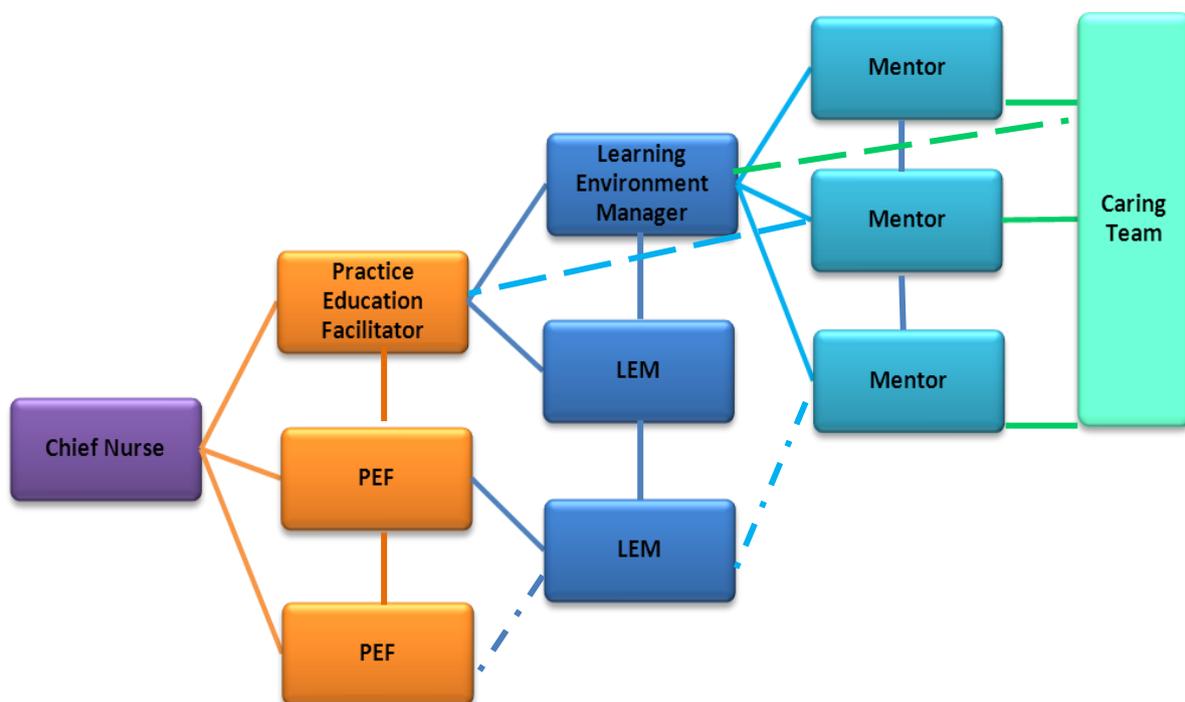


Figure 9.6 Example of an Organisational Mentoring Support Matrix

PEFs reported developing mutual support systems with PEFs in other local organisations, and in some instances groups of PEFs held regular formal meetings to support each other. Some Universities also developed formal meeting strategies between academic staff, PEFs and LLs to manage consistency and effectiveness of practical placements, and which also served as a source of mutual support.

Students were regarded as part of the formal matrix because they were required to self-assess.

Where students had insight into their own shortcomings, mentors felt better able to cope with

awarding a fail grade. Mentors also noted that some students were continuing with their nursing programme despite having their own concerns about their ability. Such students were relieved when the decision to withdraw from the programme was taken out of their hands. Mentors then also expressed relief, because this was a situation in which everyone benefitted.

9.2.2.2 Underwriting Support

Underwriting support refers to support available from administrative departments and official bodies that could help shield the mentor from some of the personal risks they identified in failing a student (Figure 9.7).

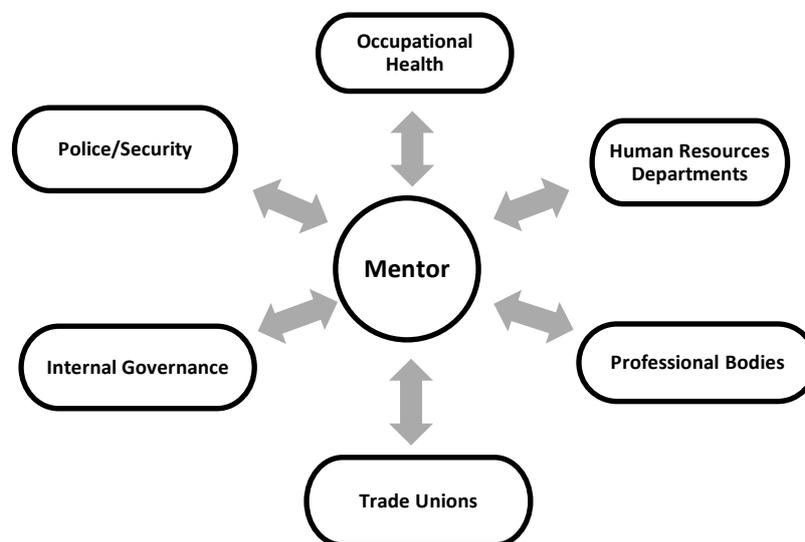


Figure 9.7 Sources of Underwriting Support

Practice Education Facilitators were best acquainted with these support structures, and in times of need could act as a conduit between the mentor and the appropriate sphere of support.

Occupational health departments could provide stress management resources for mentors, and could also clarify whether or not there were health reasons for the student's underperformance.

"The occupational health consultant worded it very professionally, that there was no, absolutely no reason whether it be physical or mental, absolutely no reason that he could find that this student could not and should not function." (LT03)

Human resource departments could provide helpful advice when students claimed that they were the victims of discrimination, bullying or harassment by the mentor. Internal governance within

some organisations backed mentors' decisions, by refusing to provide the student who had failed with further placements, demonstrating to the mentor that their own organisation supported their professional judgement even when 'the University' found in the student's favour. It was noted that male participants also looked to their professional bodies or trade unions to provide them with representation and support, and were much clearer than female participants about the official procedures which existed to protect them. Formal support was most effective when it originated from the top of the organisational hierarchy and permeated through all levels.

9.2.3 Getting the Message from the Top

It was notable that mentors were more assured in organisations which made it explicit that mentoring and assessing were valued at every level, which is consistent with Duffy's (2003, 2006, 2013a) findings. Participants in this present study reported that the message was most powerful when it came from the most senior nurse within their organisation.

"We are really well supported in our placement learning team. Our chief nurse comes to these meetings. We meet with him and have catch-ups with him and he expects that we are the voice, you know. So we're really well supported." (PE07)

Where participants sensed that mentoring and assessing were not given high priority they felt unsupported, a finding which the Willis Commission (RCN 2012) also noted. The conflicting expectations, discussed in chapter 5.2, were heightened when there was no clear message from the top. Hence it was important to receiving a consistent message from all senior stakeholders.

Where this worked most effectively PEFs had direct contact with chief nurses who, they felt, valued their role. Senior nurses showed their unity with PEFs by contributing to LEM meetings and mentor updates, making their expectations of mentors clear, emphasising how robust assessment of students contributed to the quality of care within the organisation, and resourcing this.

"[The organisation] is standards driven and if a hospital or clinical area has very clear and specific targets that need to be met then mentors are more likely to fail for those reasons." (PE02)

"They feel as though the role is being valued and they think these people above us appreciate what we have to do." (LT03)

In such circumstances the most senior nurses in the organisation made it clear to all tiers, including mentors, that supporting and assessing students was an important part of the nursing role. This was reflected in the quality metrics of the organisation, and given a place of prominence in their statutory and mandatory training programme. A collegiate response could be seen to emerge from this network of support. This offered the mentor a dependable base from which to act and strengthened decision resolve.

9.3 SECURING AN EXPERT MENTOR

Participants identified the most influential person within the social matrix as the 'mentors mentor' (MM). This was the individual in whom the mentor had the most confidence, and who would help them when they encountered an underperforming student. They were identified as having a number of key attributes which made them such a valued resource (Figure 9.8).

The MM could be any person the mentor chose, but it was most often a LEM, PEF or LL as they were the people most likely to have all four key attributes. This is consistent with both Robinson *et al.* (2012) and the Willis Commission's (RCN 2012) findings, that the PEF role was crucial in enabling

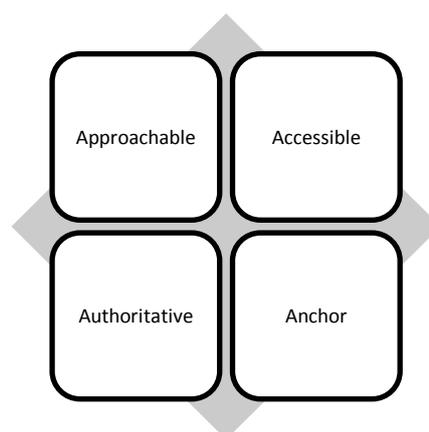


Figure 9.8 Key Attributes of the Mentor's Mentor.

mentors to fulfil their role effectively. Mentors expressed a deep affection and high regard for the PEF because they had stood by them during a difficult experience and a level of mutual trust had developed.

“Well I just love my [PEFs], I’ve got a really good working relationship with them. They’re reliable, available, very, very supportive and fair.” (MA01)

“The god-send! [laughs] Without her we wouldn’t have [failed the student]. She’s very approachable and sort of down to earth, the fact that you could just contact her. So it’s sort of relaxing that you could just sit down over a cup of tea and discuss things.” (MA04)

“They’ve always been there and been the best thing ever.” (MA09)

9.3.1 Accessing an Approachable Guide

The first two attributes, approachability and accessibility, are considered together since they are closely entwined. The MM needed to be approachable. This meant they were seen as affable and encouraging; they were not intimidating and understood the reality of the mentor’s role. Mentors were relaxed about approaching them and confident they would respond with helpful, practical advice. The MM was usually a person formally attached to the work area. The more often the mentor saw them, the more familiar they became, and the less anxious the mentor was about approaching them for help. Regular visual sighting of the MM was important in making the mentor feel secure.

PEFs and LLs noted that “doing Queen Mum visits” (PE02) to practice areas was the best way to ensure that mentors were familiar with them. This meant that PEFs had to invest a lot of time in visiting areas to become known. However, the benefit was that this increased mentors confidence to approach them with queries and requests for help. This is consistent with Parker’s (2010) observation that perceived support was linked with availability and Rooke’s (2014) finding that visible support enhanced mentors’ confidence. Once embedded as a resource, the MM usually became an essential part of the mentors’ support matrix.

“Invariably we become known. And when doing Queen Mum visits in the afternoon at the hospital I used to manage to do at least a floor now I’m lucky if I manage to get past two wards.” (PE02)

Thus, the more accessible the MM was, the more approachable they seemed, because they were an established part of the extended team.

“It’s hard to say to someone who you don’t know that well that there are concerns whereas it’s easy with somebody that I’ve known for years.” (MA03)

When a problem arose the mentor knew who to contact, and that this was expected of them. In most situations the mentor had easy access to their phone number and e-mail address, which were clearly and accessibly displayed in the practice environment. PEFs and LLs recognised how important it was that mentors knew and trusted them. O’Brien *et al.* (2014:23) have also noted that mentors in Australia are, “significantly more satisfied with their role” when they know the person designated to support them. Bennett and McGowan (2014) have also reported that on-going support is important to mentors when they are assessing students.

The speed of response seemed to be a key aspect in reassuring the mentor, and a prompt physical presence in the practical area showed support and commitment.

Interviewer: *“She’s just here?”*

MA11: *“She is.”*

Interviewer: *“She’s just so available?”*

MA11: *“Yes, yes, she is. I mean I rang her a few times about that particular student and every time she’s there.” (Laughs)*

Interviewer: *“She’s there?”*

MA11: *“She’s just there.” (Laughing)*

Interviewer: *“So she just appears, like your fairy godmother?”*

MA11: *“**Yes! Yes!** And she’s....I know that if I wanted her...if I needed her to come up in a second she’d be there.”*

Interviewer: *“That quick? And what if she’s on holiday?”*

MA11: *“Then I’d ring [names another PEF] and then [names another PEF].”*

Interviewer: *“So you’ve got a network here?”*

MA11: *“Yeah, yeah I think so. Absolutely, yeah.”*

Interviewer: *“What does that do?”*

MA11: *“It just makes them real. It just makes you feel more comfortable about telling them how you feel, a bit more honest and open with them. It makes you feel more able to express the slightest worry.”*

The view that approachability and accessibility are essential is shared by mentors in other recent studies (Carr and Gidman 2012, Jokelainen *et al.* 2013). Hence, PEFs who worked on site were most able to provide a speedy response, and participants in this present study recognised how important this was.

“There’s a huge thing about mentors knowing that there’s all this support but when they call on the support it’s got to be there. It’s no good saying ‘Oh well, I’ll get to you three weeks on Tuesday’ because, you know what, the student will have gone by then. You’ve got to be able to get there; you’ve got to be apparent.” (PE03)

The visible presence of the PEF during ad hoc visits could remind the mentor about an issue they had been too busy to action, eliciting an, *“Oh, I’m glad I’ve seen you” (PE01)* reaction. This response has also been observed in Canadian mentors (Luhanga *et al.* 2010). Hybrecht (2011) also noted that the more frequently Belgian mentors were visited, the more supported they felt. PEFs in the present study noted that once they had supported a mentor in a challenging situation, the mentor was more likely to contact them promptly the next time an issue occurred, and encourage colleagues to do likewise.

Accessibility was further enhanced by LEMs, PEFs and LLs making themselves available outside normal working hours. LEMs were most likely to offer their telephone number to mentors when they were off duty, but PEFs and LLs were also identified who had done this.

“[PEFs] were very easily accessible as I’ve said they’d be out in the evenings. We could ring them and within an hour they’re here to help with the students.” (MA01)

“[LL] gave us her mobile phone number and was letting us call her sort of late at night and things as well, if we had a bad time, because I mean, I know I was quite often on a night shift. So she’d phone me on my night shifts about 10 or 11 o’clock just to see how things were going.” (MA04)

These participants felt they had a responsibility to support mentors at the time they needed it. In some circumstances, dealing with a problem immediately prevented it becoming a protracted issue. Having the e-mail address of a PEF or LL also gave the mentor the opportunity to send a message at a convenient time, if they had access to IT resources, although this was not always picked up and dealt with so speedily.

Even in the most challenging circumstances, mentors described how they had accessed a mentors’ mentor. One participant recounted that she had no access to a PEF or LL, but knew a lecturer at the partner university because they had undertaken a course together. She contacted him and asked for his support and guidance. This was the only reason she felt she was able to the fail the student.

Every participant in this study identified a person whom they drew on to act as their own mentor. No cases were identified where a mentor had failed a student without access to this type of support.

9.3.2 Involving an Authority on Assessment

Mentors were unfamiliar with the precise protocols necessary to fail a student (see chapter 8). When they did need to follow processes meticulously they sought an expert guide, to lead them through convoluted and tortuous procedures. PEFs and LLs recognised that dealing with failing students took up a significant portion of their time, and so they were more familiar with the processes than mentors. PEFs and LLs felt they were considered, “*the naughty nurse*” (LT02) by students because they most frequently appeared in placement areas when a student was underperforming.

Mentors initially sought an expert as, “*a second pair of eyes*” (LT02) who would moderate their view of the student, and confirm whether or not they were being too harsh. PEFs recognised the importance of their role in calibrating the standard to be achieved across placement areas. In circumstances where the student and mentor were in conflict, PEFs acted as an arbitrator and mediator to review the situation and preferred to see themselves as an impartial intermediary.

“You have to only validate the people you truly believe are making the right decision. You can’t just do it as a blanket thing you know – ‘I’m the PEF therefore my mentors are always right come what may.’ I mean it’s not that kind of you know – My country, my country may she always be right but right or wrong my country – you know? You’ve got to not be partisan because you’re allegiance is professional isn’t it rather than personal.” (PE03)

Mentors displayed a tendency to believe PEFs would act as their advocate and protect them from the student. This was a difficult situation for PEFs, particularly where their remit was to remain neutral and be seen as supportive to both parties. It was noted that there were variations in the expectations each employer had of their PEFs which meant that the role was not consistent across the country. This could create challenges and confusion for students and HEIs where the PEF role differed substantially between various placement providers.

PEFs were also used as a quick reference resource because they could answer queries much more expediently than a document or website. They were usually able to contextualise NMC competencies and demystify complex academic jargon, although they too noted they could sometimes have difficulty with this. They had a sound knowledge of where processes most often went astray, and could keep the mentor on track. They could also confirm or quash anecdotes which mentors had picked up from colleagues, and so had a strong role in dispelling professional myths and rumours. The PEF provided advice to help the student learn and could suggest suitable resources, techniques and approaches for the mentor and student to use to develop areas of weakness. They were also knowledgeable about who could be contacted at the University to access further help and resources. In this way they could reassure both parties that help was at hand, and that a positive outcome was still possible if remedial action was taken.

9.3.3 Anchoring to a Mainstay

Much of the difficulty in failing a student occurred at an emotional level. Here the MM acted as a stabilising force, providing both the opportunity to vent feelings safely, and seek comfort and reassurance. The importance of emotional support in reducing burnout, in those who mentor new registrants, has been noted by Schaffer (2013). The findings of the current study suggest that mentors of pre-registrants need similar provision. Having strong social capital fortified the mentor, and the most essential part of this support network was the MM, who was valued as a reliable and steadfast resource by all participants in this study. They epitomised the 'core of steel' discussed in Chapter 5, and provided a strong role model for the mentor in how to manage an underperforming student, on both a practical and emotional level.

The approachability of the MM was important to the mentor in relation to how much they would divulge about their emotional turbulence. The better they knew the MM and the more comfortable they felt with them, the more likely they were to disclose their feelings and ask for support. MMs

expressed this role as acting like a “comfort blanket” (**LT03**). This term was not used in a derogatory sense, but rather to indicate the depths of insecurity from which mentors needed to be liberated.

LT03: *“I don’t know who gets the most comfort out of that relationship (laughs) ...I suspect the mentors.”*

Interviewer: *“But it’s a comfort thing?”*

LT03: *“I think it is.”*

Interviewer: *“So your role is as a comforter?”*

LT03: *“Yes, I’m a comfort blanket I think.”*

The MM’s role here addressed refocusing values and beliefs, overcoming fear and guilt, and developing resilience in the mentor. The emotional labour this demanded took its toll on MMs and they identified that they also needed their own anchor to hold them steady whilst they supported, what at times could be, a distraught mentor. This corresponds with findings from social work (Rawles 2013), that most stakeholders involved in a fail event needed support to cope. Hence, the majority of people involved in managing the student relied on an interwoven network of emotional support, in which everyone was reaffirming and reassuring each other. This had the effect of stabilising and securing the mentor emotionally, so that they had the self-possession to, “grasp the nettle” (**PE02**) and fail the student.

9.4 SINGING FROM THE SAME SONG SHEET

Ultimately participants in this study felt that, when the wider team involved in managing an underperforming student was consistent and cohesive in approach, it became possible to assess students rigorously and fairly. Trede *et al.* (2014) report paramedics also value this. This was referred to as ‘singing from the same song sheet’.

“I felt someone needed to bridge the gap between practice and academia so we could be singing from the same hymn sheet.” (MA15)

“Ultimately it came around to we were singing from the same song sheet.” (MA04)

“I think to know that both sides are singing from the same song sheet is quite comforting.” (LT01)

Consistency meant that all practical assessment policies and procedures were applied universally, and the same systems and techniques were used in all similar situations. This signified that each student could be compared to an agreed level of performance, which promoted transparent processes and allowed everyone to measure easily and correctly against this indicator. In this way governance of practical assessment could be unambiguous, constant and dependable, providing students and mentors with a secure basis from which to act.

“You know you have rules and regulations and everybody has to keep them. Because if everybody doesn’t it all starts to fall apart.” (PE03)

Feelings of security were further enhanced when mentors experienced that the message and the actions of ‘The University’ were consistent with their profession’s and employer’s values about patient safety and wellbeing, a position encouraged by the Francis Report (DH 2013). The mentor then felt they were a part of a robust team. Where practice partners and senior levels of university management demonstrated compatibility of purpose, removing incompetent student nurses from programmes became an expectation, rather than an antagonistic struggle.

“We are singing from the same hymn sheet and that’s what it’s all about. [Faculty] don’t want students to pass that are not going to be competent and capable and nor do [practice] and we are going to support them in that.” (LT08)

This type of collaboration epitomises that recommended by the Willis Commission (RCN 2012). In such circumstances participants felt that they did not have to ‘fight to fail’ but that their professional judgement was respected as that of a nurse acting to safeguard the public; an aim which the nursing profession, health care providers and the university hierarchy shared.

9.5 DISCUSSION OF CATEGORY B

The findings of this category indicate that mentors drew on a network of people to enable them to work through the three steps explained in chapters 6, 7 and 8, which were necessary to formulate a fail decision. Engaging with other people was important to mentors during such a stressful episode

because, as social beings, they sought out human contact to reduce feelings of isolation and sustain them at a difficult time. This helped them to feel heard, reassured and validated. Mentors indicated they drew on a wide range of people, and used each to provide different elements of support. These will be discussed in terms of both Putnam's (2001) theory of social capital and Wenger's (1998) work on communities of practice.

9.5.1 Social Contacts

Read (2014:997) defines workplace social capital in nursing as, "nurses shared assets and ways of being and knowing that are evident in, and available through, nurses' networks of social relationships at work." This current study demonstrates that such social capital does not just exist to support nurses in their caring role, but extends to mentoring functions. Gauntlett (2011) points out that social capital ought to be built above the baseline necessities which the employer should be obliged to ensure are in place. In this study a significant portion of the social capital on which participants drew was informal and put in place by mentors themselves, because social capital offered formally by both their employer and 'The University' was limited. This substitution of capital has been noted by Field (2003), who observes that people will use alternative forms of social capital to compensate for shortfalls in others.

Putnam (2001:18-19) argues that, "the core of social capital theory is that social networks have value...social contacts affect the productivity of individuals and groups." He defines social capital as the "features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives" (Putnam 1996:56). This offers the concept of a social ecosystem on which mentors drew for three benefits; problem resolution, maintaining professional standards and providing encouragement. From this perspective, social capital can be viewed as a stock resource which mentors had access to in the forms of bonding, bridging and linking capital.

Bonding social capital is seen by Putnam (2001) as the glue which reinforces loyalty and cements group identity. It ties together people who are in similar situations. For mentors, this type of social

capital refers to some of the informal support networks on which they drew: family, friends, colleagues, and patients. Bonding capital was used for emotional support and verification of judgements. This helped mentors to ensure they were acting for the benefit of the group. Solidarity has previously been identified as important characteristic of mentors who will fail students (see Chapter 5.3.1).

Bridging social capital is seen by Putnam (2001) as lubricating links to external assets and more distant ties. This can be seen to relate to the formal support networks, on which some mentors were also able to draw, and which helped them to access higher tiers of management within their own organisation, and links at "The University". Where bridging capital was available, mentors were more likely to be able to access additional assets, such as time from managers and provision of extra sources of support for the student (Chapple and Aston 2004).

Woolcock (2001) suggests a third type of social capital, 'Linking Capital', which extends to a wider range of resources. This might be likened to the underwriting support networks which mentors identified. These comprised facilities such as human resources departments, trade unions and in one case the police. This type of capital was drawn on particularly when relationships with students became strained, and mentors felt they needed significant reinforcement or protection. PEFs in this study were able to provide or facilitate access to all three types of social capital, and this is perhaps why they were mentors' most valued asset when managing an underperforming student.

Some differences in the way male and female participants used social networks were noted in this study. Males tended to access underwriting support more readily for instrumental assistance, whilst female participants relied more heavily on informal networks for emotional support. This is consistent with Putnam (2001:94) who terms these types as "machers" and "schmoozers". Machers are more inclined to take action to make things happen and are more commonly male, whilst schmoozers are more likely to draw on cosy, intimate, reflective relationships and tend to be female. This explains some of the differences in approach between male and female participants observed in

this current study, and could also explain the anxieties mentors expressed when managing a student of the opposite sex. This is an area which would benefit from further investigation.

Read (2014:1005) recommends that nurse leaders should incorporate development of social capital into their decision making processes, and reduce their restricted focus on, “economic capital as the bottom-line”. Following the Francis Report (DH 2012) this view has come sharply to the fore. This also fits with Coleman’s (1994) view of social capital as a mechanism which influences the quality of an organisation’s human capital. Specifically in this context, that robust practical assessment of student nurses improves the employability of new registrants. Investing in support mechanisms for mentors is a quality control strategy which all healthcare organisations should consider.

9.5.2 Communities of Practice

It was notable that in work areas where mentors felt able to fail students, arrangements were in place for groups of staff to support each other professionally. Although the term ‘communities of practice’ was not used by any participant, the group structures described bore a strong resemblance to this concept. Communities of practice (CoP) are defined by Wenger (1998:4) as, “groups of people who share a concern, a set of problems or a passion about a topic, and who deepen their expertise in the area by interacting on an on-going basis”. This fits well with the mentor activities noted in this study. CoPs in nursing usually promote collaborative learning and enhance care practices (Andrews *et al.* 2008). However, it is just as appropriate for them to exist to develop mentoring and assessing practice, and this seems to be what was happening, particularly where LEMs and PEFs met regularly. In some situations CoPs were also identified at ward level and in these circumstances mentors recognised their value, particularly in supporting neophyte mentors to fail underperforming students. The activities which groups undertook that were consistent with CoP functions (White 2010) were: supporting assessment decisions, being available to each other at critical points, facilitating mentor role modelling, and observation of best mentoring practice (Andrews and Ford 2013, Billings and Kowalski 2008). These intentions seem to be similar to the NMC’s (2008a)

purpose in mandating that mentors have the opportunity to discuss challenging situations with peers in order to demonstrate they have updated. It is suggested that CoPs are more effective in achieving cohesive mentoring at difficult times because they can be drawn on more immediately, at point of need, rather than retrospectively at annual updating events, when the difficulty might have occurred a long time ago.

It appeared that within such CoP, mentors and LEMs were developing confidence to challenge and change the practice of failing to fail. Furthermore, some were also developing practices which attempted to influence university assessment procedures. This has the potential to ensure assessment of practice is driven by practicing nurses rather than HEIs. This is not necessarily a comfortable process between HEI and care sector, but it seems to be a method which has the potential to facilitate emergence of new practices, which better fit the way mentors work. It is likely that the reports such as 'Francis' (DH 2013a) and 'Keogh' (DH 2013b) will have an empowering effect. This may galvanise mentoring CoP to voice concerns about the function and process of university practical assessment procedures, particularly when these do not seem to fit with professional obligations to make patient wellbeing the central consideration of practical assessment decisions. A positive, collaborative approach will be needed by all stakeholders to proactively manage adjustments, whilst maintaining professional respect across organisations (Andrew *et al.* 2009).

9.5.3 Equipping Expert Helpers

The pivotal role which PEFs can play in helping mentors to feel secure enough to fail a student became apparent during this study. PEFs were considered an integral support and were warmly appreciated by mentors. This finding runs counter to reports that PEFs and LLs struggle to be recognised and accepted in clinical areas (Dickson *et al.* 2006), taking between 4 and 7 years to break down the barriers and become accepted by mentors (Ramage 2004). The difference perhaps was, that this current study did not focus on situations where things were running smoothly and

mentors were functioning within their comfort zone. In more usual circumstances the PEFs standing is low in clinical areas, because they cannot be an expert in the specifics of the care delivered in every clinical area in which students are placed. Hence, their credibility is often reduced because mentors feel themselves to be more capable (Ramage 2004, Clarke *et al.* 2003). In the more intense and emotional circumstances of failing a student PEFs seemed able to break down barriers (McArthur and Burns 2008) by becoming an essential and credible expert in failing students; an area in which mentors did not feel so secure (Carlisle *et al.* 2009). This connection between PEF and mentor was then further enhanced because the PEF spent extra time in the particular practice area, focusing on the needs of individual nurses and students. A reciprocal arrangement was reached, as both the mentor and PEF were now giving to the relationship, and a close bond was built. This explains why mentors were then perceived to respond positively when the PEF arrived in the placement area, rather than greeting them with the more demeaning “Hello part-timer” reported by Ramage (2004:291) when things were going smoothly. However, given the increased visibility of the PEF during episodes of failure it is not a surprising finding that they felt they were regarded as the “naughty nurse” (**LT02**) by students, and sensed that much of their value to mentors was in their “fire-fighting” abilities (Clarke *et al.* 2003:110, McArthur and Burns 2008).

