THE DEVELOPMENT AND IMPLEMENTION OF A NATIONAL FRAMEWORK FOR THE ASSESSMENT OF CLINICAL COMPETENCY OF FIRST YEAR NURSING STUDENTS

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DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of the Doctor of Education is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of knowledge breach any law of copyright, and has not be taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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GLOSSARY

An Bord Altranais

The Nursing Board (prior to 2011 under the Nurse Act, 1985).

Associated Health Care Providers (AHCP's)

Hospitals and services that provide clinical placements for students.

Assessment

This is the opportunity to provide feedback, support and guidance, while encouraging the student to identify their learning needs (Royal College of Nursing, 2017).

Assessment in Clinical Practice

The key concepts associated with clinical assessment are that assessment must judge the students' abilities in clinical practice; include an opportunity for self-assessment and make explicit the expected outcomes and criteria and include feedback (NMBI 2016 a, b).

Assessment (formative)

This is an attempt to understand more about the student, discovering the nature and quality of their learning, their strengths and weaknesses, and their individual style of learning (Royal College of Nursing, 2017).

Assessment (summative)

This determines the extent to which a student has achieved the outcomes and objectives for the programme. Either as a whole or a substantial part. It contributes to a grade or award of attainment, related to the stated outcomes of the programme (Royal College of Nursing, 2017).

Audit

An educational audit involves monitoring, measuring and evaluating clinical practice placement areas, and related learning resources, ensuring they meet the required standard to support quality student learning (Royal College of Nursing, 2017).

Candidate

A person pursuing a training course leading to entry to a division of the register and whose name has been entered on the Candidate Register.

Candidate register

The Register of candidates established and maintained by NMBI with the names of students undertaking training.

Clinical Placement Co-ordinator (CPC)

Drennan (2002) defined the Clinical Placement Co-ordinator (CPC) as "an experienced nurse who provides dedicated support to nursing students in a variety of clinical settings" (p 428). The primary functions of the role include guidance, support, facilitation and monitoring of learning and competence attainment among undergraduate nursing students through reflective practice.

This is one of the roles that will help to ensure good quality clinical placements (Royal College of Nursing, 2017).

Colleagues

Co-workers, other health and social care professionals, other health care workers and nursing and midwifery students.

Competence

The attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a registered nurse (Requirements and Standards for Nurse Registration Education Programmes 2016, p 17).

Competences

The development of competences for a specified discipline represents the goal of an education programme; competences are specified in a manner that renders them assessable and develop incrementally throughout a programme of study.

> *"Competences represent a dynamic combination of cognitive and meta-cognitive knowledge, intellectual and practical skills and ethical values" (Nursing Subject Area Group (SAG) of the Tuning Project 2011.9).*

Competence

Competence is an expected level of performance that integrates knowledge, skills, abilities and judgement (American Nurses Association, 2008)

Competence framework

A complete collection of competencies and their indicators that are central to and set the standards of effective performance for a particular client group (Nursing and Midwifery Council, 2010).

(HEI's)

Higher Education Institutions (13).

> **AIT** – Athlone Institute of Technology.

DCU – Dublin City University

DKIT - Dundalk Institute of Technology.

GMIT – Galway/ Mayo Institute of Technology.

ITT - Institute of Technology, Tralee.

LYIT – Letterkenny Institute of Technology.

NUIG – National University of Ireland, Galway.

STACS – St Angela's College, Sligo.

TCD – Trinity College Dublin.

UCC – University College Cork.

UCD – University College Dublin.

UL – University of Limerick.

WIT – Waterford Institute of Technology.

Indicators

Statements of the behaviour that would be observed when effective performance of a competence is demonstrated.

Knowledge

The cognitive representation of ideas, events or happenings. It can be derived from practical or professional experience as well as from formal instruction or study. It can comprise description, memory, understanding, thinking, analysis, synthesis, debate and research.

Learning outcomes

Defined as "as statements of what a learner is expected to know, understand and be able to demonstrate after completion of a learner experience and are the expression in terms of the level of competence to be obtained by the learner" (Nursing Subject Area Group (SAG) of the Tuning Project 2011:9).

Link lecturer

The role of the link lecturer is to liaise with clinical staff. Their aim is to foster a partnership with the university and practice areas, offering educational advice and support to students and qualified nurses. They monitor placements, undertake the educational audit and inform the University of any changes and developments (Royal College of Nursing, 2017).

Personal tutor

This person is a university appointed lecturer, whose role is to provide a supportive relationship with students throughout their programme of study (Royal College of Nursing, 2017).

Preceptor

A registered nurse or midwife who has undertaken preparation for the role and who supports undergraduate nursing or midwifery students in their learning in the practice setting and assumes the role of the supervisor and assessor of the student achievement of clinical learning outcomes and competence (NMBI 2016 p 133).

Protected time

Specific periods of time allocated for reflection during supernumerary placements and the final internship clinical placement (Nurse Education Forum 2000).

Reflective time

Reflective time of a minimum of 4 hours per week should be an integral component of any supernumerary nursing, specialist placement and the internship period.

Registered nurse

A nurse whose name is entered in the nurse's division(s) of the register of nurses.

RGN - Registered General Nurse.

RCN - Registered Children's Nurse.

RNID - Registered Intellectual Disability Nurse.

RPN - Registered Psychiatric Nurse.

Responsibility

The obligation to perform duties, tasks or roles using sound professional judgement and being answerable for the decision made.

Standards

Authoritative statements developed, monitored and enforced by the NMBI to describe the responsibilities and conduct expected of a registered nurses and midwives. These standards are based on the principles and values that underpin professional practice.

Sufficient knowledge

Having knowledge equal to the proposed end as specifies in a learning outcome or practice based indicator as judged by the person evaluating the performance of the student or peer.

Supernumerary status

Students undertaking the pre-registration education programme have supernumerary status during the programme with the exception of 36 final placement weeks' internship, which consolidates the completed theoretical component of the programme. Students will continue to need support and supervision during the internship period to enable them achieve and clinical competence within the clinical practice environment.

Clinical practice placements provide learning opportunities, which enable the achievement of the learning outcomes. The supernumerary status of the student during the period of clinical placement is an important factor in enhancing the educational value of the experience.

The key features of supernumerary are:

Allocation to a clinical practice placement is driven by educational needs enabling the student to achieve stated learning outcomes.

The student actively participates in giving care appropriate to the student's level of knowledge and practical experience, with the supervision and direction of a Registered Nurse.

The student is surplus to the rostered complement of nurses.

The clinical placement allows for purposeful/focused learning where the student applies the theoretical knowledge to health care practice and develops the integrated knowledge, competence, skills and professional attributes essential to a professional practitioner of nursing.

The student takes an active role in achieving the learning outcomes whilst acknowledging and respecting the interests/rights of the person using health services.

Supervision

The provision of oversight, direction, guidance or support by a nurse or midwife to students or unregulated health care workers (HCW). Supervision maybe direct or indirect (NMBI, Scope of Nursing and Midwifery Practice Framework. 2015:14).

Direct supervision

The supervising nurse or midwife is actually present and works with the student or unregulated Health Care Worker (HCW) undertaking a delegated role or activity.

Indirect supervision

Implies that the nurse or midwife does not directly observe the students or the regulated or unregulated HCW undertaking a delegated role or activity.

Both direct and indirect supervision can include oversight, direction guidance and support and evaluation (NMBI, Scope of Nursing and Midwifery Practice Framework. 2015:14).

Disciplines of nursing

The four nursing disciplines are General nursing, psychiatric nursing, intellectual disability nursing and children's nursing.

NMBI

The Nursing and Midwifery Board of Ireland promotes high standards of professional education, training and practice and professional conduct among nurses and midwives.

Nursing standards

Practice and education is governed by Nurse Registration Programmes Standards and Requirements (NMBI 2016).

Proficiency Assessment Form (PAF)

Proficiency Assessment Form developed by An Bord Altranais to assess student nurses' clinical nursing skills in clinical practice.

Undergraduate education

This is a four/four and half year programme of study leading to the award of degree.

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ABSTRACT

Judith Foley

The Development and Implementation of a National Framework for the Assessment of Clinical Competence Assessment of First Year Student Nurses.

The desired outcome of this study is to develop and implement a national competence framework to facilitate the assessment of first year nursing students undertaking the four year/four and half year degree programme in the four disciplines of Nursing in the Higher Education Institutions in Republic of Ireland. The four disciplines are General Nursing, Psychiatric Nursing, Intellectual Disability Nursing and Children's Nursing. The total intake of nursing students is 1,683 per year.

The literature associated with the study mainly involves an examination of the concept of competence and the assessment of competence. The literature further focused on aspects of learning that impacted on assessment of clinical competence, assessment of clinical competence learning, theoretical models used to assess competence. In addition, the literature related to the process of assessment to include the supporting structures and the components of assessment documentation to include the concept of reflective practice and the models in use.

Quantitative and qualitative research paradigm are explored. Various research methodologies are examined and a rationale for choosing action research as the chosen research strategy is set out. Coghlan and Brannick's model of action research is applied through three action research cycles: each involving diagnosing/constructing phase; planning action phase; taking action phase and evaluating action phase. The sample is described and related ethical considerations are highlighted along with research methods and data analysis. The research findings focusing on the views of participants involved in the assessment of nursing students which informed the final development of competence assessment framework following by roll out and implementation by all Higher Education Institutions (HEI's) and Associated Health Care Providers (AHCP's).

CHAPTER ONE: INTRODUCTION AND CONTEXT

1.1 Introduction

Nurses are a heterogeneous group who practice in a variety of healthcare settings and therefore must possess the motivation for lifelong learning and the ability to transfer new knowledge and skills into healthcare for individuals, families, groups and communities in all settings in which healthcare services are needed. Nurse education must prepare nurses who are educated at degree level and who are competent to take on the challenging roles now and into the future in a changing healthcare setting. The continuing development of new nursing roles is an exciting challenge for the profession, which emphasises the importance of redefining the boundaries of practice.

All practitioners have value in the delivery of health care and, although patients and clients may have access to care, the need for up-to-date and competent registered nurses in all clinical areas remains paramount. Those providing education need to respond to change to meet the challenges of educational reform and ensure that quality nursing care to meet the challenges associated with growing complexity of science and technology requires more knowledge and information and a range of new competencies for nurses. The increasing chronicity of diseases and treatment options will expand the role of nurses and the impact of information technology requires our recognition systems to go beyond the mere input model of education preparation to an output model. Therefore, nurse education has undergone significant reform in Ireland over the past thirty years, moving from an apprenticeship model to University based model. Commensurate with these changes the standards for education and training of nurses have been reviewed and are overseen by An Bord Altranais agus Cnáimhseachais na hÉireann, the Nursing and Midwifery Board of Ireland (NMBI). This chapter outlines the international and national context within which this research is being undertaken. NMBI is the statutory regulatory body for the nursing and midwifery professions, responsible for the registration, control and education of nurses and midwives. NMBI as an organisation is self-regulated and the key to effective self-regulation is transparent, consistent, effective, proportional and necessary systems and standards to ensure

protection of the public (Government of Ireland, 2004). The responsibilities and duties of NMBI are defined by the provisions of the Nurses and Midwives Act, 2011. NMBI's primary mission is public protection and this is maintained through its principal functions of; establishing and maintaining a register, providing education and training, providing guidance for the professions of nursing and midwifery and inquiring into complaints.

Central to its remit for education, NMBI is committed to ensuring the integrity of the practise of nursing through the promotion of high standards of professional education, training and practice (Government of Ireland, 2011). To achieve this, NMBI, as the regulatory authority has re–developed Standards and Requirements for Nurse Registration Education Programmes (NMBI, 2016), revising and updating the previous standards developed in 2005 (An Bord Altranais, 2005). The primary purpose of these new standards is to develop flexible, innovative, practice-oriented registration programmes for undergraduate nursing programmes at the 13 Higher Education Institutions (HEI's) in Ireland and their associated health care partners (AHCP's). These standards will ensure that programmes of education refocus from being syllabus driven to a terminal outcomes competence model of education. Inherent within these education standards are the identification of competencies that must be achieved for entry to the Register of nurses maintained by NMBI. To achieve this, a set of assessment framework must be developed to ensure that the process and outcomes reflect the stated standards. The current study fulfils this requirement and will focus on developing a national framework for first year nursing students that will incorporate the process of assessment, national assessment documentation and guidelines for students undertaking degree programmes in nursing.

The purpose of any nurse registration education programme is to ensure that on successful completion of the programme the graduate is equipped with the knowledge, understanding and skills necessary to practise as a competent and professional nurse. The aim is to ensure that the graduate acquires the competences for critical analysis, problem-solving, decision-making, collaborative team-working, leadership, professional scholarship, effective interpersonal communication and reflection that are essential to the art and science of nursing (NMBI, 2016). Safe and effective practice requires a sound

underpinning of theoretical knowledge that informs practice and is in turn informed by practice. Within a complex and changing healthcare service and population focus, it is essential that practice is informed by the best available evidence and that graduates develop a capacity for continuing professional development to maintain competence over a potentially long professional career (NMBI, 2016 p 18).

Clinical assessment in nurse education is important part of the student journey and may have implications for students, preceptors and those receiving nursing care. Assessment in clinical practice can be challenging, but is the backbone of the student acquisition of nursing knowledge and skills over time. Furthermore, it is essential to determine competence in order to register as a qualified nurse (Phelan *et al*, 2014). In Ireland, the pre-registration education consists of a four year/ four and half year degree programme, during which, in addition to theoretical study in a University or Institute of Technology, the student is exposed to a variety of clinical practice in a diversity of clinical learning environments. Nursing is a practice based discipline and a fundamental element of the nursing programme is the clinical learning environment. The Royal College of Nursing (RCN) in describing practice placements during the pre-registration programme of study claim:

> they should be provided to facilitate the development of skills, competence and confidence and identify the community focus of care, the continuing nature of care, the need for acute and critical care and the multi-professional approach to care. A good practice placement has a direct bearing on your ability to work effectively and integrate theory to practice and is a place in which your competence will be assessed in a range of skills and behaviour (2017, p 4).

The desired outcome of the present study is to develop and implement a national competence framework to facilitate the assessment of nursing students undertaking the four year degree programme in the four disciplines of nursing across the Higher Education Institutions (HEI's) in Republic of Ireland. In addition, guidelines regarding the components of assessment process will be developed. The author as part of her role as Chief Education Officer is responsible and accountable to ensure that HEIs and their associated healthcare partners (AHCP's) meet the Nurse Registration Programmes Standards and Requirements as published by NMBI in 2016, thus ensuring the mission of NMBI that is public protection and patient safety. These standards and requirements not only meet the standards of the NMBI but also ensure that the recommendations of

the Report of the Undergraduate Nursing and Midwifery Programmes are implemented (Department of Health, 2012). Furthermore, the revised nursing competences and the theoretical and clinical instructions in hours as set by the European Union in the EU Directive 2013/55/EU ((Kajander-Unkuri *et al* 2016; European Commission 2013) are met. This research project considers all of these drivers and outlines the development of the competence assessment framework and associated documentation and guidelines from 2014 to the end of 2018.

1.2 Overview of the study

The long term aim of the study is to support the mission of the Nursing and Midwifery Board of Ireland (NMBI) to ensure patient safety and protection of the public as set out in legislation through the development of a national framework and competence assessment documentation and system to facilitate the competence assessment of first year nursing students in Ireland. The primary aim of this study is to develop a national competence assessment framework for pre-registration nursing in Ireland using action research. Chapter One introduces the issue and provides a brief overview of the chapters in the thesis and discusses the contextual issues of importance in the development of the framework. The original main research questions for the overall research project is as follows:

- What theoretical framework/model for the assessment of competence should underpin the national competence assessment framework?
- What are the key elements of a national system to facilitate the competence assessment of nursing students in Ireland?
- What assessment tools, documentation and assessment processes should be developed?

Chapter two reviews national and international literature with specific relevance to the study aim and its practicality in informing the study. Nursing students are adult learners, therefore theories of adult learning are explored and the importance of the clinical learning environment is outlined. The chapter also outlines the concept of competence and the tools used to measure competence in nursing, and highlights that there is no

established definition of competence in the literature. Finally, theoretical models for the assessment of competence and reflective practice are critically reviewed as both are components of the competence assessment documents. This chapter concludes with a proposed theoretical framework for the study based on the key theories discussed in the literature review.

This study employs an action research approach. Chapter three details this methodological approach and provides a rationale for the approach. The development of the documentation and ethical considerations are also explored. Chapter four summarises the key finding of the SWOT analysis regarding theoretical models for the assessment of competence, the survey questionnaire and the focus group interviews outline the findings regarding the process, competence assessment documentation and guidelines. Chapter five outlines and discusses key findings from the study and these are contextualised to existing literature. Chapter five summarises the key issues and findings of the study and Coghlan and Brannick's model (2014) of action research is applied through three action research cycles: each involving diagnosing/constructing phase; planning action phase; taking action phase and evaluating action phase. Finally, recommendations in the domains of professional, organisational, educational and research are provided.

1.3 Statement of the problem

In 2012 the Department of Health issued the Report of the Review of the Undergraduate Nursing and Midwifery Degree Programme (2012). The Report recommends that:

> The Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/Health Service will review student clinical assessment processes including documentation to promote standardisation of clinical assessment in line with competence goals for the four nursing programmes (p 61).

In line with this a national approach to competence assessment was recommended. This arose from reported weaknesses (Department of Health 2012, C10.1 p 15) in the assessment of student nurses' clinical learning. The approach aims to ensure standardisation and to reduce variation between competence schemes, documentation and the process of assessment. The literature also supports this requirement. Therefore there is a requirement to develop an evidence based standardised competence

assessment documentation for application in Irelands pre-registration nurse education programmes.

1.4 Context

1.4.1 International context

Nursing in Ireland has been heavily influenced by the European Union (EU), the European Higher Education Area (EHEA) and the Bologna Process. Directives from these agencies must be applied with the Irish context and require address in any regulatory or developmental processes with outcomes for nursing in Ireland. Further influencing directives include the European Union Council Directives for nursing (2005/36/EC) (European Commission 2005) as amended by Directive 2013/55/EC (Kajander-Unkuri *et al* 2016; European Commission 2013) and EU green paper on the modernisation of professional qualifications (European Commission 2011a).

Ireland's membership of the EEC brought significant changes regarding free movement of labour throughout the member states for many professions. This free movement required a legislative basis to agree minimum training standards to include nursing known as European Directives. In 1977, new directives on the mutual recognition of nursing qualifications were written and accepted by the European Parliament. These directives were regarding mutual recognition of qualifications and in relation to explicit requirements of the training programme were related specifically to 'nurses responsible for general care', that is the Registered General Nurses (RGN) in Ireland. In 1989 a further European Directive was agreed by the member states regarding the balance of theoretical and clinical instruction in nurse education programmes (Fealy, 2006; Fealy *et al* 2009; European Commission 2005, 2011, 2013). The responsibility for ensuring that these directives were met at that time rested with the regulatory body (ABA) and remains to this day, detailed now in EU Directive 2013/55/EU. NMBI has developed a quality assurance framework and standards and requirements (NMBI, 2016) and the European Union Directives are embedded in the standards. The Higher Education Institutions (HEI's) agree and provide assurances that the standards will be met during the implementation of the degree programme over the period of approval of five years (Nurses and Midwives Act 2011, Part 10).

The Bologna Declaration is considered to be the 'the single most important reform of higher education taking place in Europe in the last 30 years' (Palese *et al* 2014 p.1), incorporating 46 European Union countries with the aim of creating a more coherent, compatible, comparable and competitive European Higher Education Area. It requires a European system of comparable degrees, two cycles of undergraduate programmes, degree and bachelor, and postgraduate programmes at masters and doctorate level, and a European Credit Transfer System (ECTS) (Palese *et al* 2014). The promotion of mobility of education and students, and the promotion of an education quality control system is also inherent in the declaration. Furthermore, the Bologna Declaration ensures the centrality of quality in education by ensuring European cooperation in quality assurance procedures (Collins and Hewer, 2014) and these are vital components in standardising outcomes of European degrees programmes. However, the lack of a collective mechanism across Europe for quality control to monitor nursing programmes, is a particular challenge (Collins and Hewer, 2014). This omission from the Declaration is a missed opportunity to facilitate standardisation and mobility across Europe. This omission requires that member states identify their own quality mechanisms, one of which is the establishment of a competence assessment document for pre–registration nurse education programmes.

A major driver in the development of these competences are the outcomes of the Tuning Project which arose from the original Bologna Declaration 1999 (Confederation of EU Rectors' Conference, 2000). This required subject specific competencies, for particular disciplines including nursing through a process known as Tuning. The Tuning principles were to inform both the curriculum content and the skills, learning outcomes and domains of competence at baccalaureate degree level in the signatory nations. Such realignment aimed to ensure that the revised learning outcomes would adequately prepare the student nurse with the competences for safe, effective, skilled knowledgeable and ethical practice yet with an adaptive skill set suited to Ireland's changing health service. The revised *Requirements and Standards for Nurse Registration Education Programmes* (NMBI, 2016) take this into account; however, a standardised competence assessment document is now required to support this inclusion.

1.4.2 Irish context

Nursing has experienced a period of enormous change in the past 40 years and Treacy (2005) expounds the significance of the introduction of nurse training into higher education institutes in 2002. This was brought about by the aforementioned European drivers resulting in significant changes to the education and training of nurses in Ireland. Firstly, with a move away from the traditional apprenticeship model also referred to as 'in–house training' (Treacy, 2005 p.47) whereby nursing students were educated and trained in schools of nursing located within teaching hospitals. This model was evaluated by the Nursing Board (An Bord Altranais) and O' Shea (2013) and a lack of clinical teaching, a focus on on–site work rather than learning were identified as critical weaknesses. This situation was not unique to Ireland and internationally nursing knowledge was embedded in nursing practise (Risjord, 2010) and not in educational institutes. Furthermore, nursing students involvement in non-nursing duties was highlighted as an issue and was seen as an extension of woman's' role in society and the notion of virtuous caring (Nolan, 2005). Secondly, in 1994 the transition from the traditional 3 year apprenticeship nurse training to the introduction of a 3 year diploma in nursing with supernumerary status for students was introduced. Finally and significantly, the establishment of the Commission on Nursing in March 1997, after a period of industrial unrest, played a fundamental role in the reform of nursing in Ireland. The Commission examined issues relating to the role of the nurse, managerial opportunities, the training and education requirements for nurses and made recommendations for the modernisation of nursing career pathways and education systems (Government of Ireland, 1998). The diploma programme was welcomed; however, there were concerns in relation to content and the implementation of the programme as it did not afford nursing students the experience of a third level education. Consequently, the rationale for the degree programme arose in response to the recommendations of the Report of the Commission on Nursing: A Blueprint for the Future (Government of Ireland, 1998) which stipulated that:

> The future framework for the pre-registration education of nurses be based on a four year degree programme in each of the disciplines of general, psychiatric and mental handicap nursing approved by the Board which will encompass clinical placements including twelve months continuous clinical placement (p. 10).

This created the impetus for the establishment of a pre-registration degree programme and the recommendation that the four year Bachelor Degree become the 'sole route of entry' (McNamara, 2005 p. 54) into nursing practice and thus began the transition of nurse education from the then diploma level programme to a Bachelor of Science in Nursing degree. As part of this transition in 2002, all pre-registration undergraduate nurse education programmes were integrated into third level academic institutions known as the Higher Education Institutions (HEI's). Other policy documents which were peripheral but supported the proposed change to a degree programme included the Nurse Education and Training Evaluation in Ireland (1998) report and the Report of the Nursing Education Forum (2000). It should be noted that these documents referred to direct entry programmes for the disciplines of general, psychiatric and intellectual disability nursing. However, recommendations for children's nurse education were the subject of a separate report which required an integrated children's and general nursing integrated programme (Department of Health, 2004). This is significant as prior to this the only route for this discipline was a post registration programme.

Currently, nurse education in Ireland is provided by seven universities, namely: University College Dublin, University College Cork, University Limerick, National University of Ireland Galway, St Angela's College, Sligo, Trinity College Dublin and Dublin City University. The Institutes of Technology providing nurse education programmes include Dundalk, Athlone, Waterford, Tralee, Galway/Mayo and Letterkenny. Arrangements are based on a partnership approach, based on a formal written memorandum of understanding which ensures the theoretical component of the programme is delivered by the HEIs and the clinical component delivered by the AHCP. Student numbers for the four disciplines of nursing are determined by the Department of Health yearly and are based on workforce planning and changing societal needs. Currently, the total number of nursing students undertaking pre-registration degree programmes is 1683 (NMBI, 2018). In 2018, the student numbers for the four disciplines of nursing are as follows:

Discipline of Nursing	Providing - HEI's	Number of students (2018).
General Nursing	13 HEI's	925
Psychiatric Nursing	12 HEI's (Not provided by STACS)	423
Intellectual Disability Nursing	8 HEI's (Not provided by AIT, GMIT, ITT, NUIG, UCD)	210
Children's and General Integrated programme	4 HEI'S (Provided by UCD, UCC, TCD, DCU)	130
TOTAL NUMBER OF STUDENTS PER YEAR (2018/2019)		**1688**

Table 1.1: Pre -registration student numbers for 2018/2019.

NMBI has presided over these changes over time, securing its status as a critical driver in the development and regulation of nursing in Ireland. This warrants a brief discussion of the evolution of its role and function over time.

1.5 Development of standards and requirements by NMBI

The Nurses Registration Act of 1919 provided for the registration of general, psychiatric and intellectual disability nursing (Robins, 2000), thereby setting an early regulatory standard for these disciplines. A supplementary part of the register was established regarding sick children's nursing at a later date (An Bord Altanais, 1994). The nursing board, known at the time as An Bord Altranais developed rules in 1988, 1991 and 1994, for the education and training of student nurses. The rules identified both the minimum theoretical and clinical instruction for all the disciplines of nursing and examination criteria. These rules stated that the registration examination should consist of continuous assessment to establish proficiency in clinical practice skills and a written examination (An Bord Altranais 1988, 1991 and 1994).

1.5.1 Evolution of the process regarding the development of standards of education and assessment.

ABA rules dictated the programme outcomes. However, a Proficiency Assessment in Clinical Practice Skills Form and a Proficiency Assessment Action Plan Form were developed in the 1980's by ABA to allow for the assessment of nursing students in practice. This later became the 'Proficiency Assessment Form' (Appendix 1). The form

was divided into eight sections with a Likert scale of 1 to 4 with 1 = Very Good; 2 = Good; 3 = Fair and 4 = Unsatisfactory and based on the rating, a general rating was determined in the following areas:

Application to Nursing Care

Quality of Student Performance

Attitudes to Relatives and Visitors

Professional Behaviour

Attitudes to Patients

Relationship with Co-workers

Ability to Communicate in Writing

Ability to Communicate Verbally

The students' rating was determined by the ward sister/charge nurse and was signed by both the ward sister/charge nurse and the student nurse. The signature of the student nurse ensured that the student read the form and understood the contents. There was a requirement, if the overall performance rating was deemed to be 3 or 4 that a discussion needed to take place with the matron/chief nursing officer and principal tutor/tutor. This process was in the form of a Likert scale and was entirely subjective with no qualitative input from the student or the assessor. The development and review of standards and requirements in 2000, 2005 and 2007 rendered the PAF system obsolete. This coupled with the devolution of the assessment process to HEIs led to a competence based approach which was structured in domains.

The current standards were issued in 2016 following the review of the Degree Programme in 2012 in line with European developments and policy as highlighted previously. The review included an extensive 2 year period of consultation with relevant stakeholders, a comprehensive review of international literature and systems. These new standards 'constitute an important development by NMBI towards enhancing its role in the protection of the public and supporting registrants in demonstrating their competence to practise safely, compassionately and effectively to deliver quality safe practice" (Nurse Registration Programmes Standards and Requirements, 2016 p. 7). The

domains of competence have been aligned to and developed from the Nursing Subject Area Group competences for Nursing as part of the Tuning Process across Europe. In formulating the competences, the Board has mapped these against those of the Australian, Canadian (British Columbia), New Zealand and UK Nursing and Midwifery Council regulatory standards for Registered Nurses and against the European Federation of Nurses Associations Competence Framework (2015) for consistency of content. The framework for competence assessment introduced by the Nursing and Midwifery Board consists of six domains of competence representing the key functions of the nurse (See appendix 2). These broad domains incorporate standard performance criteria and indicators. These are statements about nursing practise against which the students' performance can be assessed (Fahy *et al*, 2011):

- Professional values and the conduct of the nurse competences
- Nursing practice and clinical decision making competences
- Knowledge and cognitive competences
- Communication and interpersonal competences
- Leadership, management and team competences
- Development of leadership and professional scholarship competences (NMBI, Nurse Registration Programmes Standards and Requirements (2016, p 6).

The extensive feedback received throughout the consultation process regarding the standards and requirements for nurse registration programmes highlighted the need for NMBI to issue a national framework for the assessment of clinical competence. This was proposed to give greater specificity to the process and model of clinical competence assessment. This is central to the current study which is highly relevant and timely.

1.6 Conclusion

This chapter has provided an overview of the education and training of nurses in Ireland and the role of the regulatory body therein. Furthermore, the critical European and Irish drivers for the redevelopment of standards and requirements for nurse registration education programmes in Ireland has been outlined. Aimed at flexible, innovative, practice oriented registration programmes for undergraduate nursing in Ireland, these standards represent the latest development in the trajectory of nursing from apprenticeship to University based programmes in Ireland. This has necessitated the development of a national framework for the assessment of clinical competence to

ensure a standardised approach which meets both the mission of NMBI, the Department of Health in Ireland and the international drivers. This research aims to address this gap in the regulation and education of nurses in Ireland. The following chapter will explore the relevant literature in this area and will synthesise the various tenets supporting the research process.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This study sets out to develop a national standardised competence framework for year one of the pre–registration nursing programmes in Ireland. The previous chapter provide an overview and introduction to the study including the background and context. The original main research questions for the overall research project is as follows:

- What theoretical framework/model for the assessment of competence should underpin the national competence assessment framework?
- What are the key elements of a national system to facilitate the competence assessment of nursing students in Ireland?
- What assessment tools, documentation and assessment processes should be developed?

This chapter further discusses the empirical and contemporary literature with particular relevance to adult learning, theoretical models, the concept of competence and how it is assessed. A number of key areas emerged as important in the development of the competence framework. These are learning theory, tools used to measure competence, clinical learning environment and support structures, reflective practice and the requirement for guidelines for users of the competence framework. These were synthesised into a theoretical framework as an outcome of the literature review and will be used to structure this literature review and the analysis of findings. The theoretical framework outlines learning, the assessment process and competences.

2.2 Literature search and search strategy

A literature search was conducted of the following electronic databases CINAHL, Medline and the search engine, Google Scholar using key search terms in title; and terms in abstracts. Search parameters included peer reviewed, research articles in English language only and for the period 1 January 2004 to 31 December 2018. Resulting titles and abstracts were reviewed and only studies with the defined search parameters were

used. Papers with theoretical perspectives on education were also reviewed. Literature review and corresponding national and international public policy documents, identified but not published in main databases were obtained and reviewed. Further references were obtained by following up on citations from papers reviewed, some from outside the search parameters where deemed relevant.

2.3 Learning

Nurse education has a long history of providing learning in the classroom and practice setting as determined by the regulatory bodies both national and international with the development of standards that must be achieved to register as a nurse. The assessment of learning and learning outcomes are intricately linked and the student is required to demonstrate the achievement of learning outcomes throughout the trajectory of the degree programme. These learning outcomes are influenced by regulatory body as outlined in standards documents and the chosen theoretical model(s) (Appendix 1) and are assessed using the domains of competence (Nurse Registration Programmes Standards and Requirements, NMBI, 2016). The theoretical model(s) for the assessment of competence will be discussed in this chapter. Currently, the degree programme are managed by the HEI's in conjunction with AHCP's. The governance of the degree programme is the responsibility of the Local Joint Working Group who develop a formal Memorandum of Understanding between each HEI and associated AHCP's describing mutually agreed planned approaches to ensure the degree programme meets the standards and requirements developed by the regulator. Since the publication of the Mid-Staffordshire National Health Service Foundation Trust Public Inquiry (2013), McSherry *et al* (2015) stated, how external review was embraced by staff to move staff from feelings of anger and defensiveness and loss of confidence to embrace opportunities to build bridges, increase transparency and genuine partnerships between universities and healthcare providers. Furthermore, the author suggests that engagement of academics in the practice setting will ensure partnership and support for staff and students and will have transparent outcomes for student's practice and education.

The public have a fundamental right to expect registered nurses to be competent therefore both theoretical and clinical learning needs to be assessed thus meeting the

mission of NMBI to protect the public and ensure public safety. Furthermore, the appropriate assessment methodologies regarding learning must be developed to ensure patient safety (Helminen *et al* 2014). Whilst many theories and definitions of learning exist, the definition that resonates most with nursing and so is adopted for the purpose of this study is: Learning is 'a process through which individuals assimilate knowledge and skills that result in relatively permanent behaviour changes' (Morely *et al* 2004 p 87). The development of nursing knowledge has followed a similar trajectory to that of learning theory over time. To inform the process it is prudent that the historical context is briefly outlined.

2.3.1 Aspects of learning impacting on assessment of clinical competence

The Nightingale nurse was educated in accordance with a pedagogical belief system, existing only to carry out the orders of the physician (Risjord, 2010). In this instance learning was determined by the physician; however the evolution of nursing recognised that knowledge was embedded in practice resulting in what Risjord (2010 p. 8) described as a 'pedagogical consequence'. This manifested in a gap between theory and practice, with a clear division evident between what was taught in classrooms and what was learned in practice. The advent of the adult learner in nursing through the adoption of andragogy (Knowles, 1984) proposed that student nurses, as with other learners, were self–directing individuals with life experience which cognitively influenced what and how they learn. Contemporary views on nursing knowledge and skill situate this adult learning within the social environment. Social learning is embedded in the theory of social constructivism in that practice and the practice setting and nursing students shape each other through the student's process of sense making and action or in and through social interaction (Bryan and Teevan, 2005). Fundamentally, meaning is constructed, not created by humans when they engage with the world. This engagement has a social component which is also intrinsic to the process of learning in nursing.

2.3.2 Social learning

Social learning proposes that people are not passive recipients of knowledge and that they learn best when involved in the process of social activity (Lave and Wenger, 1991). Consequently, knowledge and skills are not solely the possession of an individual but are

shared and developed with other members of society and this interaction influences how much learning ensues. This perspective was also supported by prominent learning theorists Vygotsky and Bruner whose seminal works argued that knowledge was socially constructed (Aubrey and Riley 2016) via social interaction with people referred to as 'Most Knowledgeable Others' (MKOs). The process of learning within this theory is through social interaction and occurs in Zone of Proximal Development (ZPD) which was described by Vygotsky as:

> 'distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers' (Vygotsky, 1978 p 86).

This theory of situated learning is particularly relevant for practice-based learning and is therefore central to nursing as the majority of learning in the current programme is situated in clinical practice. Mc Sharry (2012) and Mc Sharry and Lathlean (2017) claim that the situational learning theories of Lave and Wenger (1991), and Vygotsky's (1978) theory of social constructivism provide a suitable educational foundation for clinical learning when applied to nursing. In practice this theory situates the preceptor and/or clinical placement co–ordinator as the MKO and the student nurse as the learner. The distance between the student nurse's ability to undertake the function competently without supervision and their need for supervision can be referred to as (ZPD) see Fig. 2

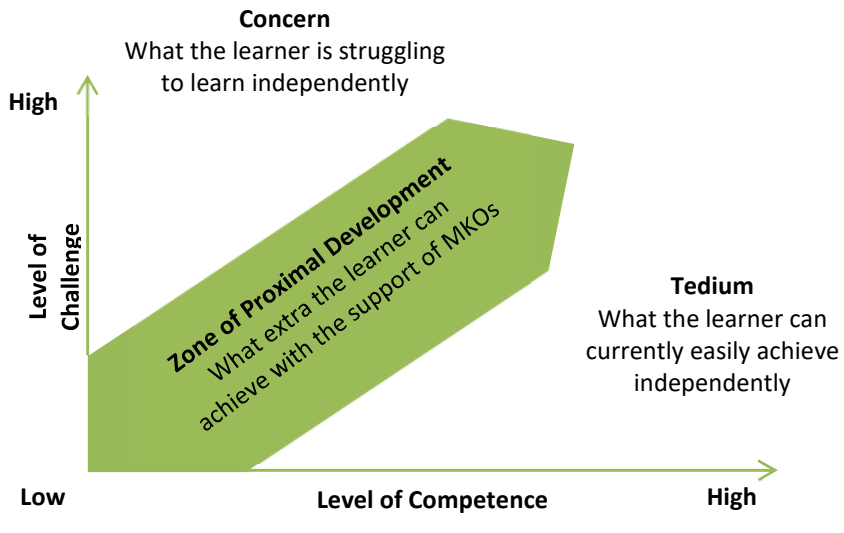


Figure 2.1: The zone of proximal development (Adapted from Bates, 2016 p 46).

In an assessment process the identification to the extent to which the learner is situated within the ZPD dictates the intervention of the MKO. Within the nursing context this facilitates the clear identification of the learning needs of the student nurse and potential input in terms of levels of intervention required on the part of the preceptor who is the MKO. This issue warrants further exploration as a theoretical baseline for assessment processes within the context of this study.

2.3.3 Scaffolding and the ZPD

Scaffolding as conceptualised by Bruner (1976) is frequently cited alongside Vygotsky's work and within this context is related to the role of clinical teacher while the student is in the ZPD. Scaffolding refers to the process of and extent of assistance provided to the learner by the teacher or in this instance the preceptor. The requirement for the extent of this 'scaffolding' theoretically declines over time as the learner increasingly gains in confidence and competence.

The scaffolding process accesses what level the student is at, and the preceptor plans activities to progress the student along the learning continuum, this process is aligned with the concept of continuous assessment in nursing practice. Scaffolding knowledge either theoretical or practical allows the learner to transfer 'knowledge in waiting to knowledge in use' (Spouse, 2003 p 202). This is facilitated in a number of ways by the MKO or preceptor, such as formal teaching, questioning, written assignments, reflection and learning when observing others with experience. Collins *et al* (1991) posit that the preceptor can employ six techniques to ensure the nursing student moves along the learning continuum, thereby developing both performance, clinical reasoning and thinking competence. The first three focus on developing the nursing student's ability to perform in practice including: modelling where the preceptor demonstrates the object to be learned; coaching which involves delegating and guiding the nursing student's activity and observation of the performance (Collins *et al,* 1991) and finally by providing ongoing appropriate feedback. Furthermore, McSharry and Lathlean (2017) propose that the preceptor should try to verbalise their thought processes while participating in practice so that the nursing student can gain insight into their problem solving and clinical reasoning skills.

The next three strategies of Collins and colleagues approach focus on developing the nursing students' thinking skills. Articulation refers to the preceptor questioning the student nurse to facilitate their problem solving skills. This involves the preceptor questions around the rationale for care and why the student may have chosen one action over the other. A questioning approach such as "what if" scenarios allows the student and preceptor to access what action the nursing student may have taken if the practice situation became more complex (Collins *et al*, 1991; Mc Sharry, 2012). This approach is closely aligned with the principles of reflective practice which will be further explored in this chapter. Finally, the teaching technique of exploration is suggested whereby the preceptor encourages the nursing student to set their future learning goals and practice more independently (Collins *et al*, 1991; Mc Sharry, 2012; Mc Sharry and Lathlean, 2017). The value of synthesising the works of Vygotsky, Bruner and Collins *et al* is in the potential to structure the identification of learning needs, align them with preceptor interventions to maximise the assessment process in practice. It is timely that assessment in nursing is now explored.

2.4 Assessment

2.4.1 Assessment of clinical competence

Assessment is a crucial component of education and an important component of the student experience. Students participate in many clinical learning environments that provide different experiences over the trajectory of the degree programme. The current assessment process for nursing in the HEIs includes two main strategies of assessment: assessments undertaken in the clinical placement environment and those related to practice which are taken as pieces of academic work in the form of formal examinations/assessments. Assessment methods enable the student to develop a variety of skills and abilities such as interpreting, information gathering, and analysis allowing the student to apply theoretical principles to clinical practice. As early as 1982, Benner asserted that clinical assessment can be seen as having two related functions. The first is from an education perspective whereby the assessment process should provide information to students and teachers on what learning is to take place and what is required in order to improve the teacher learner process. The second function is a

gatekeeper to the profession whereby only professionals with the prescribed competences can register as nurses. This is reflected in Fordham's (2005) assertion that a competence based approach to assessment determines the effective application of knowledge and skills in practice and further states that assessment is critical to ensure the maintenance of professional standards and is synonymous with the measurement of performance. In other words, the aim of the regulatory purpose of assessment is to make an absolute judgement as to whether a student's practice meets the standards set by the profession and to determine if a student has meet the academic requirements of a clinical programme. Therefore, determining clinical competence is a critical component of the assessment and learning process of the undergraduate nursing degree programme.

The relationship between competence and learning outcomes are closely related concepts (Flanagan *et al* 2000 p.361):

> Learning outcomes relate to what the learner will be able to do at the end of a period of learning and are statements which relate therefore to educational outputs of student learning rather than educational inputs, the teacher-directed taught content.

This approach fosters the development of a range of new skills, has the potential to challenge and change practices and ensures the integration of knowledge, skills and attitudes are measured when assessing competence (Garrett, 2013). However, Watson *et al* (2002) argue that competence has become synonymous with performance. Traditionally, in Ireland and other countries, a check list regarding assessment of clinical practice was used which determined a pass or fail. This system was characterised by formative and summative assessment processes. Conversely, Cowan *et al* (2007) and Cant *et al* (2013) argue that a competence based approach to assessment works to evaluate performance and to ensure the effective application of professional competencies such as knowledge, skills, values, abilities and attitudes in the practice setting. These are referred to as holistic in nature and the use of this holistic concept is proposed to ensure the development of more precise competence standards and assessment instruments (Cowan *et al* 2007). However, a review of international literature by Helminen *et al* (2016) identified common discrepancies in the assessment process and recommended that appropriate assessment methods must be developed

to ensure patient safety. Furthermore, the review highlighted that those assessing students should have the necessary skills regarding the mentoring and assessment role. The mentor requires support by the educational institutions particularly regarding appropriate education and training to ensure competence when assessing student nurses. It is suggested that quality assessment processes provide competent nurses and consequently ensure patient safety. This fundamental premise underpins the main objective of the current research.

In order to achieve the above, assessment is regarded as an integral component of the learning process and not simply a means of measuring achievement (Hughes and Quinn, 2013). Furthermore, Rust (2002) asserts that assessment criteria related to all modules are clearly related to the learning outcomes, and it is important to map the learning outcomes of the modules to the programmes subject requirements. These outcomes form the basis for planning assessments which in turn must be appropriate for the level of each learning outcome and relevant to the aims of the programme (Hughes and Quinn, 2013). The learning outcomes and competences devised by NMBI are broadly consistent with these propositions and the first three stages of Benner's seminal work on stages of clinical competence development in nursing (1984, p 13-14). Levels 1 and 2 are representative of the novice practitioner who has limited exposure to and experience of practice setting. Level 3 is representative of the advanced beginner stage whilst Level 4 is consistent with the expectations of a newly qualified nurse as a competent practitioner (NMBI, 2016 p 22).

Continuous assessment of practice is fundamental to the degree programme and within the Irish context the assessment of clinical practice commences in the first year of the programme and the trajectory of assessments increases in complexity as students move through the programme of study. In year one the emphasis is on fundamental nursing care but in later years the emphasis has shifted towards evidence based decision making, problem solving, critical analysis, reflective skills and the ability essential to the art and science of nursing while managing the care of groups of patient (ABA 2005; Hunt *et al* 2012). Learning is nurtured and assessment is of benefit when based on the everyday practices that present themselves in the clinical learning environments in which students are situated. Henderson (2012 p. 42) stresses that students assessments

should not be 'siloed' around tasks but that assessment should be flexible enough to allow the student to demonstrate attainment of the standards across as many situations as possible in the clinical setting. Similarly, Hunt (2012) and Price (2012) believe that assessment is not a single event, highlighting that it involves observing students throughout their placement across the trajectory of the degree programme and making a decision about their performance both at a specified intervals and at the end. Assessments should be carried out within the context of practice so that evidence of skills, professional behaviour and knowledge is captured.

Commensurate with this approach, NMBI have advocated that practice based assessments of competence are based on an explicit theoretical model (NMBI, 2016 p 122). The theoretical frameworks/models underpinning nursing undergraduate programmes in Ireland at time of this study. It should be noted that some HEIs used more than one theoretical model as identified (See appendix 3). The following table identifies the number of HEI's utilising certain models:

Author	*Model*	*No of HEIs using*	*Author*	*Model*	*No of HEIs using*
Bondy (1983)	Criterion referenced definitions for rating scales in clinical evaluation	4	Bloom (1956)	Taxonomy of educational objectives for knowledge based goals	2
Steinaker and Bell (1979)	Experiential learning taxonomy	5	Benner (1984)	Levels of practice and experience	8

Table 2.1: Models of Competence Assessment underpinning undergraduate programmes in Ireland.

To inform the decision making process for the identification for a common national theoretical model for the assessment of competence as required by NMBI, these models were explored in the literature.

2.4.2 Bondy (1983) Criterion-referenced Definitions for Rating Scales in clinical evaluation

The criterion–referenced definitions for rating scales in clinical evaluation model (Bondy, 1983) is in use in three of the thirteen HEIs in Ireland (Appendix 1). This model proposes that the evaluation of competence can be subjective and unreliable and therefore developed criteria using a five point rating scale to evaluate the clinical performance of nursing students. Five levels of competence are identified across three evaluation areas, professional standards, quality aspects of the performance and assistance needed to perform the behaviour.

Scale Label	**Standard of practice**	**Quality of Performance**	**Level of assistance required**
Independent	Safety is a high priority. Accurate. Achieves intended outcomes. Insightful behaviour appropriate to context.	Proficient, coordinated, confident and expedient.	Rarely required supporting cues.
Supervised	Safe. Accurate. Achievement of intended outcome. Sound insight with behaviour generally appropriate to context.	Proficient in most situations. Confident. Expedient.	Requires occasional supportive cues.
Assisted	Safe. Accurate. Achievement of most objectives for intended outcomes. Behaviour generally appropriate to context.	Proficient throughout most of performance when assisted.	Requires frequent verbal and occasional physical directive in addition to supportive cues.
Marginal	Safe only with guidance. Not completely accurate. Incomplete achievement of objectives for intended	Very limited skills. Unable to demonstrate confidence, efficiency and/or co-ordination of activities.	Requires continuous verbal and frequently physical directive cues.

	outcomes. Some insight into behaviour.		
Dependent	Unsafe. Unable to demonstrate expected behaviour or skill. Lack of insight into behaviour appropriate to context.	Unskilled. Unable to demonstrate behaviour/procedure. Lacks confidence and understanding of provision of safe environment.	Requires continuous verbal and physical directive cues.

Table 2.2: Bondy's Scale for assessing competence adapted from Kathleen Nowak and Nursing and Midwifery Board of Australia (NMBA, 2015).

In clinical nursing practice, Bondy's (1983) scale label indicators, of dependent, marginal assisted, supervised and independent, provide for a range of descriptors that may indicate the clinical evaluation of students overall performance on each clinical placement. In year one and two assisted level is expected and by third year this increases to supervised and by fourth year the student is expected to be independent.

2.4.3 Steinaker and Bell (1979) Experiential Learning Taxonomy

The Experiential Taxonomy Learning Theory was developed by Norman Steinaker and Robert Bell in 1979. It is used as an approach to teaching and learning and experiential learning follows in a sequence of categories, each comprising of five levels. Firstly, Steinaker and Bell (1979 p. 22) define exposure as the consciousness of an experience. Exposure is where a student has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the clinical placement. Secondly, participation has been described as the level at which one decides, on the basis of data already received to become physically a part of the experience (Steinaker and Bell, 1979 p. 24). Participation is where a student becomes part of the experience, transitioning with the support of a preceptor to participant rather than an observer (De Montfort University, 2017). Thirdly, according to Steinaker and Bell (1979 p. 29) identification occurs when the student actively participates in the experience and uses earlier learned knowledge and experience. In order words, identification is where a student takes more responsibility for their own learning and participation and initiates appropriate action and evaluates same (De Montfort University, 2017). Next,

internalisation is where a student applies experience to other situations (Steinaker and Bell, 1979). In a similar vein, a student makes informed decisions based on the information available and works as an autonomous practitioner and finally dissemination is where a student informs and influences others regarding their experience (Steinaker and Bell, 1979), and the student uses critical analysis to determine the outcomes of their actions and can give rationale for their action to others (De Montfort University, 2017). In summary, the taxonomy begins when the student is exposed to a teaching-learning experience and develops to the point where the student has internalised the experience and is disseminating the experience to others. Steinaker and Bell (1979) perceived this taxonomy as:

> A functional vehicle for providing the complete classification of human activity from the moment the learner is exposed to the possibility of an experience to its highest level of completion (p, 19).

In clinical nursing practice, the criteria outlined by Steinaker and Bell (1979) experiential learning taxonomy are exposure, participation, identification, internalisation and dissemination. These are utilised to determine the students overall performance on each clinical placement. In year one and two the levels of exposure and participation are used and expected and by third year and four year the levels utilised are identification, internalisation and dissemination to determine the achievement of competence. In summary, in clinical practice, the assessment of competence from year 1 to year 4 and 4/5 correlates to the theory of experiential learning and the taxonomy of exposure, participation, identification, internalisation and dissemination represent the level the student has reached and at the end of the degree programme, students will be able to work at the level of dissemination to be enabled to register as a nurse. In summation, the following table outlines the levels:

Exposure level	The student is introduced to and is conscious of an experience
Participation	The student has to make a decision to become part of the experience
Identification level	The student identifies with the experience both intellectually and emotionally

Internalisation level	The student progresses to this level when the experience begins to affect daily life, changing behaviours and ways of doing things
Dissemination level	The student now expresses the experience, advocating to others

Table 2.3: Steinaker and Bell levels of experiential learning identified by Nicklin and Kenworthy (2000 p 21)

Furthermore, Nicklin and Kenworthy (2000) suggest that this taxonomy is suited to competence based approaches to assessment where progressive stages of performance criteria, have to be identified and measured as in nursing. While, this is a learning theory it has been adopted in nursing to assess the competence of nursing students. Interestingly, the School of Nursing and Midwifery, University College Cork linked the Experiential Learning Theory (Steinaker and Bell, 1979) to the Requirements and Standards for Nurse Registration Education Programmes 2000 and 2005 developed by ABA and interpreted exposure in the nursing context:

> "The student observes a competent practitioner carrying out aspects of nursing care and shows a willingness and ability to relate the observed practice and its underlying theory to her/his own previous experience. The student is able to discuss with the practitioner how certain aspects of care are carried out and identifies sources and types of information required to enhance further application of knowledge to the observed practice" (2011, p 7).

Similarly participation is interpreted with regard to standards set out by ABA:

> *"The student participates with the supervision of a competent practitioners in carrying out aspects of care, having demonstrated knowledge through discussion. The student discusses with the practitioner aspects of care and its rationale, decision making, practical skills, and means of acquiring further information and opportunities for practice. The student is able to engage in psychomotor and interpersonal skills, and is able to use communication and problem solving skis with guidance" (2011, p 7).*

The identification level, internalisation level and dissemination level are not explored for the current study as the new NCAD is developed only for first year nursing students and only the levels of exposure and participation relate to this cohort.

2.4.4 Benner's (1984) Levels of Practice and Experience

Benner's Levels of Practice and Experience Model of competence assessment underpins the undergraduate nursing programmes in eight of the thirteen HEIs in Ireland. Benner's (1984) seminal work on competence development among nurses, particularly in the context of skill and proficiency enhancement among expert nurses, has provided a strong theoretical framework for competence acquisition (Meretoja *et al* (2004). Nevertheless, its operationalisation and application to both nursing students and practitioners has been a gradual process. Benner identified five levels of practice ranging from novice to expert based on the work of Dreyfus and Dreyfus (1981) to which she refers to extensively. She states that the Dreyfus model is 'developmental, based on situated performance and experiential learning' (p.188). She describes the main characteristics of the different stages or levels of practice and identifies five levels of proficiency in clinical nursing practice.

Benner's model of developing competence where the process of skills acquisition proceeds from novice to expert practice has been critically examined from both a theoretical and operational perspective by a number of researchers since its creation. Lyneham *et al* (2008) investigated the final stages of expert practice and this in turn is defined as 'intuitive practice' by Benner (1984) and Dreyfus and Dreyfus (1986, p 380). Their discussions of expert practice and its preceding stage, proficiency, signal that the notion of intuition develops principally in a registered nurse rather than during initial development of a nurse. In conclusion, Benner (1984) model incorporates four levels of competence for the student to achieve over the four years of the programme. These are beginner, advanced beginner, competent and proficient. The underpinning philosophy of the adapted model is one of empowering students to achieve the appropriate level of independent practice. Furthermore, Meretoja *et al* (2004) adapted Benner's theory to develop and test a new instrument, namely the Nurse Competence Scale (NCS), which is used to measure competence of registered nurses in many different hospital environments.

This framework will enable the student to develop their knowledge, skills and attitudes incrementally over the 4 years of each programme. In summation, the following table outlines the stages:

Stages/Levels	**Description of Levels**
Stage 1: Novice	The novice or beginner has no experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The nursing student is taught the rules to help them apply theory to clinical situations and to perform tasks.
Stage2: Advanced Beginner	The advanced beginner demonstrates acceptable performance based on previous experience gained in real clinical situations.
Stage 3: Competent	The competent nurse has undertaken the job for a number of years has gained experience and therefore can plan actions with a view to achieving efficiency and long term goals. She/he has the ability to manage the complexity of clinical situations.
Stage 4: Proficient	The proficient nurse perceives and understands the situation as a whole and continuous to learn from experience in certain clinical situations and can determine if plans require modifications.
Stage 5: The Expert	The expert no longer relies on rules, guidelines or principles to determine actions. The nurse has a large repertoire of intuitive experience in clinical situations and is extremely capable and skilful.

Table 2.4: Benner's (1984) stages of clinical competence (p 20-32)

2.4.5 Bloom's (1956) Taxonomy of Educational Objectives for Knowledge-Based Goals.

Bloom's Taxonomy of Educational Objectives for Knowledge-Based Goals (1956) is the taxonomy of learning behaviours was developed in 1956 by educational psychologist Dr Benjamin Bloom and his colleagues. Three domains were identified; cognitive (knowledge), affective (attitude of self), and psychomotor (skills). These domains are often referred to in the literature as KSA that is Knowledge (cognitive), Skills

(psychomotor) and Attitudes (affective). This taxonomy aimed to ensure higher order thinking such as applying, analysing, synthesising and evaluating knowledge rather than rote learning among students. The cognitive domain (knowledge-based) is often used to structure curriculum learning objectives and assessment processes and involves knowledge and the development of intellectual skills (Bloom 1956). The categories commence with the simplest moving to the complex that is knowledge, comprehension, application, analysis, synthesis and evaluation. Subsequently, Krathwohi (2002) based on the work of Anderson (2001) revised the cognitive domain to reflect active thinking by changing the names of the six categories to remembering (knowledge), understanding (comprehension), applying (application) analysing (analysis), evaluating (synthesis) and creating (evaluation). This taxonomy of educational objectives uses a scale to express the level of expertise required to achieve measurable learning outcomes which will allow one to choice appropriate assessment methods (Hughes and Quinn, 2013; Bloom *et al*, 1956). The primary limitation for the purpose of this research is the sole focus on educational objectives and the dearth of evidence reviewing the approach. Using Bloom taxonomy the student followed a theoretical concept using a sequence of levels starting with fundamental knowledge then progressing through increasing complex phases until the highest level of understanding is reached which Dean and Kenworthy (2000 p 53) stated was in the lack of any accurate significant experience.

Levels of Expertise	**Description of Level**
1. Knowledge (Basic knowledge)	Recall, or recognition of terms, ideas, procedures, theories.
2. Comprehension (Understanding)	Translate, interpret, extrapolate, but not see full implications or transfer to other situations, closer to literal translation.
3. Application	Apply abstractions, general principles, or methods to specific concrete situations.
4. Analysis	Separation of a complex idea into its constituent parts and an understanding of organisation and relationship between the parts. Included realising the distinction between relevant and extraneous variables.

5. Synthesis	Creative, mental construction of ideas and concepts from multiple sources to form complex ideas into a new integrated and meaningful patterns subject to given constraints.
6. Evaluation (Valuing)	To make a judgement of ideas or methods using external evidence or self-selected criteria substantiated by observations or informed rationalisations.

Table 2. 5: Bloom *et al* (1956) taxonomy of educational objectives

2.5 Competence

2.5.1 The requirement for competence in nursing

Professional competence is a fundamental requirement in nursing practice with competence attainment from theoretical and clinical perspectives forming an integral component of pre-registration undergraduate nursing degree programmes. To qualify for professional registration means achieving competence described by Cant *et al* (2013) as a defined set of skills, knowledge, know-how and professional attitudes that denote the unique practice of a particular discipline. The concept of competence forms an essential basis for clinical assessment for nursing (McCarthy and Murphy, 2008) and determines suitability for registration (Heaslip and Scammell, 2012). Within the current pre–registration nursing degree programmes in Ireland, half of the hours are allocated to the clinical practice setting, and both the clinical competence and theoretical assessments must be successfully completed in order to qualify for registration as a nurse. These requirements are summarised in Table 3.3, 3.4, and 3.5 below. This model takes cognisance of the European Directive 2013/55/EU (Kajander-Unkuri *et al* 2016; European Commission 2013).

The theoretical and clinical instruction for the nursing degree programme.
Having regard to the European Union Council Directive 2013/55/EU. The theoretical and clinical instruction shall comprise of no less than 4,600 hours
Theoretical instruction – no less than one third of 4,600 hours = 1,533 hours
Clinical instruction – no less than half of 4,600 hours = 2, 300 hours

Table 2.6: The theoretical and clinical instruction for the nursing degree programme (NMBI p 70).

The NMBI total requirements of the programmes (RGN; RNID; RPN) are 144 weeks as outlined below (NMBI, 2016 p 70, 93, 108):

Essential Requirements of the programme	**Number of weeks**
Theoretical instruction	63 weeks
Clinical instruction	45 weeks
Internship	36 weeks
Total	**144 weeks**

Table 2.7: The essential requirements of the programmes (RGN; RPN; RNID).

The NMBI total requirements of the programmes (RGN/RCN integrated programme) are 170 weeks as outlined below (NMBI, 2016 p 80):

Essential Requirements of the programme	**Number of weeks**
Theoretical instruction	75 weeks
Clinical instruction	59 weeks
Internship	36 weeks
Total	**170 weeks**

Table 2.8: The essential requirements of the programmes (RGN/RCN).

Definitions of competence are disparate and the lack of a consensus in defining this concept renders it difficult to establish a common international definition and subsequent approach. This will be discussed in greater depth within this chapter.

The desired trajectory for competence development changes incrementally over time. A nurse's level of competence is influenced by her educational preparation, frequency of clinical exposure and the duration of experience in a particular clinical setting. A competence framework illustrates the standards for competence. Frameworks of nursing competence are delineated by the identification domains of professional practice that a student is required to meet in the form of terminal objectives, performance criteria and indicators or critical elements (Butler *et al* 2011; An Bord Altranais 2005; Fordham 2005; NMBI 2016). The competences encompassed within the six following domains of practice:

- Domain 1: Professional values and the role of the nurse competences
- Domain 2: Nursing practice and clinical decision making competences
- Domain 3: Knowledge and cognitive competences
- Domain 4: Communication and interpersonal competences
- Domain 5: Management and team competences
- Domain 6: Leadership and professional scholarship competences

(NMBI, 2016 p17-19).

These domains of competence represent a broad enabling framework to facilitate the assessment of pre-registration undergraduate nurses' clinical practice. Furthermore the identification of performance criteria and indicators within each domain are standardised according to the relevant division of the register.

Commensurate with the research, the structures supporting the competence approach includes a team and partnership approach when assessing the student nurse, and agreement of assessment processes by key stakeholders including Clinical Nurse Managers, Clinical Placement Coordinators, Nurse Practice Development Coordinators, and academic nursing lecturers. The outcome of the process is that the undergraduate nursing student is deemed to be either competent or not and where competence has not been achieved the undergraduate will be given opportunities to develop

competence. The framework for assessing competence is critical in ensuring this outcome is achieved.

2.6 Development of processes and documentation to measure competence

In Ireland competence documentation are developed by the individual HEIs to assess student nurses' competence in clinical practice over the trajectory of the four year/ four and half year degree programme. This means that there are at least, 13 sets of competence documents in circulation, with some HEI's having discipline specific documents at any given time, all with the same outcomes as defined by NMBI. These documents have various titles and recording processes with some common themes but all with the same outcome. See Figure 2.2.

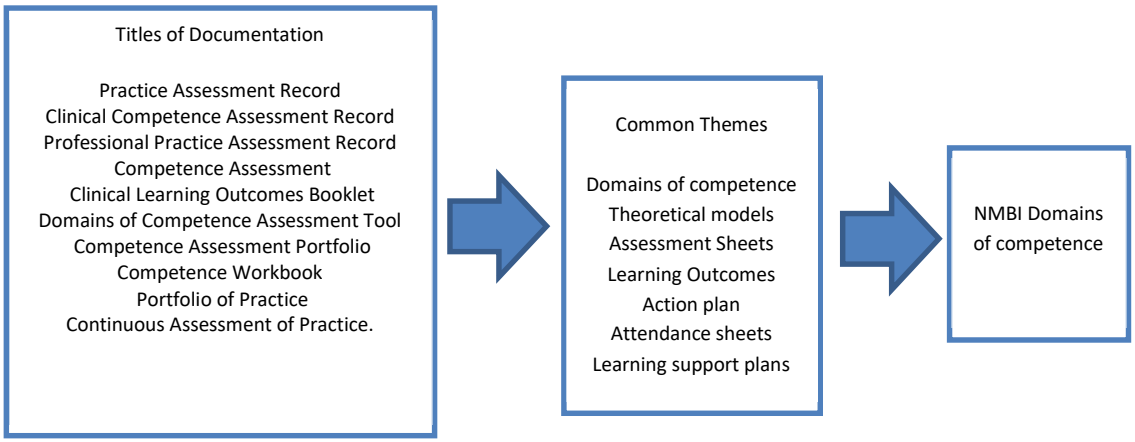


Figure 2.2: Titles of documents used for competence assessments in 13 HEIs in Ireland (2017)

This is not unique to Ireland and internationally there are similar challenges. Documents may or may not include domains of competence advocated by the respective regulatory body, theoretical frameworks and learning outcomes. Within the Irish context this will be remedied by the introduction of new Nurse Registration Programmes Standards and Requirements (NMBI, 2016), requiring all HEI's to review existing degree programmes, taking cognisance of the standards. The timeframe for completion is September 2018 with an assessment framework to include documentation to be known as the National Competence Assessment Document (NCAD) for first year nursing students, which is the subject of this research. Irrespective of the documents utilised in clinical practice, strategies used to measure competence in clinical practice will include 'observation of

practice, interviews, reflection on practice and the supervised performance of skills' (Phelan *et al* 2014).

It is important to highlight that there is a dearth of literature around specific competence assessments for pre- registration nurses. In the majority of the literature reviewed, the concept of the assessment of competence was from a registered nurse perspective and were unrelated to student nurse competence, for example Meretoza *et al* (2004), Muller (2012), Wangensteen *et al* (2015), Flinkman *et al* (2016), Lejonqvist *et al* (2016), Hamstrom *et al* (2012) and Lima *et al* (2015). In addition, the literature, tested the psychometric properties of instruments in order to evaluate, performance, skills, knowledge abilities and attitudes (Lin *et al* 2010; Hou *et al* 2010; Muller *et al* 2012; Wangensteen *et al* 2015). In attempting to operationalise Benner's theory (1984) to measure competence acquisition among nurses, Meretoja *et al* (2004) adapted Benner's theory to develop and test a new instrument, namely the Nurse Competence Scale (NCS), which is used to measure competence of registered nurses in many different hospital environments. They found Benner's model to be robust and sufficient in the development of their scale of competence.

Prior to the development of this instrument, few tools existed to measure competence among registered nurses. The authors adapted Benner's seven categories of competence, namely helping role, diagnostic functions, managing situations, therapeutic interventions, ensuring quality and work role to structure response categories. The initial process to generate indicators included a literature review and a semi-structured questionnaire with a sample of registered nurses that incorporated Benner's first three levels of competence, beginner (novice), advanced beginner and competent. Using content analysis methods, the resulting 1308 descriptions of categories and levels generated initial 193 indicators. This number was then reduced by 20 to 173 items after further logical consistency testing. Further validity review testing by 26 nurses and managers and the pilot using 30 registered nurses (nurses and their managers in medical and surgical settings), expert group review and second pilot reduce the number of indicators to 73 with seven categories adapted from Benner (1984), using a visual scale format. This extensive instrument development process was further tested for its validity and reliability through self-assessment by a sample of 498

registered nurses working in 19 different clinical environments in a teaching hospital in Finland. Results indicated high level of internal consistency, contents constructed and concurrent validity. The scale was found to be more sensitive in identifying levels of competence than the existing 6D developed by Schwirian in 1978 to evaluate the performance of nurses and the Visual Analogue Scale (VAS) (Meretoja *et al* 2004) and had the advantage of being comprehensive when utilising for self-assessment of competence by nurses. Whether it could be utilised or adapted for undergraduate nursing competence acquisition purposes would need to be determined. Yet the beginner, advanced beginner and competent levels are generally consistent with undergraduates nursing student competence acquisition.