Once PEFs had been involved in a failing event they usually became a readily accepted and valued part of the clinical team. Mentors were far more likely to call the PEF early the next time there was a problem, and would encourage their colleagues to do likewise. In the same way, they were also more likely to instigate conversations if the PEF visited the area, and seek help with more minor issues on which previously they would not have sought advice. This was because they had become familiar with one another as they had worked through a difficult experience together, they felt they had shared values and could rely on each other, which built a bond of trust (Ramage 2004).

Once staff in a practice area had “grasped the nettle’ (**PE02**) and failed one student they were more likely to do this again when a student underperformed, particularly if they had one consistent person supporting them with whom they had built a bond. In this way, it was possible that certain practice

areas did develop an accurate reputation as a place where students were more likely to fail a placement, this being a reflection of the willingness to adopt robust expectations and assess rigorously rather than because the placement had an intolerant approach to students. This study found no evidence of malicious intent in mentors who reported that they had failed students. Quite the reverse: every mentor described going above and beyond the call of duty to try to help the student to pass the assessment before they would consider failing them. However, this may be because only participants who were confident of their integrity volunteered to participate, and so the sample could be biased towards mentors who had the best intentions when failing students. It would be challenging to attempt research to investigate mentors who are not confident about their competence, who abuse their legitimate power, or who consciously or unconsciously seek to fail students. Nevertheless, it would be a valuable exercise to try to establish how prevalent such mentors are, and to explore their behaviours and motivations, in order to reduce the future development of toxic mentors.

Practice Education Facilitator roles differed across organisations with limited consistency of functions, this has been reported previously (Clarke *et al.* 2003, Lambert and Glacken 2005). This is not currently a mandatory role and is not articulated in the NMC (2008a) SLAiP standards, which govern mentoring. There is a need to formally recognise this pivotal role. Currently, in England, the employment and availability of such staff is dependent on the level of commitment individual healthcare organisations place on such roles. Integration of the role into the NMC (2008a) SLAiP standards would help to emphasise the importance of support for mentors in practice based areas. This would be a first step in developing a clearer more consistent PEF role (Williamson and Webb 2001). Mentors, HEIs and students could have a constant expectation of the services those fulfilling the role offered, rather than the variable provision on offer across healthcare placements which has existed for the last decade (Lambert and Glacken 2005). In Scotland, (NHS Education for Scotland 2013) a robust, nationally agreed, PEF framework is in place, which provides role descriptors to clarify responsibilities and expectations.

Alongside this, it seems likely that formally preparing PEFs for their role would enhance role confidence and competence. Andrews and Ford (2013) found that most PEFs currently either make up the role as they go along, or learn by observing a more experienced PEF. This happens because there is no formal programme to prepare PEFs for a role which sits between clinical practice and higher education (White 2010, Clarke *et al.* 2003). It seems clear that such a role is necessary considering its continual re-emergence from the embers of previous iterations of clinical teachers and lecturer practitioners, each of which was abandoned because of reported difficulties. A repetitious cycle of, “throwing the baby out with the bathwater” seems to have continued (Mannix *et al.* 2006:5). Mentors in this study clearly articulated that such a role is essential to them when they are managing a student who is failing. There is a need to explore approaches to ease the difficulties inherent in the PEF role rather than repeatedly abandoning and then reinventing the role itself (Lambert and Glacken 2005).

Alongside the traditional classroom teaching elements which have been delivered, tailored PEF courses would need to include a more substantial focus on managing practice based assessments. This is the main reason mentors call on PEFs for help (Carlisle *et al.* 2009) and where a significant amount of PEF time is currently spent. Therefore PEF preparation programmes should focus on practical, rather than academic, learning and assessment and should incorporate the elements indicated in Figure 9.9 to ensure that PEFs have been thoroughly prepared to support mentors appropriately when students are failing.

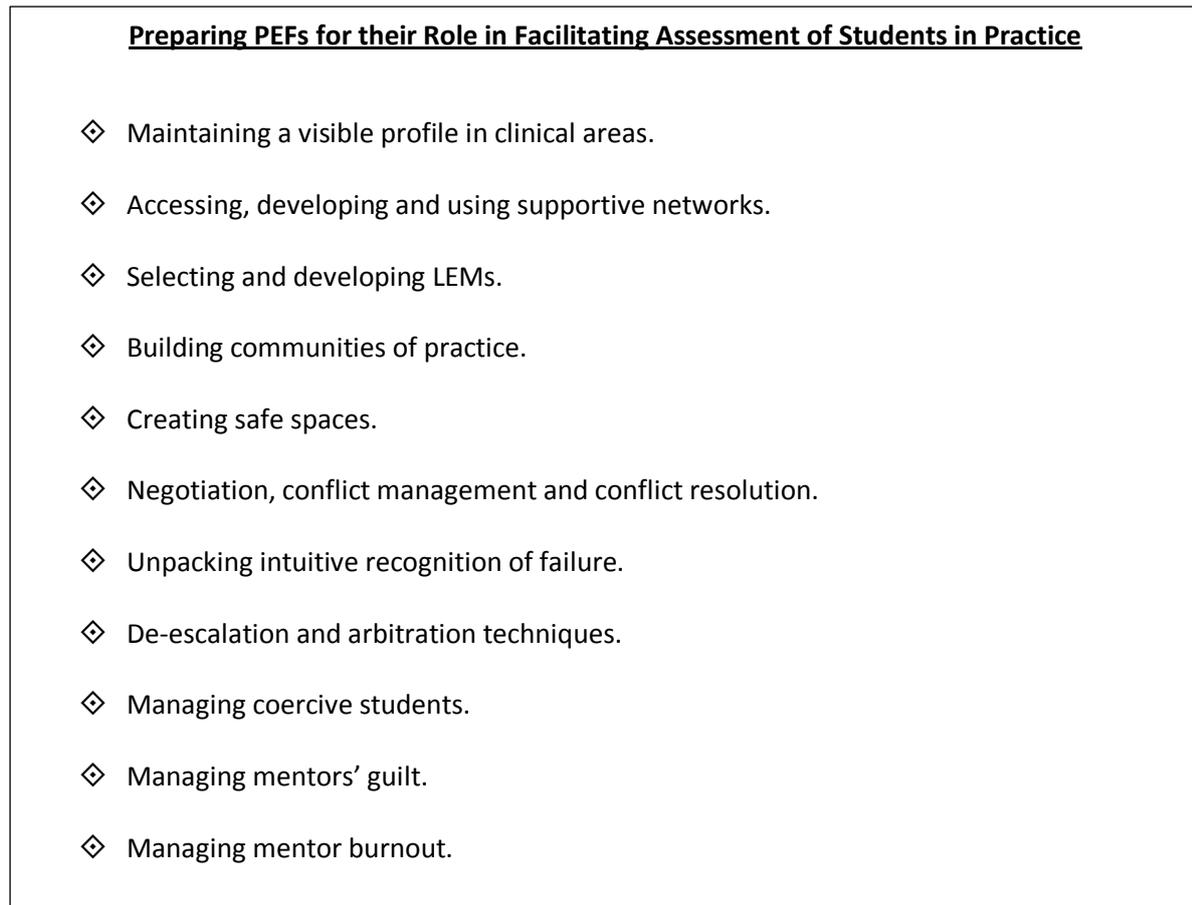


Figure 9.9 Preparing PEFs for their Role in Facilitating Assessment of Students in Practice

Furthermore it is suggested that a national formal agreement is needed about where this role is positioned logistically and hierarchically. It may be helpful to consider PEFs in the same way as other clinical nurse specialists, and possibly give them a title which is indicative of this standing. In this way their value would formally be recognised.

9.5.4 Placing Patients at the Centre

The findings of this study demonstrate that the problems involved in failing a student in practice do not rest with difficulties in identifying under-performance; mentors indicated they could generally do this quickly and easily. This has probably long been the case. Mentors in Duffy's (2003) study recognised they had failed to fail underperforming students, which presupposes they were able to recognise such students. When mentors can already effectively recognise the 'gist' of underperformance, it is an unnecessary and time consuming activity for professional bodies and HEIs

to engage in production of additional descriptors and procedures to help mentors identify incompetence.

It is an uncomfortable finding of this study that, to fail underperforming students, mentors had to navigate significant obstacles: economic considerations, protection of business interests and clashes of organisational culture. Nevertheless, recently published findings from several enquiries and commissions about failings in the Health Service (DH 2012, 2013 a, b & c) identified that similar drivers have been more influential than quality patient care. The difficulty for mentors in this current study lay in a system which often did not acknowledge the importance of their role, disregarded the distress inherent in fulfilling the obligation to fail, provided scanty formal support mechanisms to help negotiate impenetrable protocols and bureaucracy and seldom sought or recognised the mentor voice as instrumental in protecting patients. On a more optimistic note this study also demonstrated that some healthcare and academic organisations had established ways to ensure mentors felt secure enough to fail students who they recognised were underperforming.

9.6 SUMMARY OF CHAPTER 9

This chapter has presented the category “Drawing on an Interpersonal Network”. The interpersonal support networks on which mentors draw when they encounter challenging or underperforming student nurses have been demonstrated. The reasons why such social support is essential in assisting the mentor to build a secure fail decision have been explained. Chapters 5 - 9 have offered a discourse about the context and process of developing a secure fail from the mentor’s perspective. The core category “Standing Securely” will be presented next.

Chapter 10

The Central Category : Standing Securely

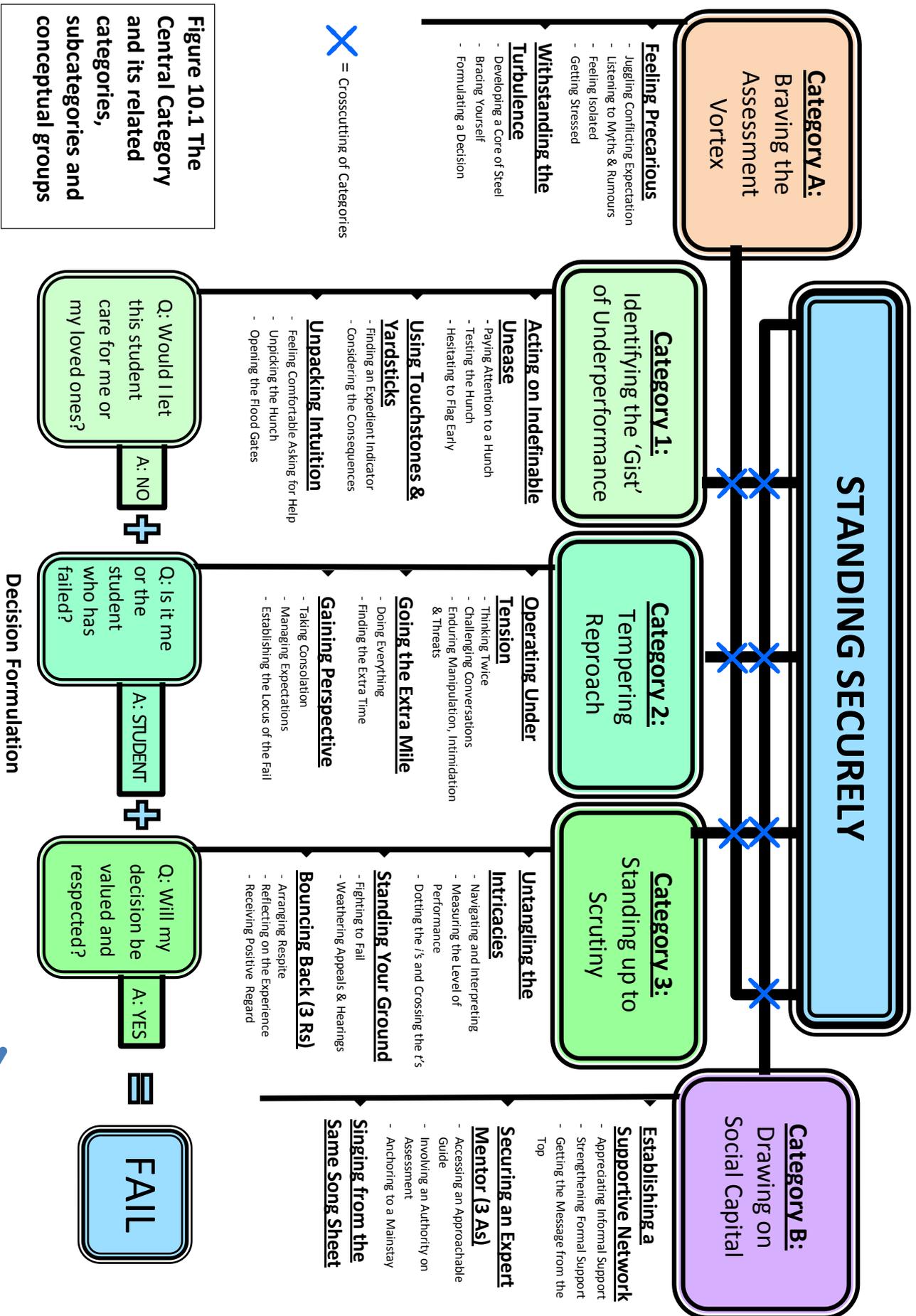
10.1 INTRODUCTION TO CHAPTER 10

This chapter presents the central category “Standing Securely”. It begins by discussing the evolution of this category and goes on to demonstrate how it unites the categories presented in chapters 5 – 9 to form an explanatory whole (Corbin and Strauss 2008). The substantive theory associated with the central category is explored, and the key factors which enable a mentor to stand securely are situated within this to offer an explanatory framework.

10.2 THE CENTRAL CATEGORY

“Standing securely” finally emerged as the central category following lengthy, protracted deliberation. This confirms Stern and Porr’s (2011) view that the core concept does not inexplicably emerge from data. Several potential central categories were explored using techniques of constant comparison, storylines, and diagrams. Each of these was evaluated, and found to be a slightly uncomfortable fit which ‘forced’ the data. One participant likened the reluctance and pain associated with failing a student to “*grasping the nettle*” (PE02), and for some time this was the working title of the thesis. However, this only appeared to demonstrate *what* mentors were doing, and did not offer a full explanation of *how and why* they were doing this.

A chance meeting with a participant from the study brought clarity. At the time, diagramming was a central technique being employed to try and establish the core of the data. The mentor noticed a sketch of the category that became ‘braving assessment vortex’, and enquired about it. An explanation of this rough diagram resonated very strongly with her feelings about how unsettling the experience was. From this discussion came insight that the turbulence of the experience needed to be calmed, and that the mentor needed to feel stable in failing the student. Further examination of transcripts and field notes revealed safety, security and ‘standing your



X = Crosscutting of Categories

Figure 10.1 The Central Category and its related categories, subcategories and conceptual groups

ground' as recurrent themes within interviews and field notes. It became noticeable that mentors needed to be able to stand securely to fail an underperforming student, and that the data contained substantial information about how this was accomplished. A diagrammatic representation of the central category and its related categories, subcategories and conceptual groups is presented in Figure 10.1.

10.3 THE SUBSTANTIVE THEORY – STANDING SECURELY

The aims of this investigation were to develop a theory which would explain the factors that influenced the role and function of those involved in failing student nurses in practice in England, and to formulate a proposition that would inform both the future preparation of assessors and the assessment of nursing practice. Corbin and Strauss (2008) indicate that the purpose of a grounded theory is both to tell a story which makes clear key aspects of a phenomenon, and to offer an explanation which will enhance understanding. The central category of this study, "Standing Securely", is now explained.

Mentors needed to feel secure in their role in order to fail student nurses who were not meeting required standards; this meant they needed to feel safe and sound. Feeling safe meant that their role was endorsed, giving them both authority and protection. Feeling sound entailed having the means and wherewithal to conduct robust, clear and fair assessments, which they felt confident about. This was achieved through: the mentor being committed to the assessment role; knowing that reinforcement was available; becoming established and comfortable in the role and feeling that the ethos of rigorous assessment was durable and resilient against censure.

The feeling of security was not achieved by implementing one, or even several, large interventions alone. Instead, it was achieved when a lot of small adjustments were made, in a number of different places, which cumulatively made a substantial difference. The thread which held this together was a social core, in which human contact was critical to the mentor's ability to manage the challenges of the

event. Effective, cumulative gains (Brailsford 2011) were identified, in which successive elements contributed to building a state of affairs in which the mentor could 'stand securely'. These 'cumulative gains' have been presented throughout the five preceding categories (Chapters 5-9). Here, they combine to demonstrate how they bolstered and sustained mentors throughout the experience of failing a student in a practical assessment.

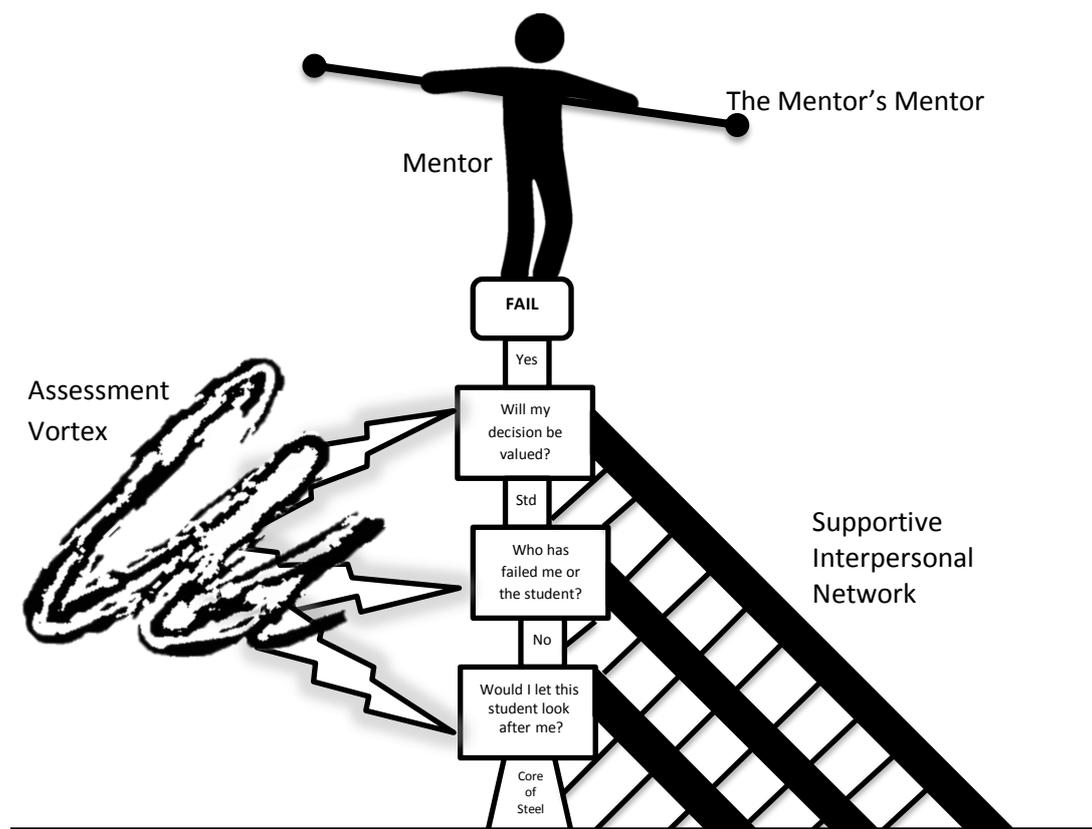


Figure 10.2 Standing Securely

Figure 10.2 demonstrates this process visually by showing the three stages of decision making (Categories 1, 2, & 3), buttressed by a supportive interpersonal network (Category B), whilst under duress from the assessment vortex (Category A). The process of decision formulation, even when built upon the mentor's own core of steel (Category A), was precarious and likely to collapse in the absence of a supportive network. The supportive buttress therefore needed to be robust and stable enough to endure buffeting from the assessment vortex. The mentor was further steadied by a mentor's mentor

who acted as a knowledgeable guide, helping them to withstand the pressure, and navigate a route through the assessment judgements, to a point where the fail decision could be established safely and soundly.

10.4 RESONANCE WITH EXISTING THEORY

Theories of social support identify the processes through which individuals' wellbeing can be enhanced via social ties and interactions. These theories are concurrent with the views participants expressed in this current study: that the support they had been given by individuals and groups of people had been the most influential factor in enabling them to fail an underperforming student. Various theories of social support have been posited. Each focuses on particular aspects including: the networks which provide support (Putnam 2001); the outcomes of the support (Albrecht and Adelman 1987); the interactions involved (Gottlieb 2000); the types of support (Schaefer *et al.* 1981); theories of perceived versus received support (Norris and Kaniasty 1996); optimal matching between individual and support (Cutrona and Russell 1990) and comparisons between buffering and direct-effect hypotheses (Taylor 2011).

Theories which addressed stress and burnout in the workplace were also of relevance (Lambert 2010, Baruch-Feldman *et al.* 2002, Bourmans and Landerweerd 1992, Ivancevitch and Ganster 2014).

Participants in this study also indicated that they sought social support to help them manage the challenges and stressors involved in undertaking the role of mentor to an underperforming student.

Each of the theories cited above contributed to understanding what was 'going on' in this grounded theory study. However, House's theory of Work Stress and Social Support (1981, 1985, House *et al.* 1988, 2004, Burgard *et al.* 2013) drew together an explanation of all these elements. This theory offers insight into the various dimensions of social support in stressful work situations, resonates with the themes from this study, and offers a framework which is congruous with the core concept 'standing securely'. In particular it considers causes of stress from the perspective of work and employment and so is a good fit with the stress of mentoring in the workplace; it promotes the centrality of social

mechanisms in managing stress which were accentuated by participants in this current study; and most significantly it emphasises the importance of identifying the **actions** inherent in the process of managing work related stress through social support mechanisms. This fits well with grounded theory methodology, with the aims of this current study, and assists in demonstrating and explaining the actions which can be undertaken to enable mentors to award a fail grade when necessary.

10.4.1 Work Stress

Those working in public services have consistently been identified as being particularly exposed to high levels of work stress (Huynh and Xanthopoulou 2013, Page and Jacobs 2011, Gonzalez-Moralez and Rodriguez 2010). Role overload and role ambiguity have been identified as two particularly taxing work-demands (Jimmieson *et al.* 2010) and, when combined with the high stakes and human consequences involved in the decision making processes of vocational professions, can be a particularly stressful blend (Coget and Keller 2010).

Mentors' work stress was explored in Category A, which explained how participants felt buffeted by a large number of conflicting expectations, mainly generated through the clash between academic and practice based cultures. This caused uncertainty and anxiety, which was exacerbated by colleagues withdrawing from the challenging situation, leaving the mentor isolated. Mentors felt precarious because failing a student challenged their belief in themselves as 'good' mentors which compromised self-assurance and diminished feelings of role security. Further strain was added by the complexity of processes, and the intimidation and coercion to which the mentor might be subjected. Many participants explained the worry, pressure and tension that the situation had caused them, and most reported responses characteristic of stress. Participants made it clear that failing a student nurse in a practical assessment should be regarded as a significant source of work stress, which impacted substantially on their wellbeing over a period of at least several weeks or months. The after effects could have a residual impact upon mentors, and others involved in the event, for a considerable period of time, and could compromise both their wellbeing and role efficacy.

10.4.2 Social Support

What was particularly notable in this study was that all participants identified mechanisms which helped them to cope with the stressors; stabilising them sufficiently to go on to fail the student. The support usually took the form of social support networks rather than material resources. Kaplan *et al.* (1977) point out that social support is only likely to be protective where stressful circumstances exist. People do not look to this support when the status quo is being maintained. This was clearly demonstrated by one participant in the current study, who noted how support from others was particularly sought at this challenging time:

"We seek out help when there's a problem. We don't go and converse about things when things are all hunky-dory and lovely and maybe that's the crux of the matter." (LT02)

However, Jimmieson *et al.* (2010) noted that it could be precisely at such times that co-worker support and team cohesion also diminished. This is consistent with mentors' reports that, on occasion, fellow mentors could retreat from the situation when they encountered a failing student, leaving them feeling isolated at work. In such circumstances, mentors who went on to fail students drew on their most trusted supporters to help them through the stressful event, both in the workplace, and from their wider social network. Mentors sought out supporters whom they anticipated would provide the type of support they felt they needed (perceived support), whereas the formal support provided through official channels was not always received positively (received support), and could at times increase stress (Taylor 2011). This was found to be particularly harmful when supporters emphasised how stressful the situation was (Beehr *et al.* 2010). This was reflected in mentors' reported tendencies to shun electronic resources and academic lecturers, neither of which provided the perceived support that mentors wanted.

10.4.3 Actions on Stress

House (1981:26) defines social support as, “a flow of emotional concern, instrumental aid, information and appraisal between people”, and proposes that these have three **actions on stress**: to eliminate/reduce, compensate, or buffer. In terms of mentoring this applies as follows:

- to eliminate or reduce the stressor by changing the mentor’s work situation;
- to enhance elements of the mentors’ life to compensate for the stress;
- to block the impact of the stressor by buffering the effects on the mentor.

House (1981) further posits that such support must consider both the nature of the person (mentor), and the surroundings in which that person is functioning, so that both the cause and the symptoms of stress are managed. However, a certain amount of residual stress is necessary for the person (mentor) to function at an optimal level. In care environments, mentors viewed stress as an occupational hazard which could not be avoided. Hence, the ‘compensatory’ and stress ‘buffering’ actions of House’s theory were particularly useful tools for moderating their stress, although a small number of ‘eliminating/reducing’ actions were noted.

The key groups of **supportive undertakings** which help mentors are: sharing emotional concern; providing appraisal; supplying instrumental aid; and conveying information. When these **supportive undertakings** are related to the **sources of support** (identified in chapter 9), a matrix of support is generated which is shown in Table 10.3.

This Table can be used to assess the mentor’s level of social support. This is done by marking the relevant cell in the grid when a supportive undertaking is performed by a supportive source. The supportive source can have one of three **remedial actions on stress**. When mentors have a dense network of social support, which provides the supportive undertakings the mentor perceives they need, they are more likely to fail an underperforming student (Stohl 1995).

REMEDIAL ACTION ON STRESS		SOURCES OF SUPPORT (SOCIAL CAPITAL)																									
		Informal External					Informal Internal					Formal Internal				Under-writing											
		Partner	Family members	Friends	Ex-colleagues	Contacts/acquaintances	Paid Help	Other nurses	Ancillary staff	Patients/clients	Relatives/visitors	Other students	Other Health Profs	Organisationally based PEFs	Ward/team based LEMs	Team Leaders/Managers	The Student	Other mentors	Link Lecturers	University staff	Human Resources	Occupational Health	Professional bodies	Trade Unions	Internal governance	Police or security	
SUPPORTIVE UNDERTAKINGS	Emotional	Esteem																									
		Affect																									
		Trust																									
		Concern																									
		Listening																									
	Appraisal	Affirmation																									
		Feedback																									
		Social comparison																									
	Information	Advice																									
		Suggestions																									
		Directives																									
		Evidence																									
	Instrumental	Time																									
		Labour																									
		Resources																									
		Environment																									
		Rewards																									

Table 10.3 Supportive Undertakings & Remedial Actions Employed by Social Supporters (Adapted from House 1981)

The three components of the support matrix; sources of support, supportive undertakings, and remedial actions on stress, will now be considered in more detail in relation to the central category ***Standing Securely***.

10.4.3.1 Supportive Undertakings

Supportive undertakings were in evidence across much of the data provided by participants. However, akin to participants in both House (1981) and Schaefer *et al.*'s (1981) studies, mentors emphasised that emotional support was most significant in enabling them to fail students. House suggests that without emotional support the 3 other types of supportive undertakings were of only limited assistance. Hence, emotional support should be regarded as the core supportive undertaking, with the other 3 types contributing supplementary reinforcement to varying degrees, depending on the individual mentors perceived needs.

This is consistent with much of the literature on social support in vocational professions. This suggests that emotionally focussed interventions are the most common coping mechanisms, rather than direct action coping mechanisms which act to eliminate the stress (Dewe 1989, Himle *et al.* 1991, Yildirim and Aycan 2008, Lambert 2010, Gonzalez-Morales *et al.* 2010, Van-De-Ven *et al.* 2013). There are several possible explanations for this, the most useful being that either stressors cannot usually easily be removed in such occupations, or because vocational professions traditionally attract higher numbers of females, who demonstrate a tendency to use passive avoidance strategies to cope with stress (Day and Livingstone 2003, Hobfoll 2013). It was noted in Category B (Chapter 9) that male participants in this study tended to draw on underwriting support more than female participants. This indicated a tendency towards a problem/solution focused approach in male mentors in this sample.