Moreover, O'Connor *et al* (2009) in their study outlined the process of implementing and evaluating a competence assessment tool for student nurses, across three universities and associated clinical placements in Ireland. Firstly, the methodology included the development of assessment tool, drafting of standards for practice under each domain of competence (NMBI, 2005) and a shared specialist placement document (SSPD). Secondly, to evaluate the usability and suitability of the SSPD, the findings suggested that both students and preceptors considered the tool an accurate indicator of student competence. A Survey using a questionnaire enquiring into structure, process and outcomes of using the tool (p 495). Results were determined by using descriptive and some correlation statistics using SPSS and thematic analysis regarding qualitative findings. They concluded that the findings were consistent with other studies findings regarding the preparation of assessors, the unfamiliarity with the tool, and the need for considerable time to use the tool, however it would appear that there was extensive support regarding the use of the domains of competence framework as developed by ABA, as a means of assessing student competence.

The completion of a competence assessment provides evidence of student learning and the attainment of competence but is not without its problems. Three Irish studies (McCarthy and Murphy, 2008; Fahy *et al* 2011 and Butler *et al* 2011) identified many factors that impact on the assessment of nursing students in practice to include difficulties in understanding language, process not standardised, lack of continuity when it became to preceptorship, and time constraints. Therefore, as Henderson (2012)

states the challenge is to develop a tool with sufficient written criteria that can guide preceptors that is not prescriptive around a specific task. The National Competence Standards for the Registered Nurse in Australia, forms the basis of such an assessment. The limitation is while preceptors who work alongside students and inform the assessment of student ability by readily differentiate between exemplary standards of practice and poor performance, they are not always able to articulate their observations that clearly communicate the standard of student practice. Therefore, the above studies concluded that a well-designed tool to facilitate learning, teaching and assessment in clinical practice can assist preceptors to review, confirm and validate student practice to better aid in the monitoring of standards.

2.7 Supporting structures for assessment

Structures for collaborative working between HEIs and practice areas are suggested to be greatly enhanced if based upon a shared vision and commitment to supporting a quality clinical learning environment (Rose, 2008). This must be supported by the presence of formalized infrastructures that allow for oversight of and clear communication among both practice and academia. Within the Irish context a partnership approach between HEIs and AHCP delivers the nursing programmes. Simply the HEIs deliver and assess the theoretical component and the ACHP sites facilitate and assess the clinical component of the programme using preceptors and clinical placement co–ordinators. The assessment processes for the theoretical component must meet NMBI standards and requirements and relevant HEI requirements. The three critical supporting infrastructures for assessment of nursing students in clinical practice are: Clinical learning environment, preceptorship and reflective practice.

2.7.1 Clinical learning environment (CLE)

Clinical learning is an essential component of becoming a nurse and nursing students are capable of promoting patient safety and delivering good outcomes for patient care if a quality clinical learning environment exists in their organisations (Kullberg *et al,* 2016; Roney *et al* 2017). A quality learning environment is where students learn to integrate the theory and practice of nursing and the most important people responsible

for the development of a quality clinical learning environment are staff nurses, clinical managers, and lecturers (Seshan *et al* 2011). A longitudinal qualitative study carried out by Brown *et al* (2008) in the United Kingdom identified critical components of the experience of clinical practice in relation to the learning environment and the experience of nursing older people. The study found that students do not necessarily enter nurse training with negative tendencies towards working with older people, but that such negative opinions develop during training as a result of clinical placements. The authors concluded that if students experienced an 'enriched' environment characterised by a positive attitude towards older people, that students would have a positive experience during placements. The characteristics of a positive learning environment combined with a synthesis of the literature in this area are shown in Table 2.7:

Findings	**Author(s)**
Adequate preparation of the nursing student for their placement.	Kermode (1987), Windsor (1987).
Effective communication between HEI's and AHCP's.	Nolan (1998).
The quality of staff student relationships particularly between preceptor and student.	Dunn and Hansford (1997), Saarikoski and Leiono-Kilpi (2000), Hart (1992).
The extent to which students feel welcome on placement.	Young (1997), Nolan (1998).
The creation of a supportive learning environment that is both safe and professionally stimulating.	Nelson (1991), Yung (1997). Fink (2005), Vallant (2004).
A leader who creates a supportive placement culture and has a positive attitude towards students and their needs.	Cooper (2001), Saarikoski and Leiono-Kilpi (2002), Vallant (2004).
The quality of the student-patient relationship.	Sword (1994), Dunn and Hansford (1997).

Table 2.9: Synthesis of the clinical learning environment literature from Brown. J. Nolan. M. Davies. S. Nolan. J. Keady. J. (2008 pp 1216)

In summation, the importance of a quality clinical learning environment is essential where nursing student feel safe, welcomed and supported. In addition, the relationship with both staff and patients is of paramount importance and the requirement of a partnership between the university and the clinical placements is necessary.

A further exploratory study carried out by Chuan and Barnett (2012) in Malaysia, offered an alternative perspective on the student experience. They described and compared perceptions of the clinical learning environment by nursing students (*n* = 142), staff nurses (*n* = 54) and nurse tutors (*n* = 8) and identified factors that enhanced or inhibited student learning. The findings suggested that factors inhibiting student learning included busy wards, student overload and students used as part of the workforce. Conversely, participants in the study mostly viewed the clinical learning environment as a positive experience. However, there was a substantial difference between the groups. The most positive component identified by students and preceptors alike was 'supervision by clinical instructors'. The 'friendliness of the clinical learning environment' was reported more often by staff nurses compared to students and tutors. Factors that enriched learning included: attitudes of staff nurses towards students learning; variations of learning opportunities during placements; adequate equipment and time to attend to clinical procedures. Similarly, Seshan *et al* (2011) identified that facilitative factors include empowering ward manager, positive ward climate, team work and team work related to continuity of care, supportive positive relationships, trust, and student involvement as active members of the team. In contrast, inhibiting factors were hierarchical structures, rigid ward rules, lack of team support and no commitment to teaching, task allocation, and student not working as an active member of the team regarding patient care, inadequate supervision of students and little opportunity to observe and work with registered nurse. Furthermore, within the Irish context, a three interview process is utilised for clinical placement of 4 or more weeks, however, Butler *et al*, 2011 found that preceptors reported a lack of continuity with particular nursing students in the conduct of initial, mid-point and final interviews, variability on the length of time allocated to differing students and lack of some type of moderation system to help reach an overall pass-fail judgement in a fair and consistent manner.

In 2003, ABA published guidance on the key points that may be considered when developing a quality learning environment and identified that a quality learning environment is influenced by:

- Dynamic, democratic structures and processes
- A ward/unit area where staff are valued, highly motivated and deliver quality patient/client care
- Supportive relationships, good staff morale and a team spirit
- Good communication and interpersonal relations between registered nurse and student
- Acceptance of the student as a learner who can contribute to the delivery of quality patient care (An Bord Altranais, 2002 p.3).

This guidance and criteria therein were updated following an extensive review of the literature (Carney, 2017). Critical to this review was the identification of the need for nursing students to feel valued, be motivated and be accepted as a learner capable of contributing positively to patient/client care delivery. The guidance stresses the need for all those involved in teaching and supporting students in HEIs and ACAPs alike, to promote these positive factors. A frequent finding in the studies reviewed related to the students' appreciation for the support provided to them by preceptors. Furthermore, the nature and frequency of communication between the HEI's and the AHCP, can impact on student teaching and learning positively or negatively (Carney, 2017). Similarly in the UK, the Royal College of Nursing (2017) identifies that effective practice placements: promote learning; ensure that the statutory requirements are met; learning outcomes and competencies are achieved through adult learning processes; develop cultural competence; develop confidence in providing patient/client centred care; work within a wide range of unpredictable changing health environments within a multi-professional arena; work in partnership with appropriately trained preceptors to identify learning opportunities to meet the learning outcomes of the programme; and bridge the theory practice gap (RCN, 2017 p. 6).

Patients have a right to expect safe, competent nursing care at all times. This includes care provided by student nurses. When learners participate in providing patient care, a nurse supporting the learner is responsible for ensuring patient safety while facilitating a positive learning experience. The literature has shown that the quality of clinical supervision provided is the key influence on the quality of the clinical placement and,

ultimately, on the competence of the nurse. Appropriate systems to support student learning coupled with supervision provides assurance to the public that practice is safe and does not place them at risk. Nurses have a professional obligation to support learners to develop and refine the competencies needed for safe, ethical and effective practice, and to support the development and socialization of students who are learning (NMBI, 2014). Central to all of this is the role of the preceptor in clinical practice.

2.7.2 The role of the preceptor and CPC in the assessment process

Nursing students undertaking the registration education programme do so under the supervision of a Registered Nurse who has been designated as his/her preceptor and under the wider supervision and direction of a team of Registered Nurses within each practice setting. 'A preceptor is a registered nurse who has undertaken preparation for the role and supports undergraduate nursing students in their learning in the practice setting and assumes the role of the supervisor and assessor of the student achievement of clinical learning outcomes and competence' (NMBI 2016, p. 133). The terms, preceptors, supervisor, mentor and assessor have been used somewhat interchangeably in different jurisdictions with differing connotations of the role (Bray and Nettleton, 2007), however, the term preceptor is utilised in Ireland, the term mentor is utilised in other countries to denote the same role for example in the UK. This role supports the overarching aim of the programme to ensure that the graduate acquires the competences for critical analysis, problem-solving, decision-making, collaborative team-working, leadership, professional scholarship, effective interpersonal communication and reflection that are essential to the art and science of nursing. Likewise, Peate (2018) articulated the importance of recognising the mentor's role in assessing nursing students and their accountability as gatekeeper to the profession and protecting the public (p 355).

Safe and effective practice requires a sound underpinning of theoretical knowledge that informs practice and is in turn informed by practice. Within a complex and changing healthcare service and population focus, it is essential that preceptors facilitate nursing students to achieve these outcomes and that practice is informed by the best available evidence and that graduates develop a capacity for Continuing Professional

Development (CPD) to maintain competence over a potentially long professional career. Undergraduate nursing students vary widely in their life experience on entry to an education programme. They normally develop their confidence and competence to practice as a nurse over the duration of their programme but at different rates of progress. This depends on their prior knowledge and experience in healthcare, and also the rate at which they begin to apply knowledge and skills and professional values to practice placement as they encounter patients, service users, interdisciplinary colleagues and family members.

The use of preceptors has received widespread recognition in nursing education as a critical means of teaching and assessing, supporting and facilitating students in clinical practice. The preceptor is essentially a role model exhibiting behaviours that reflect the values and beliefs of the nursing profession (Zilembo and Monterosso, 2008a ; Zilembo and Monterosso, 2008b). Within the Irish context preceptors are registered nurses who are formally tasked with this role and The Code of Professional Conduct and Ethics for Registered Nurses (NMBI, 2014 p.27) makes this explicit for registered nurses in this regard. It outlines standards of conduct and the means by which registered nurses are expected to support nursing students in their learning and ongoing development of their professional values, practice and conduct. A large study recently undertaken by Navarra *et al* (2018) concluded that mentorship ranked as the most important component of a successful degree programme and ensures that students become lifelong learners and engage in education, research and policy in the future. Critical success factors identified included ensuring that students become lifelong learners, engage in the profession to include education, research and policy. Essentially, a mentorship programme improves the students' education experience and is essential for the advancement of nursing and development of future nursing leaders. However, the right characteristics in mentors/preceptors are essential to the success of this as a supportive process.

A considerable body of literature exists around the necessary requisites or characteristics of good preceptors. Good communication skills and positive attitudes to teaching and learning (Byrd *et al* 1997; Myrick and Yonge, 2002; 2004), personal and professional qualities (Gray and Smith, 2000; Finger and Pape 2002), ability to stimulate decision making and critical thinking (Myrick, 2002) and good leadership qualities

(Lockwood *et al* 2003) are all prevalent in the literature. A synthesis of essential traits from the works of Rose (2008), Smedley and Penney (2008), Altmann (2006), Robinson *et al* (2012) and Stewart *et al* (2010) include:

- Ability to act as a professional role model and willingness to teach
- Ability to recognise cultural and individual diversity needs
- Assertiveness and flexible as regards change and ability to deal with conflict
- Effective clinical, teaching, assessing and facilitation skills and delivering evidence-based practice and skill in the nursing process
- Professional, competent, confident and motivated in their own role and in the role of preceptor
- Patience and the ability to guide the student through complex activities and tasks

However, a robust infrastructure for assessment must be established to support the critical work of the preceptor (Rose, 2008). The current degree programme structure in Ireland is reliant on additional clinical support staff for students whilst on clinical placement including preceptors, associate preceptors, clinical placement co-ordinators (CPCs) and link lecturers (LL) from the affiliated Higher Education Institutions and Associated Health Care Partner. Despite these support structures other factors have been identified in the literature as impacting on the effectiveness of the undergraduate student nurse clinical assessment of competence particularly regarding the role of preceptors.

The role of the preceptor is to develop competence, support and facilitate nursing students to understand placement learning outcomes and to meet their learning needs during practice experience. There is an additional requirement not only to support and facilitate the student nurse but also to take part in their assessments of practice. In addition, part of the role involves evaluating and befriending, in the light of maintaining objectivity, were selected by the preceptors as being the most challenging aspects of their role (Finnerty and Collington, 2012). However, in an Irish study by McCarthy and Murphy (2010) despite express reservations about the complexity of the role, 88.6% of the preceptors valued working with students. Interesting, a study found that a preceptor who was more highly qualified academically, who was seen as a sound role model clinically, used adult learning strategies to foster problem-solving and provided clear

feedback for competence development was praised by undergraduate nursing students (Omer et al, 2013).

In some cases, an undergraduate student nurse will require additional guidance and support to achieve aspects of his/her practice which have been identified to them as not meeting the required standard. In some cases, a Learning Support Plan will be developed and the student nurse will avail of the support of the Clinical Practice Coordinator (CPC). A CPC, a role unique to Ireland, has been defined as 'an experienced nurse who provides dedicated support to nursing students in a variety of health care settings' (Drennan, 2002 p 482). As distinct from the role of the preceptor as stated above, the primary function of the CPC is to support both the nursing student and the preceptor in the monitoring, assessment and attainment of competence.

The issue of failure is prevalent in the literature with Duffy (2003) finding that those who assess clinical practice were reluctant to fail student nurses. This generated uncertainty about the fitness to practice of some registered nurses with potential risk for patients and the public. In response to this, Hunt *et al* (2012) further explored this issue and confirmed discrepancies between failure in theoretical and practical assessments regarding nursing programmes in England. Failure in relation to theoretical assessments exceeded failure rates for practical assessments by five to one. Within the Irish context a study by McCarthy and Murphy (2010) found that more than three-quarters of the sample of preceptors in their study had never failed a student in clinical assessment and nearly half expressed concerns that to do so might be construed negatively by clinical nurse managers as evidence of poor supervision. Inherently, these findings support those of Duffy (2003) and Luhanga *et al* (2008) who have argued that assessors of practice regularly find it difficult to fail student nurses. A number of factors appear to contribute to this situation including the preparation and support that assessors receive and this supported by a study by Moore (2009) where in one study, preceptors reported that they had never had their supervision and assessment of practice formally evaluated, suggesting that HEI's should give consideration to development and use of instruments such as the *Preceptorship Evaluation Survey*. Furthermore, Calman *et al* (2002) in a Scottish study relating to 13 validated, diploma of higher education found a lack of consistency regarding the education of those who assess nursing students. Furthermore, there is a need to encourage preceptor to question the competence of

students and the continued development of a process to support assessors to fail underperforming students. The latter is considered essential to promote public confidence. A study by Fitzgerald et al (2012) inherently, explored the support structures for nursing students relating to the possibility of a failed placement or when a nursing student was demonstrating difficulty in achievement competence, the use of action plans were put in place. However, the action plans were formulated jointly with academic staff to address concerns frequently did not relate to the specified issue of concern nor provided evidence that these issues had been discussed formatively with the student prior to the plan being drawn up (Fitzgerald *et al* 2012). Therefore, leading to an inappropriate conclusion with no tripartite relationship to determine the outcome of the placement for nursing students. The nursing student may be deemed incompetence with no input from the nursing student which will influence the progression for that student. It is noteworthy that Heaslip and Scammell (2012) acknowledged the support given to preceptors by faculty academic staff is valued particularly in the context of working with students who are struggling to achieve competence. Conversely, a study in the Unites States of America by (Couper 2018) found that it was difficult to fail students because of lack of organisational support along with role stress and concluded that it is essential that those in senior roles retain effective communication and provide the necessary support for those who assess nursing students. The theme, requirement of university support was also articulated in an Australia study regarding the concept of failure to fail that concluded that further investigation into this issue is required to ensure nursing students are fit for purpose to ensure patient safety (Hughes *et al* 2016).

In addition, Heaslip and Scammell (2012) identify that the aim of educationalists is to provide students that are fit to practice, but concerns have been raised internationally regarding student competence at the point of registration. They proposed a practice assessment tool outlined an evaluation of the student and preceptor experience both using a grading system in the assessment process. However, the study further concluded that there was no evidence that a grading scheme made preceptors any more confident in failing students than a pass-fail assessment even though mentors (64.3%) reported feeling confident to use a grading scheme to rate competence attainment. Again, the main finding, also reported by Dobbs (2017) related to the preparedness of the

preceptor regarding the assessment of students particularly with regard to the management of failing students. In an Irish study undertaken by Butler *et al* (2011), over half of the respondents felt that their preceptorship preparation had adequately prepared them for their role. Furthermore, the importance of providing feedback in timely manner to ensure student learning was raised. In this regard they advocated that feedback should be ongoing and not just at the end of a clinical placement to ensure further development of skills and confidence for the student. In addition, while it was recognised in the literature the importance and the requirement for preceptors to support nursing students, a study by Gidman, McIntosh, Melling and Smith (2011) using a qualitative interview approach in a mixed methods study suggest that the perceived nursing student supports in practice in United Kingdom identified that some nursing students encountered negative attitudes among preceptors who argued that their primary role was patient care rather than mentoring students. From the Irish perspective, Cassidy *et al* (2012) found that, preceptors reported feeling torn between the competing demands of caring for patients whilst the staffing resource was under provisioned and of inadequate time for supervision and clinical assessment of competence among their allocated nursing students. It was also further ascertained by Mallick and McGowan (2007) that nurse preceptors, necessitate time allowance, emotional support, acknowledgement and financial inducement from health services in recognition of the burden and responsibility of the supervision process similar to other health professions such as occupational therapy and physiotherapy.

2.8 Reflective practice and self-evaluation in the assessment process

Reflection and reflective practice are well represented in the nursing literature, frequently described as essential attributes of the competent nurse. Reflection is viewed as a key learning tool to improve practice and apply one's knowledge, skills and behaviour to care for patients (Botten, 2012). Reflection promotes critical thinking in nursing and has been incorporated into pre-registration programmes in Ireland since 2005. NMBI directs that reflective practice be at the core of the undergraduate degree programme for nursing, both from a theoretical and clinical perspective, and that this reflection must take place throughout the teaching/learning process of the four year/four and half year trajectory of the degree programme. A full review of the evolution of reflection is beyond the remit of this paper, however the importance of

reflection to enrich learning can be traced to Aristotle. Dewey's seminal work on reflection in 1910 remains at the forefront of writings in this area. Atkinson and Irving (2013) state that Dewey's work postulates that reflection, liberates professionals from routine activity and action and he also highlighted the need for thinking to be linked to action. Furthermore, Dewey's process of reflection is interlinked to the process of problem-solving where learning is linked to solving the problem and returning to the process of reflection. In nursing, reflective practice came to the fore in the 1980s with the publication of Donald Schon's highly influential 'Reflective Practitioner' (Schon, 1983, 1987). In contrast, to Dewey, Schon argues that professionals in practice, meet complex situations which cannot be solved by technical rational approaches only and he suggests that learning is facilitated by reflection (Atkins and Murphy, 1993). The facilitation of reflective practice is proposed by Cassidy (2009), to be embedded in phenomenology where the student immerses themselves in practice. Reflection-on-action occurs after the experience where practitioners analyse the consequences of action. In contrast, reflection-in-action occurs during the experience or scenario, and is the process of 'reflecting upon intuitive knowing that is implicit in a practitioners' actions, whilst at the same time carrying out those actions' (Hughes and Quinn, 2013 p 484). Reflection-on-action is critical for learning, and reflection-in-action is a critical competence for effective practice (Johnston and Fells, 2017). Both of these are necessary for the development of competence in nursing.

This use of reflection has been related to a number of positive benefits for professionals such as developing their capacity for self-assessment and critique, challenging their existing knowledge base, engaging in lifelong learning, making sense of their experiences, improving decision making (Smith and Trede, 2013), and enhancing learning (Ash and Clayton, 2004). Over time numerous models of reflection have emerged to guide practitioners from various professional backgrounds. These were primarily based on the works of Dewey, Schon and Kolb, are usually cyclical in nature and are used to guide the process of reflection. These include Borton's framework for guiding reflective activities (1970), using the process of description, analysis and synthesis, Boud's reflective learning model (1985) with stages of experience, reflective process and outcomes, description, feelings, evaluation, analysis, conclusion and action plan, Gibb's model of reflection (1988) with levels of description, feelings, evaluation,

analysis, conclusion and action plan, and Johns model of structured reflection (1994) with stages of description of the experience, reflection and influencing factors. In other words, could I have dealt better with the situation utilising empirics, aesthetics, ethics and personal learning. In nursing the models most prolifically applied in practice are John's and Gibb's and are frequently cited in HEI documentation. The choice of model is usually dependent upon the student's stage of training and personal development. Reflective practice is an important and integral part of the degree programme from both a theoretical and clinical perspective to ensure that nurses are competent and can utilise the skills of critical analysis, problem solving, decision making and reflective skills. The degree programme allows nursing students to use reflective practice to learn from experience and to continually support professional practice throughout the trajectory of the nurse's career. The current Standards and Requirements for Nurse Education (NMBI, 2016) make provisions for reflection as an integral component of degree programme and many of the HEI's use Gibbs Model of reflection and the rationale for this choice is that the model is cyclical in nature and is simple to apply in practice and has a focus on self–awareness (Atkins and Murphy, 1993). The model is illustrated in figure 2.4 and the questions suggested in its application are identified in table 2.10

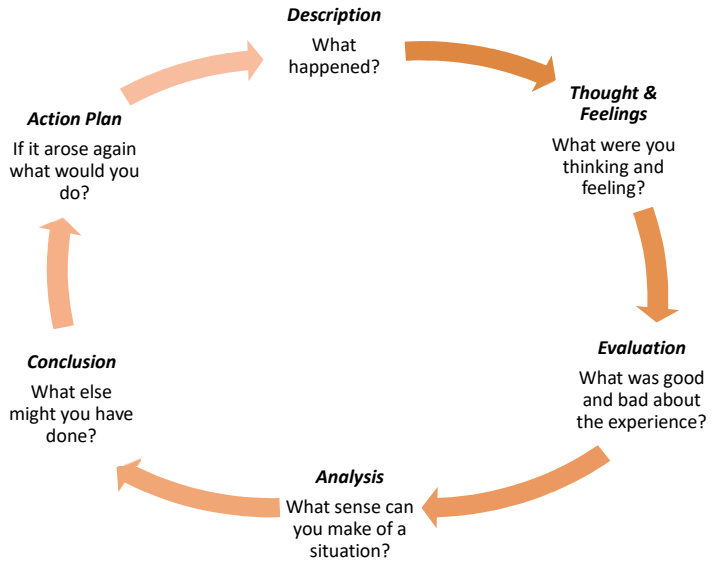


Figure 2.3: Gibbs model of reflection (1988)

Stages of the reflective cycle	Questions
Description	What happened?
Thoughts and feelings	What were your thoughts and feelings during the experience?
Evaluation	What approaches worked and which ones did not work?
Analysis	What sense can you make of the situation?
Conclusions	After evaluating the situation, what conclusions can you come up with?
Action plan	What would you do differently?

Table 2.10: Questions to be considered when using Gibbs Model of reflection.

To embed reflection in the clinical learning and assessment process NMBI have directed that provisions be made in all undergraduate degree programmes for nursing in Ireland for clinical 'protected time status'. This aims to provide students, with opportunities to engage in self-reflection or reflection with other students and clinical staff, who support learning in practice in the clinical setting. To this end The Nurse Registration Programmes Standards and Requirements (NMBI, 2016) states:

> Specific periods of reflective time are allocated for reflection during supernumerary placements and the final internship placement (Nurse Education Forum 2000). Reflective time equivalent to a minimum of 4 hours per week should be an integral component of the internship period of clinical allocation to enhance the consolidations of theory to practice (HSE/HR Circular 030/2009). The time allocated for reflective practice during supernumerary placements and the structures in place for the implementation pf protected reflective time during the period of internship should be agreed formally between the HEI's and the associated health care providers and included in the memorandum of understanding (p 127).

While reflection and reflective practice are advocated by the regulatory body, the facilitation is viewed by Brown and McCormack (2011) as not an 'easy or comfortable experience' (p 5), particularly in the every changing acute hospital setting.

Linked to reflection is a related concept of evaluation in that evaluation is the process of evaluating a reflective experience. There is a paucity of literature regarding these two related concepts in nursing. The Southampton values based model regarding the nursing students' self-assessment of learning need and expectations was reviewed by the researcher and permission

was sought to use this model to guide the nursing student when using the self-evaluation component of the document (See appendix 4, 5, 6).

2.9 Statement of the problem

This chapter delineated the critical issues associated with the assessment of pre-registration nursing programmes from the literature and from contemporary practices in HEIs. A theoretical framework was identified which outlined the three interacting domains as learning, assessment and competence which were subsequently used to structure the review of the literature.

Social learning was identified as underpinning the processes in relation to learning in clinical practice. The application of scaffolding as a means of supporting student learning and key activities for use in this process were synthesised from the works of prominent writers in the field and applied to the context of nursing assessment in clinical practice. Three critical infrastructures were identified from the literature for the operationalisation of student learning as the clinical learning environment, preceptorship and reflective practice.

This chapter provides a robust rationale for the development and structure of a standardised competence framework, associated processes and documentation. The development of these three pillars will fulfil regulatory requirements, standardise disparate practices and provide an evidence based approach to the process. Furthermore they bridge the existing gap for a standardised approach to competence assessment for undergraduate nurse education programmes. The following chapter will outline the methodological considerations in addressing the following research questions:

- What theoretical framework/model for the assessment of competence should underpin the national competence assessment framework?
- What assessment documentation and assessment processes should be developed?
- What are the key elements of a national system to facilitate the competence assessment of nursing students in Ireland?

2.10 Theoretical framework for this study

Chapter one outlines the international and Irish context requiring NMBI to develop a standardised approach to the assessment of undergraduate nurses in Ireland. These are contextualised to the overall approach to the literature review in Fig 2.1 below. Critical to the development of the framework are the theoretical issues underpinning the approach from learning, assessment and competence perspectives. These critical domains will guide this literature review, which aims to examine and synthesise the literature to inform the theoretical model underpinning the system (research question 1) and the key elements of a national system (research question 2), and the standardised national assessment tool and process (research question 3).

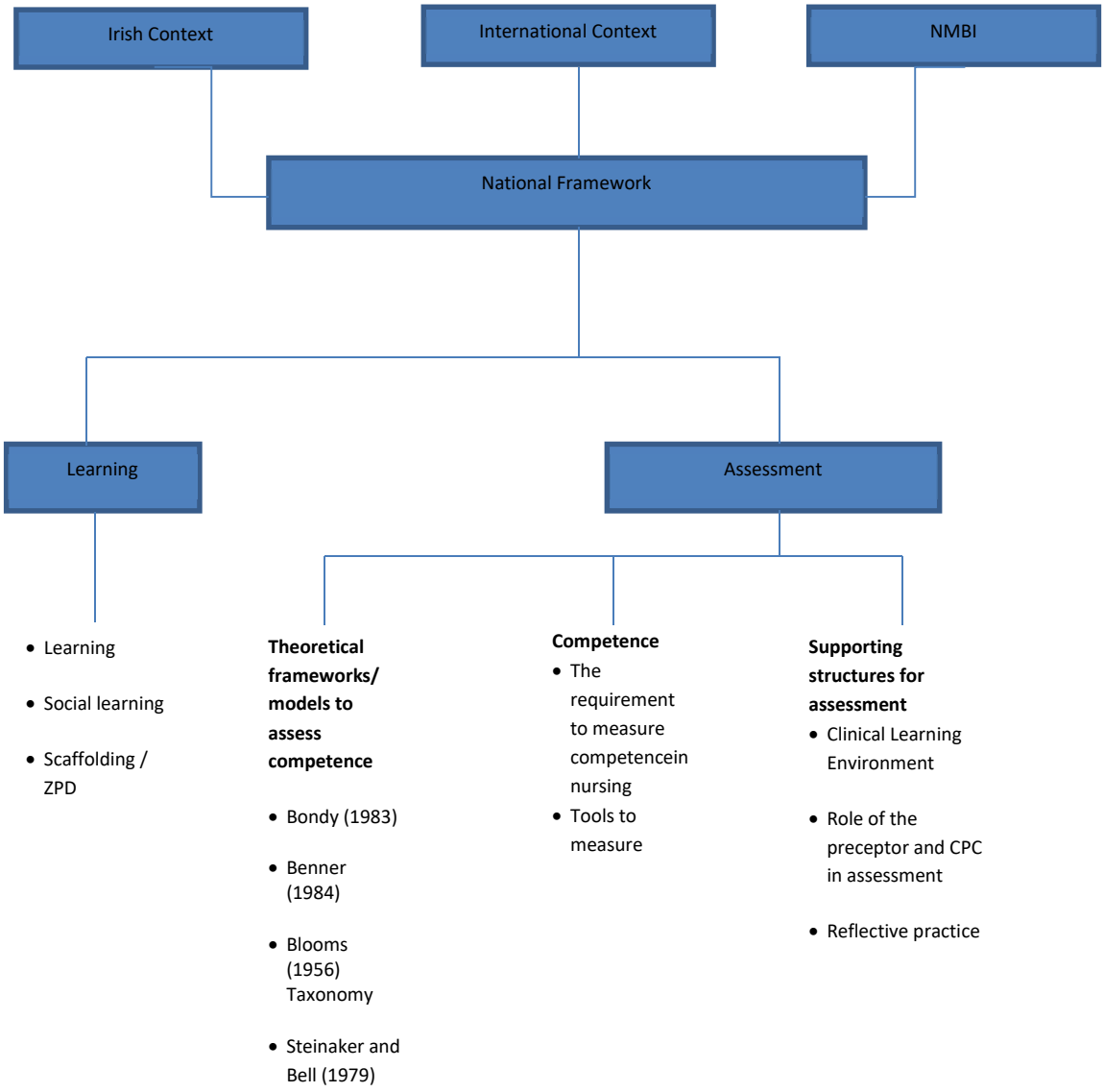


Fig 2.4: Theoretical framework for this study

The theoretical framework (Figure 2.4) for the current study includes the international context and outlines the European influences for nursing in Ireland. European directives must be applied in the Irish context which is the responsibility of NMBI. The domains of competencies contained in the standards and requirements for the degree programme take cognisance of European legislation and ensure adequately prepare the student with the competencies for safe, effective, skilled, knowledgeable and ethical practice. Regarding the Irish context, nursing and nurse education has experienced huge change and the introduction of nurse education into the university sector has ensured that nurse education has moved from the traditional apprenticeship model. Currently, nurse

education in Ireland is provided in seven Universities and six Institutes of Technology with a total intake of 1688 nursing students and the standards and the domains of competence will ensure that the mission of NMBI will be assured thus protecting the public as advocated by Bradshaw and Merrimen (2008); Licen and Plazar (2015) and Saleh *et al* (2017). The development and implementation of a national framework for the assessment of clinical competence of nursing students consists of the development of a process/system and documentation regarding assessment and guidelines. This framework will take cognisance of the findings in the literature regarding learning, assessment and competence. Learning is explored particularly in relation to assessment of clinical competence in social situations such as the clinical placement sites.

2.11 Conclusion

As set out in the introduction to the literature review, the desired outcome of the study is to develop a national standardised competence framework for year one of the pre–registration nursing programmes in Ireland. The literature associated with the study mainly involves an examination of the concept of competence and the assessment of competence. The literature further focused on aspects of learning that impacted on assessment of clinical competence and theoretical models used to assess competence. In addition, the literature related to the process of assessment to include the supporting structures and the components of the framework for assessment and assessment documentation was included in the literature review and included the concept of reflective practice and the models in use. The development of national standardised competence framework and supporting documentation can make a significant contribution to support nursing students and those who have roles regarding advising, supporting and assessing nursing students going forward.

CHAPTER 3: METHODOLOGICAL CONSIDERATIONS

3.1 Introduction

The overall aim of the research is to support the strategy direction, and mission of the Nursing and Midwifery Board of Ireland (NMBI) that is patient safety and pubic protection as set out in legislation, the Nurses and Midwives Act (2011). In tandem, the study will address the recommendation in the review by the Department of Health entitled Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes (2012 p. 61) which stated that the:

> Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/ health service will review student clinical assessment processes including documentation to promote standardisation of clinical assessments in line with competence goals for the four nursing programmes.

The desired goal and outcomes of the study is to develop and implement a research informed national system to facilitate the competence assessment of nursing students in Ireland. Action research, the chosen methodology for this research, almost always commences with a question such as how can we improve the situation (Reason and Bradbury 2008) and therefore the original main research questions for the overall research project is as follows:

- What theoretical framework/model for the assessment of competence should underpin the national competence assessment framework?
- What assessment documentation and assessment processes should be developed?
- What are the key elements of a national system to facilitate the competence assessment of nursing students in Ireland?