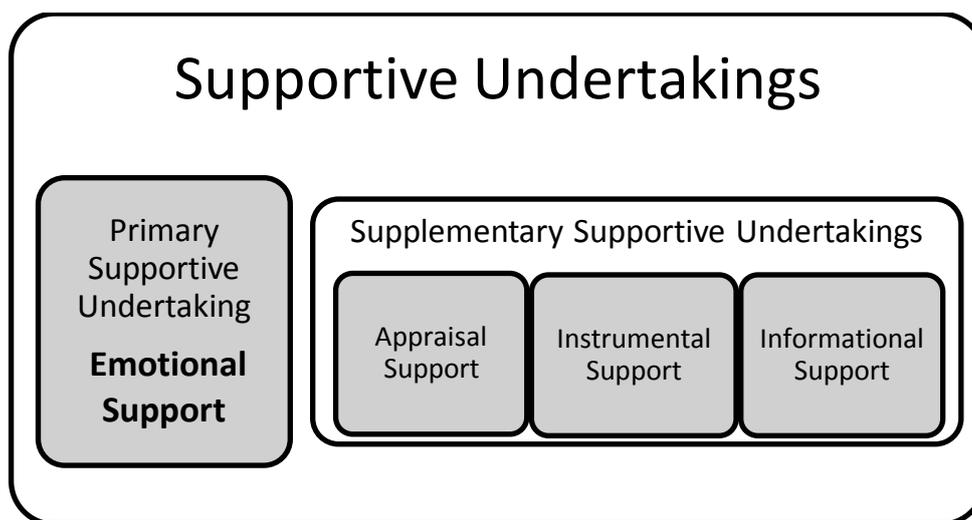


Figure 10.4 Supportive Undertakings

Emotional support is defined by House (1981:24) as, “the provision of empathy, caring, love and trust”. Schaefer *et al.* (1981) also reported on this form of support, which was provided in a number of ways. Participants described examples of how supporters helped them to calm down, allowed them to vent feelings, provided physical comfort, offered reassurance, shared distress and helped them to gain closure. House (1981) breaks down emotional support into the elements of: esteem, affect, trust, concern and listening. Examples of each type of emotional support reported by mentors are provided in Table 10.5.

Type of Emotional Support	Examples
ESTEEM	Confirming the mentor as ‘good’, recognising the value of practical expertise.
AFFECT	Sharing distress, encouraging mentors to vent feelings, offering strategies to manage guilt and fear.
TRUST	Giving credibility to the mentor’s judgement, showing solidarity.
CONCERN	Helping to gain closure, offering physical comfort.
LISTENING	Heeding and attending to the mentor’s concerns.

Table 10.5 The Elements of Emotional Support

Appraisal support involves the transmission of information to help mentors evaluate themselves, rather than the affect involved in emotional support, or the aid involved in instrumental support (House 1981). In this study current study, this comprised elements which Cohen and Willis (1985) term adaptive appraisal: evaluation of judgement and performance, along with guidance on further professional development. This included such things as receiving affirmation of a job well done, and indicators that their professional judgement was valued and noted. Potentially negative appraisal, from such quarters as the media and prospective employers, could also act as a strong motivator to avoid future criticism. House (1981) identifies three elements to appraisal support: affirmation, feedback and social comparison. Examples of each type of appraisal support noted, by mentors in this study, are provided in Table 10.6:

Type of Appraisal Support	Examples
AFFIRMATION	Gaining approval and confirmation of actions and outcome.
FEEDBACK	Receiving reviews of performance as an assessor, and suggestions for further development. Being provided with information about the final outcome for the student.
SOCIAL COMPARISON	Obtaining corroborating judgements from others about the student's performance.

Table 10.6 The Elements of Appraisal Support

Informational support is defined by House (1981:25) as, “providing a person with information that the person can use in coping with personal and environmental problems”, and furthermore, “helps people to help themselves”. Both Schaefer *et al.* (1981) and Goldsmith (2004) also recognise this form of support. Participants in this study reported access to a variety of different types and sources of information which were helpful. Examples included; clarifying the expectations of both the mentor and student, providing accessible contact details of practice education facilitators and link lecturers, interpreting complex academic language and assistance with procedural requirements. House (1981) distinguishes four elements of informational support: advice, suggestions, directives

and evidence. Examples of each type of informational support mentors noted are provided in Table 10.7.

Type of Informational Support	Examples
ADVICE	Guidance about how to conduct challenging conversations, provision of tips about providing evidence in panels and hearings, sharing strategies to avoid pitfalls.
SUGGESTIONS	Help unpacking intuitive sense of students' incompetence, learning from others mistakes, ideas about substituting one approach for another.
DIRECTIVES	Instruction about how to interpret complex learning outcomes and follow procedures, clarification of role expectations.
EVIDENCE	Provision of examples and availability of role models, reviewing outcomes and planning for the future.

Table 10.7 The Elements of Informational Support

Instrumental support (Table 10.8) occurs when individuals, "help other people to do their work [or] take care of them" (House 1981:25). This is also referred to as tangible support (Schaefer *et al.* 1981) or physical help (Mattson and Gibb-Hall 2011). In this study this involved provision of a variety of resources, the most critical of which was time to undertake the role. Further examples of

Type of Instrumental Support	Examples
TIME	Being given specific allocated time for mentoring activity, prearrangement to take time owing from extra mentoring activity.
LABOUR	Colleagues taking on part of the mentor's workload, domestic responsibilities being undertaken by a friend or family member, PEF acting as record keeper during interviews.
RESOURCES	Buddy mentors, posters publicising PEF contact details.
ENVIRONMENT	Provision of safe spaces to use for interviews, establishment of communities of practice.
REWARDS	Peer acknowledgement, formal recognition from managers and HEIs.

Table 10.8 The Elements of Instrumental Support

instrumental support included, organisational provision of learning environment managers, and visible assistance in threatening situations. House (1981) categorises five elements of instrumental support: time, labour, resources, environment and rewards. Examples of each type of instrumental support identified by mentors are provided in Table 10.8.

The list of examples provided here is not exhaustive. Many more illustrations of supportive undertakings were identified across the five categories which evolved into the core category - 'Standing Securely'.

10.4.3.2 Remedial Actions to Manage Stress

Remedial actions to manage stress were identified in much of the data provided by participants (Taylor 2011). The three types of remedial actions reported by House (1981) were all distinguishable in participants' accounts. Without these stress reducing effects it seems unlikely that mentors would have failed students, because the pressure became unbearable and the mentor would freeze or take flight, which is consistent with stress response theories (Crosby 2008). House (1981) breaks down remedial action for stress into the activities of: elimination/reduction, compensation, and buffering (Figure 10.9). Examples of these activities, as reported by mentors, are provided below:

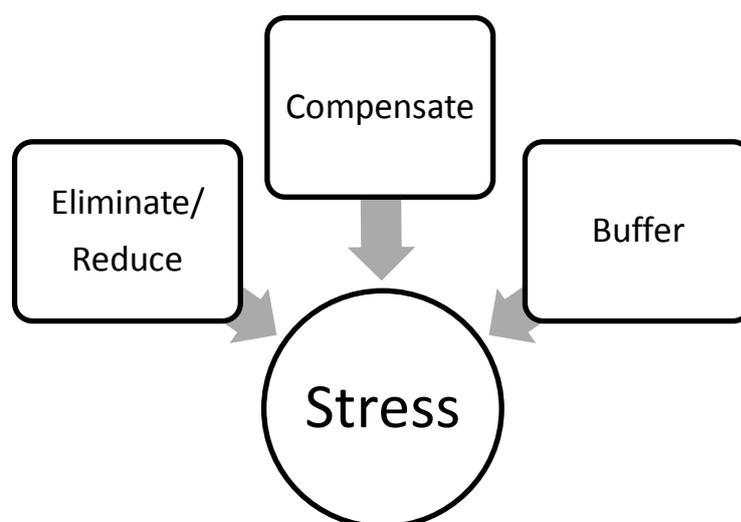


Figure 10.9 Remedial Actions to Manage Stress

Eliminating/reducing stress was the least commonly identified of the three remedial actions. This was because, usually, neither the student nor the mentor could be removed from the partnership if it was to progress to a point where a fail decision could be reached. This was one of the key reasons why direct action stress coping strategies, aimed at eliminating the threat, were of limited use (Dewe 1989). However, on occasions it was reported that tutors had removed students from the placement area where their behaviour had been extreme. On another occasion the police were called to remove a threatening individual from the vicinity of the workplace. A further stress reducing measure was for universities to manage students' expectations regarding practical assessments. In some case this was felt to moderate students' extreme responses when they were told they were not performing to the required standard, and hence reduced the pressure on the mentor.

Compensating for stress involved offsetting the stress of mentoring the student with another activity. Mentors felt that being given time back, when they had worked over with failing students, was an effective compensatory mechanism, as was interacting with other students within the placement area, who responded to their teaching and feedback more positively. Gaining positive recognition and credit for their dedication and persistence, in making the right decision even though it had been difficult, also counteracted the stress.

Buffering stress was the most commonly noted supportive activity, and involved cushioning the stressful effects of mentoring and assessing an underperforming student (Cohen and Willis 1985). Buffering activities included: recognising the danger the student could pose to loved ones; appreciating that the mentor had done all they could to help the student pass; being given affirmation that concerns were valid; having opportunities to express feelings; receiving physical comfort and reassurance; and reducing feelings of isolation all contributed to buffering. Where the mentor felt they were acting in the best interests of patients, their employer, their profession and the partner university; and all of these groups regarded them positively for doing this, stress was most successfully buffered.

10.4.3.3 Sources of Support

Sources of support were explored in some detail in Chapter 9, and it is not the intention to revisit this again in detail here. However, House's (1981:29) observation that, "humans are somehow protected against the effects of stress by the presence of a familiar person" has resonance with observations made in this study, particularly regarding mentors' tendency to draw on two relationships. This section focuses on these two types of supporters who participants indicated were most influential, that of a spouse or other close friend, and that of the 'mentor's mentor'.

Much of the support mentors alluded to in this study was informal. House (1981:29) suggests this is because, "the people we intuitively think of as sources of support are not people we barely know, but our parents, spouses and friends". This is consistent with other studies which have demonstrated that partners are the most significant source of support in coping with vocationally focussed work stress. Page and Jacobs (2011) have observed the importance of a partner's support in coping with some of the emotional demands of police officers' work. Huynh and Xanthopoulos (2013) reported that family support was important for fire-fighters in protecting against burnout and Lovseth and Aasland (2010) recounted similar findings in those working in the emergency services. Having one or more stable and established relationships is usually, therefore, helpful in order to obtain social support. More importantly House (1981) suggests that it is beneficial if this is someone that mentors feel cares about them. This may explain why mentors often referred to family members and friends as their first option when seeking support and comfort.

House (1981: 56) goes on to demonstrate that, to a lesser degree, people are also protected from stress, "by others whom they have had at least one previous interaction". This sheds light on why it was helpful for mentors to be familiar with PEFs and LLs before they felt able to call on them for help, and illustrates why having one consistent link was important (Ismail *et al.* 2013). In such cases, when mentors had had one effective encounter with a PEF, they were more likely to call on them again in challenging situations. Experiencing effective social support during one stressful experience increased the likelihood that mentors would access this means of social support with reduced

hesitancy the next time. Furthermore, if this support could be sourced at work they were also likely to influence other mentors to do the same, using a mechanism which Christakis and Fowler (2009) term 'flow across social ties'. This was partly instigated by one person's tendency to copy another, but had added strength when several social sources gave additional authenticity to the message that it was a secure thing to do. In this way social support flowed across larger groups, increasing the tendency of mentors to become tied into a network, where failing underperforming students was the norm, and they felt they could stand their ground securely as 'good' mentors for doing this.

In an age where technology is usually championed as the remedy for deficiencies, it is notable that nurse mentors in this study shunned it, in favour of the human touch. Easy access to a social support network was the key factor which increased mentors effectiveness. This acted to offset stress in their assessment role, and helped them to stand securely and fail underperforming students in practical assessments.

10.5 SUMMARY OF CHAPTER 10

This chapter has presented the central category "Standing Securely". This substantive theory is related to House's (1981) theory of Work Stress and Social Support. The emergence of this central category has been discussed and an explanation of how and why it unites the categories presented in chapters 5 – 9 is presented. The key processes and actions which enable a mentor to stand securely, and the context within which this occurs, are situated within this explanatory framework.

Chapter 11

Evaluation and Ways Forward

11.1 INTRODUCTION

This final chapter begins with some reflections about my research journey, illustrating some of the most pertinent things that were learnt both professionally and personally from undertaking this study. The chapter next considers the ways in which the quality of a grounded theory study can be judged, and goes on to evaluate this study using Charmaz's (2006) criteria, as suggested by Corbin and Strauss (2008). Recommendations are then made about actions and strategies which might be implemented to help mentors fail underperforming students, and suggestions are made about areas which would benefit from further investigation. Finally the strategies employed to disseminate the findings and recommendations of this study are presented. Where personal reflections are included I have written in the first person.

11.2 SOME REFLECTIONS DURING THE RESEARCH JOURNEY

This section presents a selection of reflective narratives compiled during the research process. These are presented from a retrospective viewpoint and so should be considered as reflection-on-action (Schön 1983), and demonstrate how I, "consciously reviewed, described, analysed and evaluated [my] past practice with a view to gaining insight to improve future practice" (Finlay 2008:3). They also capture some of the reflection-in-action (Schön 1983) which took place whilst conducting the study. Four particularly pertinent extracts have been chosen from the wider archive of reflections that were generated as part of the iterative process of grounded theory.

11.2.1 Maintaining Neutrality

One of the challenges presented to me by this study was investigating an area which was closely entwined with my role as practical assessment co-ordinator. It was particularly important to acknowledge that being a nurse and a nurse teacher might impact on how I reacted to mentors' accounts. It was therefore imperative that I scrupulously monitored myself to foster a neutral stance. The rigorous, on-going checking mechanisms of grounded theory offered tools to moderate the possibility of my own views intruding. Strategies were built into each phase of the study to address this.

Reflexion was a central strategy employed from the commencement of the study. Birks and Mills (2011) suggest that a vital element of this is probing your own assumptions and then actively exploring opposing assumptions. I managed this by taking field notes immediately after each interview in which I recorded words or phrases which had caught my attention as either conforming with, or contrary to, my assumptions. I also made a reminder note that I needed to reflect on these more deeply, (see Appendix 4.11). Subsequently, I reflected on my interpretation of such phrases and words by probing my assumptions, and searching for opposite assumptions. Further scrutiny of transcripts was also undertaken to identify if I had made further unnoticed assumptions. I used a number of the analytic processes recommended by Corbin and Strauss (2008) to constantly challenge myself, particularly 'waving the red flag'; 'asking so what'; and seeking out negative cases. These techniques are detailed in Chapter 4.4.3.2.

The importance of building in such strategies was demonstrated early in data collection. I had not anticipated the strength of feeling participants would express. I struggled to strike a balance between authentically interpreting their views and presenting these in a rational way. At the start of the study I had reflected on my own preconceptions and now reviewed these to evaluate if they were intruding on the study. However, since I had not anticipated that mentors would have such extreme feelings, there was little to indicate that I was imposing my own initial views. I next

reviewed transcripts and voice recordings. Each, without exception, contained strong evidence of the emotions failing a student had generated in participants. I recognised that I found some of these accounts powerful; I examined their on-going effect on me and how this was influencing my presentation of the findings. I found that my motivation was to authentically represent mentors' experiences which I considered both important and positive. However, on reading excerpts of my writing I concluded, with the help of my supervisors, that on occasions I was using language which had the effect of dramatising situations. This was exacerbated by my enthusiastic tendency to use in-vivo codes. Written drafts were therefore reviewed for emotive language. Each instance was compared with the original data and analysed to assess whether it was helpful in interpreting participants' accounts. In-vivo codes were also reviewed to ensure they added explanatory power. Findings were redrafted with the aim of authentically representing participants' views, whilst interpreting these through a more neutral lens.

It is important to acknowledge that this study inevitably provides the mentors' perspective about failing students, since this was the aim of the study. The views of other stakeholders may differ from these. However, evidence was available to demonstrate that the current knowledge base is strongly biased towards the student view of mentoring and assessment in practice (Schaffer 2013). This study was helpful in redressing the balance by offering a mentor perspective.

11.2.2 Achieving Saturation

Ascertaining whether or not I had achieved saturation was challenging. I found most of the definitions and explanations provided by the Grounded Theory masters nebulous. There seemed something over ambitious and unrealistic in the premises that a grounded theory study should explore a new area about which little was known, and that data collection should continue until no new concepts were appearing (Corbin and Strauss 2008). This indicated to me that nothing short of a life's work was compulsory if both were to be accomplished. This did not seem achievable in one thesis which was bounded by both a word and time limit. I therefore reflected on the level of

saturation which could realistically be achieved in this study. My interpretation of saturation was that it seemed to have two aspects: breadth of coverage and depth of probing, as represented in Figure 11.1.

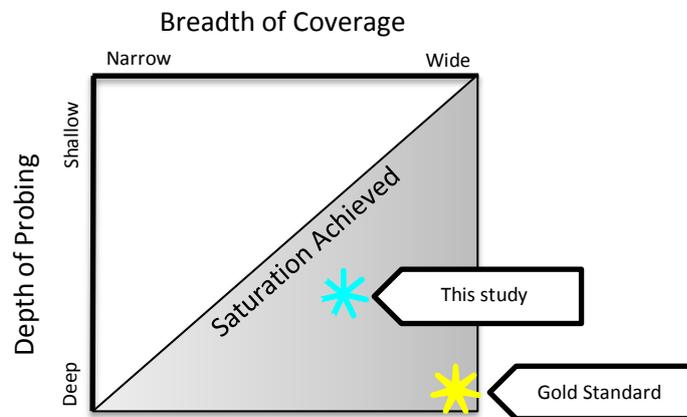


Figure 11.01 Achieving Saturation

I concluded that a GT study which had a wide breadth of concepts and demonstrated a great depth of probing was the gold standard. However, to achieve this in an area where little was known would require a team of researchers undertaking investigation over an unspecified, but probably significant, number of years. I concluded that, in this study, saturation would have been achieved when the data collected fell within the grey shaded area of Figure 11.01. Whilst this remains a subjective and arbitrary judgement, it helped me to reach a pragmatic decision about how much further sampling was required once the core category emerged, and reassured me when I decided the time had come to stop sampling.

The decision that saturation had been achieved was made by: re-listening to voice-recordings of interviews to check that no further concepts were uncovered; using the analytic tools which Corbin and Strauss (2008) recommend to consider data from other perspectives (see Chapter 4.4.3.2); considering if the sample omitted specific groups of mentors who may have alternative views; and reviewing the overall scheme for gaps in explanations. When no new avenues of exploration appeared to be presenting themselves I concluded I had achieved saturation. Data collection

therefore ceased when categories were considered well developed, and no significant major new concepts were emerging which informed the central category.

11.2.3 Limits of Theoretical Sensitivity

The limits of my own theoretical sensitivity became apparent to me once it emerged that much of the mentor's journey was an emotional one. I realised that I was not well steeped in psychology. I was reassured by my supervisors that I was not expected to be. Nevertheless, it was both frustrating and a relief to find theories from other disciplines that encapsulated elements I had struggled to articulate from the data. I realise that there are, almost certainly, a number of psychological perspectives which have not as yet been fully developed, particularly with regard to Category 2 – Tempering Reproach. This category, in particular, has the potential for further analysis, specifically with regard to moral contracts and power imbalances. However, I am content that some new aspects have emerged which can be explored in more depth in post-doctoral work. I would anticipate undertaking this in partnership with others, with expertise in psychology.

11.2.4. Personal work-stress and social support

Undertaking this study gave me a lot of insight into work-stress, particularly that experienced by mentors, because I too succumbed to this. There came a point in this study where I felt it would be unethical not to start raising some of the preliminary findings. I sought out people whom I had assumed would be as concerned as I was. However, I became increasingly anxious about how the findings were received, and began to feel precarious myself. My perception was that talking about failing a student was mentioning the unmentionable; that I had raised something awkward and uncomfortable which should be kept hidden. I became anxious because it was perceived that I was attempting to increase attrition rates. However, I felt I had a huge responsibility to both patients and mentors to raise these concerns robustly: as a registered nurse, this was the primary directive of my code of conduct, "Make the care of people your first concern" (NMC 2008b:1). I also felt strongly

that because participants had trusted me enough to share their experiences, I was morally obliged to represent these. Nevertheless, I felt paralysed and stopped working.

The following quote was probably the single, most helpful thought to hold onto during these challenging times. It was given to me by several people who recognised that I was struggling.

"It's the same each time with progress. First they ignore you, then they say you're mad, then dangerous, then there's a pause and then you can't find anyone who disagrees with you."

- Tony Benn, 1991, to The Observer.

The insight I acquired at this time helped me to see the experience of failing students more clearly through the mentor's lens. If I was feeling so anxious and paralysed as a senior nurse, how much more difficult was it for junior nurses who had not long registered and needed to assert their views to "The University"?

During this time I drew on all the social support mechanisms which mentors had explained to me. I began to reach a deeper appreciation of why mentors had told me that paper resources helped very little, and why one PEF had told me to set fire to them all. I looked at the components of the 'core of steel' which mentors told me they needed. I decided that I too must develop these qualities if I was to complete and disseminate this study. However, developing a 'core of steel' when feeling isolated is very difficult, and it was interpersonal support which helped me to do this. I became the last participant in the study, as my own reflections contributed to the analysis. I now see that reflective practice as a way of interviewing yourself during the research process. It acts as a mechanism to moderate personal intrusion. In this way researchers can both acknowledge their presence in the study and evaluate their effectiveness in authentically interpreting participants' voices.

Finally the Francis Report (DH 2013a) was published and with it came a plethora of recommendations: a duty of candour; putting patients at the heart of our work; dealing with the culture of blame; adequate nurse to patient ratios, and so on. These findings resonated strongly with the findings of this study and gave me the boost I needed to stand securely. I began writing again.

11.3 JUDGING THE QUALITY OF THE STUDY

Glaser and Strauss (1967) argue that the most effective test of quality in a grounded theory study is how useful it is in practice; or as Oktay (2012:111) contends, “the proof is in the pudding”. Corbin and Strauss (2008) suggest that Charmaz (2006) offers the most comprehensive set of criteria for evaluating grounded theory studies, because she addresses both scientific and creative benchmarks. These are organised into four categories: credibility, originality, resonance, and usefulness. This study will now be considered in relation to these four elements.

11.3.1 Credibility

Criterion: Intimate familiarity with the topic. Whilst it has been possible to search the literature and engage with a number of ‘experts’ in this field of study, there is always room to further enhance familiarity with a topic. This should be the on-going aim of any researcher. I am keen to explore new perspectives on this topic. I see this as an enduring undertaking which will never be complete.

Criterion: Data sufficient to merit claims. Achieving saturation was challenging. It is acknowledged that there is always room in a grounded theory study to gather further data. However, this was considered carefully, as described in section 11.2.2. Areas which would benefit from further exploration have been identified throughout the thesis.

Criterion: Systematic comparisons. Constant comparative method and theoretical sampling were used to ensure that the evidence included in this study was explored and compared through several interviews. Categories have emerged by identifying variations in responses. This helped to develop the dimensions and properties of each category.

Criterion: Categories cover wide range of observations. Since this was a relatively new area of study, breadth of categories was considered important. This provided an interpretation of the array of actions which helped mentors. A compromise was therefore reached between delving deeply into a limited number of areas, or representing the wider range, with a view to encouraging further more extensive research in areas of particular relevance.

Criterion: Strong links between gathered data, argument and analysis. In order to maintain robust links between data, argument and analysis, data were reviewed constantly, throughout every stage of the study, to ensure emerging concepts were grounded. Analysis and arguments have usually been supported with original quotes from the data. However, this produced some unexpected challenges; some mentors could take a substantial proportion of the interview to explain an issue. Quoting several pages of text as an idea was unpacked, was not feasible. In such instances the mentor's explanation has been précised. It is acknowledged that this does not provide the reader with such an explicit audit trail back to the original data.

Criterion: Provision of enough evidence. Participants' contributions are referred to throughout the findings sections of this thesis. Several pertinent quotes were identified, which were of relevance to each conceptual group. Originally more extracts were included to illustrate findings, but these were edited down to accommodate the word limit of this thesis. In a few places a large number of quotations have been cited to emphasise universal agreement amongst participants.

11.3.2 Originality

Criterion: Fresh categories which offer new insights. Using in-vivo codes and gerunds were helpful in gaining fresh insights. A dynamic representation of what could be done to enable mentors was achieved by ensuring that each category demonstrated action. Whilst a number of the areas covered in this study have been dealt with in other research studies, these usually speculated about what might help mentors. They have not identified the actions which mentors who failed students confirmed were useful. From this perspective the categories are fresh.

Criterion: Analysis offers a new conceptual rendering of the data. The three-stage decision-making process presented in this study is a new interpretation of the process through which mentors work to decide whether or not they will fail a student. Elements of this have been referred to in previous studies, but this is the first time these have been brought together to offer an explanation of how and why mentors decide whether or not to fail an underperforming student.

Criterion: Social and theoretical significance is included. This theory has been developed through constant referral to a range of both social and theoretical knowledge. Some insights have been drawn from seemingly inconsequential everyday experiences, conversations and observations. For example, the discussion with a colleague about a quote from Star Wars, presented in Chapter 8.5.2. Other analyses have been developed through examining theories which constitute 'thinking outside the box', such as ornithology (Chapter 6). Theoretical significance in this study is not only related in the central category, but is threaded throughout each subsidiary category as well. Whilst theories from within the discipline of nurse education and mentoring are central to this study, other theoretical perspectives have also been used to further develop the explanatory power of this study.

Criterion: Challenges, extensions or refinements to current ideas or practices are included. The reflective account presented in section 11.2.4 demonstrates that challenging current practices is not easy. However, in completing this study I have acknowledged that this is an obligation I must meet. It is daunting to note that some of the recommendations are directed towards senior stakeholders and professional bodies. However, the response to phase one of this study indicated that there are those who are willing to consider extensions and refinements to practice. Contributing the findings from phase two of this study to the debate is the proper, professional thing to do.

11.3.3 Resonance

Criterion: Portrays fullness of the studied experience. I intended to return sections of the findings back to participants for comments and I met with a number of the participants at several conferences. They were keen to find out about progress, and I was able to show them elements of the findings, and to explore these further with them. This was extremely helpful and in future I would try to build this into the research design. Later I presented some preliminary findings at an international conference and participants were again in the audience. They were keen to offer views and feedback on the resonance the findings had for them, and other mentors also contributed to this discussion. This continued to assist with refining the theory. Finally I asked some mentors who had failed students in practice to read sections of a late draft. Confirmation was received that the

findings represented their experiences closely. One told me he had found himself yelling “Yes, yes, yes! That’s right!” at his computer when reading sections. This reassured me that I had captured the authentic experience of mentors .

Criterion: Reveals both liminal and unstable taken for granted meanings. During the course of each interview the participant’s meaning was clarified by reflecting words or phrases back where there was the possibility that a tacit assumption was mistakenly being made. It is probable that having been immersed in the world of practical assessment for such a long time, some of participants meaning has been taken for granted. However, I attempted to ward against this. I have reviewed the first reflexive piece which I wrote at the beginning of this study. Although some of my preliminary opinions are reflected in the findings of this study, others have been shown to have little significance. This was further confirmed by a PEF with whom I had previously worked, and interviewed late on in the study. Once the voice recorder had been turned off this person exclaimed “Well I’m really surprised and pleased by what you asked me. I expected **you** to be focussed on other things than that.” (Field Note AC.3) Probing suggested that I had asked questions which got to the heart of what failing meant to this person.

Criterion: Draws links. Glaser and Strauss (1967) call this checking that bridges can be made between the theoretical thinking of the researcher, and the pragmatic thinking of those in the field. Standing securely as a term had “grab” with participants (Glaser 1998). In other words, this term echoed the situation which needed to be achieved to be able to fail a student. However, it was also pertinent to the theoretical perspective of managing work stress through social support, inherent in theory.

Criterion: Makes sense to readers. Writing this thesis has been, for me, the most challenging element of undertaking this study. I have struggled to write in plain English. I find this ironic given that obfuscation is one of the criticisms that this thesis levels at practical assessment documents and processes. Following my own advice, I have run sections through the SMOG (Simplified Measure of Gobbledygook, McLaughlin 1969) indicator and have been horrified at the high scores. Having

reflected on this I have come to understand that this was because I wanted to include every precise detail; I now realise this is not the purpose of analysis. I now believe the purpose of the research process to be stripping the data back to the most important key elements, and explaining these with clarity, so that they are widely accessible. I hope I have sufficiently tamed my tendency to obfuscate, but it is ultimately for future readers to decide if this is so.