To achieve the goal of this research it will be necessary to examine and consider a number of research paradigms from a philosophical and methodological perspective in terms of aligning methods with the aims, objectives, and refining the research questions. This chapter outlines in detail the methodology approach, the main considerations regarding the paradigm choice underpinning the research, rationale for choosing action research as a methodology. Other relevant considerations such as data collection,

sampling and analysis are outlined. Finally, ethical issues, rigour of the study and the limitations of the study are addressed.

3.2 Research paradigm

Research studies are guided by the choice of methodologies which is influenced by a research paradigm. The application of research methods is based on the researcher's chosen paradigm which can be influenced by the philosophical concepts and basic beliefs of ontology, epistemology and methodology which are all interlinked. Furthermore, all impact on the chosen research methodology and related research methods. In other words, knowledge, relationship between the researcher and the participants of research, and how the researcher will source knowledge needs to be considered. An understanding of one's own worldwide view can be addressed by answering the following questions which are relevant to the choice of paradigm and methodology as stated above, which in turn will influence the choice of research methods. (Table 4.1).

Ontological	What is the nature of the knowable? What is the nature of reality?
Epistemology	What is the nature of the relationship between the knower (the inquirer) and the known (or knowable)?
Methodologies	How should the inquirer go about finding out knowledge?

Table 3.1: from "The Paradigm Dialog" by Egon C. Guba (1990:- p 18).

The term paradigm was described by Thomas Kuhn (1962) as a means to describe an approach to research. Burke Johnson and Onwuigbuzie (2004) cited that Thomas Kuhn (1962) promoted the idea of a research paradigm which is described as:

> a set of beliefs, values and assumptions that a community of researchers have in common regarding the nature and conduct of research. The beliefs include but are not limited to ontological beliefs, epistemological beliefs, axiological beliefs, aesthetic beliefs and methodological beliefs (p 24).

Kuhn (1959; 1970) believed that paradigms are required to allow researchers to conduct research, define problems, select methods and evaluate research (Benton and Craib 2001 p 59). Furthermore, Crotty (2006) states a paradigm is a belief system based on epistemology which is a branch of philosophy that is concerned with the study of knowledge and is a way of understanding and interpreting 'how we know what we know'

(p 8). Simply put, a paradigm is a 'basic belief system that represents a worldwide view that defines the nature of the world' (Guba and Lincoln 1994, p 107). Moreover, Stetsenko and Arievitch (1997) state that a paradigm can be understood as a set of critical assumptions that has deep historical origins (p 159). There are many different paradigms described in the literature and uncertainty exits regarding what constitutes a paradigm. Creswell and Creswell (2018:6) outline four worldviews of paradigms which are post-positivism, constructivism, pragmatism and advocacy/ participatory paradigms.

Postpositivism • Determination • Reductionism • Empirical observation and measurement • Theory verification	Constructivism • Understanding • Multiple participant meanings • Social and historical construction • Theory generation
Transformative • Political • Power and justice orientated • Collaborative • Change-orientated	Pragmatism • Consequences of actions • Problem-centred • Pluralistic • Real-world practice oriented

Table 3.2: Creswell's and Creswell's four worldviews and terms used to describe each (2018 p 6).

Similarly, Flick (2009) discusses post-positivist, constructivist and pragmatic beliefs and adds to the breadth of knowledge by including a transformative paradigm. In addition Guba and Lincoln (2018) outline the paradigms of positivism and critical theory. In previous research Guba (1990 pp. 17-27) analyses the traditional paradigm of positivism and three other paradigms which he suggested may replace and challenge the more traditional paradigm of positivism. These are post positivism, critical theory, constructivism and participatory. He compares the differing paradigm perspectives using the concepts related to philosophy of knowledge; ontology, epistemology and methodology. The researcher outlines the various paradigm beliefs as outlined above using various sources including Lincoln *et al* (2018) 'Paradigmatic Controversies, Contradictions and Emerging Confluences, Revisited'. In addition, the author outlines certain belief systems in more detail before detailing the appropriate paradigm stance for her line of inquiry. For the purposes of this research, the researcher has chosen to further expand in the following paradigms:

- Positivism
- Post-positivism
- Quantitative and qualitative paradigm
- Pragmatism

The above were selected on the basis that some elements have relevance for the current research project while others were outlined in order to add to the debate and argument regarding the choose paradigm.

3.2.1 Positivism paradigm

One of the first theoretical perspectives of epistemology, positivism was first described in the nineteenth century by a French philosopher, Auguste Comte (1798-1857), and in the 1920s, positivism was associated with a group of philosophers, mathematicians and physicists known as the Vienna Circle. Positivism may be characterised by its 'claim that science provides us with the clearest possible ideal of knowledge' (Cohen *et al* 2005, p 9). In other words, positivism is grounded on the certainty that there are two types of scientific knowledge, facts, and theories about facts, and it is viewed by Hogg and Vaughan (2011) as the accepted way to discover true knowledge. It is acknowledged by McGregor and Murnane (2010) that the positivistic paradigm is associated with natural sciences such as physics and chemistry, and it is important to add that positivism is related to empirical science (Crotty 2006 p 27). Within the positivistic approach, knowledge is derived from data using scientific methods to test a hypothesis, and reliability and validity are measured using statistical measures. Therefore science is only based on what we can directly observe and on one's experience, and this experience is at the core of scientific knowledge. Hogg and Vaughan (2011) acknowledge that social psychology is based on the paradigm of positivism, and they have been criticised for this position because objectivity cannot be achieved as with natural sciences. Many other paradigms have been proposed such as humanistic psychology, discourse analysis and social constructionism. However, some social psychologists defend positivism by ensuring rigour using appropriate scientific research methods. Likewise, Bhaskar (1997) states that 'one of the chief objections to positivism is that it cannot show why, or the conditions under which, experience is significant in science' (p13). Furthermore, Cohen *et al* (2005) state that positivism provides the clearest possible idea of knowledge, but

it is difficult to apply this paradigm in the study of human behaviour because of the complexities of behaviour within the social world (p 9). Finally, positivism is embedded in realist ontology. In other words, reality exists based on natural laws and the purpose of science is to "predict and control natural phenomena" (Guba, 1990 p 19). However, there has been a paradigm shift among researchers particularly in the area of social science.

Morgan (2007) suggests that:

> For most practising researchers, however, the most important implication of this paradigm shits was to legitimatise alternative paradigms such as constructivism or critical theory. Most important, the ability to rely on these other belief systems, justify both the pursuit of different kinds of research questions and the use of different kinds of methods to answer these questions.
>
> (Morgan, 2007 p 59)

3.2.2 Post-positivism paradigm

According to Crotty (2006 p. 29) the "attenuated form of positivism" is known as post-positivism. Many researchers rejected the narrow view of positivism that is that science provides us with knowledge only through control and scientific rigour. The post-positivistic paradigm assumes that research "should not be value free and unbiased but be value laden, subjective and intersubjective" (McGregor and Murnane, 2010 pp. 422). It is important to add that the researcher and participants are key players in the research process. Rigour is determined using the concept of trustworthiness, by ensuring credibility, transferability, confirmability and authenticity are achieved. Furthermore, McGregor and Murnane (2010) argue that the post-positivistic paradigm is linked to human and social sciences and both are described as two traditional views that influence research. It is important to note that many scholars associate quantitative research with the positivism paradigm and qualitative methods with the post-positivistic paradigm. Clark (1998) acknowledged that empirical methods can be influenced by a positivism philosophy but researchers need to recognise the important contribution of a post-positivism philosophy as it avoids the shortfalls associated with the positivism approach. This post-positivism paradigm is similar to anti-positivist or interpretivist views of certain researchers, who state that scientific methods used with the positivism paradigm are

not useful in certain situations because of the involvement of human beings who think, reflect and change behaviours (Abbott, 2010).

3.2.3 Quantitative and qualitative paradigm

The terms quantitative and qualitative are frequently used in two distinctive discourses. In one sense the term refers to a research paradigm and in another, they refer to research methods (Somekn and Lewin, 2011; Creswell and Creswell, 2018) or design (Polit and Beck, 2006). Despite the use of different terminology to describe key approaches to research, both qualitative and quantitative approaches dominant the literature. Much has been written about the qualitative and quantitative approaches to research and differences between them (Quinn Patton, 2015; Macnee and McCabe 2008; Cohen *et al* 2005; Polit and Beck, 2006, 2010; Grove *et al* 2013; Creswell and Creswell, 2018). The supporters of qualitative and quantitative research paradigm have debated about the superiority of their respective paradigm for many years. Another debate in the literature relates to the terms qualitative and quantitative not as a research paradigm but as research design or methods (Creswell and Creswell, 2018). As outlined by Topping (2010) qualitative and quantitative research have different characteristics and originate from different scientific traditions and forms of knowledge (p 129). It can be argued that the quantitative and qualitative methods of research can complement each other because they generate different kinds of knowledge and sometimes are used in a mixed methods approach to research. Grove *et al* (2013) postulates that many researchers believed that quantitative research was the only scientific method which is based on the philosophical assumption of positivism and defines quantitative research as:

> A formal objective, systematic process implemented to obtain numerical data for understanding aspects of the world (p 23).

Thus quantitative research emphasises numbers and statistics in the collection and analysis of data. Furthermore, quantitative research:

- Entails a deductive approach to the relationship between theory and research, in which an accent is placed on theory testing.
- Incorporates the practices and norms of a natural science model and of positivism in particular, and

- Embodies a view of social reality as an external, relatively constant, objective reality.

(Bryman and Teevan 2005 p 15).

Gerrish and Lacey (2010) concur with Grove *et al* (2013) and Bryman and Teevan (2005) when they claim that quantitative research methods are based on a positivist position (p 134). In addition, quantitative research as a methodology is concerned with the measurement and assurance of the criterion of reliability, validity and generalisability to determine cause and effect. Many researchers identified the need from an alternative to positivism and a shift away from quantitative research as it does not allow for choice, individuality and therefore identified a qualitative paradigm and as an alternative methodology. Qualitative research can be defined as:

> A situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that makes the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them.
>
> (Denzin and Lincoln 2018 p 10).

In contract, the qualitative approach to research was viewed as more subjective, holistic and related to social situations and the experience of groups and individuals in social situations. It is research 'conducted within an interpretivist paradigm framework, a social constructionist paradigm framework as opposed to a positivist paradigm framework' (Quinlan, 2011 p 13). In addition, others have defined qualitative research as

> A means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures, collecting data in the participants setting, analysing the data inductively, building from particulars to generate themes, and making interpretations of the meaning of the data.
>
> (Creswell and Creswell, 2018 p 250).

This definition also outlines the process of qualitative research which can be related to the chosen research strategy of action research. In addition, Bryman and Teevan (2005

p 15), state that qualitative research as a strategy relies on words both in the collection and analysis of data and that:

- Predominantly emphasises and inductive approach to the relationship between theory and research and the generation of theories.
- Rejects the practices and norms of the natural scientific model and of positivism in particular, for an emphasis on how individuals interpret their social world and
- Embodies a view of social reality as a constantly shifting and emergent property of individuals' creations.

In the 1990's Guba and Lincoln argued that qualitative and quantitative methods can be used irrespective of the chosen paradigm (Guba and Lincoln, 1994). In a similar vein, Burke Johnson and Onwuigbuzie (2004), Tashskkori and Creswell (2007) state that qualitative and quantitative methods are not linked to a particular paradigm, but two distinct paradigms that is a positivist perspective regarding quantitative methods and a constructivist perspective in relation to qualitative methods (p 304). Furthermore, Burke Johnson and Onwuigbuzie (2004) link qualitative methods also with the paradigm of interpretivism and state that 'differences in epistemological beliefs should not prevent a qualitative researcher from utilising data collection methods associated with quantitative research and vice versa' (p 15). This study adopts a qualitative approach as there is no hypothesis, numerical data or positivist frame and it sought to generate new insights through action, reflection on experiences and generation of new ideas and processes.

3.2.4 Inductive reasoning

Another debate in the literature regarding quantitative and qualitative research is the concepts of deductive (deduction) and inductive (induction) reasoning. Neary (2001) states that a qualitative approach to understanding and determining theory is inductive and therefore deductive reasoning is normally linked to quantitative research. Furthermore, Quinn Patton (2015) examined the concept of inductive analysis and proposes that new explanations, results and theories are derived from the data of a qualitative study (p 541) and that this is essentially inductive in nature and allows for more robust exploration and greater insight into the area of study succinctly view inductive or induction analysis (David and Sutton, 2007 p 44). In line with this the study inductive reasoning was utilised. The outcome of inductive analysis as described by

Thomas (2006; p 240) is the formulation of categories that summarise the raw data into themes. He further identifies five important features as follows:

Category label	Word or phrase used to refer to category. Label has meaning.
Category description	Includes key characteristics or patterns.
Text or data associated with the category	Text coded into category.
Links	Each category may have a link or relationship with other categories.
The type of model in which the category is embedded	Consistency with the inductive process. Such models or frameworks represent an end point of the inductive process and are not set up prior to the analysis.

Table 3.3: Inductive analysis

3.2.5 Pragmatism

Pragmatism is a philosophy developed in United States of America and is firstly associated with the work of Charles Sander Peirce (1839 – 1891) who saw it as "method of reflexion having for its purpose to render ideas clear" (Peirce in Crotty, 1998:73). The worldview of pragmatism was further espoused with the work of James (1842-1910) and Dewey (1859-1952) as cited by Benton and Craib (2001) and is viewed as an interpretative approach. According to Denzin and Lincoln (2005 p. 53) the term pragmatism:

> …links theory and praxis and experience emerges in a continual interaction between people and their environments; accordingly, this process constitutes both the subjects and objects of inquiry.

Pragmatism is a unique philosophical worldview that emphasises the nature of experience and pragmatists focus on outcomes of action and shared beliefs and therefore as a qualitative inquiry framework, one is directed to seek practical and useful answers and understanding than can solve problems (Quinn Patton, 2015). In other

words, pragmatism concentrates on the research problem and uses whatsoever approaches are necessary to understand and resolve the problem. Morgan (2007) asserts that a pragmatic approach places emphasis on shared meaning and joint action or to 'what extent are two people satisfied that they understand each other, and to what extent can they demonstrate the success of that shared meaning by working together on common projects?' (p. 67). Morgan further states that:

> issues of language and meaning are essential to pragmatism, along with the emphasis on the actual interaction that humans use to negotiate these issues. It would be foolhardy to claim that every person on earth could eventually arrive at a perfect understanding of every other person on earth, but for pragmatism the key issues are, first how much shared understanding can be accomplished and then, what kinds of shared lines of behaviour are possible from those mutual understandings.
>
> Morgan (2007 p 67)

Feilzer (2010) questions the notion that the paradigm of pragmatism, is linked only to mixed methods research. She further purports that:

> pragmatism does not require a particular method or methods mix and does not exclude others. It does not expect to find unvarying causal links or truths but aims to interrogate a particular question, theory, or phenomenon with the most appropriate research method.
>
> Feilzer (2010 p 13)

Both Morgan (2007) and Feilzer (2010) critical review pragmatism and the common methodologies positions in social science that are qualitative and quantitative research. Morgan provides a simple summary of her proposed framework as follows:

	Qualitative Approach	**Quantitative Approach**	**Pragmatic Approach**
Connection of theory and data	Induction	Deduction	Abduction
Relationship to research process	Subjectivity	Objectivity	Intersubjectivity
Inference from data	Context	Generality	Transferability

Table 3.4: A pragmatic alternative to the key issues in social sciences research methodology (p 71).

He argues that the key features that distinguish between qualitative and quantitative approaches to research are inductive reasoning and deductive reasoning. However, this linear approach of moving between theory and data does not happen in reality as abduction reasoning allows for movement back and forth between induction and deduction. He concludes that 'pragmatic approach is to rely on a version of abductive reasoning that moves back and forth between induction and deduction' (p 71). He rejects the dichotomy between subjectivity and objectivity and promotes intersubjectivity and suggests that the pragmatism emphasis is on the latter and this stresses the importance of communication and shared meaning that are central to a pragmatic approach between the researcher and the participants. He further argues that knowledge is not always context-dependent or generalised and suggests that pragmatists favour the idea of transferability in that one cannot assume that knowledge we gain from research can be transferred to all potential settings. In a similar vein, Feilzer (2010) argues that pragmatism reject the qualitative and quantitative divide and end the paradigm war as they do not care what methods they use. The most important question is whether the methodologies chosen has enabled the researcher to find out, what the researcher wants to know.

3.2.6 Paradigm choice for current research project

This study uses a research design operating within the pragmatic paradigm, as the researcher believes with those authors who state that any philosophy that limits the research design should be rejected. The pragmatic approach focuses on the research problem and uses various research methods to understand and solve the problem. According to Creswell (2007 p 23), in practice, using the worldview of pragmatism, the researcher uses various methods of data collection to answer the research question and focuses on the practical implication of the research. The practicality and action foundation of pragmatism attracted the researcher as she hoped that the research would lead to action on the part of the researcher and the participants of the researcher, to determine new knowledge and bring about change. In addition, action research and the philosophy of pragmatism have much in common in that action research can be represented as a contemporary interpretation of pragmatism (Pedler and Burgoyne 2015 p 182). It is important to add, Creswell and Creswell (2018) purports that:

Pragmatism as a worldview or philosophy arises out of action, situations and consequences rather than antecedent conditions (as in postpositivism). There is a concern with applications – what works – and solutions to problems. Instead of focusing on methods, researchers emphasise the research problem and use all approaches available to understand it"

(Creswell and Creswell 2018 p 2)

Table 3.5 Choosing a Research Paradigm.

	Positivism	Postpositivism	Critical Theory	Constructivism	Advocacy/ Participatory
	Positivism assets that objective accounts of the real world can be given (Denzin and Lincoln, 2005, p 27) Positivism may be characterised by its claim that science provides us with the clearest possible idea of knowledge (Cohen et al, 2005) Realists, "hard science researchers"	Postpositivism holds that only partially objective accounts of the world can be produced for all methods for examining such accounts are flawed (Denzin and Lincoln, 2005, p 27) A modified form of positivism	Critical Theory articulates an ontology based on historical realism, an epistemology that is transactional, and a methodology that is both dialogic and dialectical (Denzin and Lincoln, 2005, p 187) +Feminism +Race Create change, to the benefit of others oppressed by power	Constructivism is an ontological position asserting that social phenomena and their meanings are produced by social actors through their social interactions and that they are in a constant state of negotiation and revision (Bryan and Teevan, p 13) (Naturalistic inquiry) (Constructionism) Or interpretivist Gain understanding by interpreting subject perceptions	Postmodern Transformation based on democratic participation between researcher and subject
Ontology (Nature of reality).	Beliefs in a single identifiable reality. There is a single truth that can be measured and studied. The purpose of research is to predict and control (Guba and Lincoln, 2005).	Recognise that nature can never fully be understood. There is a single reality but we may not be able to fully understand what it is or how to get it because of hidden variables and a lack of absolutes in nature (Guba and Lincoln, 2005).	Human nature operates in a world that is based on a struggle for power.	Relativist: Realities exist in the form of multiple mental constructions, socially and experientially based, local and specific, dependent for their form and content on the persons who hold them (Guba, 1990, p 27).	Participative reality: subjective-objective reality, co-created by mind and the surrounding cosmos Guba and Lincoln, 2005, p 195).

				Relativism: local and specific constructed realities Guba and Lincoln, 2005, p 193).	
Epistemology (The theory of knowledge).	Belief in total objectivity. There is no reason to interact with who or what researchers study. Researchers should value only scientific rigour and not its impact on society or research subjects (Guba and Lincoln, 2005).	Assume we can only approximate nature. Research and the statistics it produces provide a way to make a decision using incomplete data. Interaction with research subjects should be kept to a minimum. The validity of the research comes from peers not from the subjects being studied (Guba and Lincoln, 2005).	Research is driven by the study of social structures, freedom and oppression, and power and control	Subjectivist: Inquirer and inquired into are fused into a single entity. Findings are literally the creation of the process of interaction between the two (Guba, 1990, p 27). The philosophical belief that people construct their own understanding of reality: we construct meaning based on our interactions with our surroundings (Guba and Lincoln, 1985).	Critical subjectivity in participatory transaction with cosmos, extended epistemology of experiential, propositional, and practical knowing; co-created findings (Guba and Lincoln, 2005, p 195).
Methodology (mechanisms used to discover knowledge).	Belief in the scientific method. Value a gold standard for making decisions. Grounded in the conventional hard sciences.	Researchers should attempt to approximate reality. Use of statistics is important to visually interpret our findings. Research is the effort to create new knowledge, seek scientific discovery. There is a unified method.	Dialogic/Dialectical (Guba and Lincoln, 2005). Search for participatory research which empowers the oppressed and supports social transformation and revolution (Merriam, 1991, p 56).	Hermeneutic, dialectic: Individual constructions are elicited and refined hermeneutically and compared and contrasted dialectically with aim of generating one or a few constructions on which there is substantial consensus (Guba, 1990, p 27).	Political participation in collaborative action inquiry, primacy of the practical; use of language grounded in shared experiential contexts (Guba and Lincoln, 2005, p 195). Experiential knowing is through face to face learning, learning new knowledge through the application of the knowledge. Democratisation and co-creation of both content and method.

					Engage together in democratic dialogue as co-researchers and as co-subjects (Heron and Reason, 1997).

Table 3.5: Adopted from unpublished thesis (Bodkin. 2013) with additions citings Norman K. Denzin and Yvonna S. Lincoln 2005, 5th Edition, The Sage Handbook of qualitative research, Thousand Oaks: Sage Publications and Norman K. Denzin and Yvonna S. Lincoln 2018, 5th Edition, The Sage Handbook of qualitative research, Thousand Oaks: Sage Publications. "Paradigmatic Controversies, Contradictions and Emerging Confluences, Revisited" by Yvonna S. Lincoln, Susan A.Lynham and Egon G. Guba (2018: 114 – 117) in The Sage Handbook of Qualitative Research edited by Norman K. Denzin and Yvonna S. Lincoln (5th Edition) which cited "The Alternative Paradigm Dialog" by Egon C. Guba (1990) and "Paradigmatic Controversies, Contradictions, and Emerging Confluences" by Egon C. Guba and Yvonna S. Lincoln, 2005 in Yvonna S. Lincoln (3rd Edition). Cohen, L., Manion, L. and Morrison, K. (2000) *Research Methods in Education.* 5th ed. Routledge Falmer: London. Bryman, A and Teevan, J. J 2005, Social Research Methods, Oxford: University Press

3.3 Action research as a research methodology

Qualitative research has evolved from humanistic origins, predominantly the behavioural and social sciences, in an attempt to understand the 'unique, dynamic, holistic nature of human beings' (Burns and Grove 1993 p 27). The main principle of this project involves identifying a problematic issue within professional practice, determining a possible solution, trying it out, evaluating it and changing practice in light of the evaluation thus the methodology chosen will be action research. The design of the doctorate thesis will explore action research as a collaborative approach with multi- stakeholder involvement to map a national framework for the assessment of clinical competence and the current systems and explore new possibilities to achieve evidence based nationally agreed assessment methodologies that facilitate standardisation of clinical assessments.

3.3.1 Historical origins of action research

Hampshire (2000) and Reason (2006) articulated that the origins of action research began in the United States of America with the work of a social psychologist, Kurt Lewin and in the United Kingdom with the work of the Tavistock Institute. Both applied action research in industry (p 337-338). Lewin believed that research should be based on a social construct and should result in change in society. He believed that action research should allow researchers and practitioners to solve problems in practice, thus ensuring that research is not only the gift of academics but also it ensures the role of practitioner as researcher (Treacy and Hyde, 1999). The key feature of action research identified by Lewin (1946) is the importance of engaging participants during the course of the research process. There has been a proliferation of definitions, meaning and uses of the term action research within the literature. Some would argue that action research is not easy to define, as it is an approach to research rather than an explicit method and is an approach to research that has rejected the more traditional positivist and interpretative understandings to science when applying theory to practice (Meyer 1999/2000 p 39).

3.3.2 Action research defined

Kemmis and McTaggart (1988) defined action research as

> a form of collective self-reflective enquiry undertaken by participants in school situation in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out' (p 5).

This definition emphasised that the research should be undertaken by participants in social practices. Coghlan and Shani (2014) take cognisance of a definition which outlines the themes of action research which are 'emergent inquiry process, applied behavioural and organisational science problems, collaboration and co-inquiry and reflexivity' (p 525). Parahoo (2006) purports that action research has two distinct elements, namely, action and research, proceeding to define action research as a process of planning, implementing and evaluation in practice. The definition of action research put forward by Barbour (2008:172) encompasses the concept of 'self-reflective enquiry', Bradbury and Reason (2003: 155) outlines the principles of action research as 'grounded in lived experience, developed in partnership, addressing significant problems, working with, rather than simply studying people, developing new ways of setting/theorising the world and leaving infrastructure in its wake'. In other words, action research is grounded in our lived experience and ideas (Gaya, Reason and Bradbury, 2008:15). Life experiences are the main influences that support action research. These experiences frequently accompany or influence the interest in particular philosophical and academic perspectives, so that both theory and practice are seen as providing grounding (ibid p 16). Therefore, within action research the participants should feel that the share control of and responsibilities for the project, the problems that arise and the problems it sets out to overcome.

Adamson and Dewar (2015) purports that 'action research is deliberately concerned with the process development, improvement and continuous learning' (p 156). In summary, Riel (2007) further purports that critical reflection is central to action research and when this reflection is based on careful examination of evidence from multiple perspectives, it can provide an effective strategy for improving the organisation's ways of working and the whole organisational climate (p. 249). In two

studies outlined by Swantz (2008), the author stated that participation and action made research contextual. The roles of the researcher and the researched interchanging in the course of communications through which there was a shared development of knowledge and leaning to understanding people's problems. (p 33). Therefore, action research in this project involves collaborating throughout the project with the key stakeholders. It involves identifying with them the key concerns relating to nursing students in relation to competence assessment. Action research is viewed as a systematic cyclical method of planning, taking action, observing, evaluating and critical reflection prior to the next cycle. Somekh (2006) states 'action research integrates research and action in a series of flexible cycles involving holistically rather than separate steps: collection of data about the topic of investigation; analysis and interpretation of data; planning and introduction of those changes through further data collection, analysis and interpretation' (p.6).

> Action research is 'a participatory democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview. It seeks to reconnect action and reflection, theory and practice in participation with others, in pursuit of practical solutions to issue of pressing concerns to people. More generally it grows out of concerns for the flourishing of individual persons and their communities'.
>
> (Reason and Bradley 2008 p 4).

Hence, action research can be viewed as a way to bring about change (Webb, 1989). Similarly, action research involves interpreting and explaining social situations while implementing change that adopts a participatory approach involving participants in the change and the process (Meyer 2010 p 257). Furthermore, Coghlan and Brannick (2014) outline four broad characteristics of action research, research in action rather than research about action, a collaborative democratic partnership, research concurrent with action and a sequence of events and an approach to problem solving.

According to Elliot (1991: 49)

> the fundamental aim of action research is to improve practice rather than to produce knowledge. The production and utilisation of knowledge is subordinate to, and conditioned by, this fundamental aim.

The overall aim of the research is to implement a national competence framework and process for undergraduate nursing education programmes and this involves identifying a problematic issue within professional practice, determining a possible solution, trying it out, evaluating and changing practice in light of the evaluation thus the methodology chosen is action research. The problematic issues relate to findings regarding reported weaknesses in the current assessment processes of student clinical learning resulting in strong recommendations for a national scheme for assessment of undergraduate practice competence (Department of Health, C10.1) The recommendation is the development of a new system and instruments of assessment for nursing students, which the study aims to achieve through action research. In summation, this research thesis is part of the work of the Chief Education Officer and is a recommendation by the Department of Health (Report of the Review of Undergraduate Nursing and Midwifery Programmes 2012*).* Therefore, the rationale for selecting action research is that that it is suited to a situation where the perceived need for change has been identified by those within the setting of nursing and nurse education. Action research in this study will contribute to the development and implementation of a competence assessment document for nursing students and those involved in nurse education and those who support students in practice, thus supporting the concern of the researcher regarding who benefits from this research. Having discussed broad assumptions, the following pages focus on the detail of the various types of action research and will examine action research phases or cycles and outline the particular cycle to be used in the research design.

3.3.3 Types of action research.

The literature outlines many types of action research. Firstly, Carr and Kemmis (1986) distinguish three kinds of action research based on Habermas (1972, 1974) theory of 'knowledge constructive interests' that are technical action research, practical research and critical action research. Furthermore, McKernan (1991 p. 16, 17) classification of action research reflects the work of Grundy (1982 p. 353) who identifies three modes of action research; technical, practical and emancipatory as follows:

- The scientific–technical views of problem solving
- The practical–deliberative action research
- The critical– emancipatory action research

Furthermore, McKernan (1991 p 16-17) classification of action research, reflects the work of Grundy (1987) who discusses three modes of action research: technical, practical and emancipatory as follows:

- The scientific-technical views of problem solving
- The practical-deliberative action research
- The critical-emancipatory action research.

Regarding the scientific technical view of action researcher, early advocates put forward the scientific method of problem solving and stated that action research projects necessitated a logical research process and an inductive process are specified. The goal of practical-deliberative action research is 'understanding practice and solving immediate problems and responses to the immediate situation which is deemed problematic' (McKernan 1991 p 20). Herr and Anderson (2015) provide a comprehensive summation of the three major set of interests proposed as related to research aims as follows:

Knowledge interest	**Research aims**
Technical (uses empirical analytic science and instrumental reason)	Explanation through empirical facts and generalisations
Practical/communicative (uses hermeneutical/interpretive sciences)	Illumination of understanding of participants
Emancipatory (uses critical reflective/ action sciences)	Critical reflection – how understandings are constrained or distorted by power relations

Table 3.6: Summary of Habermas knowledge interests (p 36).

In Australia, significant work was carried out regarding action research particularly critical emancipatory action research by Carr, Kemmis and McTaggart in the 1980's and in:

> …emancipatory action research, the practitioner group takes joint responsibility for the development of practice, understandings and situations, and sees these as socially-constructed in the interactive process.
>
> (Carr and Kemmis, 1986 p.203).

Grundy (1987) distinguishes the technical, practical and emancipatory modes of action research as follows:

> emancipatory action research has a different relationship with knowledge from those relationships indicative of either the technical or the practical interest. When the technical interest predominates, action is regarded as the implementation of knowledge which has been developed in the realm of discourse and then applied in the realm of practice. The practical interest generates a relationship such that knowledge is reflectively generated through the meaning making processes of action and this knowledge then informs future action. Emancipatory action is a form of struggle and as such can look to theory for information but not direction (p 134, 135).

In other words, technical action research seeks to deliver more efficient effective practice using the practical skills of the participants and reflection is related to solving immediate problems. In contract, practical action research aims to improve practice through the application of wisdom of the participants and reflection is used to add to the capacity of self-evaluate by the participants. Furthermore, emancipatory action research takes cognisance of social systems as well as being focused on individual practice (Leitch and Day 2000). This study is situated within the practical knowledge interest as it aims to illuminate the understanding of participants as it undergoes the process of action research in order to address the problem. Having outlined the types of action research the literature provides a number of models which can assist the researcher in the process, it is timely that these are explored.

3.3.4 Models of action research

The origins of action research are credited to Kurt Lewin (1951) who believed that the motivation to change was related to action. He summarised the steps of a model of action research as unfreezing, changing and refreezing or put another way, planning, action and results. Building on this foundation McNiff (1995 p. 22)) interpreted Lewin's work as a cynical process of planning, acting, observing and reflecting. Action research

has since been represented as a cyclical process and more recently Waterman *et al* (2001) propose a model represented by a cycle which includes the steps problem identification, planning/action and evaluation (see Fig.3.1).

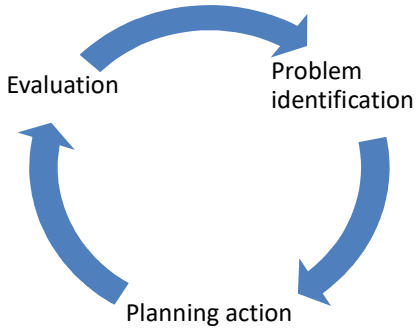


Figure 3.1: Action research model (Waterman *et al* 2001).