11.3.4. Usefulness

Criterion: Interpretations can be used in the everyday world. This is the criterion which demonstrates whether the grounded theory has practical value and application. Testing if this were the case meant seeking the views of those who assessed students. The resonance of the study with mentors goes some way to suggesting that this interpretation can be used in the everyday world. Both PEFs and LLs have also confirmed that it offers a good fit with their activities and experiences when supporting mentors who fail students. This lends further evidence to suggest that this theory is useable in the everyday world.

Criterion: Categories suggest a generic process. Theoretical sampling ensured a wide range of participants were included in this study to develop generic fit. The categories which emerged were scrutinised for fit with nurses from all four fields of nursing, in institutional and community settings, across both the public and private sector, by using techniques of constant comparison. This helped to explain the dimensions of categories and consider whether they worked across the range of settings student nurses were assessed in. The explanatory framework identified by this study may also have applicability beyond nursing. Members of other health related professions have identified that the model would work within their area of practice.

Criterion: Processes have been examined for tacit implications. Various analytic processes such as the 'flip flop' and 'so what?' techniques were used to examine data, in an attempt to draw out tacit implications. Abductive reasoning also helped to me to make analytic 'hops' (rather than leaps) which abstracted the data into processes evident, but not explicitly described in the data. Hence, the

three-stage decision process emerged from participants' accounts, even though none explicitly told me that this was what they had done.

Criterion: Analysis has sparked further research. Three further studies are already being undertaken locally, as a result of interest in specific areas of this study. Invitations have also been received to collaborate with one other University nationally, and two Universities internationally, as result of this work.

Criterion: Contribution of the work to making a better world. This study contributes to making a better world because it offers insight into the actions that can be taken to ensure that mentors feel secure in recognising, managing, and if necessary, failing underperforming students. This reduces the likelihood of unsafe nurses entering the profession and putting the public at unnecessary risk.

11.4 CONTRIBUTIONS TO KNOWLEDGE

This study set out to investigate professional concerns about mentors' reluctance to fail student nurses in practice placements. It explored the processes and contexts which had enabled mentors to overcome this hesitance. The experiences of mentors were examined using an interpretivist grounded theory approach. This study reveals, for the first time, the difficulties that mentors, practice education facilitators (PEFs) and link lecturers (LLs) overcome when they fail student nurses in practical assessments. Multiple factors contribute to these difficulties. First, the workload and expectations placed on mentors create stress and conflict. Mentoring and assessing are not factored into workloads and consequently the whole system runs on good will, largely outside of working hours. There is continuous tension between meeting patients' needs and ensuring that students achieve the desired learning outcomes at the required level. Some students seem not to appreciate that patients' needs are prioritised above their own. Mentors working in private sector placements indicate that the time consuming and stressful nature of hosting one underperforming student may result in their organisation being reluctant to offer further placement opportunities.

Second, students can behave manipulatively or aggressively when mentors provide feedback which indicates that they are not currently practising at the standard required to pass. On occasions this can result in mentors being subjected to verbal and physical threats which they generally manage with little formal organisational support or backing. Student behaviour of this kind has not been documented in previous studies about assessing students in practice placements.

Third, there is a perceived cultural gap between universities and healthcare organisations; priorities, systems and procedures are regarded as markedly different. Mentors, PEFs and LLs viewed higher tiers of university management as “The University”, an indomitable entity oriented towards student satisfaction and attainment. “The University” was perceived to be dissociated from and often in conflict with the demands of clinical practice which focused on the safety and well-being of patients. This cultural gap has not been reported in previous studies about the assessment of student nurses in placement.

In addition to the difficulties experienced by the mentors, this study reveals for the first time a three stage decision-making process which is undertaken by mentors and assessors when deciding to fail a student. Each incremental stage of this process strengthens the mentor’s perception that their decision is secure. The three decisions are:

Question 1: Would I let this student look after my loved ones?

Answer: No – proceed to question 2

Question 2: Is it me or the student who has failed?

Answer: The Student – proceed to question 3

Question 3: Will my decision be valued and respected?

Answer: Yes – Award fail grade.

The first decision requires the mentor to identify the “gist” of underperformance using tacit knowledge, rules of thumb and cross-checks with others. At this stage, the mentor may not be able to fully articulate why they feel the student is not at the required standard, but are clear that they would not want the student to look after their loved ones. Mentors are more likely to raise their

concerns early if they have access to a supportive PEF or LL. Such supporters help them to unpack their concerns into tangible indicators which can be clearly articulated to students.

The second decision involves identifying the locus of the fail. Here mentors question whether they have let the student down. If they feel they have not 'gone the extra mile' in helping an underperforming student to achieve they are reluctant to award a fail grade, even when the student is clearly not achieving the required standard. Furthermore, mentors are hesitant to deliver negative feedback to students because of the tensions this can cause. Substantial emotional support is required at this stage to help the mentor rationalise the decision. Mentors who identify themselves as having a core of steel are most likely to recognise that their primary responsibilities are to patients and their profession. Such mentors are able to identify that it is the student who has failed the assessment, rather than that they are to blame for failing the student.

The third decision focusses on whether the mentor feels their judgement will be valued. Where mentors are held in regard, as equal partners with academic staff who assess students, and are afforded the same protections and safeguards, they are most likely to fail an underperforming student. Particular tensions surround appeals and fitness for practice procedures which mentors find confusing, daunting and intimidating. In such situations mentors often feel they have to fight to fail students. However when a mentor's decision to fail a student is overridden by a university, they may be reluctant to fail students in future practical assessments.

Mentors find practical assessment procedures and documents difficult to interpret and navigate. The assessment process is simplified where yearly progression criteria are used rather than competency statements, which mentors find nebulous. However this study primarily demonstrates, for the first time, that mentors value social ties far beyond paper-based or technological resources when they are managing an underperforming student. Mentors who fail students develop their own personal support networks because formal organisational support is often limited; a mentor's home-

life can be substantially disrupted whilst they are managing an underperforming student and personal relationships can suffer as a result.

At the centre of the mentors' social support network is a 'mentor's mentor' (MM) who acts as a human 'sat nav' to guide them through the assessment process. This MM role is at its most effective when it is fulfilled by a Practice Education Facilitator who is an accessible, approachable, authority on assessment processes and who acts as an emotional anchor. In organisations where the chief nurse effectively communicates the importance of assessing the future workforce directly to mentors a sense of mentor security is further reinforced. Where communities of mentoring practice are in place a collegiate response emerges from a strong network of social support which acts to strengthen mentors' resolve.

Following the experience of failing a student, mentors benefit from a period of replenishment because the experience is both emotionally and physically draining. Replenishment involves providing the mentor with: some respite from students; some time to reflect on the experience of failing, which is of most benefit when it includes formal debriefing; and positive regard as a mentor. Failure to provide these three elements can result in mentor burn-out.

This study is the first to examine mentors' perspectives of how and why they were enabled to fail student nurses in practical assessments in England and it also resonates with those reported by other vocationally-based professions, both nationally and internationally. The challenges faced by mentors in this study have contributed to national understanding of the processes and context which combine to facilitate robust assessment of the future nursing workforce and ensure patient safety and public confidence in professions which provide essential care and services.

11.5 RECOMMENDATIONS

In keeping with the underpinning philosophy of grounded theory, this concluding section presents the processes and context which most effectively enable mentors to fail underperforming student

nurses. The recommendations from this study are organised around each stakeholder group concerned with the preparation and assessment of student nurses.

11.5.1 Recommendations – Professional Bodies

The recommendations in this section focus on three principal areas: the Pre-registration nursing standards (NMC 2010a); the Standards to Support Learning and Assessment in Practice (NMC 2008a); and the representation available for mentors from the RCN and trades unions. The key recommendations in this section are: that the named mentor system would benefit from restructuring to reduce the isolation experienced by some mentors when they are supervising a failing student; that the mentor and assessor roles should be separated to reduce role conflict and assessors should formally be selected based on the qualities identified as the ‘core of steel’; and that the RCN and trades unions should consider how they can offer more visible and robust support to mentors when their conduct and professionalism is brought into question by students. A full list of recommendations for professional bodies can be found below in table 11.2.

RECOMMENDATIONS – PROFESSIONAL BODIES	Page Number
Pre-registration Nursing Standards	
Reconsider how the ‘named mentor’ approach is implemented to reduce mentor isolation and assessment paralysis.	99
Consider how to promote team approaches to mentoring and assessment processes.	199
Devise clearly articulated progression criteria for each academic year.	167
Offer further clarity and detail about what represents acceptable progression at the end of year 2 of pre-registration nursing programme.	184
Consider implementing one national system of practical assessment to provide a consistent approach.	185
Concentrate on addressing the difficulties identified in distinguishing between pass and fail grades before embarking of more detailed grading of practice.	184
Standards to Support Learning and Assessment in Practice	
Separate mentor and assessor roles.	111 and 152

Use selection criteria to identify assessors with a core of steel.	111
Review circular 33/2007 (NMC 2007c) and consider how mentors can best retain written evidence of their assessment decisions in order to justify and defend these if necessary.	175
Work in partnership with local education and training boards, practice placement providers and universities to develop mentoring and assessment metrics.	203
Review and develop consistency of the PEF role nationally.	208
Inclusion of the PEF role into the Standards to Support Learning and Assessment in Practice (NMC 2008a).	217
Tailored preparation of PEFs for this pivotal role with focussed content about managing practice based assessments.	217- 219
Reinforce the requirement that all nurse academics engage in nursing practice.	113
Representation for Professionals	
Make evident the professional mechanisms and resources available to support mentors if students make claims of bullying, harassment and/or discrimination.	137

Table 11.2 Recommendations for Professional Bodies

11.5.2 Recommendations – Content of Mentor Preparation Programmes and Updates

Mentor and assessor preparation programmes should include: the mechanisms which mentors use to identify expediently that a student is underperforming; the psychological theories and techniques which assist mentors to manage their own and the student's responses when unsatisfactory performance and failure requires discussion; and how to access and develop the social support mechanisms to enable mentors to cope and function effectively during and after the experience of failing a student. A full list of recommendations made regarding the content of mentor preparation programmes and updates can be found in table 11.3.

RECOMMENDATIONS – CONTENT OF MENTOR PREPARATION PROGRAMMES	Page Number
Achieving safe uncertainty.	107
Recognition primed decision making, including use of heuristic devices.	130

Managing and avoiding drama triangles.	108-110
Recognition of coercive students and models of mentor empowerment.	155-156
Conducting challenging conversations	159
Managing psychological contracts	159
Emotional intelligence	160
Clarifying and differentiating between appeal and fitness for practice procedures;	173
Collegiate responses, communities of practice and supportive mechanisms.	194-203

Table 11.3 Recommendations Regarding Content of Mentor Preparation Programmes and Updates

11.5.3 Recommendations – Universities

Universities should ensure that priorities, processes and procedures relating to assessment are values based and patient focused; assessment outcomes should be recorded in an accessible way and considered alongside the theoretical components of a course. A full list of recommendations for universities can be found in table 11.4

RECOMMENDATIONS – UNIVERSITIES	Page Number
Primacy of the Patient	
Acknowledge the mentors' voice as instrumental in protecting patients.	219
Nurse academics need to be courageous in being candid with their University employers about how business approaches are undermining professional values and patient safety.	113-4
Practical Assessment Processes	
Consider how to develop practical assessment process which are less impenetrable and more in tune with the way mentors work.	167 and 183
Development of narrative approaches to recording practical assessment decisions.	170 and 184
Reviewing the linguistic barriers in practical assessment documents through mechanisms such as the SMOG calculator and Plain English Campaign.	186
Consider how assessment deadlines and timeframes can acknowledge the unscripted and changeable nature of nursing workloads.	165

Work in partnership with local education and training boards, practice placement providers and professional bodies to develop mentoring and assessment metrics.	203
Mentor Support	
Recognise that electronic and paper based support resources are of little value to mentors if they are passive information giving tools.	189
Devise virtual support mechanisms for mentors and students which are interactive and visual to enhance social capital.	189
Demonstrate to mentors that they are held in regard as equal partners with academic staff who assess students.	181
Afford mentors the same protections and safeguards as academic colleagues.	181
Senior members of Faculty to recognise the value of their feedback to mentors.	179
Private Sector Placements	
Develop mechanisms to support private sector placements especially whilst they are facilitating an experience for an underperforming students	94
Management of Student Expectations	
Develop students' skills in critiquing their own performance objectively.	143
Mentors' judgement to be given pre-eminence over students' self-assessment.	182
Failing a practical assessment to be presented as a routine possibility.	151
Make clear to students that patient care, safety and well-being must always take precedence over all other considerations.	108
Fitness for Practice Procedures	
Consider how fitness for practice mechanisms can be adjusted to have more credibility with practice partners.	182
Ensure fitness for practice panels comprise members who have specific insight into the requirements of the nursing profession and who can give careful consideration to conduct, competence, character, behaviour and health-related factors in determining fitness to practice.	173-4
Review mechanisms to make fitness for practice events less daunting.	175
Provide mentors with feedback about the outcome of assessments, appeals and fitness for practice hearings.	180
Prepare mentors for the possibility of seeing students who have been referred undertaking further practical placements.	181

Table 11.4 Recommendations for Universities

11.5.4 Recommendations – Healthcare Organisations

Healthcare organisations should promote the message that preparing the future nursing workforce is a high priority. They should further support this message via strategic approaches which include: developing formalised and accessible support for mentors during unsocial working hours; allocating time for undertaking the mentoring role; and developing selection processes to identify those most suited to undertaking this function. A full list of recommendations for healthcare organisations can be found in table 11.5.

RECOMMENDATIONS – HEALTHCARE ORGANISATIONS	Page Number
Resourcing	
Invest in support mechanisms for mentors as a quality control strategy.	214
Recognise and reward the pivotal role of PEFs in the organisation.	204
Consider mechanisms for ensuring mentors have regular visual sighting of PEFs to increase their perceived accessibility and approachability with mentors.	205
Develop LEM roles in each team.	200
Provision of support during mentors and students working hours, rather than only during office hours.	148 and 207
Consider ways in which mentoring activity can be legitimised in the working day.	144-149
Recognise the additional work and emotional loading on mentors when managing a failing student and manage workload accordingly.	92-102 and 144-149
Provide protected spaces in which mentors can hold private progression meetings with students.	160
Make formal provision of time and resources to debrief with colleagues and facilitators, particularly after challenging mentoring experiences.	179
Implement human resource strategies to help mentors cope with feelings of guilt.	158
Consider how communities of mentoring practice can be developed and sustained.	214
Endeavour to make underwriting support more visible.	202
Give mentor updating a place of prominence in statutory and mandatory organisational updates	204
Provide support to mentors prior to and during fitness for practice referrals	172

Communicating Corporate Aims	
Ensure that mentors have clarity about their organisations objectives regarding preparation of the future workforce.	94 and 203
Devise mechanisms to ensure the message is delivered by the chief nurse directly to mentors.	203
Work in partnership with Local Education and Training Boards, universities and professional bodies to develop mentoring and assessment metrics.	203
Development of direct communication links between PEFs and Chief Nurses.	203

Table 11.5 Recommendations for Healthcare Organisations

11.5.5 Recommendations – Funding Stakeholders

Negotiation of contracts between LETBs and HEIs should make allowances for positive attrition. This would diminish the risk of potential harm to patients, and the cost of litigation brought by patients who have been harmed by incompetent practitioners, and may help to reduce the number of referrals to the NMC fitness to practice committee. A full list of recommendations for funding stakeholders can be found in table 11.6.

RECOMMENDATIONS – FUNDING STAKEHOLDERS	Page Number
LETBs to be the principle gauge of customer satisfaction regarding pre-registration healthcare programmes since they pay for the service.	108
Less emphasis to be placed on the NSS as a quality indicator of University healthcare programmes.	108
Account to be taken of positive attrition in contracting arrangements between LETBs and Universities.	188
Work in partnership with practice placement providers, universities and professional bodies to develop mentoring and assessment metrics.	203
National formal agreement about where PEF role is positioned logistically and hierarchically, as in Scotland.	218

Table 11.6 Recommendations for Funding Stakeholders

11.5.6 Recommendations - Further Research

Further research is recommended into a number of areas. Recommendations have generally been noted at the relevant point in the thesis. However, several areas warrant particular attention.

Coercive students were of concern to mentors. Advice about how to manage such students was requested following several conference presentations. Therefore further investigation is recommended into effective strategies to manage such students in practice settings.

More detailed investigation into **how mentors recognise the 'gist' of a nurse** is suggested. An exploration of the strategies and techniques PEFs and LLs employ to help mentors unpack their hunch, and articulate this clearly to students, would also help to make such assessment processes evident.

Examination of **mentoring communities of practice** would be helpful, to identify the activities such groups undertake, and the effects these can have on mentoring and assessment activity.

Further exploration of the ways in which **accessible and responsive support** can be provided for mentors within their working hours would be of benefit. This may help to reduce mentor burnout.

University **appeals and fitness for practice processes** would benefit from investigation, particularly to explore the effectiveness of the various processes currently employed across England. Those processes which are the most suited to safeguarding patients might then be identified and disseminated. A full list of recommendations for future research can be seen in table 11.7.

RECOMMENDATIONS FOR FURTHER RESEARCH
Selection of practice based assessors.
Recognition of the 'gist' of underperformance.
Mentors use of heuristic devices (touchstones and yardsticks) to assess students nurses.
Mechanisms to help mentors unpack their recognition of underperformance

Clarification of the difference between robust feedback and bullying and harassment in practical assessment.
Effective strategies to manage coercive students in practice settings.
Whether there are differences in the experiences of mentors who refer students and those who fail students.
The structure, function and conduct of fitness for practice panels for pre-registration programmes.
Achieving balance between the student and mentor voice.
Appropriate maintenance of student confidentiality during the process of practical assessment.
Differences in the way male and female mentors draw on supportive mechanisms.
Explore the incidence of mentors who abuse their legitimate power and consciously seek to fail students.
How to provide effective and responsive support during mentors working hours.
The activities of communities of mentoring practice.

Table 11.7 Recommendations for Future Research

11.6 DISSEMINATION STRATEGIES

It has always been the intention to disseminate the findings of this study so that they can be debated and potentially put to use. I do not believe that a study is 'real' research until the findings have been published and others can access these. This is an ethical issue which there is not room for here. However, the intention is to present further conference papers and to publish various elements of this thesis as academic papers.

Phase one of this study has already been published in several formats (Hunt *et al.* 2011, 2012), presented at several conferences and contributed to the Willis commission (RCN 2012). Findings from phase two have been presented at national and international conferences (Appendix 11.01 and 11.02). This has resulted in an invitation to work collaboratively with Simon Cassidy, Dr. Sharon Black and Dr. Kathleen Duffy to deliver a joint symposium presentation (Black *et al.* 2013) and to develop an academic paper which focuses on the mentor's journey in failing a student. I have also been

invited to be the guest speaker at a number of conferences and have used these opportunities to not only share elements of my findings, but also to seek the views of others to further enhance my understanding of this area. Appendix 11.02 contains a full list of the opportunities for dissemination which have already been taken up and further publications are planned.

11.7 SUMMARY OF CHAPTER 11

This final chapter has presented some reflections from my research journey. Charmaz's (2006) criteria for measuring the quality of a grounded theory study have been used to evaluate this study. Recommendations have been made about actions and strategies which might be implemented to help mentors fail underperforming students. Suggestions have been made about areas which would benefit from further investigation. Finally the strategies employed to disseminate the findings and recommendations of this study have been presented.

11.8 CONCLUDING STATEMENT

In conclusion, this thesis has explored the actions that enable mentors to fail underperforming student nurses. The central principle identified is that mentors need to feel secure in their role, and that a number of actions can be taken to establish this. Currently many of the processes which enable mentors to fail students are informal, sustained by goodwill, and inconsistent nationally. Where more formal support processes are in place, they facilitate mentors to robustly assess student nurses. However, the confounding factor is the mismatch of professional, academic and health service values and cultures to which mentors are subjected. The Francis Report (DH 2013a) has recommended that patients are placed at the centre of all healthcare stakeholders activities and decisions. If this is to be achieved, stakeholders need to reach agreement about the value they placed on producing a future nursing workforce, which has been rigorously assessed as fit to function in practice settings. Furthermore, collaborative and consistent actions also need to be taken across stakeholder organisations to reinforce the mentor's position as professional gatekeeper.

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APPENDICES

APPENDICES – CHAPTER 1

Appendix – 1.01 The Workings of the Nursing Placement System in England

In England the preparation and education of nurses is regulated by the Nursing and Midwifery Council (NMC). This governing body publishes mandatory national standards for pre-registration nursing programmes. These standards specify the number of hours each student must spend in practice, how practice should be assessed and the weighting to be given to practical assessment throughout the course.

Mandatory standards for practical experience:

- Each student must undertake 2300 hours practical experience.
- Practical experience is divided between the 3 years of the programme.
- In each placement, each student is assigned to a named mentor, a registered nurse who has undergone preparation for the mentoring and assessment role. The mentor is responsible for the student's learning and development in the placement and for assessing the student.
- Practical placements must be of 4 weeks duration for a summative assessment to take place.
- Students must demonstrate progression in practice at the end of each academic year.
- Practical experience and assessment comprises 50% of the pre-registration nursing programme and should have equal weighting with academic assessment.

Each university is at liberty to develop its own curriculum and assessment processes providing these mandatory standards are met. Hence there is significant variation in the way nursing programmes are delivered and assessed across England.

Variations:

- Each university designs its own programme of practice based learning and assessment based on NMC Standards (2010). There is diversity in practical assessment procedures.
- Practical assessment documents vary in content, design and process.
- The number and duration of practical placements varies. For example some universities provide 2 or 3 different placements in each year of the programme, whilst others provide one long placement.
- The way credit is apportioned to practical assessment varies widely. For example, some Universities may deem practical placements to be discreet modules for which credits are awarded, others may allocate half of the credits for each module to practical assessment and the other half to theory; other variations also exist.
- Up to 300 hours of practice can be credited through simulation. The actual amount varies between universities.

APPENDICES – CHAPTER 2

Appendix – 2.01 Approval for Transfer from MPhil to PhD



Direct Line:
Fax:
Email:

Ref: bb/006A

12 April 2011

Mrs Louise Hunt



Dear Mrs Hunt

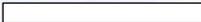
RESEARCH DEGREE REGISTRATION

I am pleased to inform you that the University's Research Degrees Committee has ratified your application at its meeting on 24 March 2011 and has registered you as a candidate for the degree of Doctor of Philosophy. The details of your registration are set out below:

Title of Programme of Research

"Assessing student nurses in practice: a critique of the processes that influence assessors' decisions to fail students".

Director of Studies



If for good reason it is no longer possible for Prof McGee to undertake the role as Director of Studies, the University undertakes to use its best endeavours to ensure that alternative supervision is arranged.

Supervisor[s]



Advisor[s]

N/A

Collaborating Establishment[s]

N/A



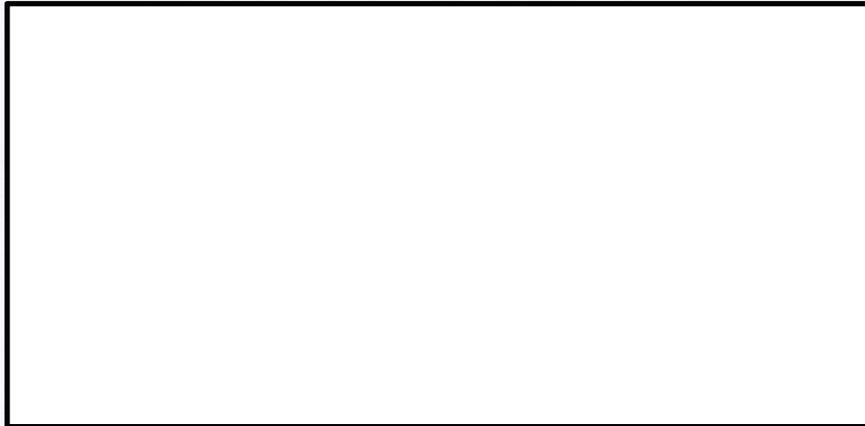
Date of Registration and Duration of Programme

As you were originally registered for Master of Philosophy, the period of registration is with effect from 18 November 2008 and is subject to the conditions specified in Section G of the University's Research Degrees Regulations (October 2010), a copy of which is enclosed. As you are registered as a part-time candidate the maximum period of study allowed is 6 years. Accordingly your period of registration will expire on 18 November 2014.

Please note that it is a condition of your registration that you are a fully enrolled student of the University throughout the period of your registration and that it is important that you notify me of any change to the above details.

If you should require any further information please do not hesitate to contact me.

Yours sincerely



Appendix 2.02 - Survey ToolCode

HEI		
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**Assessment of Pre-Registration Nursing Students**

Your Higher Education Institution has been invited to take part in a study which aims to establish for the first time the number of student nurses who fail practical assessments compared to those who fail theoretical assessments. Completing this survey this will make a positive contribution to both the maintenance of professional standards and public protection.

Notes for respondents:

This questionnaire relates to intakes of pre-registration student nurses commencing the first year of courses during the **Autumn Semester 2005**.

- If you cannot complete the information which relates to each branch please complete the total columns for each question.
- Your best accurate guess will be acceptable if you do not have precise figures.
- If your HEI ran more than one pre-registration course during this timeframe please either merge the data or complete the questionnaire for each course whichever is more convenient.

Please return completed questionnaire by Friday 12th June 2009

SECTION ONE

1. Please state the total number of pre-registration student nurses who had successfully completed this course by the end of 2008.

Total		2008
-------	--	------

2. Please state the total number of pre-registration student nurses who enrolled at the start of each academic year.

Year 1 2005-6	Foundation Programme				
	Adult	Child	M.Health	L.Disability	Total
Year 2 2006-7					
Year 3 2007-8					

Please turn over.

Code

HEI		
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SECTION TWO

The following questions relate to the summative **theoretical assessment** of this intake of students nurses.

3. Have any pre-registration student nurses from the autumn 2005 intake been referred or failed in any **theoretical assessments**?

YES	<input type="checkbox"/>	If YES please complete questions 3 – 5.
NO	<input type="checkbox"/>	If NO please go to Section Three.

4. Please state how many student nurses were referred in a summative **theoretical assessment** at the first attempt.

Year 1 2005-6	Foundation Programme					
	Adult	Child	M.Health	L.Disability	Total	
Year 2 2006-7						
Year 3 2007-8						

5. Please state how many of those students who were referred at the first attempt went on to pass the summative **theoretical assessment**.

Year 1 2005-6	Foundation Programme					
	Adult	Child	M.Health	L.Disability	Total	
Year 2 2006-7						
Year 3 2007-8						

6. Please state how many student nurses were withdrawn from the course because they failed a summative **theoretical assessment**.

Year 1 2005-6	Foundation Programme					
	Adult	Child	M.Health	L.Disability	Total	
Year 2 2006-7						
Year 3 2007-8						

Please turn over.

SECTION THREE	Code <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 15px;">HEI</td><td style="width: 30px; height: 15px;"></td><td style="width: 30px; height: 15px;"></td></tr></table>	HEI		
HEI				

The following questions relate to the summative **practical assessment** of this intake of students nurses.

7. Have any pre-registration student nurses from the autumn 2005 intake been referred or failed in any **practical assessments**?

YES <input style="width: 40px;" type="checkbox"/>	If YES please complete questions 7 – 9.
NO <input style="width: 40px;" type="checkbox"/>	If NO please go to Section Four.

8. Please state how many student nurses were referred in a summative **practical assessment** at the first attempt.

Year 1 2005-6	Foundation Programme	<input style="width: 100%;" type="text"/>			
	Adult	Child	M.Health	L.Disability	Total
Year 2 2006-7					
Year 3 2007-8					

9. Please state how many of those students who were referred at the first attempt went on to pass the summative **practical assessment**.

Year 1 2005-6	Foundation Programme	<input style="width: 100%;" type="text"/>			
	Adult	Child	M.Health	L.Disability	Total
Year 2 2006-7					
Year 3 2007-8					

10. Please state how many student nurses were withdrawn from the course because they failed a summative **practical assessment**.

Year 1 2005-6	Foundation Programme	<input style="width: 100%;" type="text"/>			
	Adult	Child	M.Health	L.Disability	Total
Year 2 2006-7					
Year 3 2007-8					

Please turn over.