Using this simple model, the research participants are involved in identifying a specific problem or problems, planning strategies to address the identified problem or problems, determining action and finally evaluating the outcomes. Other action research cycles have included other steps as identified below:

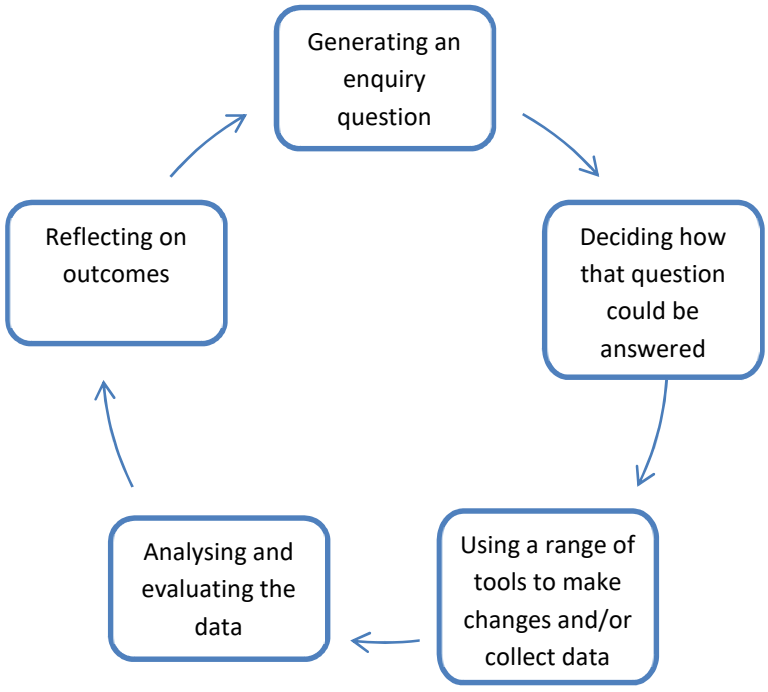


Figure 3.2: Elements of the action research cycle (Brigg and Coleman 2012 p 175).

This model has the potential to support change and improvement. The action research cycle enables participants to collect data or create an intervention based on the enquiry question, using a variety of tools to gather information, then evaluate the evidence gathered and generate strategies for action or change enquiry questions for another cycle. According to Grundy and Kemmis (1982), the action research process is grounded in two essential principles that are improvement and involvement and the action process consists of planning, acting, observing and reflecting (p 536). Reflection in this instance:

> looks back on previous action through methods of observation which reconstruct practice so that it can be recollected, analysed and judged at a later time. Reflection also looks forward to future action through the moment of planning, while action is retrospectively informed by reflection through planning (Grundy, 1987 p 145).

Based on the work of Carr and Kemmis (1986) and Grundy (1987), McCutcheon and Jung (2001) state than an 'interest in praxis is the hallmark of the critical theorist and is fundamental to an interest in knowledge as emancipatory. By praxis, critical theorists mean the emancipatory interplay between action and reflection' (p 147). They further purport that action on its own is meaningless and reflection on its own is aimless. Furthermore, Leitch and Day (2000) link action research and reflective practice and state that the particular models of action research and types of reflective processes is demonstrated by Grundy (1982) typology of technical, practical and emancipatory modes of action research.

3.3.5 Coghlan and Brannick's model of action research

Having reviewed many action research cycles, the researcher has chosen the action cycle advocated by Coghlan and Brannick (2006; 2014) which involves a collaborative problem solving relationship between the researcher and the participants aimed at solving a problem and generating new knowledge. Each cycle is categorised as a discreet element and signifies a chronological development of actions that move from one cycle of enquiry to the next. Nevertheless, each cycle overlap and are part of an iterative method where the initial cycle is constructed based on the development of knowledge from understanding. Therefore, the model and cycles of action research

will determine the stages of the research process that are developed by Coghlan and Brannick (2014 p. 11):

1. Constructing (Diagnosing)
2. Planning action
3. Taking action
4. Evaluating action

A pre step stage can also be part of the cycle giving the context and purpose of the research and research project are multiple action research cycles and taking action and evaluating that action can work simultaneously. Constructing (Diagnosing) action within this framework relates to the identification of the issues to be addressed by the process. Also referred to as a 'dialogic activity' by Coghlan and Brannick (2014 p. 10) this element of the approach forms the basis on which action will be planned or taken. Critically this step involves the identification of both context and the theoretical foundations for the proposed plans or action and Coghlan and Brannick (2014) stress that this step must be undertaken carefully and thoroughly. Constructing is collaborative in nature, involving key stakeholders and it is accepted that this constructing phase may change as the researcher engages in the iterative process of the model.

Planning follows from the constructing step and must be consistent with the essentials of the preceding phase. This phase must include collaboration and can incorporate first steps or a series of steps. During the taking action phase, plans are implemented in a collaborative way. Evaluating the action is the final step in one cycle and consists of a thorough review of the outcomes associated with the planning and action steps. Coghlan and Brannick (2014 p. 11) advocate the following as minimum for this part of the cycle:

- Does the original construction fit
- Did the actions taken match the constructing
- Was the action taken in an appropriate manner
- What feeds in to the next cycle of constructing/diagnosing, planning, taking action and evaluating that action.

The cyclical and iterative nature of the process becomes evident here where this evaluation gives rise to the next cycle of the project as follows:

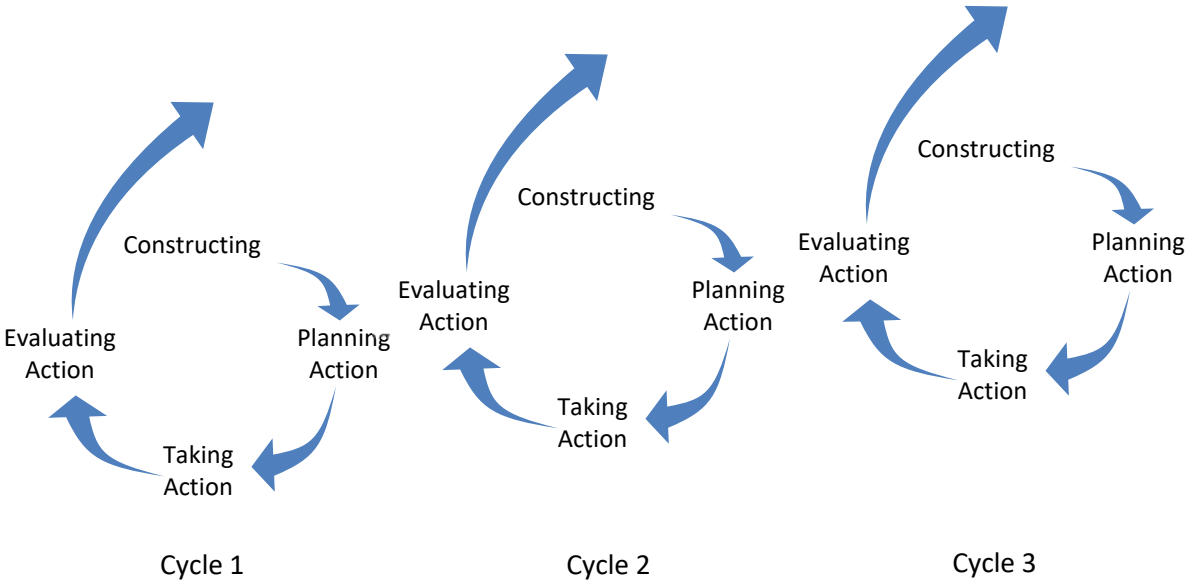


Figure 3.3: Spiral of action research cycles (Coghlan and Brannick 2014, p 11).

This model views the cyclical nature of action research as an iterative and ongoing process and embeds the concepts of continuing development until such time as the question has been addressed. Stakeholders are involved throughout the process ensuring relevance and commitment. For these reasons this is the preferred action research model for this study.

3.3.6 Rationale for selecting this approach and model

It is anticipated that using action research as a method will achieve the desired outcome of the study and will lead to the development of a competence framework and the implementation of national document to facilitate the competence assessment of nursing students in Ireland. It will allow for a further exploration of the key concerns that were highlighted in chapter two. These concerns can be explored through on-going consultation with the key stakeholder groups through each action research cycle. Each cycle of Coghlan and Brannick's model will bring the initiative closer to an agreed national competence document that will ultimately be approved by the participants and refined for eventual utilisation by all HEI's and AHCP's. Furthermore, action research is suited to a situation where the perceived need for

change has been identified by those within the setting (Herr and Anderson, 2015). Action research offers a methodology that will clearly benefit the participants. Through this process they will come to understand the choices and concerns regarding the competence assessment documents, the process of assessment and the supporting infrastructures required. They will contribute in a real way to the development of documentation, assessment strategies and process and ongoing evaluation using the cycles of action research. To the author, the development of the competence assessment framework is not merely an academic exercise as the project exists in the real world. It has the potential to have positive effect on the quality of assessment of students and those who support students during their assessment trajectory during the degree programme.

3.3.7 Action research cycles for the current study

The action research cycles within the current study are as follows:

Cycle 1

Constructing (Diagnosing)	• Documentary analysis of current assessment documentation used by the HEI's.
Planning action	• Plan to establish appropriate theoretical model/framework.
Taking action	• Establish appropriate theoretical model/framework based on previous model/frameworks. • SWOT analysis of theoretical model/frameworks.
Evaluating action	• First draft of theoretical model/framework.

Table 3.7: Action research cycle 1.

Cycle 2

Constructing (Diagnosing)	• Establish and identify gaps remaining. • Review first draft of theoretical model/framework from cycle 1.
Planning action	• Plan to develop new competence assessment documentation (NCAD) and guidelines. • Plan to develop questions for survey.

Taking action	• Develop first draft of competence assessment documentations (CAD) and guidelines to include theoretical model/framework. • Develop questions for qualitative survey to gather information from key stakeholders involved in nurse education and those who support students. • Use of survey to analysis first draft of the NCAD and guidelines.
Evaluating action	• First draft of NCAD to include theoretical frameworks and guidelines.

Table 3.8: Action research cycle 2.

Cycle 3

Constructing (Diagnosing)	• Review of documentation from cycle 2 and determine the need for further refinement.
Planning action	• Plan to establish appropriate competence assessment framework. • Plan to develop new competence assessment documentation (NCAD) and guidelines.
Taking action	• Use of focus groups to analysis second draft of NCAD and guidelines. • Based on the feedback from the focus groups. Plan to redraft the NCAD and guidelines. • Comprehensive document and guidelines finalised. • Establish appropriate process for assessment.
Evaluating action	• Final framework to include process and final NCAD and guidelines. • Dissemination.

Table 3.9: Action research cycle 3.

3.3.8 Positionality of the researcher

The term 'outsider/insider' researcher is frequently cited in the literature and describes the status of a researcher in action research studies specifically. According to Coghlan and Brannick (2014) the insider researcher is more likely to achieve successful outcomes. Streubert and Rinaldi Carpenter (2011) succulently identify these two perspectives regarding action research as follows:

> these are the insider, or emic, view and the outsider, or etic, view. This dichotomy exists because the insiders are living the problem and have a unique

understanding of it. The outsider, the researcher, is the person who comes to the situation with the intention to assist those involved but who usually is unable to internalize the situation because he or she does not live it (310:311).

Herr and Anderson (2015) outline a continuum of positions that researchers occupy when undertaking an action research study as outlined in table 3.10:

Positionality of Researcher	**Contributes to**	**Traditions**
1. Insider (researcher studies own self/practice)	Knowledge base, improved/critiqued practice, Self/professional transformation	Practitioner research, Autobiography, Narrative research, Self-study
2. Insider in collaboration with other insiders	Knowledge base, Improved/critiqued practice, Professional/organisational transformation	Feminist consciousness raising groups, Inquiry/Study groups, Teams
3. Insider(s) in collaboration with outsider(s)	Knowledge base, Improved/ critiqued practice, Professional/organisational transformation	Inquiry/Study groups
4. Reciprocal collaboration (insider-outsider teams)	Knowledge base, Improved/ critiqued practice, Professional/organisational transformation	Collaborative forms of participatory action research that achieve equitable power relations
5. Outsider (s) in collaboration with insider(s)	Knowledge base, Improved/ critiqued practice, Organisational development/transformation	Mainstream change agency: consultancies, industrial democracy learning; Radical empowerment

6. Outsider (s) studies insider(s)	Knowledge base	University-based, academic research on action research methods or action research projects

Table 3.10: Positionality of the researcher in action research (Herr and Anderson 2015 (p 40).

In the current study, the researcher situates herself at position 5 on the continuum that is outsider in collaboration with insiders as she works for the regulatory body who set the standards and requirements for undergraduate nurse education. However, she also works as an educationalist and supported undergraduate nursing students, so therefore can view the situation as a participant. These multiple positionalities of being also 'outsider within' has its advantages in that the researcher has knowledge and a perspective regarding the research but care is required by the researcher to ensure that bias is avoided therefore in carrying out the role of lead investigator, the researcher develops a professional relationship with each participant. Furthermore, Kerstetter (2012) suggests while researchers and partners of action research outlined many advantages and disadvantages of affiliating with insider or outsider researchers, few partners believed either insider or outsider researchers had any impact on the outcomes of the research.

3.4 Sampling methods

The aim of research is to explore various topics and trends throughout a particular population of people. It is impractical, and may be impossible to attempt to collect from everyone in the population so therefore a sample from the population is chosen. The sample is a subset of the population (Bryman, 2008). Somekh and Lewin (2011) suggest that a representative sample has the same range of attributes that may be found in similar populations. The researcher used a number of sampling techniques depending on the research project stage and the action research cycle.

3.4.1 SWOT analysis questionnaire sampling

Initially, a purposeful non–probability sample was used for the SWOT analysis questionnaire, which set out to determine the views of Heads of Schools of Nursing and Midwifery regarding the theoretical models underpinning the current competence assessment documents in use in the Higher Education Institutions. The sample was determined by inviting Heads of Departments (n=13) to take part in the initial phase of the study by virtue of their leadership roles and positions in nurse education.

3.4.2 Survey sampling

The population for the survey was all registered nurses in Ireland (78,092). The sample was probability as an online survey tool was used and access to the sample was voluntary through the NMBI website. The researcher could not know who would respond by the deadline for completion, all responses (n=108) were considered valid.

3.4.3 Focus group interviews sampling

For the focus groups the researcher also used a purposive sampling (also known as purposeful) regarding focus group interviews, as the participants were selected intentionally because of their common characteristics related to the research (Macnee and McCabe (2008). In other words, the sample has been chosen for a specific purpose, as it consists of participants involved in utilising the assessment tools to measure competence of nurses undertaking a degree programme. The sample was accessed by the researcher approaching the Head of Department of Nursing in all Third Level Institutions to co–ordinate separate focus groups with those who support students. Potential participants were contacted initially via email invitation and dates were given with regard to the researcher's availability to visit the college. Also, the researcher considered the timing of the focus group interview with regard to the participant's activities, to ensure a high level of participants. Those who were interested in participating in the research arrived at the appointed time. Participation in the interview process was voluntary. Signed consent was sought from each

participant at the beginning of the focus group process. All interviews were audiotaped and transcribed verbatim by an independent third party who had signed a document confirming they understood the confidential nature of the data. The transcripts were returned to the participants (N=40) for review and comment for accuracy giving participants an opportunity to review which increased the validity of the data. This is known as member checking.

3.5 Data gathering

Multiple qualitative research methods can be utilised as part of action research (Bradbury and Reason 2003 p 157).

3.5.1 SWOT analysis questionnaire data gathering

The researcher used a SWOT analysis questionnaire derived from written evidence found in curriculum documents and tools used regarding clinical assessment. The aim of this exercise was to elicit the preferred theoretical model to be included in the new assessment documents. Focus group participants were with those who support students and students themselves over the trajectory of the degree programmes.

A SWOT analysis is a tool and conventional approach for searching for insights that can provide prompts to those involved in the analysis of information with origins in Stanford University in the United States of America.

Strengths	Factors that have a positive effect on achieving objectives
Weakness	Factors that have a negative effect on achieving objectives
Opportunities	External factors that have a positive effect on achieving or exceeding the objectives not previously considered
Threads	External factors and conditions that have a negative effect on achieving objectives or making the objectives unachievable.

Table 3.11: Definition of SWOT adapted from Sincy 2016 p 34.

The SWOT analysis questionnaire included detailed information regarding the theoretical frameworks used in the HEI's which were determined by the researcher (See Appendix 2) after a review of all documentation to include curriculum documents for the four disciplines of nursing, and the assessment documentation in the 13 HEI's and ACHP's.

3.5.2 Survey data gathering

An online survey cloud based system was used to obtain data for this component of the study. Survey monkey was used for this purpose. This is widely used tool in social research which can be used to gather quantitative or qualitative data. In this instance the data was qualitative as the purpose of the survey was to determine the suitability of the new competence framework, including the competence assessment document and guidelines. Questions for the survey were generated in two sections, first demographic and professional data and second pertained to the practicalities around competence assessment in terms of: suitability, utility, clarity, fitness for purpose, suggestions for theoretical model, suggestions for improvement, current process, and potential issues for implementation. Questions were open ended and responses were in the narrative. The response rate was *n*=108.

3.5.3 Focus group interviews data gathering

The aim of focus group interviews is to collect data by seeking different opinions from various participants (Kruegar and Casey, 2009). The structure and nature of questions asked within this process warrants careful consideration. A broad interview guide (Appendix 7) was developed from themes elicited from analysis of clinical assessment tools, and a review of the relevant literature. An open questioning approach maximised the opportunity for participants to describe the key issues in relation to the research questions. Data was recorded on a digital recorder and hand written notes were also maintained by the researcher. In relation to the focus group participants, initially certain homogenous groups were invited to participant. This was changed for the last two focus groups, where mixed groups were invited to enrich the data.

3.6 Data analysis

Data analysis 'reduces, organises and gives meaning to data' (Grove *et al* 2013 p 46), and can be described as the systematic organisation and synthesis of information (Polit and Beck, 2006). Data is organised for analysis, themes are determined using coding procedures and data is finally represented in a particular format such as discussion (Creswell, 2007). Quinlan (2011) identifies four simple stages of data analysis. The first stage is description (descriptive analysis), the second stage interpretation (meaning of the data), the third stage is the conclusion stage (minor or major conclusions) and the final stage is theorisation, where meaning is derived from the data to contribute to knowledge and the overall research question. While Quinlan (2011) identified four simple steps used to analyse data, the research literature cites many approaches to data analysis, regarding qualitative research such as content analysis, framework analysis, thematic analysis, discourse analysis and narrative analysis. The author will explore content analysis and thematic analysis at a later stage. Quinn Patton (2015, p 523) has identified useful guidelines to ensure that qualitative analysis has a robust basis as follows:

Begin analysis during fieldwork	Note and record emergent themes
Inventory and organise data	Ensure you have all data labelled dated and complete
Fill in the gaps in the data	Fill in the gaps as soon as possible after the data collection
Protect the data	Make sure data is secure and backed up
Express appreciation	Thank those who have provided the data as soon as possible
Reaffirm the purpose of your inquiry	Rethink the purpose of your research and analysis and re-engage with the research question.

Review exemplars for inspiration and guidance	Examine research and seminal papers which may motivate during the data analysis
Make qualitative analysis software decisions	If you are using software, ensure that you have technical support.
Schedule intensive, dedicated time for analysis	Data analysis requires immersion in the data and it takes time.
Clarify and determine your initial analysis strategy	This process involves reconnecting with the theoretical framework.
Be reflective and reflexive	Qualitative analysis is personal and judgemental, so learn about your analysis processes
Start and keep an analysis journal	Document the analytic process as this document is the foundation of rigour. You must observe and document your own process as you are undertaking the analysis

Table 3.12: Guidelines for data analysis.

The author will now explore content analysis and thematic analysis. Both content analysis and thematic analysis are common approaches used to analysis data in qualitative research. Vaismoradi *et al* (2013) suggest that qualitative content analysis and thematic analysis are two frequently used methods in data analysis in nursing research, however, boundaries between the two have not been clearly identified. They have been used interchangeably and some researchers find it difficult to choose between them (p 398). Furthermore, Vaismoradi *et al* (2013) in their paper identify, while, the two approaches can answer the same set of questions, some researchers have reservations, about the robustness of both regarding the provision of high quality data. However, Vaismoradl *et al* (2013) suggest that the approaches to data analysis are robust and "benefit from transparent structures that, with a defined sequence of analytic stages provide researchers with clear and user-friendly methods of analysing data" (p 403).

3.6.1 Content analysis

Content analysis is defined as 'a qualitative analysis technique to classify words into text into categories chose because of their theoretical importance' (Grove, Burns and Gray, 2013 p 281, 282). Furthermore Hsieh and Shannon (2005) define qualitative content analysis:

> As a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns
>
> Hsieh and Shannon (2005 p 1278)

A theme is viewed as a broad unit of analysis and may include a sentence, phase or paragraph that are made up of ideas or make disclosures about the topic being studied. However, the most basis form of content analysis is as outlined by Newell and Burnard (2006) where the number of times words are used in the transcript. For example, the number of occurrences of words. The author will not use this form of analysis as it is not useful or valid in qualitative research. Furthermore Newell and Burnard (2006) describe content analysis as a six stage approach which involves making notes after review of data, reading data and making notes of general themes, rereading and generating headings to include all aspects of the data, reducing the codes under higher order headings, reviewing the transcripts with the higher order codes and finally, collating the organised data. Content analysis will be used regarding the findings of the SWOT analysis questionnaire. Elo and Kyngas (2008) outline a simple format as described in Table 3.10 as follows;

Content analysis (Elo and Kyngas, 2008, p 10)
Preparation Being immersed in the data and obtaining the sense of the whole, selecting the unit of analysis, deciding on the analysis of manifest content or latent content

Organising Open coding and creating categories, grouping codes under higher headings, formulating a general description of the research topic through generating categories and subcategories as abstracting
Reporting Reporting the analysing process and the results through models, conceptual systems, conceptual map or categories and a storyline.

Table 3.13: Content analysis phases.

3.6.2 Thematic content analysis

Thematic analysis is a common approach used to analyse data, primarily used in qualitative data analysis. Many authors describe thematic content analysis as staged process. Burnard (1991) and Newell and Burnard (2006) offer the following steps to guide the researcher in thematic content analysis:

Stages	**Process**
Stage one	Notes made after each interview, that is memos
Stage two	Interview transcripts are read and notes taken on general themes
Stage three	Transcripts re-read and heading written down – open coding
Stage four	Categories are reviewed are collected which may overlap
Stage five	Return to the transcripts and highlight sections that reflect the categories.
Stage six	The organised data forms the material for write up

Table 3.14: Thematic content analysis (Newell and Burnard 2006 p 100-104)

Furthermore, Braun and Clarke (2006) explore the concept of thematic analysis and suggest that 'thematic analysis is a method for identifying, analysing and reporting themes within data' (p 77). They identify six phases of thematic analysis as follows:

Familiarising with data	Transcribing the data, reading and rereading the data, noting down initial ideas.
Generating initial codes	Coding interesting features of the data systematically across the entire data set, collating data relevant to each code.
Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
Reviewing themes	Checking if the themes work in relation to the coded extract and the entire data set, generating a thematic map.
Defining and naming themes	Ongoing analysis for refining the specifics of each theme and the overall story that the analysis tells, generating clear definitions and names for each theme.
Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a report for analysis.

Table 3.15: Six phases of thematic analysis (Braun and Clarke 2006 p 77- 87).

If qualitative research is to yield meaningful and useful results it is imperative that the material under scrutiny is analysed in a methodical manner and Attride-Stirling (2001) believes that the purpose of thematic analysis is to identify patterns and then focuses on identifying meaning from the patterns initially, identified. These patterns are identified through a 'rigorous process of data familiarisation, data coding and theme development and revision'.

Having reviewed the three predominantly used frameworks for thematic analysis the researcher identified Braun and Clarke's (2006) approach for it ease of application and the researcher identified with the process more readily than the others in terms of understanding, utility and ease of use.

The first steps in data analysis were an examination of all the data collected at each stage of the research. Data from each action research cycle was analysed and findings were described prior to engaging in next cycle. Using Braun and Clarke's framework for thematic analysis (2006) the transcripts of the focus groups were read several times to identify themes and categories and the transcripts were coded. The process was used to develop categories, which were then conceptualised into broad themes. A rigorous and systematic reading and coding of the transcripts allowed major themes to emerge. The analysis of the data from interview transcripts progressed toward the identification of overarching themes that captured the phenomenon as described by the participants in the study. The initial themes and subthemes were entered into the qualitative database, NVivo 10. The transcripts of the focus groups were imported as word documents into NVivo 10 and coded. The coding framework or code known as sub-nodes, were developed based initially on the first focus group transcript, by assigning descriptors to each part of the text. The codes were continuously refined while analysing and coding the other transcripts. The codes were grouped into broader themes known as nodes in NVivo which best captured the information following Braun and Clarke's (2006) thematic analysis method. Content was checked under each node/theme and sub node/ code to ensure that information was better captured under the correct node.

3.6.3 Data analysis SWOT questionnaire

The first stage of the research involved a review of the curriculum documents (n=13), for four disciplines of nursing that is General Nursing, Children's Nursing, Psychiatric Nursing and Intellectual Disability Nursing, and the relevant tools used regarding clinical assessment in the 13 Higher Education Institution (HEI's) to determine the theoretical models used for the assessment of competence to inform the development of the national competence documentation. (See table 3.9). Content analysis was used to inform the final SWOT questionnaire (See Appendix 12). The purpose of the SWOT was to determine the perspectives of the HEI experts in relation

to the underpinning theoretical models for the assessment of competence in use across the country.

The response rate was 61%. The data was subjected to Newell and Burnard's framework for thematic content analysis (2006). To this end all questionnaire responses were read and reread and initial ideas were recorded. Codes were generated and then collated into themes, all themes were reviewed and defined and the final themes used to inform the questionnaire in relation to theoretical frameworks.

3.6.4 Data analysis survey questionnaire

The use of the survey questionnaire was to determine in particular stakeholder's views regarding the documentary aspect of the competence assessment framework Therefore the questions were related to the first draft of the Competence Assessment Documentation (NCAD) and the guidelines document (see appendix 13).Certain questions related to demographic information, the process, theoretical frameworks for the assessment of competence and the relevance of the documentation to the role of the stakeholders.

Survey monkey participants	**Number**	**Code**
Nurse Lecturers (NL)	14	NL 7; 11; 13; 15; 32; 33; 37; 41; 47; 57; 72; 95; 97.
Clinical Placement Co-ordinator (CPC)	17	CPC 8; 9; 13; 18; 20; 22; 23; 24; 31; 35; 43; 61; 64; 69; 73; 83; 89.
Clinical Allocation Officer (CAO)	1	CAO 24.
Preceptor (RPN; RNID; RGN)	6	PCP 17; 30; 42; 51; 91; 96.
Nurse Practice Development (NPD)	4	NPD 6; 38; 55; 85.
Nurse Tutor (NT)	1	NT 41.
Student (STD)	1	STD 79.

Student allocation liaison officer (SALO) and allocations liaison officer (ALO)	2	SALO 94. ALO 12.
Organisations (ORG)	3	ORG 40, 65, 105,
	48	

Table 3.16: Coding of survey monkey participants.

Focus group questions were determined based on the findings of the SWOT questionnaire regarding the theoretical models for the assessment of competence and the finding of the data analysis survey questionnaire to determine in particular stakeholder's views regarding the documentary aspect of the competence assessment framework. The questions were related to the documentation, theoretical frameworks for the assessment of competence and the process utilised in the AHCP's and the role of those involved in the process of the assessment of competence for nursing students.

Coding is a system of clarification. It gives an identity to units of data and in this case alphanumeric codes were used. The focus group data was coded according to the role of the participants to ensure anonymity and protect the identity of participants. Regarding certain participants such as the Associate Professor and the Clinical Nurse Manager were included in the codes related to nurse lecturer and preceptor grouping as the current titles if coded would identify these two participants. Also they have a role as identified by the coding of lecturer and preceptor:

Participants	**Number**	**Codes**
Preceptors (PCP).	9	PCP 1; PCP 2; PCP3; PCP 4; PCP 5; PCP6; PCP 7; PCP 8; PCP 9.
Clinical Placement Co-ordinators (CPC).	15	CPC 1; CPC 2; CPC 3; CPC 4; CPC 5; CPC 6; CPC 7; CPC 8; CPC 9; CPC 10; CPC 11; CPC 12. CPC 13; CPC 14; CPC 15.
Students (STD).	10	STD 1; STD 2; STD 3; STD 4; STD 5; STD 6; STD 7; STD 8; STD 9; STD 10.

Nurse Practice Co-ordinators (NPC).	3	NPC 1; NPC 2; NPC 3.
Nurse Lecturers (NL)	3	NL 1; NL 2; NL; 3.
	40	

Table 3.17: Coding of focus groups participants.

In presenting the data multiple perspectives are outlined by the use of quotations that provide as Denzin (2001) describes as “thick descriptions” that link to the interview content and the interactions of the interview Kvale and Brinkmann, 2009 p 278).

3.7 Rigour and quality of the study.

All research should be evaluated for its rigour including action research. Rigour refers to the’ strength of the research design’ Gerrish and Lacey (2010 p 24). To ensure a rigorous approach to the research, Lincoln and Guba’s (1985) criteria for trustworthiness in qualitative research and Herr and Anderson (2015) criteria regarding action research were considered during all stages of the data collection, analysis, interpretation and discussion. Lincoln and Guba’s (1985) criteria used to assess the degree to which a qualitative study is trustworthy are; credibility, transferability, dependability, confirmability and validity. The degree to which these were considered for this research will be outlined and a means of demonstrating the rigour and quality of the research process. The use of coding ensured that identification of participants was protected.

3.7.1 Credibility

Credibility refers to confidence in the truth of the data and interpretation of them (Polit and Beck, 2010 p. 492). This can be achieved by prolonged engagement with the subject matter, persistent observation, member checking and triangulation. This was achieved by the researcher immersing herself over a prolonged period in the process and ensuring that at each stage of each cycle there was engagement and checking with the stakeholders. Triangulation occurred by the utilisation of three

different methods of data gathering to answer the questions already explored within this chapter including a SWOT analysis, a questionnaire, an online survey and focus group interviews (see Fig 3.4). Furthermore, an external expert was requested to review the process and findings of the SWOT analysis questionnaire to ensure that the themes were appropriate and aligned with the research question.

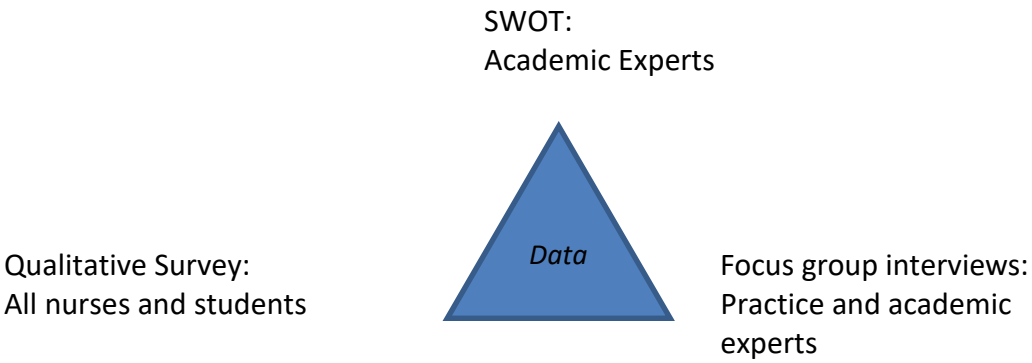


Fig. 3.4: Triangulation of data for this study

3.7.2 Transferability

Polit and Beck (2010 p. 492) refer to transferability as the extent to which qualitative findings can be transferred to other settings or groups. This is achieved by the creation of thick descriptions that can be applied in other situations and the provision of data that allows judgements by other researchers. Essentially this refers to the utility of the findings to the stakeholders and to other researchers. The first was ensured by regular engagement and checking of utility with the stakeholders as part of the structured approach which was Coghlan and Brannick's Model of Action Research. Changes were made as part of the process to ensure value and application by stakeholders. The utility to other researchers is not known at this time but will become evident upon publication of the findings.

3.7.3 Dependability

Dependability refers to the reliability of data over time (Polit and Beck, 2010 p. 492) and this was achieved by holding true to the action research process and ensuring that

the evaluation steps robustly informed the constructing step of the next cycle. Furthermore, a structured process for data analysis was used for each method applied. This ensured a robust approach, objectivity in the process and an auditable process.

3.8.4 Confirmability

Confirmability refers to objectivity that is the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit and Beck, 2010 p. 492). This was achieved by ensuring robust descriptions of cycles, methods, analysis and any iterative process so that other researchers can replicate or follow the process. This is also referred to as an audit trail. As part of the consent process participants were advised that other researchers may view the data and processes and that data would be anonymised accordingly.

3.7.5 Authenticity

This final aspect of rigour as proposed by Polit and Beck (2010 p. 493) refers to the extent to which researchers fairly and faithfully show a range of different realities. This was achieved by ensuring that the different realities of the stakeholders during the action learning cycles were identified and considered. Furthermore, the use of different methods allowed for different realities and perspectives to be identified and considered.

3.8 Ethical considerations

Research in nurse education is essential and bring together theory, education and practice and to assure public confidence regarding the nursing profession. It is therefore important that research is conducted taking cognisance of ethical considerations and that the rights of participants are protected throughout the research study. The principles governing the responsibilities of researchers when conducting research with human subjects is highlighted by the Declaration of Helsinki (1989). Three main ethical principles are outlined in the literature, namely autonomy, beneficence and justice (ICN, 1996, Beauchamp and Childress, 2001, Polit and Beck,

2004, Storch *et al,* 2004, LoBiondo-Wood and Haber 2010). The researcher contends that these principles were upheld throughout the research process.

3.8.1 Autonomy

Individuals have the right to self-determination that is they are free to choose whether or not to participate in a research study (LoBiondo-Wood and Haber 2010). The ethical considerations of autonomy was achieved by using the process of informed consent. Also participants were informed about the nature of the study and that their participation was voluntary. Therefore, the voluntary nature of participation, and in addition, the right to withdraw from the study without providing rationale, was emphasised (see appendix 8, 9, 10,11).