SECTION FOUR

Code

HEI

If there are any further comments you would like to make please use the space below:



If you would like to participate in phase 2 of this study which will be a qualitative investigation into assessment of pre-registration student nurses please tick the box below.

Thank you for taking the time to complete this questionnaire.

Please return completed questionnaire by Friday 12th June 2009 via e-mail to:

Louisehunt.research@bcu.ac.uk

or post a hard copy to:

Mrs. Louise Hunt,
Room 427, Seacole Building,
Department of Practice Learning,
Faculty of Health
Birmingham City University,
Edgbaston, Birmingham B15 3TN.

Appendix 2.3 - Explanatory Letter and Participant Information



Louise Hunt
Senior Lecturer
Department of Practice Learning
Room 427, Seacole Building.
Faculty of Health, Birmingham City University,
Westbourne Rd, Edgbaston,
Birmingham B15 3TN
0121 331 6166

14th May 2008

Dear

I am a senior lecturer in nursing at Birmingham City University where I am also registered as an MPhil student undertaking a research study entitled "Assessing student nurses in practice: a critique of the processes that influence assessors' decisions to fail student nurses". The aim of this study is to establish how many student nurses currently fail practical assessments nationally. You may remember that this was one of the key recommendations of the Duffy Report published by the NMC in 2004. In order to achieve this I am inviting Higher Education Institutions to participate in a survey which will make a positive contribution to both the maintenance of professional standards and public protection.

I have attached a Participant Information Sheet, please read this before making a decision about whether you would like to contribute to the study.

If you would like further information or clarification before making a decision please contact me on 0121 331 6166 or e-mail me at Louise.hunt@bcu.ac.uk or contact my supervisors:

I will be pleased to answer any queries or give further details.

If you are happy to participate please complete the attached questionnaire and return it to me via e-mail at Louisehunt.research@bcu.ac.uk or alternatively download a hard copy and mail this to me by 12th June 2009.

Thank you for taking time to read this letter and I look forward to hearing from you

Yours sincerely

Louise Hunt

Louise Hunt
Research Student.

PARTICIPANT INFORMATION SHEET

Assessing Student Nurses in Practice

I am an MPhil student with Birmingham City University where I am undertaking a research study entitled "*Assessing student nurses in practice: a critique of the processes that influence assessors' decisions to fail student nurses*". I am inviting you, as a representative of your Faculty, to take part in this study. To assist you in making an informed decision about whether you wish the Faculty to be involved, please take some time to read the following information and discuss the matter with others if you wish. If you would like more information or further clarification about any aspect of the study, please do not hesitate to contact me or my supervisors; our details are included in this leaflet.

Part 1

What is this project about?

The aim of this study is to find out about the factors that influence assessors when they are considering failing student nurses in practice settings. The study is in two parts. In the first part I am aiming to find out how many student nurses in England currently fail practical assessments. To achieve this I am inviting all Higher Education Institutions (HEI) that offer pre-registration nursing programmes in England to take part in a survey. This survey is necessary because the NMC does not gather this information (NMC 2003). In the second part of the study I will be interviewing assessors about failing student nurses in practice.

Why have I been approached?

I am inviting your Faculty to take part in phase 1 of the study because UCAS indicates that your Faculty offers a pre-registration nursing programme and I understand that you may be the key contact. If I have inadvertently approached the wrong person please forward this to a more appropriate member of your Faculty.

What will happen if I do not want to take part?

Your Faculty's participation in this study is voluntary and it is free to withdraw from this study at any time.

What will taking part involve?

If the Faculty does choose to take part, please complete the enclosed questionnaire which asks for information about cohorts of students who commenced their pre-registration nursing programmes in the autumn semester of 2005. The questionnaire asks for information about numbers of students who have failed practical assessments. It then goes on to ask for comparable data about students who have failed theoretical assessments. Please return the completed questionnaire to me via e-mail or alternatively download a hard copy and mail this to me.

Are there any disadvantages or risks in taking part in this project?

There are no risks in taking part in this study but Birmingham City University provides indemnity insurance for the project should anything untoward occur. All the information provided by your Faculty will be treated in the strictest confidence and anonymised. Your HEI will not be identified in the final report or any other documents relating to this research.

What are the possible benefits of taking part and how will this project help the nursing profession?

If your Faculty agrees to take part in this project, it will be contributing to a study which, for the first time, will establish the number of student nurses who fail in practice compared to those failing theoretical assessments. This is an opportunity to take part in a study which will make a positive contribution to both the maintenance of professional standards and public protection.

What if there is a problem?

The project will stop if any untoward circumstances arise that were not anticipated at the start of the project. If you feel unhappy about any aspect of the study, please contact me or my supervisors and we will do our best to resolve any problems. Contact details are provided on page 3 of this leaflet.

What will happen to the information provided?

All the information you provide in the questionnaire will be coded so that none of the information can be associated with you, your University or your Faculty and none will not be identified in the final report or any other documents generated. Information will only be used in connection with this study and not for any other purposes.

Will the information be confidential?

All the data gathered will be dealt with in accordance with the Data Protection Act of 1998. All data will be kept in a secure environment and will not be stored on the hard drive of a computer. Anonymity will be maintained by coding questionnaires and keeping these in a secure and separate place. They will be securely stored and destroyed five years after the study has been completed. Data will only be accessed by me. My supervisors will have access to the anonymised data.

What do I do if I need further information?

Please contact me

Mrs. Louise Hunt, Senior Lecturer
Department of Practice Learning
Room 427, Seacole Building.
Faculty of Health
Birmingham City University,
Westbourne Rd, Edgbaston,
Birmingham B15 3TN
Tel - 0121 331 6166
e-mail – Louise.hunt@bcu.ac.uk

Alternatively you can contact my research supervisors:

Part 2

What will happen to the information?

The information provided about your Faculty will only be used for the purposes of this project, which will include compiling reports, conference papers and publications. Your HEI will not be identified in any way in any of these documents.

What will happen if I decide not to carry on with the project?

The Faculty is free to withdraw from this study at any time without giving a reason and if requested the information already given will also be withdrawn.

What if there is a problem?

If you have any concerns about the conduct of this research please contact me in the first instance and I will do my best to discuss these with you. If you are still unhappy and wish to make a formal complaint, please refer this to my research supervisors or to:

Who is organising and funding the research?

Part of this study has been funded by the Centre for the Enhancement of Teaching and Learning, Birmingham City University.

Has this project been approved by an ethics committee?

Ethical approval has been granted by Birmingham City University, Faculty of Health, Ethics Committee.

Has the project been reviewed by an independent sponsor?

Birmingham City University has reviewed this project and agreed to act as sponsor.

Will the results be made available?

A report of the findings of this study will be sent to all participating Higher Education Institutions as well as to the Nursing and Midwifery Council and the Department of Health. HEIs will not be identified in any reports or articles which are generated as a result of this study.

Thank you for taking time to read this information leaflet. If you wish to take part in the project please complete the questionnaire and return this to me by the 10th July 2009.

Appendix 2.4 - Sponsorship Phase 1

19th November, 2008

To whom it may concern

Dear Sir/Madam,

Re: University Sponsorship Agreement

Title of Project:	Assessing Student Nurses in Practice: a critique of the processes that influence assessors' decisions to fail students
Name of Student Researcher (s):	Louise Anne Hunt
Full Title of Course:	Master of Philosophy
Name of Academic Supervisor (Chief Investigator):	<input type="text"/>

I can confirm that the Faculty of Health, Birmingham City University has agreed to take on the role of Sponsor under the Department of Health Research Governance Framework.

I can also confirm that legal liability for death or injury to any person participating in the project is covered under the University's insurance arrangements.

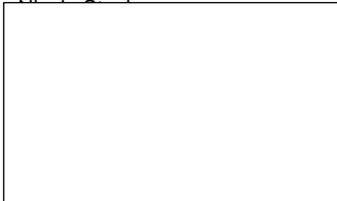
Yours faithfully,

**Chair
Academic Sponsorship and Indemnity Sub-Committee**

Faculty of Health Research Degrees Office
Birmingham City University

Appendix 2.05 - Ethical Approval, Phase 1

Address for correspondence



15 December 2008

Louise Hunt
Faculty of Health
Birmingham City University
Westbourne Rd
Birmingham B15 3TN

Dear Louise,

Re: proposed research: Assessing student nurses in practice: a critique of the processes that influence assessors' decisions to fail students.

Thank you for attending last week's meeting of the Research Ethics Committee in order to clarify points raised from your application. The committee felt that this was a very good application, clearly presented and are pleased to issue a favourable opinion.

The opinion is based on the information supplied in the list of documents enclosed with this letter. If you wish to make any substantial changes to the research please contact the Committee and provide details of what you propose to alter. A substantial change is one that is likely to significantly affect

- the safety or well being of participants;
- the scientific value of the study;
- the conduct or management of the study.

A substantial change should not be implemented until the Ethics Committee has issued a favourable opinion.

The Committee should be notified of any serious adverse events arising as a result of the research.

The Committee is required to keep a favourable opinion under review in the light of progress reports. You will be asked to submit a progress report and Sue Clarke will contact you when this is due. I hope that the research goes well and wish you every success.

Yours sincerely,



Vice-Chair,
Faculty Ethics Committee



Appendix 2.06- Executive Summary

Assessing student nurses in practice:

A comparison of theoretical and practical assessment results in England

Executive Summary

**Louise Hunt, RN, MPhil, BSc (Hons), Cert Ed, Dip MIO, RCNT.
Graduate School, Faculty of Health, Birmingham City University**

Concerns have been raised that mentors rarely fail student nurses in practice based assessments (Duffy 2003 & 2006). This has generated doubts about the fitness to practice of some registered nurses and the term *failure to fail* has been coined to describe this. This study compared national failure rates in theoretical and practical assessments on pre-registration nursing programmes. The aim was to establish the situation regarding practical assessment failure rates amongst student nurses in England.

An e-mail and postal survey was conducted of all 52 Higher Education Institutions (HEIs) in England that offered pre-registration nursing programmes commencing in the autumn semester of 2005. Responses were received from 27 (52%) HEIs, 11 provided comments and 16 provided useable numerical data about 3725 student nurses.

Key Findings and Recommendations:

i) The assessment of student nurse

Failure rates for theoretical assessments outstripped failure rates for practical assessments by 5 to 1.

This seems to support Duffy's view that practical assessors *failed to fail* student nurses. The Nursing and Midwifery Council's (NMC) guiding principle that theoretical knowledge informs practical performance should be integral to practical assessment of student nurses (NMC 2004, 2010). This raises questions about how students pass practical assessments if they do not have a sufficient level of underpinning knowledge.

There was a wide variance in failure rates between HEIs.

Two HEIs failed and withdrew students based on practical assessment results in all 3 academic years but four HEIs did not fail any students in practice at any point. The disparity in results appears to support Yorke's (2005) view that some HEIs continue to be slow in accepting practical assessment as an important element of programmes. It is a challenge for the NMC to ensure a minimum national standard of practical competence and reduce the wide variation in practical assessment results identified by this study.

Failure rates varied between academic years.

Students were most likely to pass in year 3 and were most likely to fail practical assessments and be withdrawn from programmes in year 1. The profession continues to debate the optimum time to remove incompetent students from programmes (Kevin 2006,

Luhanga 2008, Fero *et al.* 2009) but most assessors agree that the majority of students who lack competence should have been removed prior to year 3 (Black 2010).

Child branch students were found to be more successful in theoretical assessments than nurses from other branches but no differences were identified in practical failure rates between the four branches of nursing. This raises possibilities that academic ability might not necessarily translate into vocational aptitude, or that child branch practical assessors could be less prone to *failing to fail* than their counterparts in other branches.

It is therefore recommended that further investigation be undertaken regarding:

The emphasis that HEIs place on practical assessment results.

The points at which it is most appropriate to assess practice summatively.

The factors that influence the role and function of assessors including:

- the extent to which assessors test technical skills compared to higher level evidence based decision making skills.
- the effect of locally specified practical assessment outcomes.
- whether the seniority of the assessor affects readiness to fail students in practice when necessary.
- whether the assessor's branch of nursing affects readiness to fail students in practice.

ii) Higher education systems and practices

Data regarding failure in practice was not routinely gathered and reported

Several issues arose in connection with quality monitoring of courses in HEIs. First, the NMC does not require HEIs to gather data about failure in practice rates as part of annual quality review and programme approval procedures. Consequently only 1 HEI was able to provide data easily and some could not do so at all.

Second, commissioning contracts between Strategic Health Authorities (SHA) and HEIs now specify targets to ensure low rates of attrition which creates a tension between the need to ensure value for money and at the same time prevent unsafe students entering the profession.

It is, therefore recommended that:

Each HEI should be required, by the NMC, to monitor failure in practice rates as part of normal course monitoring procedures.

Further investigation is undertaken into the influence that quality monitoring processes have on practical assessment processes.

Further investigation is undertaken into the ways in which HEIs address targets for attrition in commissioning contracts.

Conclusion

This study supports the argument that *failure to fail* in practical assessment exists within the nursing profession and raises a number of questions about the influence that the systems and practices of SHAs, HEIs and the NMC have on *failure to fail*. However on a more optimistic note it also indicates that there are assessors who have failed students in practice. Currently there has been little investigation into the perspectives of such assessors particularly in terms of how they were enabled to do this. Further exploration of this issue is proposed.

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Appendix 2.07 – Published Paper

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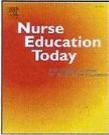
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Assessment of student nurses in practice: A comparison of theoretical and practical assessment results in England

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SUMMARY

This study was undertaken in response to concerns raised by Duffy (2003) that assessors of practice were reluctant to fail student nurses in assessments. This generated doubts about the fitness to practice of some registered nurses.

An investigation was undertaken into whether quantitative evidence supported the view that pre-registration nurses rarely failed practical assessments. Comparative failure rates from theoretical and practical assessments were requested from all 52 universities in England that offered pre-registration nursing programmes. Responses were received from 27. Findings indicated that a very small proportion of students failed practical assessments; failure rates for theory outstripped practice by a ratio of 5:1. A quarter of universities failed no students in practice. Students were most likely to fail in year one and least likely in year three. This study supports the belief that assessors of practice are reluctant to fail student nurses. It raises a number of questions about the influence that the systems and practices of professional bodies and universities have on practical assessment. However it also indicates that some student nurses have failed practical assessments and that some universities do have systems in place to address this issue.

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Introduction

The assessment of students' competency to practice is a worldwide matter of concern to all practice-based professions as diverse as teaching, accountancy, and medicine (Whiteford, 2007). For example, in New Zealand, Hawe (2003) noted that assessors of student teachers did not ground their judgements about practical competence on published criteria which made it difficult to ensure parity in assessment. In Australia, Bowrey et al. (2007 p.front cover) compared the difficulty of monitoring the skills of student accountants to "foxes becoming gamekeepers". In Scotland, Cleland et al. (2008) raised concerns about role conflicts encountered by assessors of medical students. Irrespective of the profession or country concerned there is an agreement that those who assess practice are the gatekeepers of their profession; they and they alone determine whether the practice they have observed is or is not of the required standard. If they do not fulfil this role then it is possible for under-performing students to enter a professional register with potentially risky consequences for

the client group concerned. It is to this discourse that studies by Duffy (2003) and Luhanga et al. (2008) have added concerns about the practical assessment of student nurses.

According to the International Council of Nurses, safety is the most important principle in the assessment of nursing students (ICN, 2006). In each country national standards are intended to reflect the importance of safe practice by ensuring that students achieve a baseline level of competence with which to begin their professional careers (NCSBN, 2011; ANMC, 2010; SANC, 2008). Thus, it is expected that each newly qualified nurse is able to function safely; from this secure foundation further development can then take place. However, Duffy (2003) and Luhanga et al. (2008) have suggested that pass rates in the practical assessment of nursing students appear to be higher than expected and that one possible reason is not the candidates' abilities but their assessors' reluctance to fail them. Whilst some assessors admit to being hesitant to fail students others report factors which frustrate their attempts (Gainsbury, 2010). This paper reports on a study, undertaken in England, that set out to investigate these issues in response to Duffy's (2003 p82) recommendation that "a national survey be conducted that establish the number of students who fail programmes on clinical grounds as opposed to academic grounds." Descriptive statistics are presented which compare failure rates in theoretical and practical assessments and the implications these findings have for nurse education and professional regulation are considered.

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Background

In England, pre-registration nursing programmes last for three years during which, in addition to academic study in university, the student is exposed to a range of practice in a variety of clinical placements. The assessment of practical ability begins in the first year and the nature of the assessments increases in complexity as students move through the course. In year one the focus is on essential nursing care but by year three the emphasis has shifted to evidence based decision making and the ability to manage the care of groups of patients. In this context practical assessment is carried out by designated registered nurses, working in clinical areas, who have been prepared in the education and assessment of students during practical placements (NMC, 2008). Assessment is not a single event. It involves observing students throughout the placement and making judgements about their performance both at specified intervals and at the end.

Passing these practical assessments as well as theoretical assessments should be a mandatory requirement of nursing courses (Denton 2005). However, the situation seems far from simple. First, there is a possibility that students may be more successful in practical assessments than theoretical assessments because they receive formative feedback, during their placements so that they can address their shortcomings. Lack of formative feedback has been identified as an area of weakness in theoretical assessments and may mean that failure rates for theory are unduly high (HEFCE, 2010). Second, students may experience more meaningful learning from mentors in practice where insights into previously poorly understood aspects of nursing can be found (Bradbury-Jones et al., 2010). It is also possible that theoretical assessments may not test what is required of the contemporary nurse as appropriately as practical assessments. Third, there is the issue of how universities define failure. General studies of failure rates in universities have defined *failure* principally in academic terms (see, for example, National Audit Office, 2001 and NHS London, 2009). In this context quality monitoring processes may not be sufficiently sensitive to or suited to courses with practical components. Finally, there are issues about the assessors and how they experience their role. Reports consistently identify several issues which contribute to assessors' reluctance to fail students in practical assessments. Assessment protocols are too complex (Gainsbury, 2010) or there is a tendency to pass the buck (Duffy, 2003), lack of role confidence (Scanlan et al., 2001) or the belief that the assessor is helping the student by giving them the benefit of the doubt (Boley and Whitney, 2003). Working with and observing a student in placement over several weeks can be emotionally challenging and may induce feelings of guilt if the student's career is jeopardised (Hawe, 2003). There are also indications that attempts to fail students are sometimes thwarted by university processes (Luhanga et al., 2008). Intimidation by students and threats of legal action may also discourage assessors (Dudek et al., 2005). The result is a feeling of impotence that can lead to the conclusion that attempting to fail a student in a practical assessment is futile.

Recent Nursing and Midwifery Council (NMC) reports have responded to concerns about unsafe students passing practical assessments (NMC, 2005, 2008). The Council has encouraged assessors to rigorously scrutinise students in practice by promoting awareness of roles, responsibilities and accountability. The Chief Nursing Officer's guidance makes clear that a robust measurement of quality is essential (DH-CNO, 2010). However, neither the Council nor the Department of Health (DH) has gathered data regarding failure rates in theory and practice. Instead, what have been measured are rates of attrition from health programmes. In nursing this varies, between universities, from 3% to 65% (RCN, 2008). In contrast 90.5% of students studying professions allied to health graduated (NAO, 2007). There is, therefore, no clear picture of pass and failure rates in practical assessments. This study is the first national survey to address this issue.

Please cite this article as: Hunt, L.A., et al., Assessment of student nurses in practice: A comparison of theoretical and practical assessment results in England, *Nurse Educ. Today* (2011), doi:10.1016/j.nedt.2011.05.010

Methods

The aim of this study was to establish the situation regarding practical assessment failure rates for student nurses in England. The objectives were to:

- describe and compare referral, subsequent pass and failure rates in theoretical and practical assessments;
- compare rates by academic years;
- compare rates between the four different fields of nursing for which nursing students are prepared: adult, child, mental health and learning disabilities.

A quantitative research design was selected because the information sought was most likely to be stored numerically by all universities (Cresswell, 2009). A retrospective survey technique was used to gather measurable data. No existing survey tool was available and so a questionnaire was designed to gather data relating to 3 critical points in the process of assessing theory and practice:

1. Referral - failure at the first attempt in an assessment.
2. Subsequent pass - passing an assessment which had previously been failed.
3. Withdrawal - failure at all permissible attempts in an assessment resulting in removal from the course.

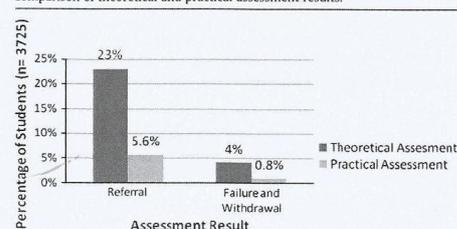
Indemnity insurance and ethical approval were obtained from Birmingham City University. The principles identified by Beauchamp and Childress (2001) were used as the basis for ethical considerations. In designing the study particular regard was given to the commercially sensitive nature of the data to be gathered and mechanisms for ensuring anonymity of all universities which consented to participate in the study.

The questionnaire was piloted in one of the other countries of the United Kingdom (UK) and found to be effective. The survey collected data about pre-registration nursing programmes commencing in the autumn semester of 2005 and concluding in 2008. This was the most recent student cohort to have completed a full 3 year programme at the time the data was gathered. All 52 universities which offered pre-registration nursing programmes in England were invited to participate. Data were examined using descriptive statistics.

Results

Responses were received from 27 universities (52%), 11 provided comments and 16 provided useable numerical data about 3725 student nurses. The principle finding of this study was that both referral and failure rates for theory outstripped practice by a ratio of more than 4 to 1 (Table 1). Three critical points in the assessment process were considered: *referral*, *subsequent pass* and *fail and withdraw*.

Table 1
Comparison of theoretical and practical assessment results.



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Referral

Comparison of referral rates demonstrated a consistently higher rate for theory than practice. Combined data for all 3 academic years showed that 23% of students were referred in theoretical assessments compared to 5.6% of students who were referred in practical assessments; a 4:1 ratio of theory to practice (Table 1).

There were wide variances in referral rates between universities which are demonstrated in Table 2. The highest referral rate for theoretical assessment was 47.4% and the lowest 1.7%. The highest referral rate for practice was 25.2% and the lowest 0.09%. In three cases the referral in practice concerned a single student.

Academic year two demonstrated the highest referral rate for both theory and practice. The lowest referral rate was in year three. This was consistent across all fields of nursing.

Subsequent Pass

Students who had been referred at the first attempt went on to pass theoretical assessments at a subsequent attempt in 76.6% of cases. Those who had been referred in a practical assessment also passed when they reattempted this in 79.5% of cases.

The tenacity of most student nurses is noted here as most remained on programmes to be reassessed. Only 6% of those who had failed either theory or practice at the first attempt did not reattempt the assessment.

Fail and Withdraw

Combined data from all three academic years showed that 4% of students failed theoretical assessments and were withdrawn from programmes as a result of this. In contrast only 0.8% of students were withdrawn from courses based on failure of a practical assessment. This demonstrated a 5:1 ratio of fails in theoretical assessment to fails in practical assessment (Table 1).

Composite data relating to all four fields of nursing indicated that failure rates were highest in year one and lowest in year three for both theory and practice. When the data was examined by field, descriptive statistics showed that the child field had a higher failure in practice rate in year three than year one or two.

Wide variations were identified between fail and withdraw rates at universities. The highest rate for theoretical assessment was 12% and the lowest 0%. One university was identified which did not fail and withdraw any students based on theoretical assessment results.

The highest fail and withdraw rate for practice was 4.25% and the lowest 0%. Twenty five percent of the universities who participated in this study did not fail and withdraw any students based on practical assessments during the 3 year programme (Table 3).

A substantial number of universities did not fail and withdraw any students based on practical assessments in each academic year. Only two universities failed and withdrew students based on practical assessment results in each of the three academic years. Table 4 demonstrates the number of universities which did not fail any students in practical assessments in each academic year. It is notable that this figure was as high as 73% in the final year of the course when practical competence to enter the nursing register is tested.

Table 2

The range of referral results from participating universities.

	Theoretical assessment			Practical assessment		
	Highest	Lowest	Range	Highest	Lowest	Range
% of total cohort referred	47.4%	1.7%	45.7%	25.20%	0.09%	25.11%

Table 3

The range of fail and withdraw results from participating universities.

	Theoretical assessment			Practical assessment		
	Highest	Lowest	Range	Highest	Lowest	Range
% of cohort failed and withdrawn	12%	0%	12%	4.25%	0%	4.25%

Discussion

Table 1 demonstrates that both referral and failure rates for theory outstripped practice by a ratio of more than 4 to 1. This may mean that, in practice settings, support for students was so effective that the majority were able to achieve the required level of competence and passed. However 25% of responding universities did not fail and withdraw any students as a result of practical assessment. This disparity in results seems consistent with Yorke's (2005) view that some universities continue to be slow in accepting practical assessment as an important element of programmes. The results also offer support to Duffy's (2003) and Luhanga et al. (2008) findings that assessors avoid failing underperforming students in practical assessments.

These findings should cause concern and have a number of implications. Students are not expected to be experts in all aspects of nursing, merely safe to be allowed to practice (Benner et al., 2009). Achieving registration as a nurse indicates to the profession, to patients and to employers, that an individual has developed a sound foundation from which to begin practising and on which further, more detailed and specialised development can be built. The practical assessment of students, therefore, serves a crucial purpose as one of the principal means through which the profession regulates entry. If it is ethically and professionally appropriate to require students to meet specified standards before they can be admitted to a profession then there is some point in assessing them. Assessment should provide a means of excluding those who are unsuitable before they reach registration. If all students pass then professional standards cannot be upheld and there seems little point in having assessments at all (Urwin et al., 2010).

Low or none existent failure rates in practice also have implications for theoretical knowledge. Practical performance should be informed by theoretical knowledge since both are integral components of courses (Denton, 2005). The high failure rate in theoretical assessments raises concerns about whether students' underpinning knowledge is considered during practical assessments. This finding might indicate that practice based assessors pass the buck to universities assuming that if they do not fail students they will never-the-less be failed in theoretical assessments. However this cannot be relied upon to identify students who are academically able but cannot translate this into practice. If assessors do not consider students' ability to base care on sound evidence practical competence is not being properly tested (NMC, 2010).

Referral and failure rates varied between academic years. Students were more likely to pass practical assessments in year three. This may be because clinical ability develops as experience is acquired (Fero et al., 2009). This finding also suggests that students whose practice was weak may have been identified during previous academic years. However many assessors admit that they do not fail students in the

Table 4

Occurrence of universities failing and withdrawing no students in practical assessments.

Academic Year	Percent of universities which failed no students in practice
Year 1	53%
Year 2	47%
Year 3	73%

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final year because they do not want to jeopardise their future so near to possible registration and this too offers a plausible explanation for lower failure rates in year three.

Referral rates were consistently highest in year two which supports Duffy's (2003) conclusions that assessors tended to give students the benefit of the doubt in year one but felt previous colleagues had let them down when they were required to refer students at a later stage. However if referral did occur in year one, students were more likely to be removed from programmes when they were reassessed than in other academic years. This indicates that some students whose practice was evidently weak were identified at an early stage and removed from programmes.

Assessors agree that the majority of students who are unsafe should have been identified prior to year three (Black, 2010). They express frustration when previous assessors seem to have passed the buck allowing unsatisfactory students to progress to the final year of programmes. However, it is accepted that some management skills cannot be tested until this stage and it is probably necessary to have some level of failure in year three. Earlier in programmes a dilemma exists for assessors. This concerns whether unsafe students should be identified and removed at an early stage because this protects the public (Kevin, 2006), or if the benefit of the doubt should be given as some need more time to accommodate and later develop competence (Luhanga et al., 2008).

Students studying children's nursing demonstrated a different profile to the other three fields of nursing. They passed theoretical assessments more often than their counterparts but were not more successful in practical assessments. This might indicate that academic ability does not necessarily translate into vocational aptitude (Hughes, 2002), or that practical assessors of children's nurses have higher efficacy in performing their role. Reliable practical assessment is more likely to take place when assessors are capable of reflecting with students so that meaning and background is captured when clinical episodes involving the student are assessed (Cassidy, 2009). This is seen to give assessors increased confidence to making judgements which might otherwise be avoided.

The Nursing and Midwifery Council of the UK has acknowledged the dilemmas assessors of practice face. In order to address these standards to support learning and assessment in practice (NMC, 2008) have been implemented. However these do not require practice based assessors to be prepared to the same level as university lecturers who assess theory. Role confidence is required to overcome the emotional issues assessors experience when failing students in practice (Bandura, 1997). If assessors of practice are well prepared to enact their role they are likely to become more effective. The current disparity in the preparation of the two groups of assessors may contribute to the differences noted between theoretical and practical assessment results.

There was wide variation in rates of referral and failure between universities for both theory and practice. Two universities failed students in both theory and practice in all three years of programmes. This suggests that effective systems and practices to support failure in practice do exist but are not widespread. The issue of inter-university reliability on pre-registration nursing programmes is the remit of the professional body. If professional bodies required data about failure rates in both theoretical and practical assessments there would be a far more comprehensive portrayal of national situations. This could aid external examiners in monitoring the consistency of standards between universities (Mott, 2010).

It is a challenge for professional bodies to ensure a minimum national standard of competence. International discussion has been ongoing regarding the merits of standardising curricula and assessment processes for nursing programmes (Lauder et al. 2008). The NMC has now proposed that universities in the UK should consider incorporating the requirements of individual employers and service users into local practical assessment criteria (NMC, 2010). The difficulty in writing

concise and user friendly practical assessment statements has been well documented (O'Donovan et al., 2004). Language becomes increasingly complex the more specific the outcome. Statements become practically unwieldy and incomprehensible to those who must apply them. It is time consuming to write employer centred outcomes which are pertinent, manageable and robust enough to differentiate between competent and failing students in practice. Centrally constructed outcomes, as implemented in Wales (WAG, 2004), might assist external examiners in monitoring standards and ensuring parity between universities in order to reduce the wide variation in assessment results identified by this study. However practical assessors often report difficulty in interpreting the complex language of professional bodies. Careful consideration is needed to ensure learning outcomes are written in language that is accessible to both students and assessors to enhance reliability of assessment processes.

It is possible that the profile of universities which did not participate in this study differed from those which provided data. The commercially sensitive nature of the information being requested may have discouraged some from participating. Other universities reported that they were unable to participate because they did not gather data about failure in practical assessments. Assessors' reluctance to fail students in practice has had a high profile for a number of years. A clearer picture of the progress being made in addressing this would be gained if relevant data were gathered at national and local levels.

The challenge of gathering standardised data limited this studies scope. If national quality monitoring was introduced it would need to take account of the diversity of assessment processes in universities. Further study of the complexities of the relationship between theoretical and practical assessment is recommended. This would require data at individual student level so that relationships between failure in theoretical assessment and failure in practical assessment could be examined in more detail using inferential statistical tests. Without effective measurement it is difficult to determine if progress is being made in addressing assessors' reluctance to fail underperforming students in practice.

Conclusion

This study demonstrates discrepancies between failure in theoretical and practical assessments on nursing courses in England. Failure rates for theoretical assessments outstripped failure rates for practical assessments by five to one. These findings support those of Duffy (2003) and Luhanga et al. (2008) who have argued that assessors of practice often find it difficult to fail student nurses. A number of factors appear to contribute to this situation including the question of whether the preparation and support practice based assessors receive encourages them to test the evidence base of students' practice.

Wide variations were identified between universities both in terms of practical assessment results and the processes in place to monitor these. Two universities failed and withdrew students based on practical assessment results in every academic year but four failed no students in practice at any point. Eleven universities attempted to provide statistics for this study but found that that their organisation did not gather data about failure in practice. This disparity appears to support the view that practical assessment is not always recognised by universities as an important element of programmes. It is recommended that more emphasis is placed on the practical element of assessment in nursing courses and that quality monitoring procedures reflect this.

Failure is a necessary possibility in any assessment process; without it passing has little value. The anomalies identified in this study are untenable for any profession which considers practice to be its core element (Scholes and Albarra, 2005). Continued development of processes which support assessors to fail underperforming students is essential to promote public confidence.

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Appendix 2.08

Book Vignette

Considering Collateral Impact

Louise Hunt on some unwanted outcomes of conversing with the press

At the time I was completing the first phase of my doctoral study a national journal published a call for people to share their views about the subject I had been investigating. I was so enthused by this interest in my subject area that I telephoned the journal. During the informal conversation which ensued I explained my study, agreed to submit a short summary immediately and accepted an invitation to write a paper for future publication. A few of my comments appeared in the next edition of the publication and, initially, I was delighted. However, several weeks later, I was disturbed to find the journal had contacted all organisations who might be able to provide relevant material requesting similar data under the Freedom of Information Act (2000). This meant that all the ethical safeguards I had built in to keep extremely commercially sensitive data confidential might now be compromised as the journal was under no obligation to maintain the anonymity of respondents.

I was horrified by the possibility that people might assume that the journal's request was in some way endorsed by me or that I was using a pseudonym to gather further information. I felt that my personal integrity was being challenged and my intellectual property disregarded. Furthermore, the journal's activities could jeopardise the second phase of my doctoral study; potential participants might feel less inclined to continue contributing if their anonymity was threatened, all be it by a third party.

Fortunately the Faculty where I was undertaking my study was extremely supportive and provided assistance in managing the situation. Guidance was obtained from specialists regarding protection of intellectual property (IP). Their advice was to gather as much evidence as possible to demonstrate that this was my IP and to make my work immediately visible by circulating an executive summary as widely as possible. A strongly worded letter of objection was sent to the journal and the Faculty subsequently published my full report with a designated ISBN number which was lodged with all relevant bodies including the British Library.

My advice is to prepare in advance with the help of a marketing department if you are thinking of contacting the press about your research. Be clear about the purpose of the contact and take into consideration the remit of the publication. Investigate whether it has volunteered to adhere to the Press Complaints Commissions Code of Practice. Although this has its critics, it does offer a process for any member of the public to bring a complaint against a publication which has undertaken to meet its code. Make an appointment to talk to a journalist and never enter into a conversation with a reporter who calls unexpectedly. Plan in advance what information you are prepared to share and what you wish to withhold. When you do speak to a journalist don't treat it as a friendly chat even if they take this approach. Think carefully before every answer you give and don't be surprised if only some of what you say is selected for publication. Whilst it can be wonderful to have your name in the paper it is important that this is alongside accurately reported findings of your work which are attributed to you.

APPENDICES – CHAPTER 3

Appendix 3.1

Relevant UK and International Research 1986 – 2008

UK NURSING (1986- 2008)

References (ordered by date)	Methodology		
	Type	Method/s	Sample size
LANKSHEAR.A. (1990) Failure to fail: The teacher's dilemma. <i>Nursing Standard</i> 4 (20) 35-37.	Qual	Focus groups	n = 34
JINKS.A., WILLIAMS.R. (1994) Evaluation of a community staff preparation strategy for the teaching, assessing and mentorship of Project 2000 diploma students. <i>Nurse Education Today</i> 14, 44-51	Mixed	Postal questionnaire Face to face interviews	n = 61 n = 10
ATKINS.S., WILLIAMS. (1995) Registered nurses' experiences of mentoring undergraduate nursing students. <i>Journal of Advanced Nursing</i> 21, 1006-1015.	Qual	Semi-structured interviews	n = 12
WILSON-BARNETT.J., BUTTERWORTH.T., WHITE,E., TWINN.S., DAVIES.S., RILEY.L. (1995) Clinical support and the Project 2000 nursing student: factors influencing this process. <i>Journal of Advanced Nursing</i> 21, 1152-1156.	Qual	Semi- structured interviews Observation	Not divulged (ND)
CAMERON-JONES.M, O'HARA.P. (1996) Three decisions about nurse mentoring. <i>Journal of Nursing Management</i> 4 (4) 225-230.	Quant	Questionnaire	n = 87
PHILLIPS.R., DAVIES., NEARY.M. (1996) The practitioner-teacher: a study in the introduction of mentors in the pre-registration nurse education programme in wales: Part 1 and 2. <i>Journal of Advanced Nursing</i> 23, 1037-1044 and 1060-1088.	Mixed	Semi-structured interviews Reflective diaries Questionnaire Observation	ND n = 133 955 ND
TWINN.S., DAVIES.S. (1996) The supervision of Project 2000 students in the clinical setting: issues and implications for practice. <i>Journal of Clinical Nursing</i> 5, 177-183.	Qual	Semi-structured interviews Case studies	n = 37 6
NEARY.M. (1997) Defining the role of assessors, mentors and supervisors. Part 1 and 2. <i>Nursing Standard</i> 11 (43) 34-38.	Qual	Interviews Questionnaires Non-participant observation	n = 155
NEARY.M. (2000) Responsive assessment of clinical competence: Part 1 and 2. <i>Nursing Standard</i> 15 (9) 34-36 and 15 (10) 35-40.	Qual	Interviews Questionnaires Non-participant observation	n = 155
ANDREWS.M., CHILTON.F. (2000) Student and mentor perceptions of mentoring effectiveness. <i>Nurse Education Today</i> 20, 555-562.	Quant	Postal questionnaire	n = 22

BROWN.N. (2000) What are the criteria that mentors use to make judgements on the clinical performance of student mental health nurses? An exploratory study of the formal written communication at the end of nursing practice modules. <i>Journal of Psychiatric and Mental Health Nursing</i> 7, 407-416.	Mixed	Content analysis Quantitative method	n = 150
WATSON.S. (2000) The support that mentors receive in the clinical setting. <i>Nurse Education Today</i> 20, 585-592.	Mixed	Unstructured interviews Questionnaire	n = 13 n = 237
DUFFY.K. (2000) The nurse lecturer's role in mentoring the mentors. <i>Nursing Standard</i> 15 (6) 35-38.	Quant	Questionnaire	n = 71
DUFFY.K., WATSON.H. (2001) An interpretive study of the nurse teacher's role in practice placement areas. <i>Nurse Education Today</i> 21, 551-558.	Quant	Questionnaire	n = 71
WILLIAMSON.G., WEBB.C. (2001) Supporting students in practice. <i>Journal of Clinical Nursing</i> 10 (2) 284-292.	Qual	Focus groups Telephone interviews	n = 25 n = 6
CALMAN.L., WATSON.R., NORMAN.I., REDFERN.S., MURRELLS.T. (2002) Assessing practice of student nurses: methods, preparation of assessors and student views. <i>Journal of Advanced Nursing</i> 38 (5) 516-523.		Postal questionnaire	n = 13
JINKS.A. (2002) Peer review of clinical education assessment: results of the clinical mentors' survey. <i>Singapore Nursing Journal</i> 29 (2) 8-12.	Quant	Questionnaire	n = 156
NORMAN.I, WATSON.R, MURRELLS.T, CALMAN.L., REDFERN.S. (2002) The validity and reliability of methods to assess the competence of practise of pre-registration nursing and midwifery students. <i>International Journal of Nursing Studies</i> 39(2) 133-145.	Quant	Multi-method approach to test convergent and discrimination validity	n = 300
PULSFORD.D., BOIT.K., OWEN.S. (2002) Are mentors ready to make a difference? A survey of mentors' attitudes towards nurse education. <i>Nurse Education Today</i> 22, 439-446.	Quant	Questionnaire	n = 198
DOLAN.G. (2003) Assessing student nurse clinical competence: will we ever get it right? <i>Journal of Clinical Nursing</i> 12, 132-141.	Qual	Focus groups	n = 8
DUFFY.K. (2003) Failing students: a qualitative study of factors that influence the decisions regarding assessment of students' competence in practice. London. UKCC.	Qual	Unstructured / semi structured interviews	n = 42
DEVIS.K., BUTLER.J. (2004) Assessment of a study day to recognise the value of mentors. <i>Nursing Times</i> 100 (32) 36-38.	Mixed	Questionnaire	n = 18
DAWSON.K.P. (2006) Jigsaws and Jugglers: Disposition, discourse and decision making in the assessment of student nurse practice. PhD Thesis. University of Stirling.	Qual	Semi-structured interviews	n = 18
DUFFY.K. (2006) Weighing the Balance. PhD Thesis. Glasgow Caledonian University.	Qual	Unstructured / semi structured interviews	n = 42
BRAY.L., NETTLETON.P. (2007) Assessor or mentor? Role confusion in professional education. <i>Nurse Education Today</i> 27, 848-855.	Mixed	Questionnaire Semi-structured interviews	n = 110 n = 20

KNEAFSEY.R. (2007) Developing skills in safe patient handling: Mentors' views about their role in supporting student nurses. <i>Nurse Education in Practice</i> 7, 365-372.	Qual	Focus groups	n = 15
SKINGLEY.A., ARNOTT.J., GREAVES.J., NABB.J. (2007) Supporting practice teachers to identify failing students. <i>British Journal of Community Nursing</i> 12 (1) 28-32.	LR	Literature review	NA
HURLEY.C., SNOWDEN.S. (2008) Mentoring in times of change. <i>Nursing in Critical Care</i> 13 (5) 269-275.	Qual	Questionnaire	n = 43
MYALL.M., LEVETTE-JONES.T., LATHLEAN.J. (2008) Mentorship in contemporary practice: the experiences of nursing students and practice mentors. <i>Journal of Clinical Nursing</i> 17, 1834-1842.	Quant	On-line survey Questionnaire	n = 161
MOSELEY.L., DAVIES.M. (2008) What do mentors find difficult? <i>Journal of Clinical Nursing</i> 17, 1627-1634.	Quant	Questionnaire	n = 86
NETTLETON.P., BRAY.L. (2008) Current mentorship schemes might be doing our students a disservice. <i>Nurse Education in Practice</i> 8, 205-212.	Mixed	Questionnaire Semi-structured interviews	n = 110 n = 20
WEBB.C., SHAKESPEARE.P. (2008) Judgements about mentoring relationships in nurse education. <i>Nurse Education Today</i> 28, 563-571.	Qual	Critical incident interviews	n = 15

NURSING – INTERNATIONAL (1986-2008)

References (ordered by date) 11	Methodology		
	Type	Method/s	Sample size
ORCHARD.C. (1994) Management of clinical failure in Canadian nursing programs. <i>Western Journal of Nursing Research</i> 16 (3) 317-331. Country: Canada	Quant	Survey	n = 94
RITMAN.R., OSBURN.J. (1995) An interpretive analysis of precepting an unsafe student. <i>Journal of Nursing Education</i> 34 (5) 217 – 221. Country: USA	Qual	Case Study	n = 1
YOUNG-BEEMAN. R. (2001) New partnerships between education and practice: precepting junior nursing students in the acute care setting. <i>Journal of Nursing Education</i> 40 (3) 132-134. Country: USA	Qual	Open-ended Survey	n = 9
HROBSKY.P., KERSBERGEN. A. (2002) Preceptors' perceptions of clinical performance failure. <i>Journal of Nursing Education</i> 41 (12) 550-553. Country: USA	Qual	Semi-structured interviews	n = 4

LAMBERT.V., GLACKEN.M. (2004) Clinical support roles: a review of the literature. <i>Nurse Education in Practice</i> 4, 177-183. Country: Republic of Ireland	Lit review	Literature Review	/
LUHANGA.F.L. (2006) The challenges for preceptors in dealing with nursing students engaging in unsafe practices. PhD Thesis. Edmonton: University of Alberta. Country: Canada	Qual	Semi-structured interviews	n = 22
LUHANGA.F., YONGE.O, MYRICK. F. (2008) Precepting an unsafe student: The role of faculty. <i>Nurse Education Today</i> 28, 227-231. Country: Canada	Qual	Semi-structured interviews	n = 22
LUHANGA.F., YONGE.O., MYRICK.F. (2008) "Failure to assign failing grades": issues with grading the unsafe student. <i>International Journal of Nursing Education Scholarship</i> 5 (1) Article 8. Country: Canada	Qual	Semi-structured interviews	n = 22
McCARTHY.B., MURPHY.S. (2007) Assessing undergraduate nursing students in clinical practice: Do preceptors use assessment strategies? <i>Nurse Education Today</i> 28, 301-313. Country: Republic of Ireland	Mixed	Survey	n = 470
WILSON.S., CARRYER.J. (2008) Emotional competence and nursing education: a New Zealand Study. <i>Nursing Praxis in New Zealand</i> 24 (1) 36 – 47. Country: New Zealand	Qual	Focus Groups	n = 15

OTHER PROFESSIONS – UK & INTERNATIONAL (1986-2008)

References (ordered by date) 9	Methodology		
	Type	Method/s	Sample size
ILOTT.I. (1996) Ranking the problems of fieldwork supervision reveals a new problem: failing students. <i>British Journal of Occupational Therapy</i> 59 (11) 525-528. Prof: Occupational therapy Country: UK	Quant	Questionnaire	n = 113
BURGESS.R., PHILLIPS.R., SKINNER.K. (1998) Practice placements that go wrong. <i>Journal of Practice Teaching</i> 1 (2) 48-64. Prof: Social Work Country: UK	Qual	Semi- structured Interviews	n = 83

SHARPE.M. (2000) The assessment of incompetence: Practice teachers' support needs when working with failing DipSW students. <i>Journal of Practice Teaching</i> 2 (3) 5-18. Prof: Social Work Country: UK	Qual	Semi-structured Interviews	n = 20
HAWE.E. (2003) It's pretty difficult to fail: the reluctance of lecturers to award a failing grade. <i>Assessment and Evaluation in Higher Education</i> 28 (4) 371-382. Prof: Teaching Country: New Zealand	Qual	Participant observation, Interviews, Document audits.	Not stated
DUDEK.N. MARKS.M. REGEHR.G. (2005) Failure to fail: The perspectives of clinical supervisors. <i>Academic Medicine</i> 80 (10) S84 – S87. Prof: Medics Country: Canada	Qual	Semi-structured interviews	n = 21
FADE.S. (2006) Assessing competence for registration in the healthcare professions: The experiences of dietitians and their students. PhD Thesis. London: University of East London. Prof: Dietetics Country: UK	Qual	Interviews Phase 1 Phase 2	n = 6+6 n = 8+4
LICARI.F., CHAMBERS.D. (2008) Some paradoxes in competency-based dental education. <i>International Journal of Dental Education</i> 72 (1) 8-18. Prof: Dentists Country: USA & Canada	Mixed	Questionnaire	n = 150
CLELAND.J., KNIGHT.L., REES., TRACEY.S., BOND.C. (2008) Is it me or is it them? Factors that influence the passing of underperforming students. <i>Medical Education</i> 42, 800-809. Prof: Medics Country: Scotland	Qual	Focus Groups	n = 70

Appendix 3.2

Relevant UK and International Research 2009 – 2014

UK NURSING (2009 - 2014)

References (ordered by date)	Methodology		
	Type	Instruments	Sample size
GURLING.J. (2009) Link mentorship: improving support for pre-registration students and mentors. <i>British Journal of Community Nursing</i> 16 (9) 435-440.	Quan	Limited response questionnaire	n = 15
SIMPSON.H. (2009) <i>Strategic Engagement for a Quality Learning Experience in Practice: Impact on Mentors and Students</i> . PhD Thesis. Edinburgh Napier University.	Mixed	Survey Interviews Focus Groups	n = 10 + 22 n = 30 n = 17 + 13 + 21 + 34
FITZGERALD.M., GIBSON.F., GUNN.K. (2010) Contemporary issues relating to assessment of pre-registration nursing students in practice. <i>Nurse Education in Practice</i> 10, 158 – 163.	Mixed	Comparative cohort study Questionnaire	n = 18 + n = 17 n = 17
GAINSBURY.S. (2010) Mentors passing students despite doubts over ability. <i>Nursing Times</i> < http://www.nursingtimes.net/whats-new-in-nursing/acute-care/nurse-mentors-still-failing-to-fail-students/5013926.article > Accessed on 27.4.10.	Quan	Survey	n = 1945
LASCELLES.M.A. (2010) <i>Students' and mentors' experiences of mentoring and learning in practice during the first year of an accelerated programme leading to nursing registration</i> . PhD Thesis. Leeds, University of Leeds.	Qual	Case study	n = 6
MIDDLETON.R., DUFFY.K. (2010) Mentoring a student immediately prior to registration: a qualitative study. <i>British Journal of Community Nursing</i> 14 (11) 481-486.	Qual	Focus groups	n = 12
TEATHERIDGE.J. (2010) Interviewing student and qualified nurses to find out what makes an effective mentor. <i>Nursing Times</i> 106 (48) 19 – 21.	Mixed	Semi-structured interviews Questionnaires	n = 8 n = 270
BLACK.S. (2011) <i>Being a mentor who fails a pre-registration nursing student in their final placement: Understanding Failure</i> . PhD Thesis. London South Bank University.	Qual	Semi-structured interviews	n = 19
JERVIS.A., TILKI.M. (2011) Why are nurse mentors failing to fail student nurses who do not meet clinical performance standards? <i>British Journal of Nursing</i> 20 (9) 582-587.	Qual	Focus groups	n = 14

MEAD.D.(2011) Views of nurse mentors about their role. <i>Nursing Management</i> 18 (6) 18 – 23.	Quan	Survey	n = 94
WISDOM.H. (2011) <i>Mentors' experiences of supporting pre-registration nursing students – A grounded theory study</i> . PhD Thesis. The Open University.	Qual	Semi-structured interviews and diaries	n = 10
BROWN.L., DOUGLAS.V., GARRITY., KIM-SHEPERD.C. (2012) What influences mentors to pass or fail students. <i>Nursing Management</i> 19 (5) 16-21.	Quan	Survey	n = 1790
CARR.H., GIDMAN.J. (2012) Juggling the dual role of practitioner and educator: practice teachers' perceptions. <i>Community Practitioner</i> 85 (2) 23 – 26.	Mixed	Questionnaires Semi-structured interviews	n = 15 n = 6
HEASLIP.V., SCAMMEL. (2012) Failing underperforming students: The role of grading in practice assessment. <i>Nurse Education in Practice</i> 12, 95-100.	Mixed	Student survey Mentor survey	n = 107 n = 112
ROBINSON.S., CORNISH.J., DRISCOLL.C., KNUTTON.S., CORBEN.V., STEVENSON.T. (2012) <i>Sustaining and managing the delivery of student nurse mentorship: Roles, resources, standards and debates</i> . London. King's College National Nursing Research Unit.	Qual	Semi-structured interviews	n = 37
SCAMMEL.J., OLUMIDE.G. (2012) Racism and the mentor-student relationship: Nurse education through a white lens. <i>Nurse Education Today</i> 32, 545-550.	Mixed	Focus groups Participant observation Documentary analysis	n = 40
VEERAMAH.V. (2012) Effectiveness of the new NMC mentor preparation course. <i>British Journal of Nursing</i> 21(7) 413- 418.	Quan	Survey	n = 199
VERRAMAH.V. (2012) What are the barriers to good mentoring? <i>Nursing Times</i> 108 (39) 12 -15.			
BLACK.S. (2014) Failing a student nurse: A new horizon of moral courage. <i>Nursing Ethics</i> 21 (2) 224-238.	Qual	Semi structured interviews	n = 19
BLACK.S., CASSIDY.S., DUFFY.K., HUNT.L.A. (2013) Failing in Practice: <i>The Mentor's Journey</i> . Symposium, RCN Education Forum Conference, June, Glasgow.	Qual	4 Studies each employing Semi-structures interviews	n = 19 n = 42 n = 43 n = 31
CONGDON.G., BAKER.T., CHEESEMAN.A. (2013) Enhancing the strategic management of practice learning through the introduction of the role of Learning Environment Manager. <i>Nurse Education in Practice</i> 13, 137-141.	Qual	Focus Groups	not stated
JOKELAJAINEN.M., TOSSAVAINEN.K., JAMOOKEEAH.D., TURNEN.H. (2013) Seamless and committed collaboration as an essential factor in effective mentorship for nursing students: Conceptions of Finnish and British mentors. <i>Nurse Education Today</i> 33, 437-443.	Qual	Focus groups	n = 39
KENDALL-RAYNOR. P. (2013) If we want caring nurses we must ensure time for good mentoring. <i>Nursing Standard</i> 27 (32) 12.	Mixed	Survey	n = 50

ROOKE.N. (2014) An evaluation of nursing and midwifery sign off mentors, new mentors and nurse lecturers' understanding of the sign off mentor role. <i>Nurse Education In Practice</i> 14, 43-48.	Quan	Survey	n = 154
TREDE.F., MCEWAN.C., KENNY.A., O'MEARA.P. (2014) Supervisors' experiences of workplace supervision of nursing and paramedic students in rural settings : A scoping review. <i>Nurse Education Today</i> 34, 783-788.	Lit Rev	Literature review	5 papers
BENNET.T., COCHRANE.J. (2014) A phenomenological study into the impact of the sign-off mentor in the acute hospital setting. <i>Nurse Education Today</i> 34, 1029-1033	Qual	Semi structured interviews	n = 6
BENNETT.M., MCGOWAN.B. (2014) Assessment matters- mentors need support in their role. <i>British Journal of Nursing</i> 23 (9) 454-458.	Qual	Focus groups	n = 35

NURSING – INTERNATIONAL (2009 – 2014)

References (ordered by date)	Methodology		
	Type	Instrument	Sample size
OERMANN.M., YARBROUGH.S., SAEWERT.K., ARD.N., CHARASIKA.M. (2009) Clinical Evaluation and Grading Practices in schools of nursing. <i>Nursing Education Perspectives</i> 30 (6) 352-357. Country: USA	Quan	Survey	n = 1573
LUHANGA.F., BILLAY.D., GRUNDY.Q., MYRICK.F., YONGE.O. (2010) The one-to one relationship: is it really key to an effective preceptor experience? A review of the literature. <i>International Journal of Nursing Education Scholarship</i> 7 (1) Article 21. Country: Canada	Lit Rev	Literature Review	n = 57
KILLAM.L., MONTGOMERY.P., LUHANGA.F., ADAMIC.P., CARTER.L. (2010) Views on unsafe nursing students in clinical learning. <i>International Journal of Nursing Education Scholarship</i> . 7 (1) Article 36. Country: Canada	Qual	Focus groups	n = 71
LUHANGA.F., DICKIESON.P., MOSSEY.S. (2010) Preceptor preparation: An investment in the future generation of nurses. <i>International Journal of Nursing Education Scholarship</i> . 7 (1) Article 38. Country: Canada	Qual	Individual and group interviews	n = 22
HUYBRECHT.S., LOECKX.W., QUAHEYHAEGENS.Y., DETOBEL.D., MISTIAEN.W (2011) Mentoring in nursing education: Perceived characteristics of mentors and the consequences of mentorship. <i>Nurse Education Today</i> 31, 274-278. Country: Belgium	Mixed	Questionnaire Semi-structured interviews	n = 112 not stated

TANICALA.M., SCHEFFER.B., ROBERTS.M. (2011) Pass/Fail Nursing student clinical behaviours Phase 1: Moving towards a culture of safety. <i>Nurse Education Perspectives</i> 32 (3) 155-161. Country: USA	Qual	Focus groups	n =11
CASSIDY.I., BUTLER.P., QUILLINAN.B., EGAN.G., MCNAMARA.M., TUOHY.D., BRADSHAW.C., FAHY.A., O'CONNOR.M., TIERNEY.C. (2012) Preceptors views of assessing nursing students using a competency based approach. <i>Nurse Education in Practice</i> 12, 346-351. Country: Republic of Ireland	Qual	Focus Groups	n = 16
LAROQUE.S., LUHANGA.F. (2013) Exploring the issue of failure to fail in a nursing programme. <i>International Journal of Nursing Education Scholarship</i> 10 (1) 1-8. Country: Canada	Qual	Interviews	n = 13
SCHAFFER.M. (2013) The mentoring-burnout relationship and predictors of nurse mentoring behaviour. PhD Thesis. Clemson University. Country: USA	Quan	Survey	n = 188
O'BRIEN.A., GILES.M., DEMPSEY.S.,LYNE.S., MCGREGOR.M., KABLE.A., PARMENTER.G., PARKER.V. (2014) Evaluating the preceptor role for pre-registration nursing and midwifery student clinical education. <i>Nurse Education Today</i> 34, 19-24. Country: Australia	Quan	Cross sectional survey	n = 337
STAYKOVA.M., HUSON.C., PENNINGTON.D. (2014) Empowering nurse preceptors to mentoring undergraduate senior students in acute care settings. <i>Journal of Professional Nursing</i> 29 (5) 32-36.	Mixed	Questionnaire	n = 28
DEBREW.J.K, LEWALLEN.L.P. (2014) To pass or fail? Understanding the factors considered by faculty in clinical evaluation of nursing students. <i>Nurse Education Today</i> 34, 631-636.	Qual	Critical incident technique	n = 24

OTHER PROFESSIONS – UK & INTERNATIONAL (2009 - 2014)

References (ordered by date)	Methodology		
	Type	Instrument	Sample size
FINCH.J.L. (2009) <i>Can't fail, won't fail – Why practice assessors find it difficult to fail social work students. A qualitative study of practice assessors' experiences of assessing marginal or failing social work students.</i> PhD Thesis. University of Sussex. Prof: Social Work Country: UK	Qual	Semi-structured interview	n = 20

MATTHEWS.I., SIMPSON.D., CROFT.A., LEE.M., MCKINNA.G. (2009) <i>Unsung heroes: Who supports social work students on placement?</i> <i>Journal of Practice Teaching and Learning</i> 9 (2) 57-71. Prof: Social work Country: UK	Mixed	Questionnaire Semi-structured interviews	n = 34 n = 9
BASNETT.F., SHEFFIELD.D. (2010) <i>The impact of social work student failure upon practice educators.</i> <i>British Journal of Social Work</i> 40, 2119-2136. Prof: Social Work Country: UK	Qual	Semi-structured interviews	n = 8
PARKER.J. (2010) <i>When things go wrong! Placement disruption and termination: power and student perspectives.</i> <i>British Journal of Social Work</i> 40, 983-999. Prof: Social Work Country: UK	Qual	Semi-structured interviews	n = 7
FINCH.J., POLETTI.A. (2013) <i>'It's been hell.'</i> Italian and British practice educators' narratives of working with struggling or failing social work students in practice learning settings. <i>European Journal of Social Work</i> . 2013. http://www.tandfonline.com/loi/cesw20 . Prof: Social Work Country: Italy and UK	Qual	Comparative (2 studies) In depth interviews	n = 26
FINCH.J., SCHAUB.J. DALRYMPLE.R. (2013) <i>Projective identification and fear of failing: Making sense of practice educators' experiences of failing a social work student in practice learning settings.</i> <i>Journal of Social Work Practice</i> . Prof: Social Work Country: UK	Qual	Case studies drawn from previous studies	n = 4
POLETTI.A., ANKA.A. (2013) <i>'They thought I wasn't good enough for social work practice'.</i> <i>Journal of Practice Teaching and Learning</i> 11 (3) 17-35. Prof: Social work Country: UK	Qual	Semi-structured interviews	n = 8
RAWLES.J. (2013) <i>Whose students are they anyway?</i> <i>Journal of Practice Teaching & Learning</i> 11 (3) 59-78. Prof: Social work Country: UK	Qual	Case studies	n = 27
ROBERTSON.J. (2013) <i>Addressing professional suitability in social work education: Results of a study of field education coordinators' experiences.</i> <i>Journal of Practice Teaching and Learning</i> 11 (3) 98-117. Prof: Social work Country: Canada	Mixed	Focus group Web based survey	n = 8 n = 57
SCHAUB.J., DALRYMPLE.R. (2013) <i>Surveillance and silence: New considerations in assessing difficult social work placements.</i> <i>Journal of Practice Teaching and Learning</i> 11 (3) 79-97. Prof: Social work Country: UK	Qual	Semi-structured interviews	n = 10

<p>SIMPSON.G., MURR. (2013) The 'not yet competent' student: Exploring narratives of failure. <i>Journal of Practice Teaching and Learning</i> 11 (3) 118-134.</p> <p>Prof: Social work Country: UK</p>	Qual	Narrative analysis of portfolios	n = 21
<p>HIGGINS.M. (2014) Can practice educators be a 'bridge' between the academy and the practicum? <i>Journal of Practice Teaching and Learning</i> . 12 (3) 62-78.</p> <p>Prof: Social Work Country: UK</p>	Qual	Interviews Focus groups	n = 20 n = 28
<p>CHAMBERS.D.W., LABARRE.E.E. (2014) Why Professional Judgement is Better than Objective Description in Dental Faculty Evaluations of Student Performance. <i>Journal of Dental Education</i>. 78 (5) 681-693.</p> <p>Prof: Dentists Country: USA</p>	Quant	Factor Analysis	n = 157

APPENDICES – CHAPTER 4

Appendix 4.01

Recruitment Information



Louise Hunt
Senior Lecturer, Department of Practice Learning,
Faculty of Health, Birmingham City University,
Room 427, Seacole Building, Westbourne Rd,
Edgbaston, Birmingham B15 3TN
0121 331 6166
Louise.hunt@bcu.ac.uk

1st June 2011

Dear

I am a senior lecturer in nursing at Birmingham City University where I am also registered as a research degree student. I am undertaking a study about failing student nurses in practical assessments. I am writing to you because I understand you have been involved in failing a student nurse in a practical assessment and so I would like to invite you to participate in this study.