3.8.2 Beneficence

The principle of beneficence involves an obligation to do no harm and maximise potential benefits (LoBiondo-Wood and Haber, 2010). Participants have the right not to be harmed. Researchers have an ethical duty to balance potential benefits against potential risks thus safeguarding and protecting participants. The researcher was aware that if there was a potential threat to the safety of participants, then the research study would cease.

3.8.3 Justice

The principle of justice is synonymous with fairness and researchers are obliged to treat participants fairly before, during and after the research study. The participants were treated in a respectful manner and non-coercive manner and afforded to ask questions to ensure full understanding of the information and its implications. Furthermore, participants were advised of their right to withdraw from the process at any time without fear of recrimination.

3.8.4 Confidentiality and anonymity

The researcher is responsible for ensuring anonymity and confidentiality of the researcher participants and the data obtained. Complete anonymity and confidentiality was ensured as follows. A participant in research is considered anonymous when no one, including the researcher, can link the study data from a particular individual to that individual (Macnee and McCabe 2008). Although the researcher knew the identity of the participants at the time, the identities were anonymised upon transcription and were not identifiable thereafter. Anonymity was assured by the researcher by ensuring that every effort would be made regarding the safe storage of transcripts, recordings and notes. In order to address confidentiality, permission was sought from the participants to use the data as part of the project. All participants were given details regarding how the interviews would be conducted, recording process and the use of audio recording and the use and storage of transcripts. They were informed that they could request a copy of their interview transcripts and review and make changes if they wished. Transcripts for some focus groups were transcribed by an independent third party who signed a confidentiality agreement.

Before the commencement of the study, the researcher received ethical approval from the DCU ethics committee in accordance with the guidelines of the university (Appendix 14). The study was considered by the ethics committee a low risk study as all participant in the study are adult volunteers. In line with the plain language statement requirements, all participants were provided with details of the study. There were no perceived risks to participants and they were assured of confidentiality. There were advised of the purpose of the study and how this research would inform the national assessment documentation for nursing students in all HEI's.

3.8.5 Conclusion

This chapter outlined the research paradigm, underpinning philosophy, model of data collection, frameworks for data analysis employed to answer the research questions posed for this study. The study employed an action research approach using Coghlan

and Brannick's Model for action research (2014). Data was gathered using a triangulated approach using a SWOT questionnaire, on line qualitative survey and focus group interviews. Data was analysed using two recognised structured frameworks namely Braun and Clarke's (2006) content analysis and thematic content analysis and Newell and Burnard (2006) content analysis. Issues of rigor were identified and the steps taken to ensure issues of credibility dependability transferability and authenticity were described. Finally, the ethical issues and concerns were outlined and addressed. The findings of the study are presented in the following chapter.

CHAPTER 4: FINDINGS OF THE ACTION RESEARCH CYCLES

4.1 Introduction

This chapter begins with the findings of the SWOT analysis to determine the preferred theoretical framework/model to be included in the competence documentation followed by the findings of the survey and finally the focus group interviews. Analysis of the data will be discussed in totality in chapter five.

To comprehensively explore the views of stakeholders regarding the competence assessment framework, a SWOT analysis of theoretical models, a survey questionnaire and focus group interviews were used to answer the research questions and to develop and implement a national framework for the assessment of clinical competence of student nurses. This chapter presents the findings from the SWOT analysis, qualitative survey and focus group interviews. Furthermore, this chapter will ascertain the findings of each phase of action research using the action research cycles identified by Coghlan and Brannick (2014, p 11). This model views the cyclical nature of action research as an iterative and ongoing process and embeds the concepts of continuing development until such time as the question has been addressed. Stakeholders are involved throughout the process ensuring relevance and commitment. For these reasons this is the preferred action research model for this study.

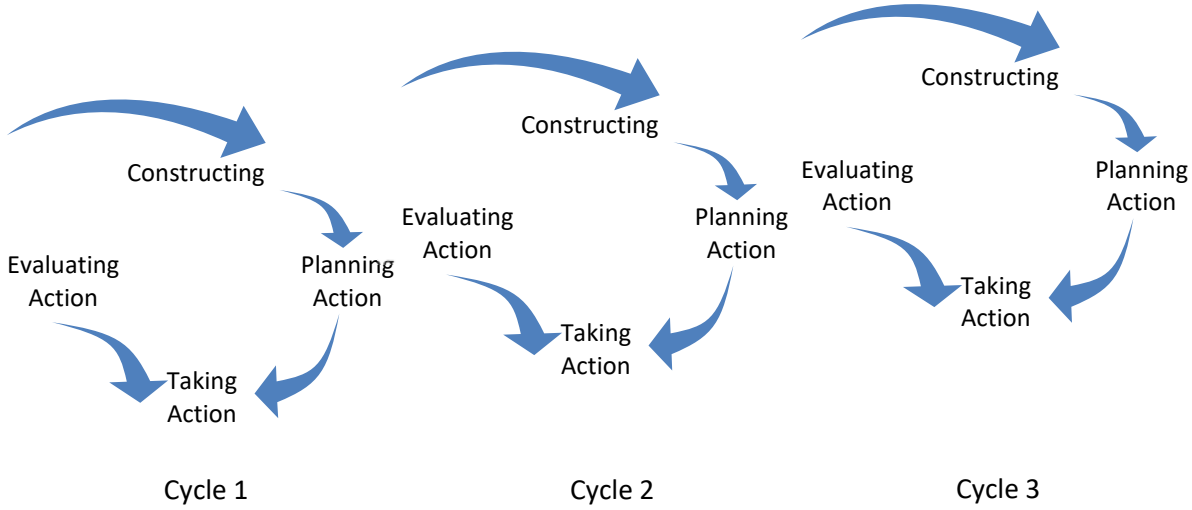


Figure 4.1: Spiral of action research cycles (Coghlan and Brannick 2014, p 11).

This chapter will be structured in accordance with findings obtained by cycle and where relevant, questions.

4.2 Findings of the first cycle of action research

The action research cycles is outlined below and will be followed to outline the findings of cycle 1.

Domains	Action
Constructing (Diagnosing)	• Documentary analysis of current assessment documentation used by the HEI's.
Planning action	• Plan to establish appropriate theoretical model/framework.
Taking action	• Establish appropriate theoretical model/framework based on previous model/frameworks. • SWOT analysis of theoretical model/frameworks.
Evaluating action	• First draft of theoretical model/framework.

Table 4.1: Action research cycle 1.

The first cycle of the action research study is related to the inclusion of a theoretical model in the final competence assessment documentation, this process is represented in table 4.1. The new documentation is required to include a theoretical model to ensure that assessment of clinical practice competence is based on a clear theoretical framework or model as indicated by NMBI.

> *"Practice based assessment of learning outcomes and competences based on an explicit model or framework for competence assessment"* (NMBI, 2016 p. 122).

4.2.1 Constructing/Diagnosing

The standards developed by NMBI will ensure that programmes of education refocus from being syllabus driven to a terminal outcomes competence model of education. Inherent within these education standards are the identification of competencies that must be achieved for entry to the Register of nurses maintained by NMBI. To achieve this, the researcher identified that a framework for the assessment of competence for nursing students was necessary. This framework will include the development of a set of assessment documents and guidelines to ensure that the process and outcomes reflect the stated standards. Therefore, the current study fulfils this requirement and will focus on developing a National Assessment Framework. The research question for the first cycle is as follows:

- What theoretical framework/model for the assessment of competence should underpin the national competence assessment framework?

The first step in the diagnosing/constructing cycle was the identification of the issues to be addressed by the action research process. This involved a documentary analysis of curriculum documents, associated assessment documentation and processes regarding the assessment of nursing students undertaking the degree programme leading to registration in the disciplines of general nursing, psychiatric nursing, children's nursing and intellectual disability nursing in HEI's (N = 13). A total of 37 curriculum documents were reviewed and it was established that 13 sets of competence documents were in circulation in Ireland at the time of data collection. All were developed by the individual HEIs and, all had the same outcomes as defined by NMBI. These documents were diverse with various titles and recording processes and some common themes were evident. However, all espoused to the same outcomes as defined by NMBI. See Figure 4.1.

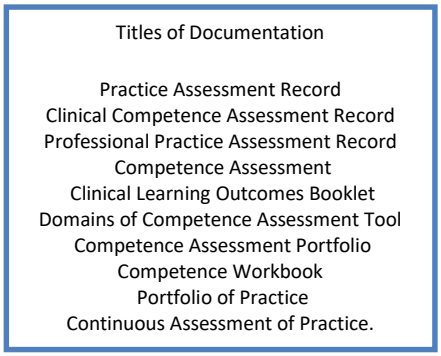


Figure 4.2: Competence assessments documentation in 13 HEI's in Ireland (2017)

Initially, all documentation was analysed to determine the current theoretical models in use to underpin their assessment framework (Appendix 1).

Documentary analysis revealed an interesting finding that that many of the HEI's (*n*=8) use a combination of theories (see table 4.3). The primary theories in use are identified in table 4.2. The competence models identified as in use nationally were Benner's Novice to expert model (*n*=8) and Blooms' (1956) competence model (*n*=2). Bondy's (1983) criterion reference model (*n*=4) and Steineker and Bell's (1979) taxonomy of experiential learning (*n*=5).

Author	*Model*	*No of HEIs using*	*Author*	*Model*	*No of HEIs using*
Bondy (1983)	Criterion referenced definitions for rating scales in clinical evaluation	4	Bloom (1956)	Taxonomy of educational objectives for knowledge based goals	2
Steinaker and Bell (1979)	Experiential learning taxonomy	5	Benner (1984)	Levels of practice and experience	8

Table 4.2: Findings regarding the theoretical models used in HEI's.

Further findings from the analysis of the HEI documentation provided direction for the trajectory of the study. A number of HEI documents included the process of competence assessment, an outline of the role of those involved in assessment including the role of the student, learning support plans or action plans. A reflective practice component was included in a minority of HEIs documentation. Other important themes included the use of the domains of competence identified in Requirements and Standards for Nursing Registration Education Programmes (An Bord Altranais, 2005), learning outcomes, assessment of practice interview forms and attendance sheets. This data enabled the researcher to determine a draft content of a national competence framework for further development in the study. Throughout the process the researcher was mindful of the need for the framework particularly the competence assessment documents needed to be reflective of the Nurse Registration Programmes Standards and Requirements (NMBI, 2016) in conjunction with the competences for entry to the register, programme learning outcomes and standards. Of particular importance regarding the assessment process are the domains of competences follows:

- Domain 1: Professional values and the role of the nurse competences
- Domain 2: Nursing practice and clinical decision making competences
- Domain 3: Knowledge and cognitive competences
- Domain 4: Communication and interpersonal competences
- Domain 5: Management and team competences
- Domain 6: Leadership and professional scholarship competences

(NMBI, 2016 p17-19).

The steps as outlined in the constructing (diagnosing) phase above informed the next step, planning action. Additionally, the documentary analysis of curricula nationally was insufficient to achieve the aim of cycle one therefore a further step was included in the diagnosing/constructing cycle which allowed for deeper analysis of the findings of the documentary analysis of step one. This involved the use of a SWOT analysis of the identified theoretical frameworks which was completed by the stakeholders. These stakeholders included the Heads of Departments in Nursing within the HEI's who play critical leadership roles by virtue of their positions in nurse education.

4.2.2 Planning action

The researcher plans to establish an appropriate theoretical mode/framework as part of the competence framework. Initially, theoretical frameworks to underpin the national competence documentation for nursing students was discussed at a meeting between the heads of nursing within the Universities and the Institutes of Technology on the 25 January 2017 and it was agreed that the SWOT analysis questionnaire and a letter of invitation would be circulated to the Heads of Department in each HEI's and it was reiterated that participation was voluntary. Letters regarding voluntary participation were posted and the questionnaires were returned by email to the education department using the email related to the department and not to the researcher's email address.

4.2.3 Taking action

The SWOT analysis questionnaire (Appendix 11) was developed with the aim of determining the views of Heads of Department of the Nursing and Midwifery Departments in the 13 HEIs in relation to the theoretical models identified in the earlier stage of cycle 1. The sample for this exercise was determined by inviting all (*N*=13) Heads of Departments to take part in the initial phase of the study by virtue of their critical leadership roles and positions in nurse education, (*n*=8: 61.5%) of those invited participated. Findings from this phase of the study are summarised in table 4.4 and will be further discussed in Chapter Five.

Inductive content analysis was utilised with a focus on the theoretical frameworks used by the Higher Education Institution (*n*=13) for this component of the study. This involved the development of categories from the raw data into a model or framework that captured key themes and processes judged to be important by the researcher (Thomas 2003, p 3). The findings were categorised into the SWOT headings of strengths, weaknesses, opportunities and treats. It was evident in the findings that there were relationships between strengths and opportunities, and weaknesses and threats therefore the presentation of findings links strengths and opportunities, and weaknesses and threats. The SWOT analysis found that no one theoretical model should be used in isolation for the purpose of this study. Furthermore, the findings

indicated that a combination of models would be beneficial as part of the assessment documentation to ensure completeness. The findings are presented in table 4.4.

	Strengths	Weaknesses	Opportunities	Threats
Bloom (1956)	Useful in assessing the student's cognition and the level of learning. *Promotes high order thinking.* *Emphasis on safe practice.* Clarity and logic makes it easy to apply and measure learning outcomes.	*Fails to acknowledge that learners may perform at different levels of proficiency.* Cognitive assessment rather than performance based. *It may be difficult to apply in practice particularly regarding skills acquisition.* *Associated with classroom learning.* Mostly knowledge orientated. *Very little evidence to illustrate how this taxonomy is effective for learning in the practice settings and complex situations.*	It can be interpreted in a way that could lead to a very structured tool. *It could be used with another model.* Useful in assessing the student's ability to think critically and problem solve and reflect. Develops critical thinking skills.	*Lack of clarity for practice.* A rigid adherence to this model could be detrimental to allowing for the development of nursing competencies. Using the theory on its own would lead to an incomplete assessment of the complexities of nursing practice. *Resistance from educators and practitioners because of its weaknesses and uncertainty of application in the clinical environment.* *Less attention paid to the skills and attitude elements.*
Benner (1984)	Widely used in nursing. *Well suited for the clinical learning environment and skills acquisition.* Benner's five stage are well defined which clearly articulates the progression from novice to expert. Focus more on performance and experiential learning. *Spiral/incremental model.* The fact that this model is well known, it could be used with another model. *Developed from observations of nurses in practice. Has potential to allow for variations across situations. A student maybe novice in one situation and advanced beginner in another situation, yet same year of learning.* Focuses in the behaviour of nurses depending on their level of understanding within nursing practice.	Requirement of research input. *Based on research and in the United States with qualified/ registered nurses and not undergraduate students.* The categories described by Benner are difficult to measure and rely on subjective and qualitative judgements. *Linear model which does not consistently meet student needs in terms of changing to a different practice setting.*	If the levels are clearly defined, it would be a very useful model. *This model ensures that students have scientific knowledge and develop the skills of critical reasoning and communication. It lays the foundation for expertise in practice.* Benner stages set on in NMBI documentation. *The opportunity of the student from novice to expert depends on the opportunities for experience available to them.*	
Steinaker and Bell (1979)	It is based on experiential learning and practice. Spiral/incremental model that encompasses the broader experience of learning. It allows the student to observe before they participate. *Identification and internalisation stages encourage the student to link knowledge and skills.* It does integrate knowledge skills and attitudes. *Works well for clinical skills.* Well known so easy to implement. *Allows for structures and objective assessment.*	Level of supervision required by preceptor unclear. *After exposure there is no mention of reflection and discussion. If reflection limited then learning is limited.* Some terms vague. Not strong for the assessment of affective and communication skills. *Focused on cognition.* Differential between identification and internalisation maybe difficult for clinical staff.	*An opportunity is that it is active learning so encourages students to engage in learning which enhances skills acquisition.* Would be very useful as part of a wider model. Potential to use for a very structured assessment which could be tested for reliability and validity. *It is very useful in terms of measuring performance in practice*	Confusion regarding levels of supervision and the level of competence to be assessed. *The use of research evidence needs to appear early in the framework.* Superficial assessment model. *The affective and cognitive domains are not measured in this theory.*

	This model takes cognisance of practice learning. *The sequencing and scaffolding of learning that is required in practice of nursing are mirrored in this model.* Offers a comprehensive and structured framework. *Use in some HEI's.* Facilitates student's application of theory to practice.	*Do not take account of the individual student's ability and the range of clinical experience.*	*and determining the level of supervision required.* Could be used to inform and outline expectations of students on clinical placement in terms of their level of engagement in experiential learning.	
Bondy (1983)	It is well predisposed as a framework of skills acquisition. *Helpful to provide a framework for objective assessment.* Focus on practice. *Measures student performance and provides students with feedback.* Reduces subjectivity and ensures fairness. *Allows staff to describe and classify more accurately the strengths and limitations of a student's performance.* Captures the essence of affective and psychomotor domains by applying the concept if increasing competence varying from dependent to independent. *It is very structures and accessible and offers a strong framework for assessment.* Performance based model and the five point rating scale are clear and make it easy for assessors to grade student performance. *Provides overall structure and framework.* Acknowledges progression of learning using the five point scale. Assessor's judgements about the student's achievement and proficiencies take into consideration the level of performance that is required for the stage of learning. *It adapts well with other frameworks.*	*Time consuming and lengthy.* Over emphasis on clinical skills development. *Not widely known or used.* This model does not assess the interpersonal and communication skills. *Very behavioural orientated.* Language of unsafe in earlier dependent phase is a concern. *Multi criteria may make it difficult to use or understand by practitioners.* The term AFFECT and EFFECT may cause confusion.	Provides a clear structure for level of support and supervision. *Offers a good starting point if combines with other models.* Criterion very suited to an undergraduate programme. *Enables assessors to describe and classify more accurately the strengths and limitations of a student's performance*. Provides more detailed, specific constructive feedback.	Overreliance on performance assessment without identifying the required level of knowledge and attitude. *If used as the only model it is to constraining and lead to narrow assessment.* *No measurement of understanding what the student is doing or thinking, clinical reasoning or problem solving skills are not measures or identified in this model.* Risk a return to task orientated approach to learning in practice. *Inappropriate use in clinical practice due to confusion over terminology.*

Table 4.3: Summation of finding of the SWOT analysis regarding theoretical models included in the Competence Assessment Document

The following conclusions were drawn from the data:

4.3 Bloom's (1956) taxonomy of educational objectives

Respondents indicated that this model can be positively employed for the development and the assessment of clinical learning outcomes. Furthermore, respondents consider Bloom's Model to be positively related to the student's ability to develop critical, problem solving and reflective skills. Conversely a number of critical weaknesses and treats were cited by participants including the inability of the model to assess performance, the complexities of nursing practice, skills acquisition and the lack of clarity inherent in the model. Importantly the respondents noted that students perform at different levels of proficiency which is not measured using this model.

4.4 Benner's (1984) levels of practice and experience

The strengths and opportunities of this model discerned from the SWOT analysis date relate primarily to the prevalence of its current use in clinical practice and there was agreement in the data that a key strength is the fact that that this model is widely used nationally and internationally. Participants welcomed the incremental focus of the levels novice to expert as it allows for the assessment of skills and performance, both highlighted as important components of becoming a registered nurse. Furthermore, the data returned indicated that the focus on novice to expert acknowledges scenarios whereby a student can be a novice in one clinical situation whilst being an expert in another. Participants further suggested that clearly defining the levels of novice to expert would be useful model when assessing student nurses. The weaknesses were in a minority and identified included the linear focus of the model and it was suggested that this model not helpful regarding students changing to a different practice setting. No treats were identified for Benner's model in this exercise.

4.5 Steinaker and Bell (1979) experiential learning taxonomy

Analysis of the data revealed the primary strengths and opportunities of this model relate to the experiential and practice based learning focus of this model. Furthermore, participants indicated that a positive component of this model includes the provision for students to observe practice prior to participating. This was cited as enabling students to link knowledge and skills and facilitating application of theory to practice. Further positive components identified in the data included that the level of supervision required by the student is acknowledged in this model. Conversely, some participants suggested that the model causes confusion relating to the supervision of students by preceptors. It is suggested that the sequencing and scaffolding of learning that is required in practice of nursing are reflected in this model. The weaknesses returned by participants centred around the use of language particularly the terms 'autonomous practitioner, identification and internalisation'. Respondents further suggested that there may be resistance from practitioners already using another model.

4.6 Bondy (1983) criterion-referenced definition for rating scales in clinical evaluation

The strengths and opportunities of this model identified by participants related to the subjectivity and the focus on skills acquisition, performance and supervision in clinical practice. It was described as 'structured and provides a strong framework for assessment and acknowledges progression of learning using the five-point scale'. A number of key weaknesses and treats were identified relating to the time needed to complete assessment and the fact that it is not widely known or used. The data revealed a concern regarding the language and terminology utilised, particularly 'unsafe' in the dependent phase and that the terms 'affect and effect' had potential to cause confusion. Participants further identified that this model would not measure clinical reasoning or problem solving skills and that there may be a risk of assessment becoming task orientated. Whilst this model is designed specifically for pre-registration nursing programmes, it did not rate positively. It is possible that the

negative ratings were commensurate with the experiences and therefore comfort associated with the use of their own named theoretical framework.

4.7 Evaluating action

The findings identified as a result of the previous stage of the cycle lead to the establishment of a theoretical model to be included in the second draft of the Competence Assessment Document (NCAD). Furthermore, the final model combines the two most positively evaluated models as a result of the process which together were analysed by the researcher and deemed to meet the standards and requirements outlined in Chapter 2. These two models combined together address issues of competence and assessment and are Benner's (1984) levels of practice experience and Steinaker and Bell (1979) experimental learning taxonomy. Therefore, the final model proposed is a combination of these two theories for the first year NCAD and ensured that the requirements of NMBI as outlined in the Nurse Registration Programmes Standards and Requirements (NMBI 2016, p 17) is met. This can be depicted as follows:

(Benner, 1984)
Novice
The student nurse has no/limited experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The student nurse is taught rules to help them apply theory to clinical situations and to perform tasks.

(Steinaker and Bell, 1979)
Exposure
The student nurse has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the practice placement.
Participation
The student nurse becomes a participant rather than an observer with the support of the preceptor where learning opportunities are identified in partnership.

Table 4.4: Identified models for National Competence Assessment Document (NCAD) for year one of the degree programme based on findings of the study.

4.8 Overall findings of first cycle

Throughout the first stage of this study, it was evident that stakeholders in general, welcomed the development of a national framework which includes the competence assessment documents. They recognised the importance of the inclusion of theoretical models for assessment of competence and provided the data necessary to determine the overall theoretical approach via the SWOT analysis. This resulting determination was that the competence assessment framework should comprise of a competence assessment document that incorporated the theoretical models of Benner's (1984) and Steinaker and Bell (1979) taxonomy that is theoretically sound and each fulfils a critical gap in the other. The next cycle aims to expand this initial work to establish the wider stakeholder views and the practicalities of implementation in practice through the use of findings of the survey and focus group interviews.

The move from a targeted sample in cycle one to a wider sample group in cycle 2 offered the opportunity for further engagement in the process of reviewing the documentation within the framework to include the competence assessment document and the guidelines.

4.9 Findings of the second cycle of action research

The second cycle of the action research related to the first draft of the assessment documentation and guidelines, this cycle is summarised in table 4.3 below.

Domains	Action
Constructing (Diagnosing)	• Establish and identify gaps remaining. • Review first draft of theoretical model/framework from cycle 1.
Planning action	• Plan to develop new competence assessment documentation (NCAD) and guidelines. • Plan to develop questions for survey.
Taking action	• Develop first draft of competence assessment documentations (NCAD) and guidelines to include theoretical model/framework. • Develop questions for qualitative survey to gather information from key stakeholders involved in nurse education and those who support students.

	• Use of survey to analysis first draft of the NCAD and guidelines.
Evaluating action	• Second draft of NCAD competed to include theoretical frameworks and guidelines.

Table 4.5: Action research cycle 2.

4.10 Constructing/diagnosing

The first action research cycle identified the proposed theoretical model(s). Remaining gaps were to be determined after the findings of cycle 2 and 3 were analysed. This cycle (2) utilised a qualitative survey to gather information to inform the first draft of the competence assessment framework, process and documentation. The purpose was to determine the views of other participants who support, guide and assess students. This data augmented existing data from cycle 1 to inform the final draft of the competence assessment documentation and guidelines.

Consequently, the research question for the second cycle was as follows:

- What assessment tools, documentation and assessment processes, and infrastructures should be developed?

4.11 Planning action

A review of assessment documentation, from a national and international perspective informed this element of the second cycle. The plan developed included the completion of the first draft of documentation related to the assessment of nursing students, and a guidance document to support this process. To achieve this the researcher developed a survey questionnaire comprised of 18 questions (Appendix 12). To access the registrant population of Ireland this survey was posted on the website of NMBI for one month. Detailed information regarding the survey was and an invitation to participate was also included in the monthly NMBI e-Zine (the newsletter of NMBI) which is emailed to all registrants.

4.12 Taking action

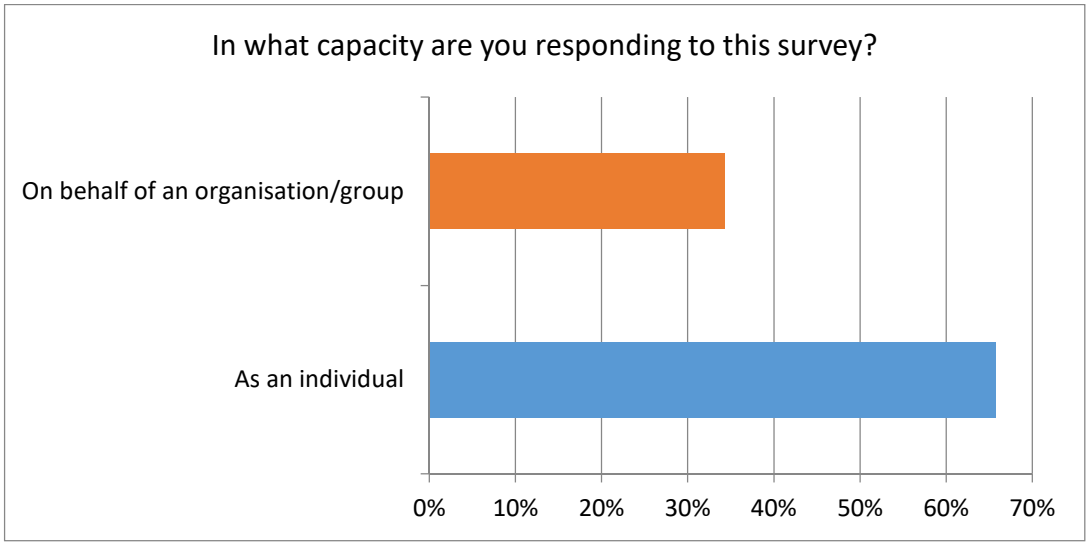
Four draft assessment documents pertaining to the four disciplines of nursing for year one (general nursing, children's nursing, psychiatric nursing and intellectual disability nursing) were developed in draft format, referred to hereafter as the 'National Competence Assessment Document' (NCAD). These documents were based on the new Nurse Registration Programmes Standards and Requirement (NMBI, 2016) which form the basis for the development of curriculum and assessment documentation by HEIs. The findings from the demographic questions stated that the majority of the respondents were employed by the Health Service Executive, followed by the Higher Education Institutions. This is unsurprising as the majority of the AHCP's are part of the Health Service Executive (HSE) who have memoranda of understanding with individual HEI's. Furthermore, the HEI's are involved in the development and delivery of the degree programme for the four disciplines of nursing. Those who identified themselves as "other" were all involved in the provision of the degree programme or teaching, supporting, guiding nursing students in the HEI's and clinical placement sites. It is important to note that the largest group to response to the survey was Clinical Placement Co-ordinators who role was identified by Drennan (2002) as

> "an experienced nurse who provides dedicated support to nursing students in a variety of clinical settings" (p 428). The primary functions of the role include guidance, support, facilitation and monitoring of learning and competence attainment among undergraduate nursing students through reflective practice.

The document with the most responses related to general nursing followed by psychiatric nursing, children and general integrated nursing and intellectual disability nursing. This is commensurate with the numbers of registrants in each of those divisions of the registers. As previously stated all registrants were invited to participate in this cycle of the study. The participants were accessed through the NMBI website and the eZine bulletin which is circulated to all registrants in Ireland monthly. The relevant documents and survey questions (appendix 12) were placed on the website of NMBI and the timeline for the process was 4 weeks (17th October 2017 to 17th November 2017).

Key findings relating to individual questions are tabulated and displayed individually hereafter. This process helped reveal the patterns which are apparent in the results. Open ended questions were thematically analysed and are also presented here. The first three questions related to demographic information and the role of the participants and the employment status of those who completed the survey (appendix 12).

4.13 Capacity to respond



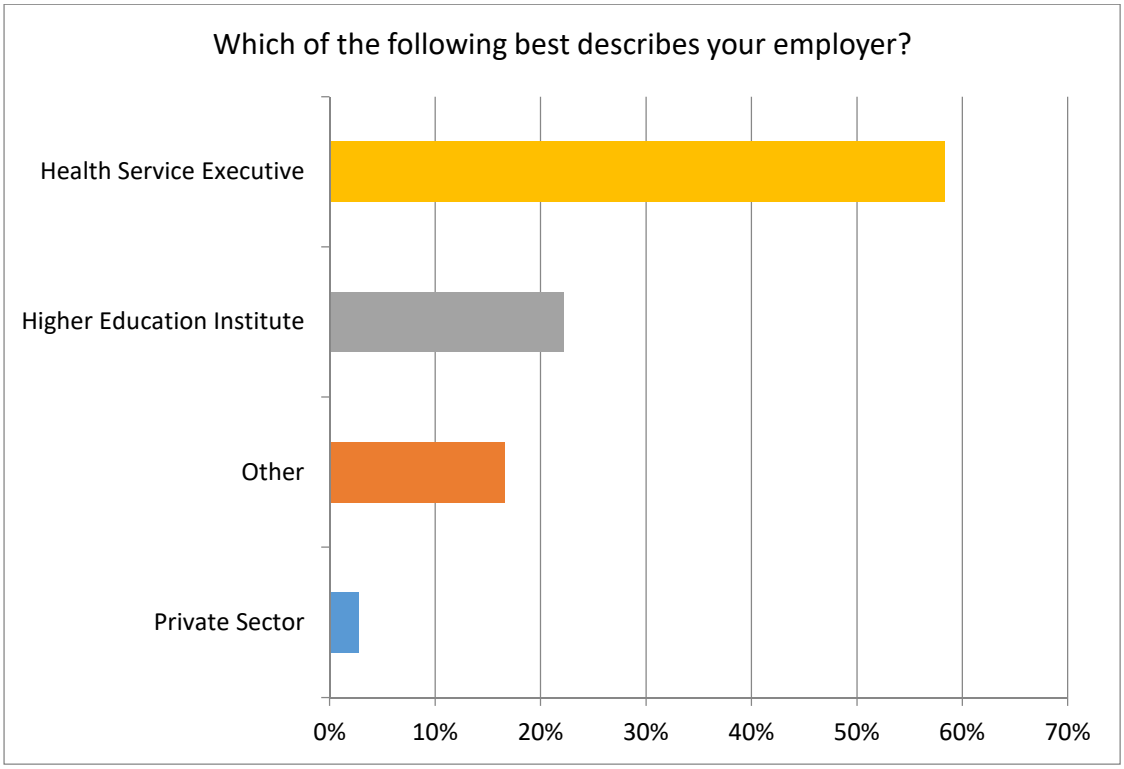
Answer Choices	**%**	***n***
As an individual	65.74%	71
On behalf of an organisation/group	34.26%	37
Total		**N=108**

Table 4.6: Findings: Question 1

Of the total number of respondents 34.26% (*N*=108), represented organisations or groups involved in student education (academic and practice). These respondents included nurse practice development teams and practice development individuals, mental health nursing groups, individual hospital groups, clinical placement co-ordinators, and regional centres of nurse education and nursing programme leads. All of these groups are critical in the delivery of the academic and practice components of the undergraduate nurse education programmes. To this end the survey captured

the voices of the critical groups from both practice and academic settings, at the centre of the delivery and support of undergraduate nurse training in Ireland.