You may have seen recent articles in the nursing press which suggest that mentors might not always be able to fail student nurses whose practical ability is weak. The aim of my study is to increase understanding of what happens in situations where students do fail practical assessments and identify what helps mentors to do this.

I have enclosed an information sheet to help you decide if you would like to participate in this study. Please read this before making a decision.

If you would like any more information to help you make your decision please contact me on 0121 331 6166 or e-mail me at Louise.hunt@bcu.ac.uk or contact my supervisors:

xxxxxxxxxx

I will be pleased to answer any queries or give further details. If you are happy to participate please either telephone me on 0121 331 6166 or Email me at Louise.hunt@bcu.ac.uk.

Thank you for taking time to read this letter and I look forward to hearing from you.

Yours sincerely

Louise Hunt RN, BSc (Hons).
Research Student.



PARTICIPANT INFORMATION SHEET

Assessing Student Nurses in Practice

I would like to invite you to take part in a research study about failing student nurses in practical assessments. Before you decide you need to understand why the research is being done and what taking part would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you would like more information. Please take time to decide whether or not to take part.

Part 1

What is this project about?

I am a nurse lecturer with 25 years of experience in teaching and assessing student nurses both in clinical practice and in academic work. I am currently registered as a PhD student at Birmingham City University and the focus of my study is the processes involved in failing student nurses in practical assessments. As a part of this I would like to talk to people who have been involved in failing student nurses in practical assessments.

Why have I been approached?

I am inviting you to be interviewed as part of this study because I understand that you have had experience of failing a student nurse in a practical assessment. The insight you can provide about this experience would be very valuable in increasing understanding of this process. If I have approached the wrong person please either ignore this letter or forward it to a more appropriate colleague.

What will happen if I do not want to take part?

Taking part is voluntary. It is up to you to decide if you would like to be interviewed. If you don't want to take part, you do not have to give a reason. You can also pull out of the interview at any time. If, after the interview, you change your mind and want to withdraw from the study all the information and data collected from you, to date, will be removed from all the study files and destroyed.

What will taking part involve?

If you do choose to take part in this study you will be interviewed by me at a mutually agreeable venue. The interview will last approximately 1 hour and will be tape recorded. This will be transcribed in full and you will receive a copy of the transcription. You will be asked to check this, make any amendments you think appropriate and return it to me. This will be the data I will use in the study. I may wish to quote from your interview in my final report or subsequent publications but you will not be identified in any way.

Are there any disadvantages or risks in taking part in this project?

There are minimal risks in taking part in this study but Birmingham City University provides indemnity insurance for the project should anything untoward occur as a result of your taking part. All the information provided by you will be treated in the strictest confidence and anonymised. You will not be identified in the final report or any other documents relating to this research. If during the interview I become aware that someone is at risk of serious harm or has been harmed the NMC Code of Professional Conduct (NMC 2008<http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Confidentiality/>) will be adhered to. This advises "You must disclose information if you believe someone may be at risk of harm, in line with the law of the

country in which you are practising.” However, this should only be undertaken in the public interest in order to “serve a broader social concern” and “disclosure should be proportionate and limited to relevant details”.

What are the possible benefits of taking part and how will this project help the nursing profession?

You may have seen recent articles in the nursing press which suggest that mentors might not always be able to fail student nurses whose practical ability is weak. Your insight into the process of failing a student nurse in practice is therefore valuable because few mentors have been able to do this. The information you can provide will increase understanding of what is effective in these circumstances. This is an opportunity to take part in a study which will make a positive contribution to both the maintenance of professional standards and public protection.

What if there is a problem?

The project will stop if any problems arise that were not anticipated at the start of the project. If you feel unhappy about any aspect of the study, please contact me or my supervisors and we will do our best to resolve any problems. Contact details are provided on page 3 of this leaflet.

What will happen to the information provided?

All the information you provide in the interview will be coded. This will ensure that none of the information can be associated with you, your Employer, University or Faculty. You will not be identified individually in the final report or any other documents which are produced. Information will only be used in connection with this study and not for any other purposes.

Will the information be confidential?

Your anonymity will be maintained by labelling recordings and transcripts of interviews with a code to protect your confidentiality. The data will be collected and stored in accordance with the Data Protection Act of 1998 and will be disposed of in a secure manner. Data will only be accessed by me. My supervisors will have access to anonymised data.

What do I do if I need further information?

Please contact me

Mrs. Louise Hunt, Senior Lecturer
Department of Practice Learning
Room 427, Seacole Building.
Faculty of Health
Birmingham City University,
Westbourne Rd, Edgbaston,
Birmingham B15 3TN
Tel - 0121 331 6166
e-mail – Louise.hunt@bcu.ac.uk

Alternatively you can contact my research supervisors:

Part 2

What will happen to the information?

The information you provide will only be used for the purposes of this project, which will include compiling my thesis, reports, conference papers and publications. You will not be identified in any of these documents.

What will happen if I decide not to carry on with the project?

You are free to withdraw from this study at any time without giving a reason and the information you have already given will also be withdrawn.

What if there is a problem?

If you have any concerns about the conduct of this research please contact me in the first instance and I will do my best to discuss these with you. If you are still unhappy and wish to make a formal complaint, please refer this to my research supervisors or to:



Who is organising and funding the research?

Part of this study has been funded by the Centre for the Enhancement of Teaching and Learning, Birmingham City University.

Has this project been approved by an ethics committee?

This study has been reviewed and approved by NHS West Midlands – Solihull Research Ethics Committee and Birmingham City University, Faculty of Health, Ethics Committee.

Has the project been reviewed by an independent sponsor?

Birmingham City University has reviewed this project and agreed to act as sponsor.

Will the results be made available?

Reports of the findings of this study will be presented at conferences and in academic papers. An executive summary will be available to all participants and Higher Education Institutions as well as to the Nursing and Midwifery Council and the Department of Health. You will not be identified in any reports or articles which are generated as a result of this study.

What should I do now?

Think about the information on these sheets, ask questions if you are not sure about anything. If you agree to take part, please sign the consent form on page 5. The consent form will not be used to identify you. It will be filed separately from all other information. If you want any more information about the study at any time please contact me.

Thank you for taking time to read this information leaflet.

Appendix 4.02**Participant Consent Form**

Name of participant: _____

Title of project: Assessing Student Nurses

Researcher's contact details: Mrs. Louise Hunt,
Senior Lecturer, Department of Practice Learning
Room 427, Seacole Building.
Faculty of Health, Birmingham City University,
Westbourne Rd, Edgbaston, Birmingham B15 3TN
Tel - 0121 331 6166 e-mail – Louise.hunt@bcu.ac.uk

Initials

I agree to take part in the above research. I have read the Participant Information Sheet, which is attached to this form. I understand what my role will be in this research and all my questions have been answered to my satisfaction.

I agree to the interview being voice recorded

I understand that I am free to withdraw from the research at any time and for any reason.

I have been informed that the information I have provided will be safeguarded by anonymising data provided by me.

I understand that extracts from my interview may be quoted in reports or publications arising from this research but that I will not be identified in any way.

I am free to ask questions at any time.

I have been provided with a copy of this consent form and the Participant Information Sheet.

Name of Participant (Print): _____

Signature: _____

Date: _____

Appendix 4.03
Risk Assessment Form

Date: 26.9.10	Assessed by: Louise Hunt	Activity: Qualitative Interviews	Review Date: January 2011
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Risk	Who might be harmed?	Level of risk	Measures to control	Result
Becoming aware of hidden emotions such as concern or anxiety	Mentor	Medium	Information sheet listing reading material and organisations which offer support	Adequately controlled
Breach of confidentiality	Student/service user/mentor/other	Low	Anonymisation of all names in recordings and transcripts. Password protected USB and external hard-drives to store data.	Adequately controlled
Coercion to participate	Mentor/other participant	Low	Self selection.	Adequately controlled
Compromised service user care by removal of mentor during a shift	Service users	Low	Interviews conducted outside working hours.	Adequately controlled
Disclosure of poor/illegal practices	Service user/student/other	Medium	Researcher adherence to the NMC Code of Professional Conduct	Adequately controlled

Key: Level of Risk - Low = it is most unlikely that harm would arise under the controlled conditions listed.
Medium = it is more likely that harm might actually occur and the outcome could be serious.
High = if harm is likely to arise it may be serious or even fatal.

Result - Trivial = the risk is insignificant.
Adequately controlled = the control measures taken reduce the risk to low level and meet legislative and policy requirements.
Not adequately controlled = further action planning and resources required.
Unable to decide = detailed and prolonged enquiry required to ascertain risk and controls.

Appendix 4.04

Supportive Resource

Thank you
For taking part in this study

I will send you a copy of the transcript of your interview so that you can check it for accuracy. If you decide you would like to add or remove any parts of it you may send me a copy of any changes. This will be the data I will use in my study.

Some useful resources about failing students :

- Duffy.K. (2007) Supporting failing students in practice 1: Assessment. Nursing Times 103 (47) 28-29
- Duffy.K. (2007) Supporting failing students in practice 2: Management. Nursing Times 103 (48) 28-29
- Nursing Times Portfolio Pages: Supporting failing students in practice. www.Nursingtimes.net/Journals/1/Files/2009/6/2/Failing%20students%20%20portfolio%20pages.doc
- Royal College of Nursing (2007) Guidance for mentors of student nurses and midwives: A Toolkit. RCN: London
- Healey.J. & Spencer.M. (2008) Chapter 12 – Failure. *In* Surviving your Placement in Health & Social Care: A Student Handbook. Maidenhead: McGraw-Hill.

If you feel you need to discuss your experiences further:

- RCN Counselling service 0345 769 7064
- Unison Welfare 020 7551 1620

If you think of anything else you would like to add please phone or Email me at
0121 331 6166
Louise.hunt@bcu.ac.uk

Appendix 4.05**Sponsorship**

Please reply to:

Centre for Health and Social Care Research
 Faculty of Health
 Birmingham City University
 City South Campus
 461 Seacole Building
 Westbourne Road
 Edgbaston
 Birmingham
 B15 3TN

3 November 2010

To whom it may concern

Dear Sir/Madam

Re: University Sponsorship Agreement

Title of Project:	Assessing student nurses in practice: a critique of the processes that influence assessors' decisions to fail students
Name of Researcher:	Louise Hunt
Full Title of Course:	PhD
Name of Academic Supervisor (Chief Investigator):	<input type="text"/>

I can confirm that the Faculty of Health, Birmingham City University has agreed to take on the role of Sponsor under the Department of Health Research Governance Framework.

I can also confirm that legal liability for death or injury to any person participating in the project is covered under the University's insurance arrangements.

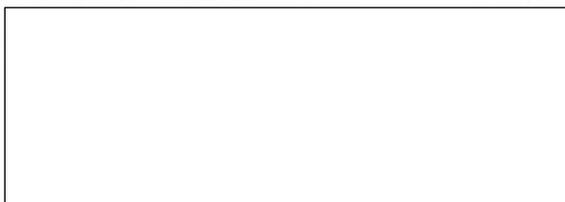
Yours faithfully

**Chair
 Academic Sponsorship and Indemnity Sub-Committee**

Faculty of Health
 Birmingham City University
 Room 270 Seacole Building Edgbaston Campus Westbourne Road Edgbaston Birmingham B15 3TN
 University Switchboard T: 0121 331 5000 Direct T: 0121 331 6189 / 0121 331 6181 F: 0121 331 6009
 W: <http://www.health.bcu.ac.uk>
 W: www.bcu.ac.uk

Appendix 4.06

Ethical Approval



08 November 2010.

Louise Hunt
Faculty of Health
Birmingham City University
Westbourne Road
Edgbaston
Birmingham B15 3TP

Dear Louise,

Faculty of Health Research Ethics Committee:

Application for Approval: 'Assessing student nurses in practice: a critique of the processes that influence assessors' decisions to fail students'

Thank you for your application to the Research Ethics Committee. The application was regarded as excellent: it was very pleasing to see that the ethical dimension of the research was well integrated into the application, reflecting a serious attempt to pursue genuinely ethical research. The Committee was pleased to see that the application engaged with the ethical frameworks of Beauchamp and Childress, Koch and others. Members were also pleased that the application built firmly on the experience of your previous research.

There were six minor issues discussed with you face-to-face in the meeting and you explained these to our satisfaction. We would recommend that you develop these points slightly more clearly in the application itself:

1. You stated that you only wish to interview staff who have failed students: it would be worth explaining why you do not wish to interview others.
2. You appear to place emphasis on interviewing staff in their homes, but in discussion, you commented that this is only a position of last resort.
3. You note that you will send a request for a nominated contact in each participating HEI. You may wish to clarify that you are working with existing contacts made in your previous research and that they have agreed to take part.
4. You note that approval will be sought of a senior member of Faculty for access to HEI staff. Again, you may wish to clarify that contacts have already been made.
5. We asked if you could clarify how you are going to recruit staff as participants.
6. We also asked if you could clarify how the recruitment poster is to be distributed.



However, these points will merely enhance the application and the Committee was fully agreed that the application should be granted approval without the need for further review by the Committee.

The Committee should, of course, be notified of any serious adverse effects arising as a result of the research. The Committee is required to keep a favourable opinion under review in the light of progress reports. You will be asked to submit a progress report and the Health Research office will contact you when this is due.

I hope the project goes well and wish you every success.

Yours sincerely

[Redacted signature box]

Vice Chair, Faculty Ethics Committee (in the absence of the Chair,

[Redacted name box]



**National Research Ethics Service
NRES Committee West Midlands - Solihull**

REC Offices
Prospect House
Fishing Line Road
Enfield
Redditch
B97 6EW
Telephone: 01527 582532
Facsimile: 01527 582540

Date: 20 July 2011

Mrs. Louise Hunt
Lead Nurse - Practice / Research Student
Birmingham City University, Faculty of Health,
Department of Practice Learning
City South Campus, Edgbaston,
Birmingham.
B15 3TN

Dear Mrs. Hunt

Study title: **Assessing student nurses in practice: a critique of the processes that influence assessors' decisions to fail students**

REC reference: **11/WM/0203**

The Research Ethics Committee reviewed the above application at the meeting held on 13 July 2011. Thank you for attending to discuss the study.

Discussion at the meeting

1. The committee questioned the sample size of 15-30. You explained that whilst you were not experienced in grounded theory your supervisory team were. It is anticipated that a minimum of 15 participants will be required but that you would continue to the point of saturation.
2. It was clarified that interviewees will receive a copy of the transcripts. Any additional points will be analysed and it will be made clear that they were additional.
3. You clarified that interviews will last approximately 45 mins – 1 hour.
4. The committee said that even if any disclosures of professional misconduct are unlikely this possibility must be included in the information sheet. You commented that this was a difficult area if it is 'hearsay' and only part of a discussion heard.
5. The consent form requires consent to audio-record.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion with additional conditions of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites**NHS Sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Other conditions specified by the REC

1. Participant Information Sheet - include a statement detailing the procedure should any disclosure be made regarding concerns of professional misconduct.
2. Participant Information Sheet - include a sentence that the study has been reviewed and approved by NHS West Midlands - Solihull REC.
3. Consent Form - include consent to audio record.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Advertisement	1	01 June 2011
Covering Letter		20 June 2011
Evidence of insurance or indemnity		29 July 2010
Interview Schedules/Topic Guides	1	01 June 2011
Investigator CV		01 June 2011
Letter from Sponsor		03 November 2010
Letter of invitation to participant	1	01 June 2011
Other: References		
Other: CV for Professor P McGee		16 June 2011
Other: CV for Dr R Gutteridge		09 June 2011
Other: CV for Dr M Hughes		10 June 2011
Other: Letter from University confirming research degree registration		12 April 2011
Other: Letter from funder		06 April 2011
Other: Risk Assessment Form	1	01 June 2011
Other: Lone Working System	1	01 June 2011
Other: Supportive Information	1	01 June 2011
Other: Non-disclosure Agreement	1	08 June 2011
Participant Consent Form	1	01 June 2011
Participant Information Sheet	1	01 June 2011
Protocol	1	16 June 2011
REC application	3.1	21 June 2011
Summary/Synopsis	1	01 June 2011

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

Appendix 4.07**Example of Recruitment Flyer**

Mentors

Have you failed a student nurse in a practical assessment?

If the answer is yes would you be interested in participating in this research project?

My name is Louise Hunt, I am a research student at Birmingham City University.

The aim of my study is to increase understanding of what happens in situations where students do fail practical assessments and what helps mentors to do this. The insight that you could provide would be very valuable because few mentors have been able to do this.



BIRMINGHAM CITY
University

If you would like more information or would like to take part please phone or Email me at
0121 331 6166
Louise.hunt@bcu.ac.uk

Appendix 4.08**Checklist for Interviews**

<u>Interview Details</u>	
Date:	
Time:	
Destination:	
Meeting Point:	
Post Code: Input to SatNav	

<u>Equipment Check</u>	
Folder with details	
IC Recorder (Black) with fresh batteries inserted	
Microphone	
Spare AAA batteries	
IC Recorder (Silver) fully USB charged	
Note pad	
Pen	
Watch	
Do Not Disturb notice	
Blue Tac	
Participant Information Sheet	
Consent Form	
Participant details sheet	
Interview Schedule	
Supportive material sheet	

<u>Actions</u>	
Turn Mobile to Silent	
Set up room – chairs at angle, table to right side of my chair with pen and notepad	
Close windows check for other background noises	
Do Not Disturb on door.	
Explain to participant, purpose of interview, will be recorded, free to stop anytime	
Check consent form signed	
Attach microphone	
Switch on both IC Recorders and check they are running.	
Interview	
Ask if willing to be contacted again to check transcript or look at findings	
Provide with supportive material	
Remove microphone	
Say goodbye and then switch off IC Recorders	
Post interview field notes	

Appendix 4.09**Interview Guide**

Questions v1	Rationale
Phase 1: The Warm-up	
Introductions: Names Thank you Purpose Consent	Rapport building, house keeping
Ice Breakers: Field of practice Years of experience Seniority	Further rapport building, obtains profile of the assessor
Phase 2: Exploratory Discussion	
I'm really interested in your experience of failing a student nurse in a practical assessment. Can you tell me more about this?	Allow participant to tell the story their way. Shows interviewer actively interested.
Do you think there was anything particular that helped you to do this?	Progressive focussing of interview towards what helped
Phase 3: Possible Areas to Probe	
Support	Resources and people who were helpful.
Procedures	Practical assessment processes.
Training	Formal and informal preparation to assess students
Partner HEI	How are they involved
Personal Qualities	Belief and value systems which influence decisions and actions
Phase 4: Summarising	
You are experienced in failing a student nurse in a practical assessment. So if a new mentor asked you for advice about doing this what would you tell them?	Ascertain key points and priorities from the participant's perspective.
Is there anything else you would like to tell me?	Opportunity to add points not specifically asked about
Thank you.	Provision of supportive material.

Appendix 4.10**Guide for Transcriber - Transcription Key:**

...	Pause between words
?	Question or rising tone
< word >	Simultaneous or overlapping dialogue
	Cuts off mid speech
<u>word</u>	Emphasised or loud word
(word)	Vocalisation or interruption
{ word }	Transcription doubt or anonymised data
*word *	Whispered
' word '	Quoting a third party

Appendix 4.11

Examples of Memos

17/6/11 memo re LTO1

What struck me about this interview was the paperwork getting in the way of assessment

- Not focussing on assessment docs
- Assess using own judgement
- Doing not writing to assess
- Logistics of filling in documents
- Overwhelmed by paperwork

This interviewee was a lecturer / personal tutor to a student who failed. I wonder what mentors say about this?

This is very interesting and opens up all sorts of possibilities about how mentors do assess. I shall listen carefully to the next participant who is a mentor (the first one) to see how its done.

Interesting too that at the point in the interview where this was discussed that the lecturer was remembering how she assessed students herself. This indicates LT & PE codes might be artificial if several reflect on their own mentor experience of failing students, but that assumes they failed a std as a mentor.

I'm surprised I'm not bothered by being told that paperwork gets in the way (need to do a reflexive piece about this).

ACTIONS: Next interview - checkout paperwork getting in the way

Reflect on why not bothered by this code

PEO2. memo. 27/6/11.

Practice Docs not useful.

This continues the theme from MAOI. Mentors don't make initial use of practice docs and use own criteria instead which are much more specific to the placement area + are more concrete. Is this so it easier to give std examples of what they must do?

However at odds with this is the PE retrospectively taking it back to the competences & showing where it fits. There is translation & interpretation going on here to ultimately justify failure in terms of assessment docs + NMC comp.encies but the language &

structure of these means the mentor doesn't seem able to use them as the primary source of assessment criteria.

What's needed are

- plain english
- reduction in repetition
- tick boxes
- clear, transparent criteria

This PE sums up assessment docs are currently a pain in the neck to mentors.

Memo 27th January 2013

Standing Securely

Failing an underperforming student nurses in a practical assessments can be seen as an emotional and anxiety provoking experience for mentors. The process occurs over a period of time and involves interactions between the mentor and other interested parties. These parties have conflicting expectations which lead to uncertainty and can challenge the personal security of the mentor. When mentors recognises an underperforming student they search for a coherent, dependable platform from which to manage the circumstance but report instead encountering a turbulent situation in which they perceive heightens their personal vulnerability. In these circumstances the mentor responds by acting to establish personal security.

(See also memo of 30.11.12)

Category 1: Settling Assessment Turbulence

1.1 Functioning in a Culture of Conflicting Expectations

Mentors initially transfer the values and attitudes employed in nursing to the role of mentoring. The focus is on nurturing and enabling the student. An assumption is made that being a good mentor is commensurate with enabling the student to pass each practical placement. This view does not change as long as only students who perform to the mentor's required standard are encountered. Turbulence builds if the mentor experiences a student who persistently underperforms and the mentor begins ***functioning in a culture of conflicting expectations***.

Vague unease is initially reported as the mentor senses that the student is not performing to the required standard, however the mentor ***struggles to articulate*** why this is sensed and asks ***it is just me?*** The mentor is reluctant to challenge the student or raise the issue with practice educators or link lecturers at this point as nothing explicit can be referred to and hence the mentor feels insecure.

The student's underperformance challenges the mentor's belief that they are a good mentor. The mentor tendency is to ***own the student*** and take personal responsibility for the student's underperformance.

Mentors report that it feels ***counterintuitive*** to fail the student. They perceive this act as harmful to the student and this runs counter to the values and beliefs system in which a nurse usually functions.

Mentors encounter a student who underperforms infrequently and so do not routinely employ the processes required to fail a student, hence the finer detail of procedures are not easy to recall. Furthermore the processes are ***not situation specific***, are perceived as ***difficult to interpret and navigate*** and the mentor fears making mistakes and ***getting into trouble*** because they have not been able to ***meticulously adhere to due process***.

There are ***conflicts in managing students' and patients' needs***. The mentor recognises that a choice needs to be made between keeping patients safe from an incompetent nurse and keeping the student nurse content at the expense of the safety of patients. The mentor struggles promote the well-being of both since one is often detrimental to the other. However the patient's well-being is to

some degree compromised if the student is to be failed because this is a **time-consuming process** which reduces the time the mentor has to deliver direct patient care.

The **expectations of the mentor's employer** emphasise promoting patient well-being and there is anxiety that time away from patients will mean the mentor **being in trouble** with their employer because they are not doing the job which they are primarily employed to do. This is reinforced by the employer's quality auditing and monitoring processes which rarely express organisational expectations about **preparing the future workforce**.

Student nurses have been socialised into **a culture of entitlement**. This is established during school years where children are exposed to an educational environment in which positive reinforcement and success are unconditional and are considered a right. Furthermore the primary focus of Universities is on promoting the student experience. This reinforces the culture of entitlement and causes conflict for students as they move between the culture of education and the culture of care. In the practice environment students find themselves no longer the primary focus and struggle with the concept that their mentor will give the patient's needs primacy over theirs. Students often react defensively or aggressively if they perceive their "rights" are being challenged and blame the mentor. This can reinforce the mentor's belief that it is they who are at fault.

The current norm is that student nurses rarely fail practical assessments and this creates an implicit social contract which enhances students' **expectation of entitlement**. If the mentor does not pass the student the student feels mistreated, believing the mentor has not fulfilled their part of the bargain. Students who have been told they are underperforming feel they have justification for **counter-challenging the mentor** and do this in a variety of ways. They may appeal against the mentor's decision or the process followed; accuse the mentor of **being an "ist"** (sexist, racist, ageist), of neglecting them or of bullying and harassment; make threats of **physical intimidation** and at times carry these out.

"The University" is perceived as a **self-interested business entity** which acts to protect its own interests rather than to ensure the safety of the public. This view incorporates a belief that "The University's" prime objectives are to **retain fee paying students** and **avoid bad publicity and litigation**. Hence "The University" is not perceived as being supportive of mentors when they fail underperforming students in practical assessments as this runs counter to **"The University's"** objectives.

Mentors, practice educators and nurse lecturers share a view of **"The University"** as an indomitable entity which holds the balance of power. All report that they do not recognise themselves or their counterparts as being part of this being. "The University" is considered a higher authority, dissociated from and often in conflict with them and as such is often regarded as the common enemy posing a threat to the security of the public.

Finally the mentor is mindful of **avoiding external attention** either from the media or the NMC. This is a double edged sword as the mentor perceives that they may bring unwanted attention upon themselves or their organisation by either acting to fail or declining to fail the underperforming student. This is reinforced by the conflicting messages the media provides about nurses; simultaneously portraying them as "Angels" and being robust in publicising lapses in duty of care.

Appendix 4.12

Examples of Integrative Diagrams

First diagram September 2011

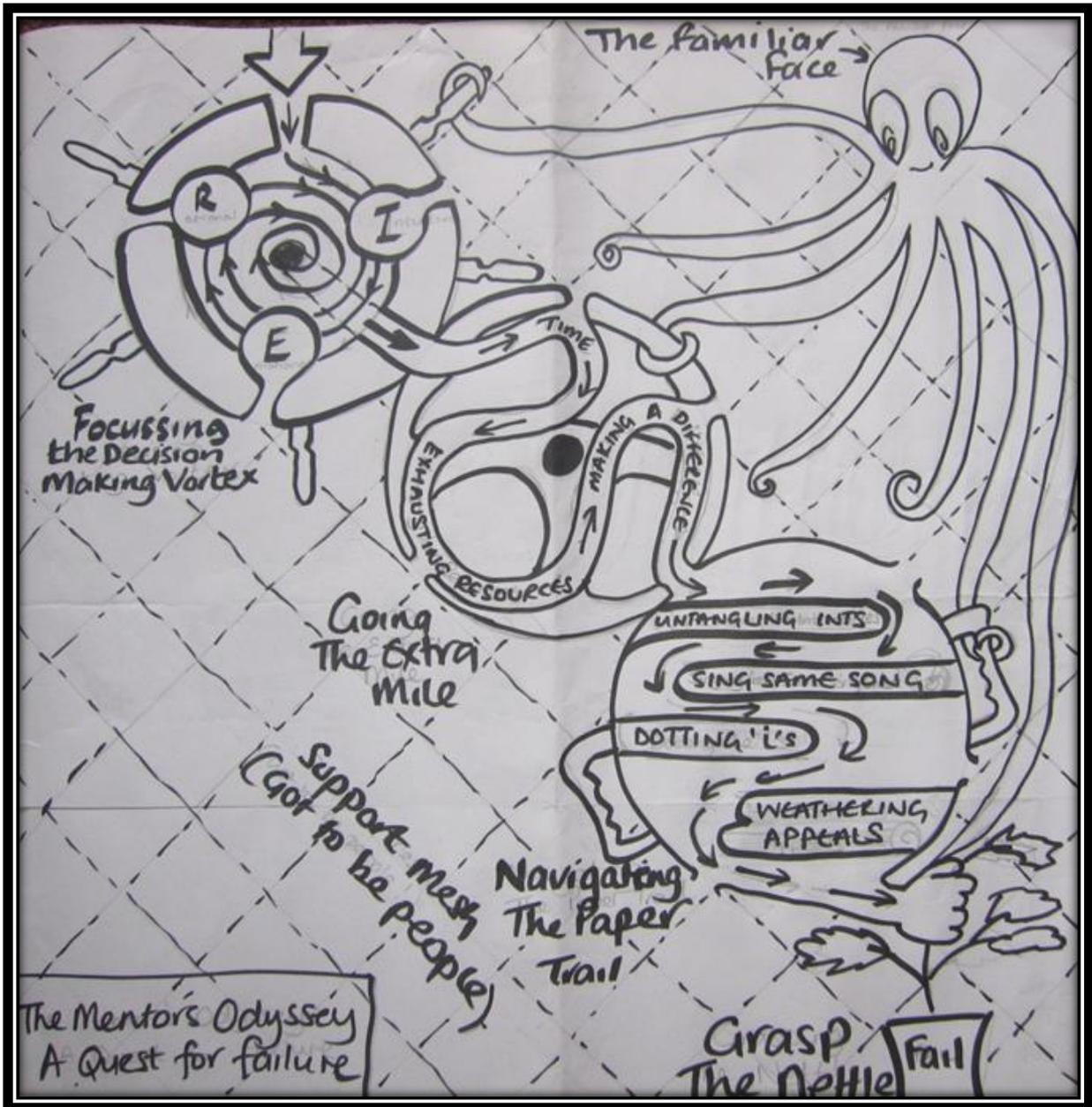
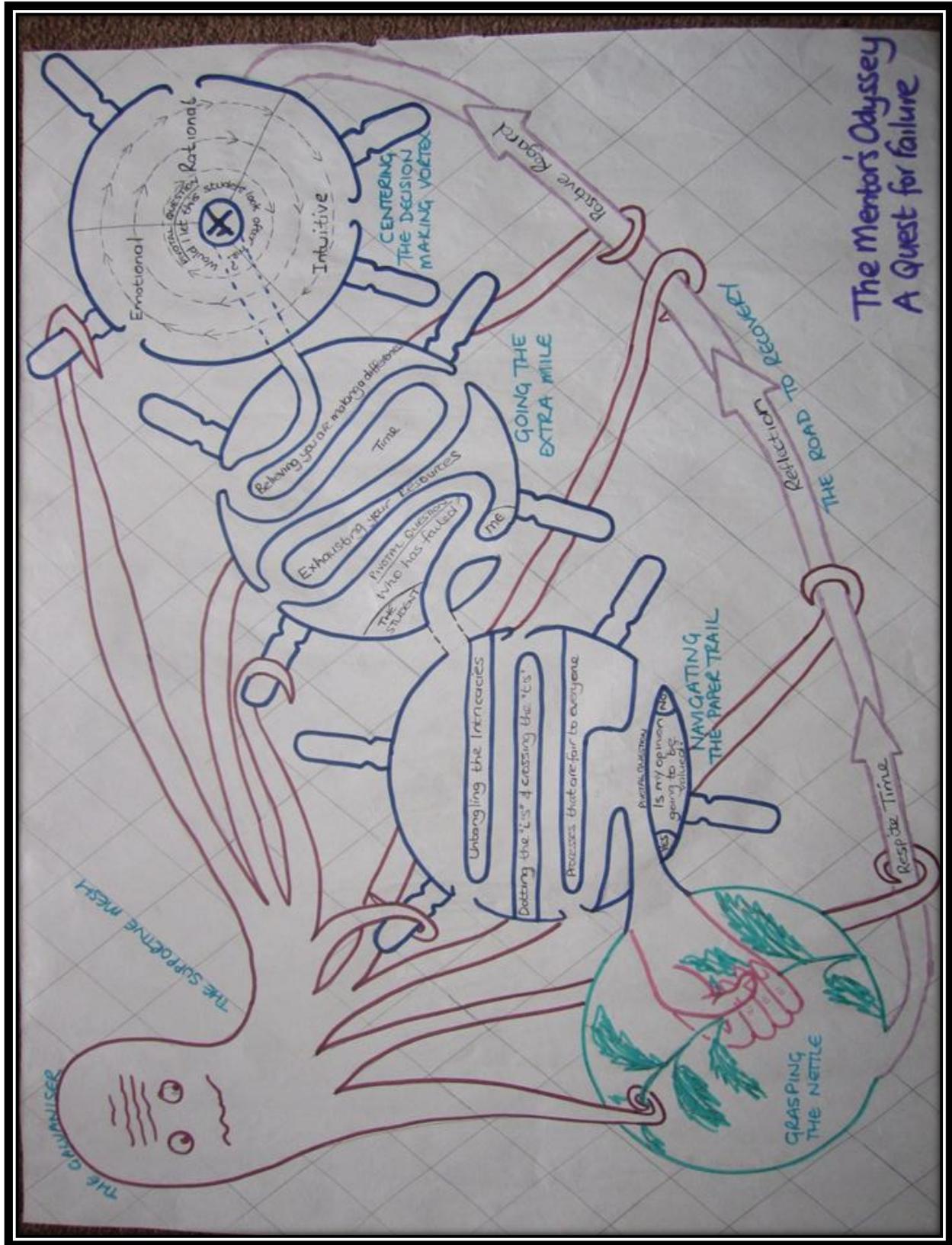
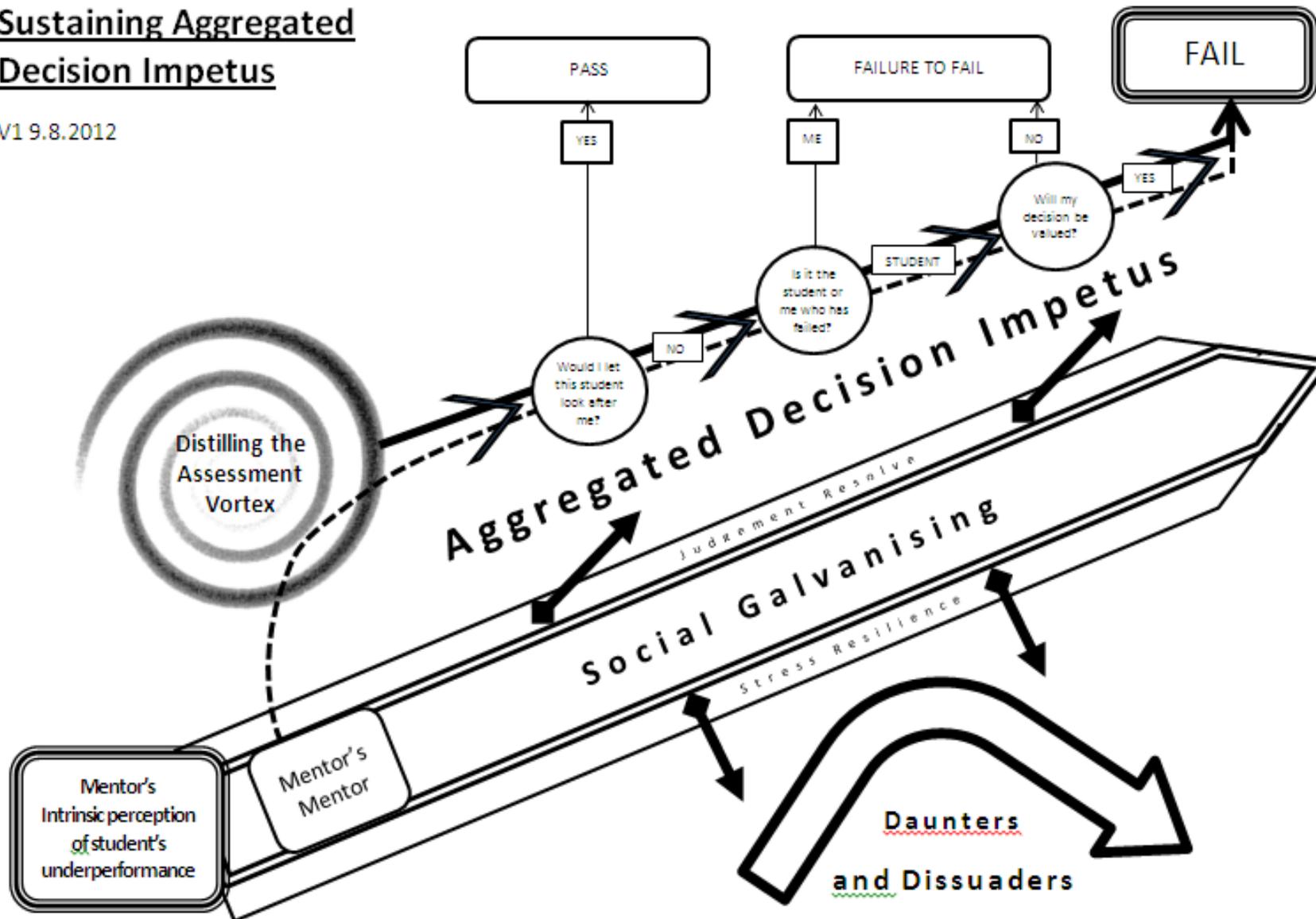


Diagram October 2011

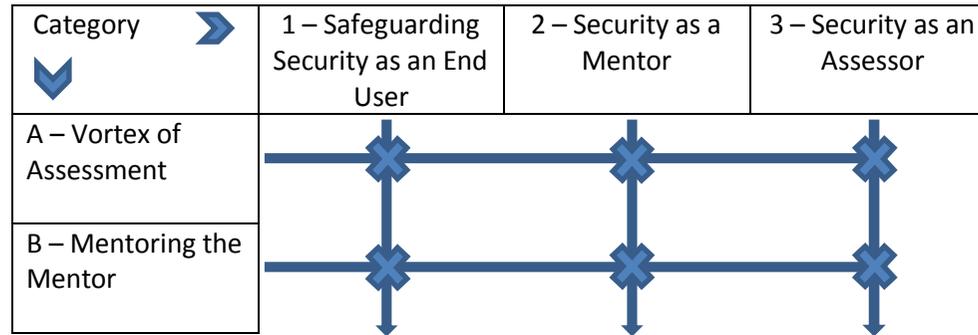


Sustaining Aggregated Decision Impetus

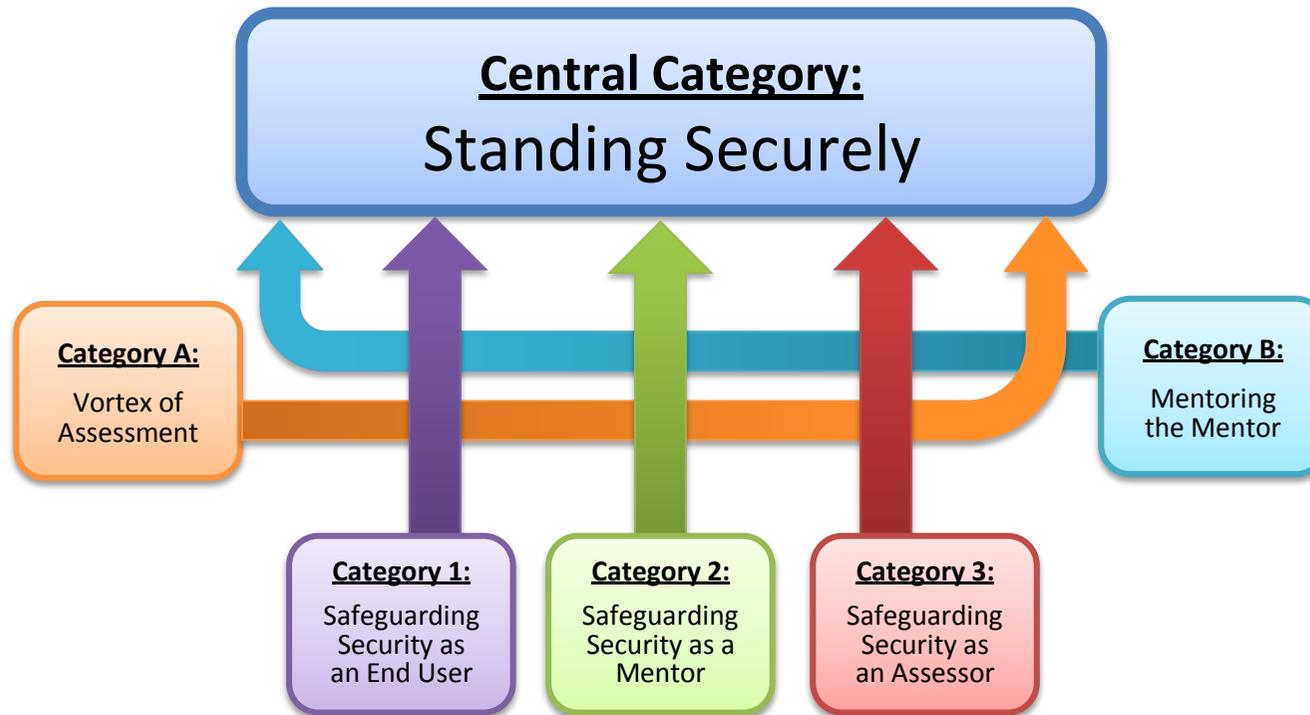
V1 9.8.2012



6.5.2013 : Cross Cutting of Categories Diagram



13.5.2013 : Cross Cutting of Categories Diagram



APPENDICES – CHAPTER 11

Appendix 11.01 : Conference Papers

FINE 2012 (Cardiff)

Grasping the Nettle:
How and why assessors will fail underachieving student nurses in practical assessments

Louise Hunt, Senior Lecturer
Department of Practice Learning
BIRMINGHAM CITY University
United Kingdom

Reluctance to fail is a global concern in many practice based professions

Psychologists in Canada, Medics in Ireland, Dentists in Scotland, Midwives in Japan, Physiotherapists in the USA, Operating Department Assistants in England, Nurses worldwide, Social Workers in South Africa, Accountants in Australia, Teachers in New Zealand

Assessing the Practice of Student Nurses in England

- 50% practical placements
- Passing practical assessments mandatory
- Students assigned a mentor:
 - Registered nurse
 - Practicing in the placement area
 - Has undergone additional preparation
 - Both teaches and assesses the student.

Study Aims

- Investigate the factors that influence the role and function of those involved in failing student nurses in practice in England.
- Formulate a proposition that informs both the future preparation of assessors and the assessment of nursing practice.

Methodology

- Grounded Theory
- Semi-structured interviews
- Recruitment of participants nationally, spread over 550 km (340 miles):
 - 7 Universities
 - 8 NHS Trusts
 - 3 Private sector organisations
- 31 participants with experience of failing a student nurse in a practical assessment:
 - 15 practical assessors
 - 8 practice education facilitators
 - 8 lecturers

Findings: Assessment Turbulence

- Struggling to articulate intuitive recognition of underperformance
- Wrangling with conflicting expectations
- Overwhelmed by convoluted processes

Findings: Smoothing the Path

Assessors need to draw on a mesh of support to be able to:

- Unpick intuitive recognition of underperformance
- Reconcile the conflicting expectations placed upon them
- Interpret and navigate complex processes

Findings: Gathering Decisions Impetus

Flowchart illustrating decision-making process:

```

    graph TD
        Q1[1. Would I let this student look after me?] -- NO --> Student[The Student]
        Q1 -- YES --> Q2[2. Who has failed me or the student?]
        Q2 --> Assessor[The Assessor]
        Q2 --> Uni[The University]
        Q2 --> Q3[3. Will my decision be valued?]
        Q3 -- YES --> Uni
        Q3 -- NO --> Fail[FAIL]
    
```

Increasing potential that assessor will fail underperforming student

Grasping the Nettle: How and why assessors will fail underperforming student nurses in practical assessments

Findings: Gathering Decisions Impetus

Continuation of Rigorous Assessment Processes

The Experience

YES

4. Am I prepared to do this again?

FAIL

Requires: Respite Reflection Regard

Further Reading: [Barratton, D. \(2009\) A Winning Advantage: The application of the game plan. "Barratton D." \(2009\) A Winning Advantage: The application of the game plan. "Barratton D." \(2009\) A Winning Advantage: The application of the game plan.](#)

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Grasping the Nettle: How and why assessors will fail underperforming student nurses in practical assessments

What Helps? The People

"Support from your colleagues, your manager, your clinical supervisor, outside work..." MA01

"Knowing where my support networks were..." PE08

"Nothing is as good as a person." MA04

"It's the people, just the people..." MA06

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Grasping the Nettle: How and why assessors will fail underperforming student nurses in practical assessments

Is there anything else that helps?

"I mean, obviously there's took out there like toolkits. There's all the stuff on the website and all that kind of stuff. And even though I was part of all the people that did it, d'you know what? Take it all off line now, burn it all on a big bonfire, and it's still the people. They don't use it.... It's all about people and face to face contact."

- PE08

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Grasping the Nettle: How and why assessors will fail underperforming student nurses in practical assessments

What would happen if the people were not there?

Speaker / Dialogue
LH: If you hadn't got (Names of Practice Educators).....
MA06 (Audible gasp)
LH: ...and you hadn't got those colleagues that come and tell you about the students when they are not performing, and you hadn't got your husband.....
MA06 (Audible gasp) Ohhh no!
LH: ...and you've seen a daughter to talk to....
MA06 (Audible gasp) Hrrmmmm.....
LH: ...and you had that student.....
MA06: Phew! ...Dear!...Ummh!...My decision wouldn't change. It wouldn't change...umh.....I think I'd still do...what my intention was and what my intention was telling me. Maybe I'd have gone off work for quite a few weeks (laughs) with stress atm...and I think it would have been more unbearable. It was unbearable at the time. I think it would have been more unbearable. I don't think I could have done it to be honest. No I wouldn't.

Further Reading: [Black, S. \(2013\) Being a Mentor: What to do if you're a Nursing Student. "The 100 Best Business, PhD Books on Undergraduate Education"](#)

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Grasping the Nettle: How and why assessors will fail underperforming student nurses in practical assessments

Drawing on a Mesh of Support

The Assessor's Mentor

- Visible
- Approachable
- Authority on Assessment

Domestic Backing

- Time
- Deputise
- Catharsis

Further Reading: [Parker, J.S. \(2008\) The 100 Best and Best Business Books. "The 100 Best Business, PhD Books on Undergraduate Education"](#)

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Grasping the Nettle: How and why assessors will fail underperforming student nurses in practical assessments

Recommendations

- Emphasis is placed on the role of face to face, accessible, expert support in placement areas
- Recognition that tacit knowledge and professional judgement are integral to practical assessment
- Simplify assessment language and procedures so that they serve assessors rather than assessors serving them
- Assessors are given formal, ongoing support during and after the experience of failing a student
- Employers effectively communicate expectations about rigorous assessment of the future workforce to assessors
- Universities manage the expectations of students so that they understand passing and failing are both possibilities
- Universities consider the message they are sending to clinical areas about the value they place on rigorous assessment, particularly in appeals situations

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Grasping the Nettle: How and why assessors will fail underperforming student nurses in practical assessments

*"Tender-handed stroke a nettle,
And it stings you for your pains;
Grasp it like a man of mettle,
And it soft as silk remains."*

- Hill, A. (c.1675) Verse Written on a Window in Scotland. In: The Works of the Late Aeneas Hill Esq. Google Books. [http://www.google.com/books?id=1m2vAAAAQAAJ&pg=PA100&dq=nettle+mettle&f=false](#)

Thank you for listening

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SYMPOSIUM RCN EDUCATION FORUM CONFERENCE 2013 (Glasgow)

Paper 4: Being Prepared To Do It Again, L. Hunt (2013)

Failing in practice - the mentor's journey

Intuition Emotion Decision-making **Recovery**

Paper 4:
Being Prepared To Do It Again

Louise Hunt
Lead Nurse – Practice, Department of Practice Learning,
Faculty of Health, Birmingham City University

1

Paper 4: Being Prepared To Do It Again, L. Hunt (2013)

Study Aims

- Investigate the factors that influence the role and function of those involved in failing student nurses in practice in England.
- Formulate a proposition that informs both the future preparation of assessors and the assessment of nursing practice.

Intuition Emotion Decision-making **Recovery**

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Paper 4: Being Prepared To Do It Again, L. Hunt (2013)

Methodology

- Grounded Theory
- Semi-structured interviews
- Recruitment of participants nationally, spread over 340 miles:
 - 7 Universities
 - 8 NHS Trusts
 - 3 Private sector organisations
- 31 participants with experience of failing a student nurse in a practical assessment:
 - 15 practical assessors
 - 8 practice education facilitators
 - 8 lecturers

Intuition Emotion Decision-making **Recovery**

3

Paper 4: Being Prepared To Do It Again, L. Hunt (2013)

The Vortex of Assessment Challenges

- Threats and Intimidation
 - Audits
 - Appeals
 - Grievances
- Fitness for Practice Hearings
- Employment Tribunals

Further Reading:
Furze, J. (2006). Culture of Fear
Realised. London: Continuum.

Intuition Emotion Decision-making **Recovery**

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Paper 4: Being Prepared To Do It Again, L. Hunt (2013)

Despondency

LTB2

"They say they're not going to assess students again. That they'll never.....I've known mentors walk out and say I will never fail anybody again. It's not worth it. I'm not being spoken to like that. I'm not being treated like that. We'll just pass them and that's tough. Somebody else can deal with it, or down and out say that they're not having a student again."

Intuition Emotion Decision-making **Recovery**

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Paper 4: Being Prepared To Do It Again, L. Hunt (2013)

Resilience

The ability to bounce back from a challenge or set back whilst retaining integrity and purpose.

Intuition Emotion Decision-making **Recovery**

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Paper 4: Being Prepared To Do It Again, L. Hunt (2013)

Despondency or Resilience?

DEVELOPMENT

CHALLENGE OR SET BACK

RESPILIENCE

DESPONDENCY

COUNTER MEASURES

TIME

Intuition Emotion Decision-making **Recovery**

Further Reading:
Coll, A.S. (2006). Resilience. London: Routledge.

7

Paper 4: Being Prepared To Do It Again, L. Hunt (2013)

Counter-measures to Enhance Mentor Resilience

Intuition Emotion Decision-making **Recovery**

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Appendix 11.02
Dissemination of Findings

Date/s	Strategy	Title	Journal/Venue/Audience
January 2011	Executive Summary	Assessing student nurses in practice: a comparison of theoretical and practical assessment results in England.	Circulated to: Nursing and Midwifery Council Council of Deans Royal College of Nursing Department of Health
January 2011	Publication of Full Report	Assessing student nurses in practice: a comparison of theoretical and practical assessment results in England.	Nursing and Midwifery Council Request ISBN: 978-0-9567669-0-8
July 2011	Conference - Guest Speaker	The Assessment of Student Nurses in Practice: A comparison of theoretical and practical assessment results in England.	Education Lead Link Conference. Guest speaker. Walsall Manor Hospital, Walsall.
Accepted August 2011	Publication	Assessment of Student Nurses in Practice: A comparison of theoretical and practical assessment results in England. Nurse Education Today.	Nurse Education Today 32 (2012) 351–35.
September 2011	Conference Paper	Assessing Student Nurses in Practice: A comparison of theoretical and practical assessment results in England.	NET Conference, Cambridge
November 2011	Research Seminar Series. Guest Speaker.	Comparison of Practical and Theoretical Assessment Results on Pre-Registration Nursing Programmes: Is there a difference?	University of Worcester. Worcester.
December 2011	Conference – Guest Speaker	Comparing Practical and Theoretical Assessment Results on pre-registration Nursing Programmes: Is there a difference?	Learning Environment Managers Conference. Chesterfield Royal Hospital. Chesterfield.
February 2012	Conference Poster	Comparing Theoretical and Practical Assessment Results on Pre-registration Nursing Programmes: Is There a Difference?	RCN Education Forum Conference, Harrogate.
October 2012	International Conference Paper	Grasping the Nettle: How and why assessors will fail underachieving student	International Federation of Nurses (FINE) Conference, Cardiff.

		nurses in practical assessments.	
October 2012	Conference – Guest Speaker	The Mentor MOT: Triennial Review. The Future Nursing Workforce “Are We Ensuring Fitness for Purpose?”	Birmingham Community Healthcare NHS Trust Mentor Conference. Birmingham.
June 2013	Conference Symposium	Failing Student’s in Practice: The Mentor’s Journey.	RCN Education Forum Conference, Glasgow.
September 2013	Conference Paper	No Stone Unturned: Addressing the Complexities of Mentoring Students in Real Life Settings.	NET Conference, Cambridge
November 2013	Conference – Guest Speaker	Bouncing Back: Replenishing mentor resilience after failing a student nurse in practice	Mentor Conference. School of Nursing and Midwifery. Keele University
November 2013	Conference – Guest Speaker	Walking the Tightrope of Supervision	Local Supervising Authority for Midwives, West Midlands Conference. Birmingham
February 2014	Conference Paper	Crucial Conversations: Providing feedback to underperforming students in practice	RCN Education Forum Conference, Harrogate
In preparation	Collaborative Journal Paper in Preparation	Failing Student’s in Practice: The Mentor’s Journey.	Nurse Education in Practice
November 2014	Conference – Guest Speaker	To be confirmed	Local Supervising Authority for Midwives, West Midlands Conference. Birmingham