4.14 Employment status



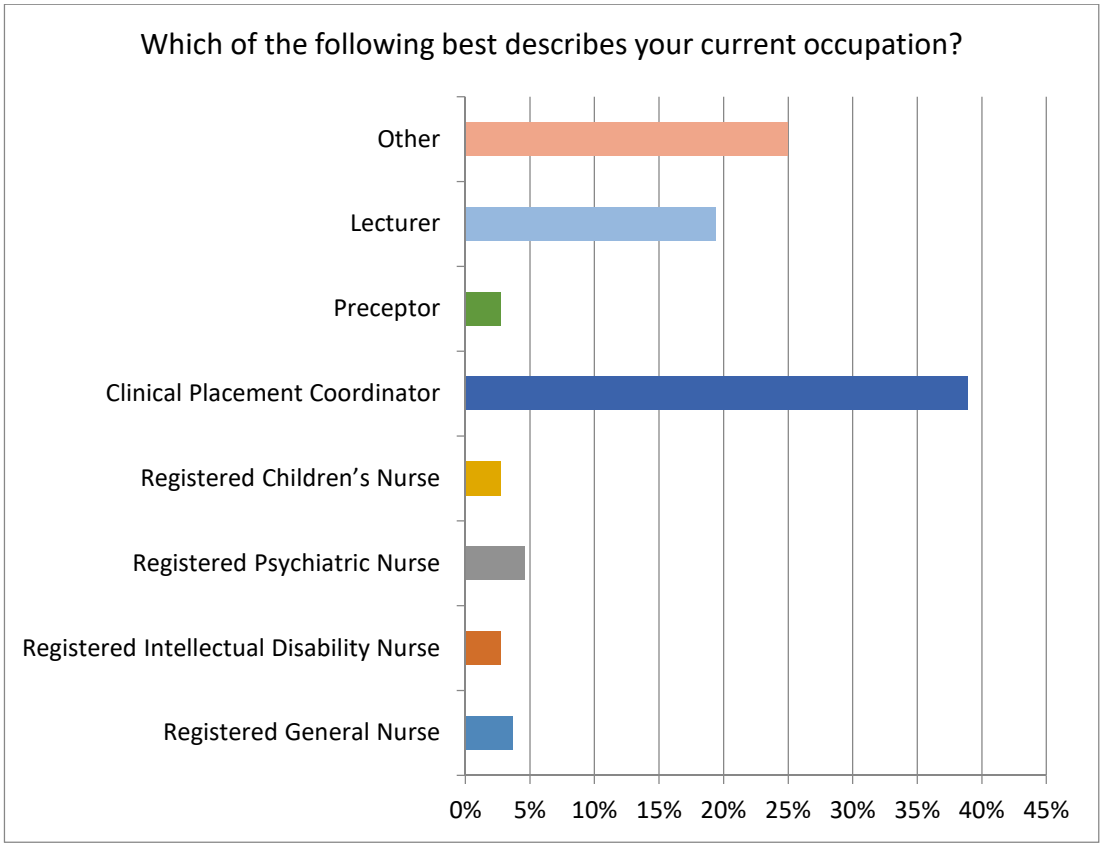
Answer Choices	%	*n*
Health Service Executive	58.33%	63
Private Sector	2.78%	3
Higher Education Institute	22.22%	24
Other	16.67%	18
Total		***N*=108**

Table 4.7: Findings: Question 2

The findings of this question relate to the employment source of the respondents and a total of 108 individuals responded. Unsurprisingly, the largest group (*n*=63: 58.33%) of respondents were employed by the Health Service Executive (HSE) followed by the HEI's (*n*=24: 22.22%), both of which play an important role in the education of student nurses. Many of the private healthcare sector sites in Ireland are not utilised for nurse education which may relate to the low response rate for that group. Other respondents included centres of nurse education and individuals who identified

themselves as interested in assessment and nurse education classified as 'other' (*n*= 18: 16.67%).

4.15 Current occupation



Answer Choices	%	*n*
Registered General Nurse	3.70%	4
Registered Intellectual Disability Nurse	2.78%	3
Registered Psychiatric Nurse	4.63%	5
Registered Children's Nurse	2.78%	3
Clinical Placement Coordinator	38.89%	42
Preceptor	2.78%	3
Lecturer	19.44%	21
Other	25.00%	27
Total		***N*=108**

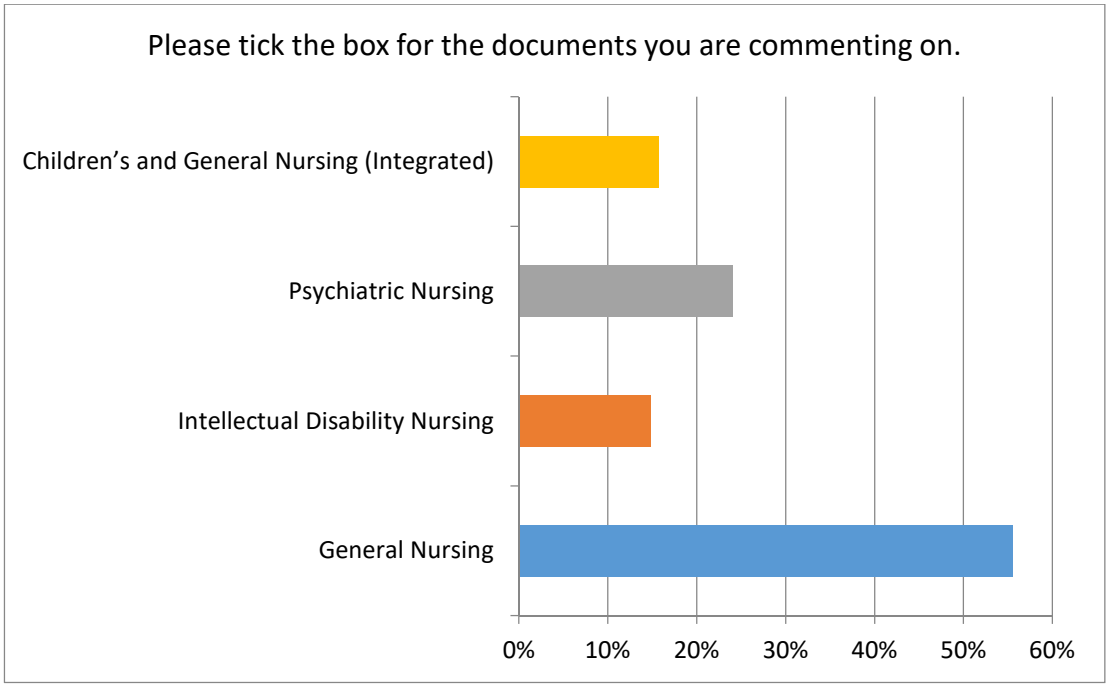
Table 4.8: Findings of Question 3

This question related specifically to those who teach, guide, support and assess students, both from a theoretical and clinical perspective. Most responses (*n* = 42: 38.89%) were clinical placement co-ordinators (CPC's), followed by lecturers (*n* = 21: 19.44%). Because of the small numbers of respondents the 'Other' category included

nurse practice co-ordinators, allocation liaison officers, clinical allocations officers, clinical educators and individuals interested in nurse education. It should be noted that the total populations for each of these groups is quite small, (1 per HSE area) which accounts for the low response rate overall. All nursing disciplines were represented.

In summation, the above questions related to demographic information regarding the participants. It was evident that those who are critical in the delivery of the academic and practice components of the undergraduate nurse education programmes and who were at the centre of the delivery and support of undergraduate nurse training in Ireland completed the survey questionnaire. Not surprisingly the largest group of respondents were employed by the Health Service Executive (HSE). Many participants of the survey questionnaire were nurse lecturers and CPC'S and have a very important role in guiding, supporting and assessing students regarding both the theoretical and clinical components of the undergraduate degree programme. Without their support, it would be difficult to sustain programmes as their roles are critical in the delivery of the degree programme.

4.16 Comments in relation to each document



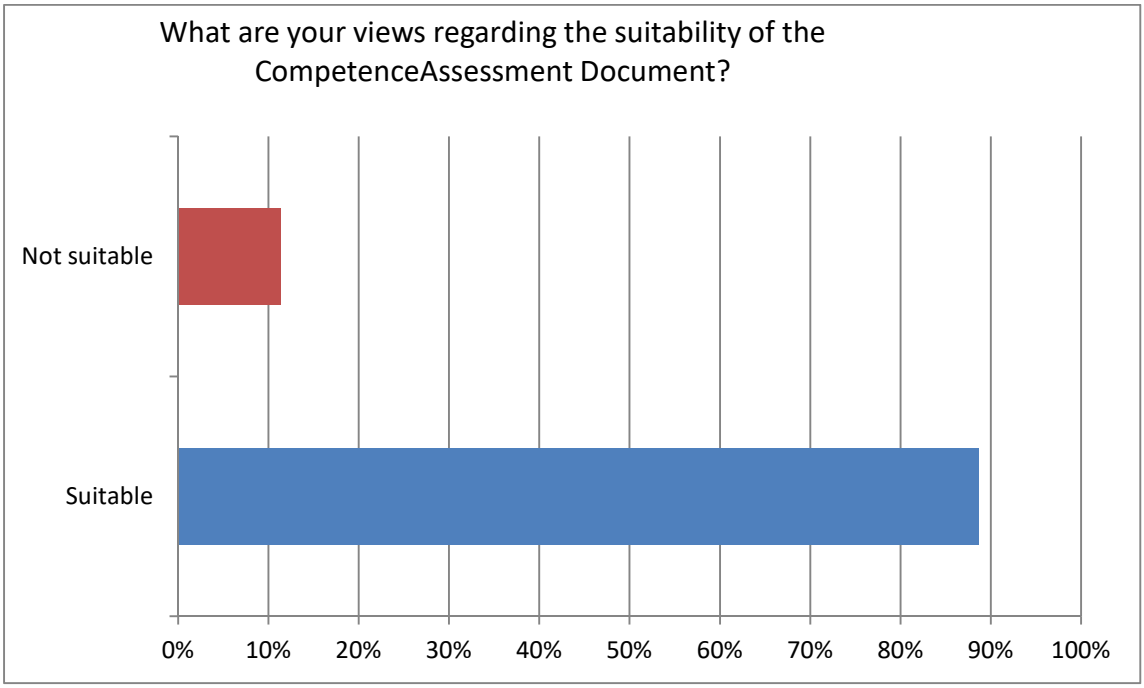
Answer Choices	%	*n*
General Nursing	55.56%	60
Intellectual Disability Nursing	14.81%	16
Psychiatric Nursing	24.07%	26
Children's and General Nursing (Integrated)	15.74%	17
Total		***N*=108**

Table 4.9: Findings: Question 4.

The findings of this question provided data relating to the respondents' relevant discipline of nursing. All four disciplines (general, psychiatric, intellectual disability, children's and general nursing) were represented. The largest response was from those registered as general nursing (*n*=60: 55.56%). This is unsurprising given that the largest group of registrants in Ireland are from that discipline (*N*=62,210) at time of study). This was followed by psychiatric nursing (n=26: 24.07%) with the lowest number of respondents from the children's and general nursing (*n*=17: 15.74%) and intellectual disability nursing disciplines (*n*=16: 14.81%).

The data outlined in the following section incorporated quantitative and qualitative findings where appropriate.

4.17 Suitability



Answer Choices	%	*n*
Suitable	88.68%	94
Not suitable	11.32%	12
Total		***N*=106**

Table 4.10: Findings: Question 5.

Q5: What are your views regarding the suitability of the Competence Assessment Document?			
	Suitable	Not Suitable	Total
Clinical Placement Coordinator	39	2	41
Lecturer	20	1	21
Preceptor	3	0	3
Registered Children's Nurse	1	1	2
Registered General Nurse	2	2	4
Registered Intellectual Disability Nurse	3	0	3
Registered Psychiatric Nurse	5	0	5
Other	21	6	27
Grand Total	94	12	106

Table 4.11 Role clarification of those who responded to Question 5

This question sought to identify the suitability of each of the assessment documents and the guidelines from the participant's perspective. The majority (88.8: *n*=94) responded that the documents were suitable and the minority (11.32%: *n*=12) indicated they were not suitable. Both CPC's and lecturers suggested that the documentation was suitable and formed the biggest groups to participate in the survey. The reasons cited as 'not suitable' were in relation to language, the omission of a section regarding clinical skills and that the self-evaluation model may not be suitable for first year student nurses.

Qualitative findings revealed that a national document was welcomed;

> *"I welcome a national standardised document for competence assessment". NL 7*
>
> *"Good to have a national competence document and guidelines for preceptors". CPC 18*
>
> *"We welcome the national document and feel it is an improvement on the current format". CPC 22*

For those participants who considered the documentation to be unsuitable, the main concerns related primarily to subjectivity, a lack of emphasis on reflection and the length of the documents;

> *"Not suitable because of lack of documented evidence and its subjective… no assessment framework". ORG 40*

There is no emphasis on reflective practice". NL 57

"I also feel critical skills need to be explicit". CPC 64

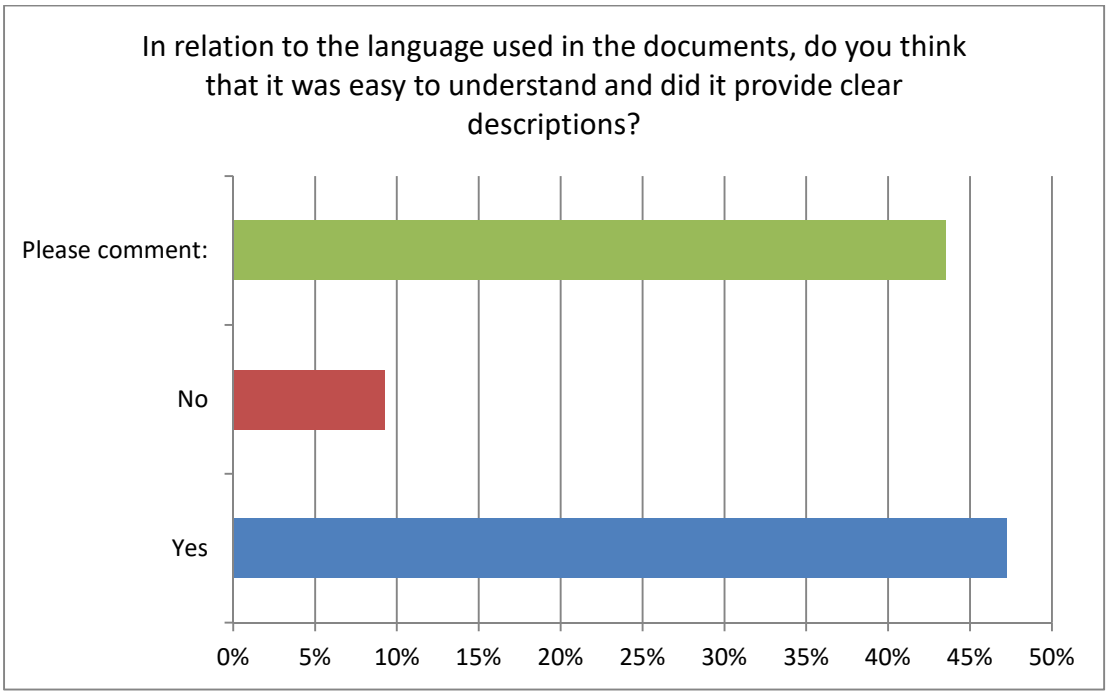
"For 1st year it is very long". ORG 105

There was opposing views about data protection and the availability of student records to preceptors from placement to placement;

"In the declaration statement under 'Record of on-going achievement', it's not fair to ask the learner to consent to allow data about them to be shared between successive preceptors". NT 41

"Strongly welcome that document covers all placements in one year so that subsequent preceptors can view previous assessments, allows more continuity to assessment process and also highlights recurring issues. CPC 43

4.18 Language usability



Answer choices	%	*N*
Yes	47.22%	51
No	9.26%	10
Please comment:	43.52%	47
Total		***N*=108**

Table 4.12 Findings: Question 6

Q6: In relation to the language used in the document, do you think that it was easy to understand and did it provide clear descriptions?				
	No	Yes	Please comment:	Total
Clinical Placement Coordinator	1	24	17	42
Lecturer	1	9	11	21
Preceptor		2	1	3
Registered Children's Nurse	1	1	1	3
Registered General Nurse	1	1	2	4
Registered Intellectual Disability Nurse	1	1	1	3
Registered Psychiatric Nurse	1	2	2	5
Other	4	11	12	27
Total	10	51	47	108

Table 4.13 Role clarification of those who responded to Question 6

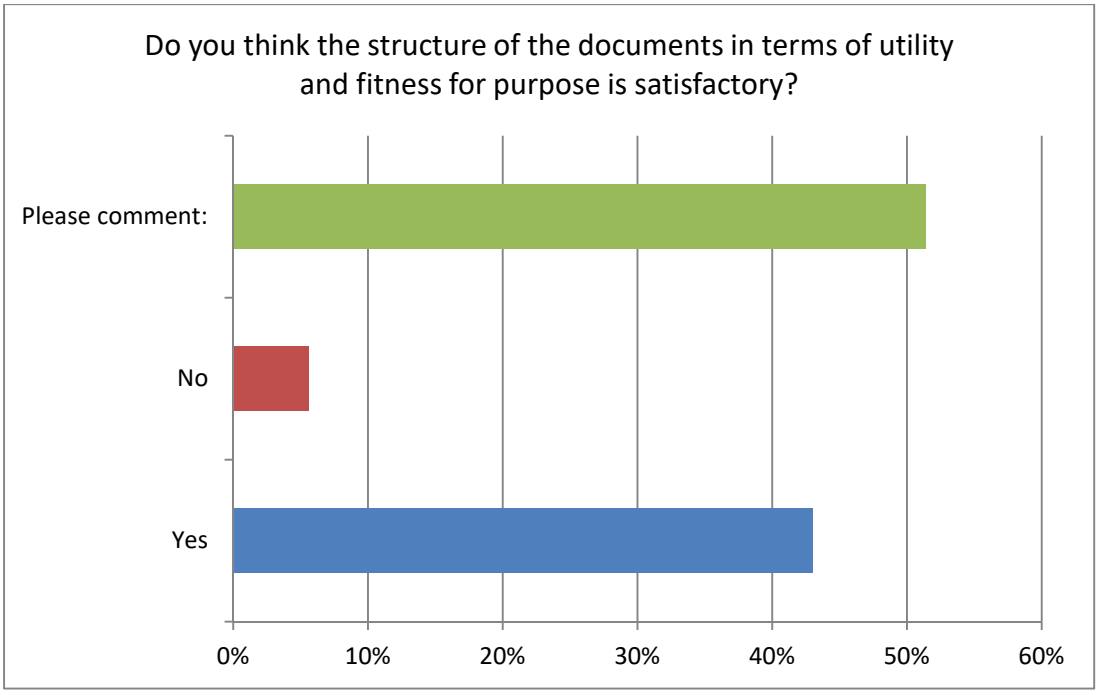
Just under half (47.22%: *n*=51) of the participants were positive about the language used in the competence assessment documents. Again CPC's the largest group of respondents stated the language was easy to understand. Positive comments included reference to clear, concise, well explained specific language. Only 9.26% (*n*=10) of participants indicated they were not happy with the language in the document. The qualitative findings revealed positive and negative aspects regarding the documentation such as clear, understandable, concise, well explained, easy to read, however, other findings suggested that the language was inconsistent and needed to be discipline specific;

"Psychiatric nursing as term is outdated". ORG 4O

"There is no reference to person-centred care". RNID 30

A number of comments in this section were excluded from the findings as they did relate to the research question and did not take cognisance of the Nurse Registration Programme Standards and Requirements (NMBI, 2016)

4.19 Utility



Answer Choices	%	N
Yes	42.99%	46
No	5.61%	6
Please comment:	51.40%	55
Total		**N=107**

Table 4.14: Findings of Question 7.

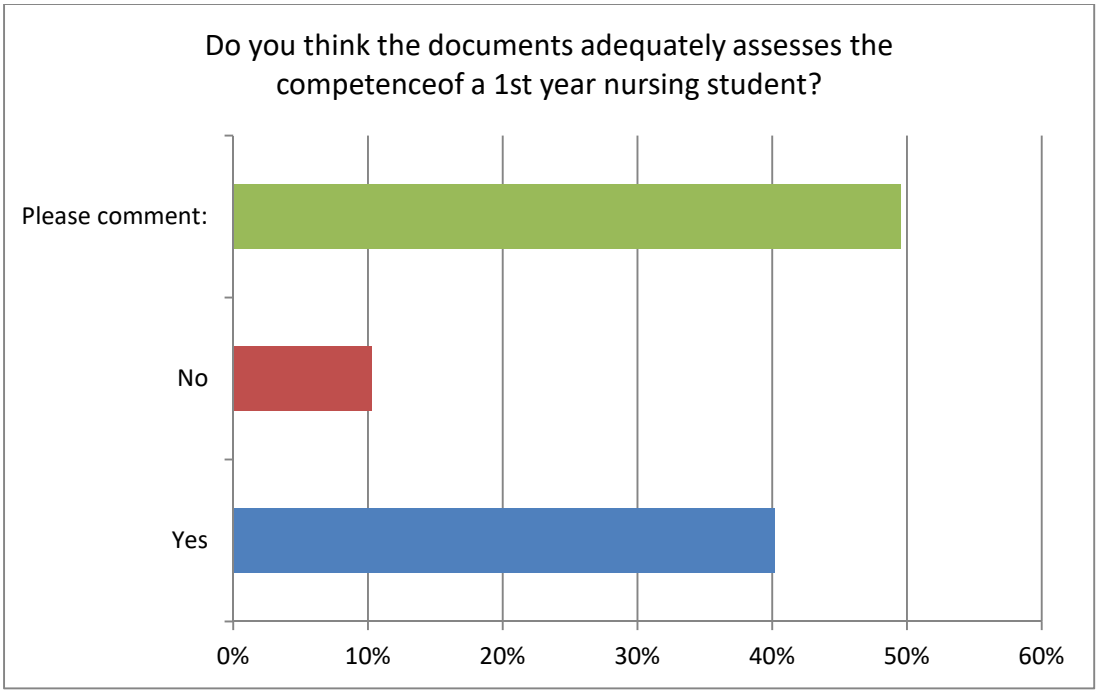
Q7: Do you think the structure of the document in terms of utility and fitness for purpose is satisfactory?				
	No	Yes	Please comment:	Total
Clinical Placement Coordinator	1	18	22	41
Lecturer	0	9	12	21
Preceptor	0	2	1	3
Registered Children's Nurse	1		2	3
Registered General Nurse	1	1	2	4
Registered Intellectual Disability Nurse	1	1	1	3
Registered Psychiatric Nurse	1	2	2	5
Other	1	13	13	27
Grand Total	6	46	55	107

Table 4.15 Role clarification of those who responded to Question 7

The overall findings for this question were positive in relation to the structure and utility. 42.99 (*n*=46) indicated that they were happy in this regard with a further 51.40% (*n*=55) making positive comments which included that the document was robust, user friendly and well defined. The majority of positive responses were provided by the CPC's. Negative comments were in the minority (5.61%: *n*=6). However, some constructive comments were made to mitigate these particularly in relation to the signatures required in the final interviews. Qualitative data findings reiterated previous comments made;

> *"I think there is a need to include a section assessing skills, medication management in addition to the domains". NL 32*
>
> **"***Remove academic link lecturer signature box on final meeting as it implies that this university link person will attend the final meeting which they do not". NL 32*

4.20 Assessment of competence for 1st year



Answer choices	**%**	***n***
Yes	40.19%	43
No	10.28%	11
Please comment:	49.53%	53
Total		***N*=107**

Table 4.16: Findings: Question 8.

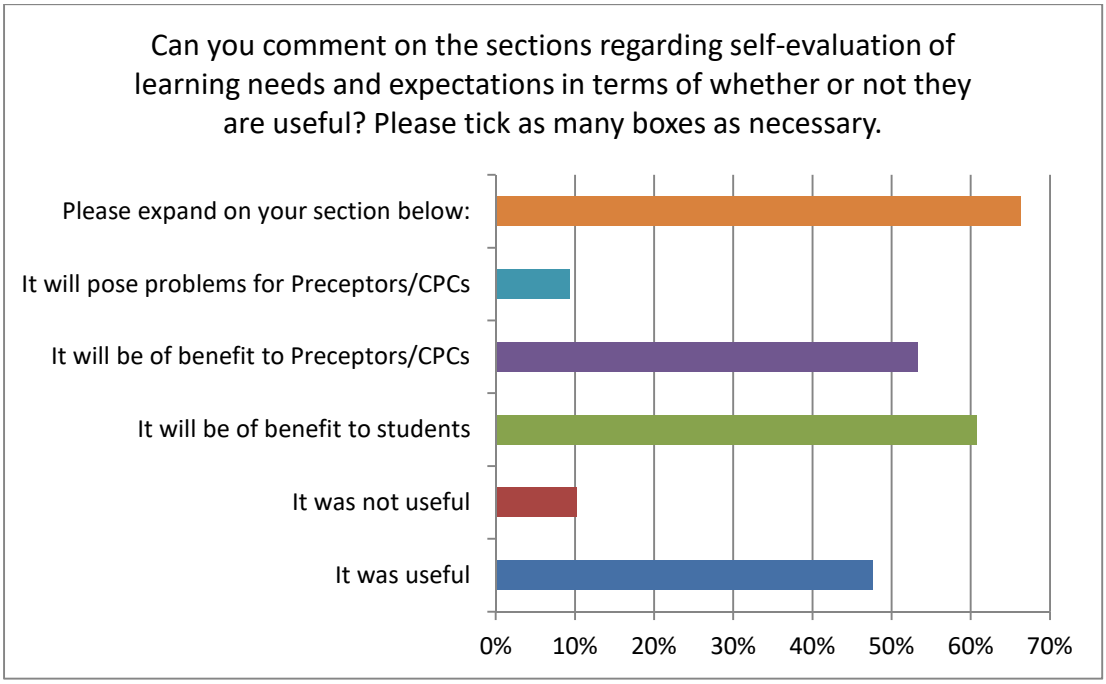
Q8: Do you think the document adequately assesses the competence of a 1st year nursing student?				
	No	Yes	Please comment:	Total
Clinical Placement Coordinator	2	14	20	36
Lecturer	1	10	10	21
Preceptor	0	0	2	2
Registered Children's Nurse	0	1	0	1
Registered General Nurse	1	1	2	4
Registered Intellectual Disability Nurse	0	2	1	3
Registered Psychiatric Nurse	1	2	2	5
Other	4	9	13	26
Grand Total	9	39	50	98

Table 4.17 Role clarification of those who responded to Question 8

Almost half of respondents (49.53%: *n*=53) chose to comment on the use of the domains of competence in adequately assessing the competencies of the first year nursing student. These were some constructive comments highlighting that indicators under some of the domains of competence were outside the scope of a first year nursing students. The remaining responses were largely positive with 40.10% (*n*=43) indicating 'yes' and the minority (10.28%: *n*=11) indicating 'no'. The qualitative data again reinforced findings from previous questions around assessment and reflection;

> *"There is no reference to levels of learning, example, Benner, Stainaker and Bell". NL 57*
>
> *"The omission of any requirements for reflection within the booklet is a huge concern. Reflection is a key requirement in the development of mental health nursing and central to values based practice, yet there is no opportunity in the document it. It's also another means of demonstrating competence". RPN 51*
>
> *"I think there needs to be a skills acquisition section whereby the theoretical knowledge and skills covered in college are monitored in the clinical placement". RPN 91*

4.21 Self-evaluation of learning needs



Answer Choices	%	n
It was useful	47.66%	51
It was not useful	10.28%	11
It will be of benefit to students	60.75%	65
It will be of benefit to Preceptors/CPCs	53.27%	57
It will pose problems for Preceptors/CPCs	9.35%	10
Please expand on your section below:	66.36%	71
Total		***N*=107**

Table 4.18: Findings of Question 9.

This question sought to gather data about self-evaluation of learning needs by the student nurse and to determine the views of those involved in assessment in relation to the benefits and difficulties of this new section of the documents. The majority of respondents indicated that the inclusion of this section in the documentation was useful (47.66%: n = 51) with 10.28% (n=11) indicating it was not useful. Similarly, over half indicated it would benefit the student (60.75%: *n*=65) and the preceptor (53.27%: *n*=57). 66.36% of respondents provided additional comments which highlighted the value of the self-evaluation section. Furthermore, the comments indicated that this inclusion would ensure the use adult learning style, identify learning opportunities specific to the placement and focus the student nurse on learning. The concept of self-assessment was seen to support nursing students to identify their own learning needs

and take ownership of their learning. This section of the documentation was also seen as supporting preceptorship collaboration and open communication. Qualitative findings also suggested that there were broader benefits to the inclusion of self-evaluation in the documentation including guidance for the preceptors, identification of student concerns, open communication and promotion of student ownership of their learning;

> *"The student required a self-evaluation to clearly identify their learning needs for the placement and it provides the preceptor with guidance on the instrument the student requires during their clinical placement". CPC 9*

> *"This is extremely beneficial as many students present with anxiety and lack confidence which is often is not seen at initial interview. Will lead to more open communication". CPC 13*

> *"It also gives them responsibility for the document and their assessment. They have to take ownership of their assessments and their objectives". CPC 35*

However, there were some concerns about the ability of students at this early stage of training to identify and articulate their learning needs;

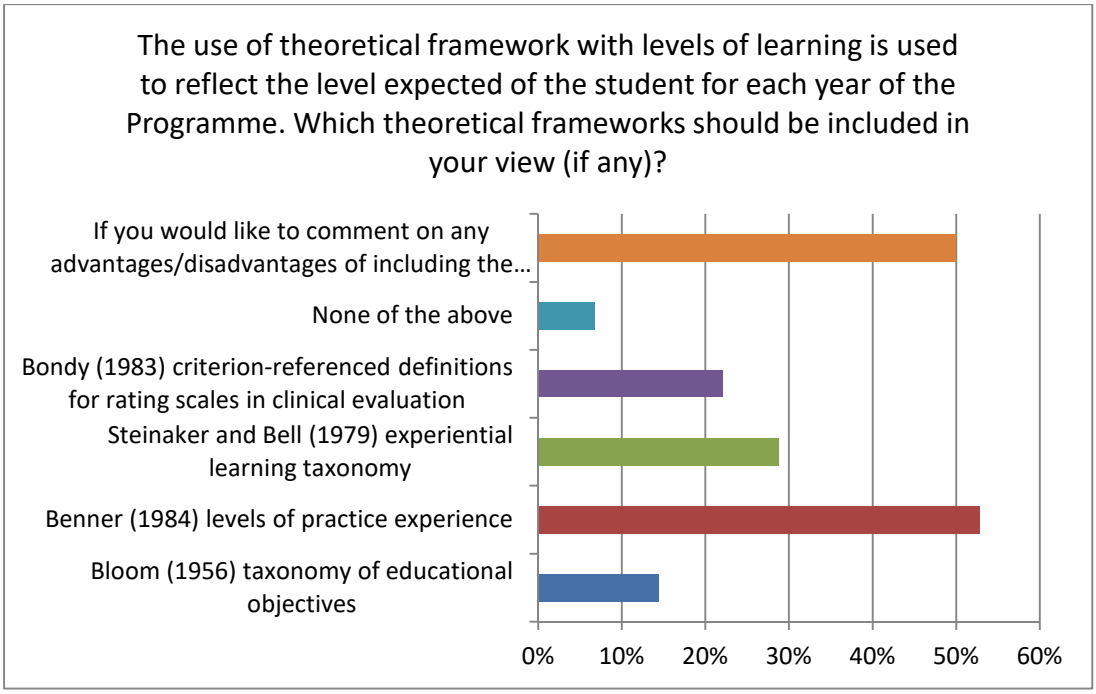
> *"First year students will find it difficult to articulate their learning needs". NL 11*

> *"Not appropriate for some first year students. May be more suitable for mature students for instance who have significant life experiences". CPC 31*

The inclusion of the values based model in self-evaluation section was viewed as helpful;

> *"A focus on the values based enquiry model is to be welcomed as it will help capture the attitude aspects of the ASK – attitudes, skills, knowledge framework". RPN 51*

4.22 Theoretical frameworks



Answer Choices	**%**	***n***
Bloom (1956) taxonomy of educational objectives	14.42%	15
Benner (1984) levels of practice experience	52.88%	55
Steinaker and Bell (1979) experiential learning taxonomy	28.85%	30
Bondy (1983) criterion-referenced definitions for rating scales in clinical evaluation	22.12%	23
None of the above	6.73%	7
If you would like to comment on any advantages/disadvantages of including the above, please do so:	50.00%	52
Total		***N*=104**

Table 4.19: Findings of Question 10.

This question focused on the theoretical models identified in cycle 1 of the study in terms of inclusion in the new documentation. Benner (1984) levels of practice experience model was identified as the most appropriate (52.88%: n=55) followed by Steinaker and Bells' (1979) experiential learning taxonomy (28.85%: *n*=30). Seven respondents (6.73%) indicated that none of the models identified were suitable, however no new models were proposed in the comments section. Bondy's (1983) criterion-referenced definitions for rating scales in clinical evaluation and Bloom (1956) taxonomy of educational objectives received the least approval responses at 22.12% (*n*=23) and 14.42% (*n*=14) respectively. In summation, the draft documentation used for the survey monkey questionnaire and the focus groups did

not include a theoretical model however question 10 was included to determine the necessary model(s) to be included in the final documentation by other stakeholders as the SWOT analysis questionnaire elicited the views, only of Head of Nursing and Midwifery in HEI'S.

In addition, the qualitative findings suggest that there was agreement in relation to the need for a theoretical framework which was viewed as important to reflect on and measure learning levels and to assist the preceptors;

> *"A theoretical framework should be used to reflect the learning levels... We welcome a standardised theoretical framework across national competences". CPC 22*
>
> *"More guidance required – perhaps a learning taxonomy will assist the preceptor with the assessment process". NPD 55*
>
> *"Consider it a necessary requisite enabling clear guidance for both the learner and preceptor". NT 41*
>
> *"Whatever framework is chosen will need to be included in the competence assessment to guide preceptors in simple terms, clearly articulating the expectations in a measurable form". RGN 42*

Some respondents commented on the utility of specific theoretical frameworks;

> *Bloom's taxonomy is good for the writing of the learning outcomes but is poorly understood…Benner is useful in clinical practice because it describes the incremental increase in knowledge and skills". CPC 69*
>
> *"I think the levels of learning need to be clear and consistent but also take into consideration the different placement journeys of the student. Bondy from experience of its use has helped staff and I do think some levels of learning needs to be included but Bondy causes a lot of confusion with the word independent". NPD 85*

Many respondents viewed Benner's (1984) levels of practice experience, as the model of choice followed by Steinaker and Bell (1979) experiential learning taxonomy;

> *"Benner (1984) levels of practice have worked well to date with clear guidance for learning levels. Steinaker and Bell (1979) incorporates reflection and therefore would be useful to". ALO 12*

Others participants suggested that;

"Achieving learning outcomes are sufficient measures of student's performance and theoretical frameworks only complicate matters in our opinion". NL 33

The findings of questions 11 to 18 were qualitative in nature. The following table outlines relating to the response rates, thereafter the thematic analysis of the qualitative findings are presented.

Question number	**Question**	**Answered (n)**	**Not answered (n)**
Question 11	How would you improve the competence assessment documents/any other comments?	100	8
Question 12	What do think of the current process used to assess competence in your area of practice?	100	8
Question 13	What are the issues with its implementation in your opinion?	99	9
Question 14	How far do you think the current interview schedule is manageable regarding time, clarity and ease of use for preceptors and students?	98	10
Question 15	How far does the guidance document provide clear direction for preceptors in their role?	97	11
Question 16	How will the document help you in your role?	88	20
Question 17	What aspects of the guidance document do you find most helpful?	86	22
Question 18	Do you have any comments in relation to the guidelines for document?	75	33

Table 4.20: Responses rates for Questions 11-18: response rates

The data generated from questions 11-18 did not produce as much data as earlier questions. However, the data obtained was rich and relevant and informed the

competence framework. Furthermore, there was an overlap of responses across all survey questions, therefore common themes were identified across all responses rather than identifying finding for individual questions. The findings of the questions again related to the content and required content, language, the process of assessment and implementation, and the role of those who are part of the assessment process.

The findings of these questions related to the content and required content, language, the process of assessment and implementation, and the role of those who are part of the assessment process. The data was detailed and rich and mixed views were revealed. Many comments were not related to the structure pf the documents and were more applicable to specific content. Participants were largely positive about the suitability of the competence assessment documents and a national standardised approach for the four disciplines of nursing were welcomed;

> *"Clinical sites being accessed by a number of HEI's – the new national assessment tool will help to avoid multiple documents being used in some clinical settings". NL 15*

The documents were also seen to address issues around transparency of assessment and preceptor justification of accountability for assessment decisions;

> *"Believe this document is timely and sets a national framework to guide assessment. It appears to be very comprehensive and offers unambiguous framework which should make it easier for preceptors to justify their decisions. Frequently preceptors feel 'exposed' when in their professional opinion the student had not reached the minimum level of competence, the guidelines make it easier to accurately identify deficiencies". NL 37*

Respondents approved the individuality of documents based on the disciplines of nursing. However, some respondents, particularly relating to the psychiatric programmes suggested that the documents did not represent mental health nursing in relation to language, title and the importance of the use of certain themes such as person centred care;

> "*Overall the document does not reflect the core of mental health nursing and the title of the document does not reflect the core values of mental health".NL 65*

"For mental health it should reflect person centred care and a recovery oriented approach". NPD 6

"The language of monitoring and gathering information and risk assessment is not person centred …ignores the centrality of the person's voice". NL 11

The three interview process were viewed as helpful and providing clear expectations for students. Participants found the documents to be concise, accurate and helpful for the preceptor. Findings suggest that both documents will be helpful because;

"This document will help preceptors and CPC's in their role and will ensure more quality assessments". CPC 13

"Standardised assessment is helpful for clinical colleagues supporting student learning". NL 15

"The preceptor will have guidance prior to the student coming out and guidance for the document". CPC 18

Other findings related to the process of assessment and the need to include an interview schedule. Many identified that the interview process was structured and fair and welcomed the inclusion of three interviews for placements of six weeks. These were deemed useful as this would allow for formal feedback early and during placement and students would be aware of expectations;

"*I think the document will speed up the interview process as it is very clear as to what is expected and the student should have their self-assessment completed prior to interview". CPC 13*

"I suggest it is manageable provided the student is prepared and the preceptor is competent and confident in their role". NL 15

"The three structured interviews are very useful. The student must be given feedback formally, and given the opportunity to address their shortcomings. This is fair to both student and preceptor". CPC 73

Again, the process of three interviews for each clinical placement was positively received by participants who recognised the important role of preceptors in this process. However some participants identified the challenges of this role in relation to assessment. There were a number of concerns around the role of the preceptor in

failing students particularly around the concept of 'exposure' (NL 37) and accountability issues for preceptors. The reluctance pf preceptors to fail students was highlighted as a concern;

> *"There is a definite reluctance to take actions to place the student on a learning support/action plan/fail the student". NL 47*

It was suggested that preceptors 'failure to fail' (CPC43) could be mitigated by support to enable preceptors to be confident and courageous in failing students;

> *"Some preceptors lack courage and accountability regarding the decision to fail a student and there is a lack of support from the HEI's". CPC 8*
>
> *"Lack of confidence of preceptor in their role may result in 'failure to fail. Preceptors busy clinical work load leaves less time to preceptor students. Assessment has become a pen and paper exercise for some preceptors". CPC 43*
>
> *"One problem is the reluctance of preceptors to fail students where this necessary. This is being addressed through preceptorship workshops and substantial support for preceptor in individual situations". RPN 51*

The fact that the assessment process results in a pass or fail outcome was deemed to create conflict for preceptors;

> *"Possible conflicting role of preceptors supporting and encouraging students v's assessment and if necessary fail students". CPC 43*
>
> *"I am happy to see pass/fail as it puts onus on the student". CPC 89*

However, as in previous findings the continuity of those who support students particularly, preceptors was identified as a challenge to the process of assessment;

> *"Preceptors have difficulty allocating time from clinical work load to interview process". CPC 43*
>
> *"…A big challenge, especially finding trained preceptors". CPC 83*
>
> *"Since staff shortage in the recession, it appears there is still shortage of preceptors so the number available don't have enough time to complete the paperwork". CAO 24*
>
> *"One of the greatest challenges will be continuity of preceptors". CPC 23*

Respondents recommended the allocation of protected time for preceptors to complete interviews and meaningful engage in the process with the student;

"*Interviews are manageable if protected time given". NPD 38*

"…needs more standardised training for preceptors and protected time for preceptors". RGN 96

"Recommend protected time to enable completion of this detailed assessment in a fair consistent and through manner". NT 41

"Preceptors need protected time to meet with the students to discuss the students learning needs, orientate the student, assess and complete the documentation". CPC 83

However, the challenges associated with this recommendation were recognised;

"It remains unrealistic to achieve protected time to complete interviews. On occasions, interviews occur outside of shift time for both students and preceptors". CPC 61

The challenge of consistency was seen to be compounded by the availability of trained preceptors;

"A big challenge, especially finding trained preceptors. In recent years many of the staff are newly qualified; need mentoring themselves and I believe do not always have the skills to assess students". The preceptorship training needs to be mandatory to get staff released". CPC 83

"…needs more standardised training for preceptors and protected time for preceptors". RGN 96

Some participants indicated that the guidance regarding an action plan was insufficient and needed to be expanded particularly for preceptors;

"Could do with more information about the supportive learning plan". NL 7

"Clarification required…learning support plan"…would require a template for this". CPC 22

Participants identified other dynamics impacting on the assessment process;

"The success of a student depends completely on how they get on with their preceptor and how they valued and treated at ward level, attitude and interactions with staff and patients can also determine success". SALO 94

Participants suggested ways to improve the document particularly around the inclusion of reflection and clinical skills;

"The document is aligned with the new standards and requirements (2016), however I am disappointed that core skills and dedicated space for written

reflections on practice experiences an learning for students are not included".NL 7

"There should be a section to document reflective pieces". CPC 9

"There are no skills identified in the document". RGN 17

"Use of reflective notes to inform the assessment process". CPC 64

"Reflection is mentioned but no reflective frameworks". NL 95

Other suggestions for improvement included the use of language, the inclusion of a record of attendance, skills list, pass/fail, progression criteria/ action plans and preparedness of preceptors;

"The language is not person centred". NL 72

"Why use 'service user' suggest use 'person' as in standards document". NL 47

"I suggest a section to record clinical placement hours". NL 13

"The pass and progression requirements should be more explicit". CPC 31

"Make clear pass progression criteria for each placement and year". RNID 30

"It may need a little further explanation if a student is failing". CPC 23

"Might the inclusion of a skills list also help the student to see and value their progression through the programme and give the assessor more evidence of student achievement on which to base their decisions". CAO 24

"As a current Children's and General intern, I believe it is important to have certain basis nursing skills integrated in the document". STD 79

However, clarity of expectations were considered to be important in the process;

"I think the document will help and speed up the interview process as it is very clear as to what is expected and the student should have their self-assessment completed prior to interview". CPC 13

The need for ongoing education was highlighted and the shortage of trained preceptors was an issues for some participants;

"Preceptors require education and workshops. A national e-programme would also be required to supplement this for new preceptors". CPC 20

The following conclusions were drawn from the data:

In conclusion, this section of the study yielded valuable data in relation to the utilisation of a standardised national documentation, suitability and language, which informed the overall development of the framework and documentation. In addition, there are four overarching themes evident from these findings of the survey monkey questionnaire, the inclusion of a theoretical framework for the assessment of competence, the assessment process, the support structures of preceptors and CPC's and reflective practice and self-evaluation.

4.24 Evaluating action

The findings from this section of the study contributed to the establishment of a competence framework which included the Competence Assessment Documentation to include theoretical frameworks and a Guidelines document. Consequently, the second draft of the assessment documents for the four disciplines of nursing included:

Section 1	Welcome to your competence assessment document Student details Record of ongoing achievement Accepting appropriate responsibility
Section 2	Clinical placement details for year one of the programme o Practice experience 1 o Practice experience 2 o Practice experience 3
Section 3	• Guidance for the undergraduate nursing student o Competence in practice o Progression o Assessment process o Initial interview o Midpoint interview o Final interview
Section 4	• Registrants signature sheet

Section 5	• Self-evaluation of learning needs and expectations • A guide to help with your self-evaluation (The value based enquiry model, McLean, 2012).
Section 6	Competence assessment interview – Preliminary interview Domain 1: Professional values and conduct of the nurse Domain 2: Nursing practice and clinical decision making Domain 3: Nursing knowledge and cognitive competence Domain 4: Communication and interpersonal competence Domain 5: Nursing management and team competence Domain 6: Leadership potential and professional scholarship competences
Section 7	• Competence assessment interview – Mid placement interview • Competence assessment interview – Final placement interview • Practice experience 1: Competence development action plan (if required)

Table 4.21: Content of the second draft of the four Competence Assessment Documents (NCAD) for first year of the programme.

In the documents, section 4 to 7 were repeated for practice placement experience two and practice placement experience three for the first year of the programmes. The next draft document within the framework was entitled 'Guidelines for preceptors on completing the competence assessment documents' and was divided into the following sections:

Section 1	• Introduction • Aim of this document
Section 2	• Competence for entry to the NMBI register • Domains of competence
Section 3	• Assisting undergraduate nursing students to develop competence

Section 4	• Supervision levels for undergraduates o Level 1 o Level 2 o Level 3 o Level 4
Section 5	• Competence assessment documentation
Section 6	• Achieving and maintaining competencies and skills • Questions that the preceptor may want to consider when making an assessment judgement • Self-evaluation model (McLean 2012)

Table 4.22: Content of the third draft of Guidance Document.

4.25 Overall findings of cycle 2

The framework and documentation were reviewed together incorporating the survey findings and the outcome informed cycle 3 of this action research study.

4.26 Findings of the third action research cycle

This section describes action research cycle 3 and presents the associated findings. The structure of this cycle is represented in table 4.5 below:

Domains	Action
Constructing (Diagnosing)	• Review of documentation from cycle 2 and determine the need for further refinement.
Planning action	• Plan to establish appropriate competence assessment framework. • Plan to develop new competence assessment documentation (NCAD) and guidelines.
Taking action	• Use of focus groups to analysis second draft of NCAD and guidelines. • Based on the feedback from the focus groups. Plan to redraft the NCAD and guidelines. • Comprehensive document and guidelines finalised. • Establish appropriate process for assessment.

Evaluating action	• Final framework to include process and final NCAD and guidelines. • Dissemination.

Table 4. 23: Action research cycle 3.

Cycle 3 aims to comprehensively explore the views of stakeholders in relation to work drafted as a result of cycle 2. Six focus group interviews, with critical stakeholder representation from across the country were undertaken to gather data to inform the competence assessment framework, process and documentation. The focus group interviews participant groups are outlined in table 4.6 as follows:

Focus Group	**Participants**	**Number of participants**
1	Preceptors	3
2	Preceptors	3
3	CPC's	11
4	Nursing students	6
5	**Mixed group** Associate Professor (1) Nurse Practice Development Co-ordinator (1) Preceptors (2) CPC's (2) Student nurses (2).	8
6	**Mixed group** Lecturers (2) Nurse Practice Development Co-ordinator (2) Preceptors (2) CPC's (2) Nurse manager (1).	9

Table 4.24: Total number of participants - focus group interviews.

4.27 Constructing/diagnosing

The researcher reviewed the competence assessment documentation and framework following data analysis. The research question for the third cycle is as follows:

- What are the key elements of a national system to facilitate the competence assessment of nursing students in Ireland?

It was evident from the findings and outcomes of cycle one and two that the framework and documentation required review. The data was extensive, however, the findings were utilised to inform the focus groups alongside the research questions of the study.

4.28 Planning action

Following a review of assessment documentation and analyses of the findings of the qualitative survey, the researcher planned to develop the third draft of documentation related to the assessment of student nurses. This would be accompanied by guidelines to inform those who would in practice utilise the competence assessment documentation for the four disciplines of nursing. Further refinement of the documentation resulted in the development of draft three of both documents and the process of assessment.

4.29 Taking action

The following section presents the initial findings from the focus group interviews and aims, to augment and validate data findings of cycle 1 and 2. The focus group questions (Appendix 13) were developed to correspond with draft three of the competence assessment documentation and the draft two of the guidelines document which was developed as a result of cycle 2. Questions relating to the process of assessment and structures to support this documentation were also included.

Furthermore, data was transcribed for each group (Table 4. 16). It was coded into areas of interest and final themes based on the Braun and Clarke's (2006) thematic

analysis method. Initial themes and subthemes identified and inputted into NVivo 12. The initial data was re-read in conjunction with NVivo 12 to determine the recurring patterns. This resulted in 13 subthemes which were further distilled into 2 final themes (see figure 4.1). The final overarching themes were identified as: competence assessment and guidance documentation; competence assessment process; roles and responsibilities. The subthemes will be used to outline the findings**.**

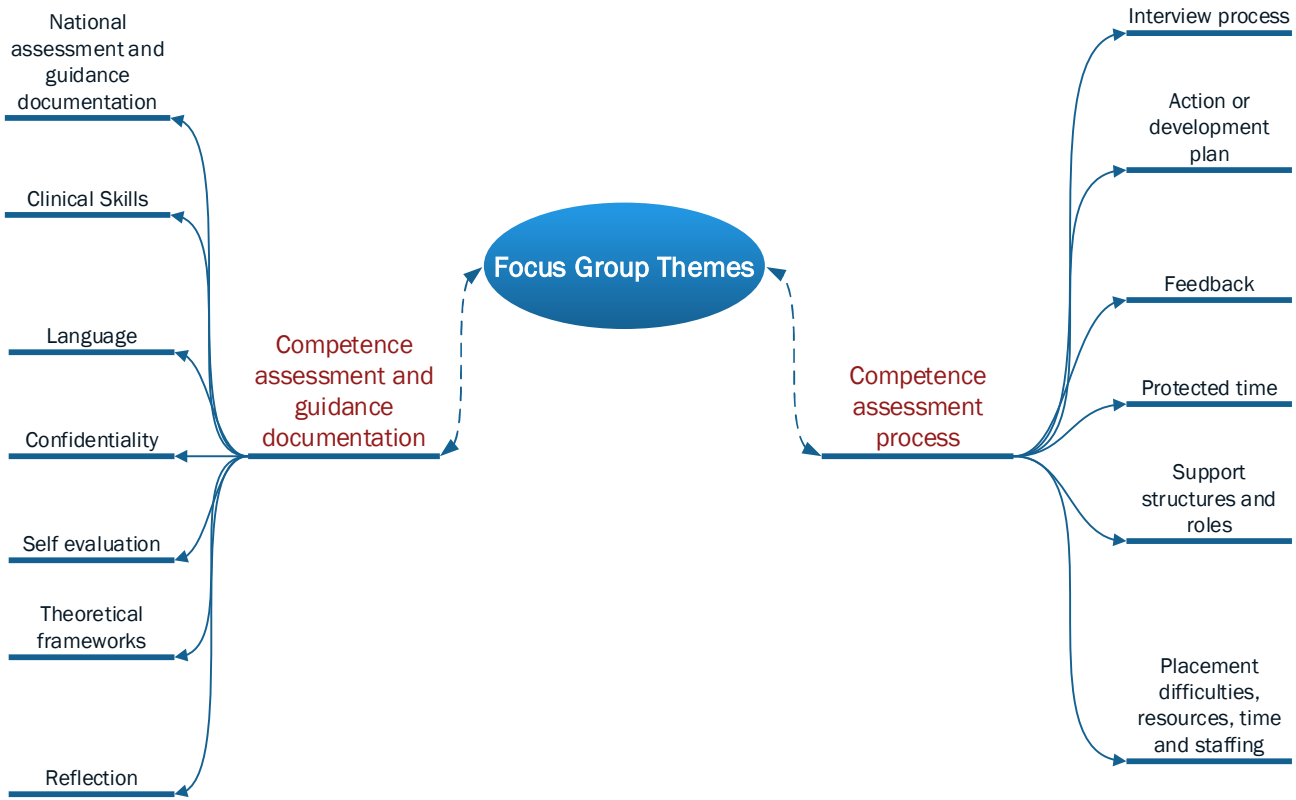


Figure 4.3 Focus group themes and subthemes

4.30 Competence assessment and guidance documentation

Seven subthemes constitute the theme of competence assessment and guidance documentation. They are national assessment documentation and national guidance document, clinical skills, language, confidentiality, self-evaluation, theoretical framework and reflection (See figure 4.1).

4.30.1 National assessment documentation and national guidance documentation

Within the subtheme of national assessment document, participants noted that the documentation was clear and easy to understand and would provide consistency nationally, however implementation was viewed as difficult;

> *"I think it easy to follow and I think there is a lot of clarity…there was a lot of assumption before because of different documents going around and different colleges had different things so you could have a student and then another student coming from another. There was lack of clarity so not it's very clear". PCP 5*
>
> *"I think it is easy to understand and clear". PCP 6*
>
> *"It's very easy to comprehend". PCP 2*
>
> *"So while the domains are similar, what was being looked for in each of the items was slightly different…as opposed to being generic item under competence". LL 1*
>
> *"It's easier to understand, it's more explicit, the domains, the competencies, the language, specific learning outcomes… and it's a national document". CPC 4*
>
> *"But how does this work with each HEI use all different ones. Does this not conflict with the document". CPC 4*

A participant responded to this question stating;

> *"But they'd be applying to a national document so if the new document comes with a competence tool… they have no choice in the matter and that's the way we need to go as there's lots of variances". CPC 11*
>
> *"Everything is quite clear so it should be the same interpretation for the two preceptors". PCP 5*
>
> *"I suppose a comment, I would have brought up…is in the long document and the assessment part, the number of times the preceptor has to sign their signature…over 70 initials indicators". CPC 15*

The national assessment documentation was welcomed because it would eliminate the need for different documents. In addition, the documents were viewed as a support tool for nursing students to reach a standard of competence;

> *"I think it should be highlighted as well that this is a support document, it's to support the student to become a nurse at the end of the day…it's not our way of critiquing or trying to pick fault, it's our way of getting them to the standard that they should be at". PCP 1*

The findings also revealed that the national assessment documentation recognised the role of the preceptor and clarified the role and expectations of both preceptor and student and the responsibilities inherent in the role of the preceptor;

> *"It's so precise it's actually helping the preceptor assess the student…you know exactly what's expected, if not it's left up to the interpretation of the preceptor of how well someone is doing or how poor or why do you need to put in an action plan in place, it will give much more guidance". PCP 4*

> *"I just think it's important that at the end of the day the preceptors are the ones who are responsible if anything goes wrong with a student, if she makes a mistake…so it's our responsibility that the student is doing the work and confident to do it…you have to be confident that they are able to do the work". PCP 2*

> *"I think it's very clear from reading it, the expectation of the preceptor, what is required of preceptors when looking after the student and what we should expect from the student". PCP 1*

Some findings relating to national guidance document only, highlighted that although the document was considered good and useful. However, there were challenges identified in relation to the actual use of these document;

> *"I do find it's a useful document, there's a lot of information but if you were to look at the title guidance for completing the assessment document, there's more in it in relation to background… but if you were a preceptor you have to go through a lot … I mean it's all very valuable information if you had the time to read it all, but if you're just looking at it to guide you doing an assessment, I think it's a lot of information". CPC 15*

> *"I nearly think that the information in the guidance document is teaching and assessing material". CPC 14*

> *"I found that the document is going to give good education in relation to what preceptorship is as opposed to completing competence assessment". NPC 2*

"Preceptors are not going to read this… this could be a guidance document on preceptorship and clinical supervision… I am still not sure if this what I should actually use or not and have totally separate to what the preceptor needs in terms of actually doing the competence assessment". CPC 3

"Preceptorship guidance document is very clear regarding the expectations of the preceptor and what is required of preceptors when looking after the student, what we should expect from student as well". PCP 1

"I like the thing with modelling, the coaching and the scaffolding". CPC 4

4.30.1 Clinical skills

The findings linked to the subtheme of using a skills component as a component of the national assessment highlighted that a skills section was a useful guidance document. However, some conflicting views were evident;

"Yeah I think I kind of do like a skills log book…it gives you an idea where you are going with the learning outcomes as well like you can kind of see sections where they haven't had that much experience with it at all… maybe a basis for first year as certain skills they won't do". PCP 6

"I do like the skills log book… it does not necessarily have to part of this document, it could be a separate log specific to years of programme". PCP 2

"I don't think we need a skills booklet for first year… the skills come with the practice". PCP 4

"The skills are important because I know some places they use skills as pass and progression". PCP 7

4.30.2 Language

The subtheme of language related to both the national assessment documentation and national guidance documentation. From a regulatory perspective, the language inherent in the documentation reflected the Nurse Registration Programmes Standards and Requirements (NMBI, 2016) which guides curriculum development and related documentation for all undergraduate nursing programmes in Ireland. The findings suggested that the language used was clear and easy to understand.

"The language…It's very easy to understand, both for the student and the preceptor". CPC 10

"The language…I think it is very clear and it explains exactly where each student is supposed to be at each level". PCP 2

"Yeah, I think it's easy to understand and I think it's important to have the same kind of language throughout as well". NPC 1

"I found the language clear and easy to understand. I didn't have any difficulty with any of the language". PCP 1

"From my point of view…I found the language is quite straight forward in terms of sign posting preceptor, because the language has been a problem in the past in what people's understanding of what's under each domain…you know it's really signed posted and you know what's expect". CPC 13

"Documents not generic for each discipline but specific". PCP 9

Discipline specific language and terms relating to the respective nursing stream documentation, were positively reviewed with some constructive comments by the participants;

"The language is very person centred". PCP 1

"I thought the language was certainly inclusive, it differentiated between children and young people throughout and it is consistent in that respect…its very user friendly and well signed posted". LL 2

"The language is quite straight forward in terms of signposting preceptors… the language has been a problem in past in terms of what peoples understanding of what's each domain is supposed to be". CPC 10

"I think if we could just keep it as the one terminology". CPC 7

"I thought the language was certainly inclusive, it differentiated between children and young people throughout it was quite consistent in that respect". CPC 15

4.30.3 Confidentiality

The subtheme of confidentiality of information arose in a variety of ways, particularly in relation action plans for failing students. The importance of keeping information confidential between the participants and the trust between the student and

preceptor was seen as important. Furthermore, honesty and informing a student if they are not progressing was identified as critical;

> *"…and the action plan and keeping it confidential rather than broadcasting it and that really important". PCP 3*
>
> *"If there is an action plan started, it is kept confidential and that it's not broadcast to everyone in the ward as there is a stigma associated… it's the preceptor, associate preceptor, ward manager, CPC and link tutor that needs to know". PCP 1*
>
> *"That a discussion that has to take place because there may be things that the student might not necessarily want disclosed but there are things that are hugely important and if you've agreed a plan… the student is clear what information is going forward to the next placement… it's a conversation that has to happen… think you could be setting up the student again for further failure if you have somebody who is going to look back and say well look no surprises, didn't get on well before". PCP 5*
>
> *"Well I suppose you don't want your decision influenced, it's important that I base my decisions on my evaluation of the student as opposed to going and referring back because then at least you know my decision making is fresh". PCP 8*
>
> *"I don't know about ward to ward confidentiality". CPC 12*

4.30.4. Self-evaluation

Participants were very positive about the inclusion of self-evaluation within the documentation and viewed it as a means of encouraging students to take ownership of their own learning and development;

> *"I think the self-evaluation of learning needs helps the student focus on what they have to learn when they come on to a new placement and I think the fact that the self-evaluation has to be completed before first interview is done should help the student focus on what they/re going to learn on placement". NPC 2*
>
> *"Self-evaluation section gives the power back to the students, to identify their own needs and to have that planned out already before they even come to meet you, it really would help". PCP 6*
>
> *"Self-evaluation is really good because it kind of situates the student in the right place for that particularly placement so they need to prepare for their*

placement and they're not being passive in their learning, it actually encourages them to be active learners". NL 1

"I think one of the real good questions from the self-evaluation is the need to use critical and analytical skills… I can generate evidence from practice… it's going to be my responsibility to demonstrate this evidence and put the emphasis very much on the student… you get them to think before they start". CPC 7

"The self-evaluation…it kind gives you focus on where, what you're done, where you've been doing and where you need to go to get what you're looking for…it actually given you your own focus". STD 9

"I think the self-evaluation of learning needs helps the student focus on what they have to learn when they come on to a new placement and we would ask them to download the learning outcomes…sometimes they do and sometimes they don't so the fact that this self-evaluation has to be complete before the first interview is done should help students to focus on what they're going to learn on placement". PDC 2

"The life and previous experience of practice they bring with me to the placement is good as we have a lot of mature students and they have really good life experience and it boosts their confidence". NPC 13

"It kind of gives you a focus on where, what you've done, where you've been doing it and then where you need to go next". STD 5

4.30.5 Theoretical frameworks for the assessment of competence

Within the sub theme of theoretical framework/model for the assessment of competence, the findings highlighted the importance of having a theoretical framework/model to be incorporated in the NCAD for the assessment of competence. It was viewed as a grading system with the appropriate prompts to determine knowledge, skills and behaviours to guide the student, preceptor and clinical placement co-ordinator;

"Theoretical framework lets you know what is expected of your first years, your second years, and your third years". CPC 5

"Because certainly first year you are a novice and hopefully by fourth year you're competent". PCP 1

"I suppose as competence is an incremental process, we're going to need some kind of grading system with the appropriate prompts for knowledge,

skills and behaviours which will guide the preceptor, student and CPC… you need to pick one and apply it nationally otherwise there is variances". CPC 11

Participants were most familiar with Benner's skill acquisition model citing its prevalence nationally and internationally. The fact that HEI's and AHCP's use different theoretical models was highlighted and a common new approach was seen as positive and was welcomed;

"I would have used Benner and I thought it was excellent because it goes through novice to advanced, beginner to competent to proficient to expert. So you can see progression both yourself and your preceptor". PCP 1

"When I was training I used Benner theoretical model, I found easy to manage". PCP 2

"In all honesty, if you were to strip every one back down, they probably all resonate with Benner, to be fair". CPC 2

4.30.6 Reflection

The findings under the subtheme of reflection reiterated the important role of reflection and common difficulties with ensuring it occurs on placements;

"We don't have any time for reflection and this is a huge issue. It happens off ward or wherever they go to the library but they go do their own self- reflection … we would read their reflections and sign them, but they're not done together". PCP 2

"We don't do reflections at all, they go off for a couple of hours over to the library to do their own reflection". PCP 6

"But there is not much learning from that, if they don't talk through the reflection with the student and I think that's where there's a really important piece of work for preceptors". PCP 5

The findings reiterated the importance of the inclusion of reflection in the documentation. The importance of a model of reflection was also acknowledged:

"What I welcome in the new ones is the reflective piece that goes in there, I think that's a very good thing that the student has to include their reflective examples, and I think that's a positive thing". NCP 2

"It would be really useful to have a model of reflection but for them to start reflecting on practice in first year and I think they need to start in first year

cause something's to go in to 4th year and they still haven't got a complete idea of what the model of reflection is". PCP 5

"Reflection really works. It's excellent that students have to reflect on each placement and that the preceptor has to discuss the reflection and while it's not a correct or incorrect reflection, it's the student's own reflection. I think it's really valuable addition". NCP 1

"I think it's really useful to have a model of reflection but they need to start reflecting on practice in 1st year because sometimes they ae going in to 4th year and they still haven't got a complete idea of what a model of reflection is". PCP 6

"Some people would rather use different reflective models, but Gibbs would be better for first years". CPC 12

"Well I have always used Gibbs. It was taught to us in 1st year and I have always used it". STD 10

"Well definitely for first year students, I think it's a good and simple model for them". CPC 12

"I think by reflecting you also learn more. Your reflecting, what were the good things, what were the bad things and what would I do differently". PCP 1

4.31 Competence assessment process

The second subthemes within this overarching theme were interview process, the utilisation of an action/development plan, feedback, confidentiality, protected time, self-evaluation, placement difficulties, resources time and staffing. The seven are inextricable linked and competence assessment is supported by the interview process which includes an action plan/development plan where required.

4.31.1 The interview process

The findings from this stage of the study indicated that the interview process was good, facilitated a smooth process and was clear for all participants;

"I think the overall process of the first, second and third interview are very important and need to stay and the first interview is probably more supported

now because of the introduction of this model so it'll actually give a little more weighting to the actual first interview… for students to think about what they want to learn in the placement". CPC 4

"I suppose in relation to the first interview you're setting out goals, in relation to the middle interview you're seeing if you've achieved the goals or what you need to work on and then the final interview is really have achieved all of the competencies and the skills required and if you haven't then that should be highlighted for your next placement so it's structured and students know where they stand and preceptors know where they stand". PCP 1

"Everything is decided at the start, the agreed date and we would always agree with the students on what outcomes they would like to achieve by the second interview…so they are not leaving to the final interview to go through all the outcomes… I like the process but it has to be managed properly". PCP 4

"So I feel if we didn't have those three interviews there's always a danger that something is going to be missed or things aren't going to be addressed at an intermediate interview so I definitely think we need the three interview". CPC 15

"But I like the process. You can lay out there straight your expectation of the student as well and just highlight any issues with the interviews to continue communications". PCP 3

4.31.2 Action plan/development plan

As identified earlier, for each clinical placement of four weeks or more the assessment process would consist of a preliminary meeting, mid placement review and an end of placement review and assessment meetings between the preceptor and the student. The mid placement review aimed to review learning experiences and progress. At this point the student and the preceptor discuss learning needs with emphasis if required on areas that may need attention around performance and achievement. Where students were not at the required standard an agreed course of action to support the student would be implemented at this point in partnership with the preceptor, clinical placement co-ordinator, clinical nurse manager, link lecturer and student. Participants referred to this process in a number of ways including Action Plan, Development Plan or Learning Support Plan, depending on the terminology used by individual HEI's;

"I don't like the word action plan, it is not helpful". PCP 6

"We would put in a development plan after the student fails or if they are going to repeat a placement… they need extra supports". PCP 5

"I think the terminology 'learning support plan' is probably the most positive that you can use for a student that's struggling because the negative connotations with a development plan or action plan, I think it's very positive". CPC 6

"Students may well and do, challenge what the findings are so the evidence is extremely important and the recorded evidence of how that fail has been, and that's why we devised our development plan as is". CPC 2

The findings indicated that the inclusion of the process relating to action plans/development plan/ learning support plan would be helpful and it would clarify roles and deficits;

"*It actually helps the preceptor assess the student, you know exactly what is expected, it's not left up to the interpretation of the preceptor of how well someone is doing or how poor or why do you need to put an action plan in place, it's much more precise. It will give them much more guidance". PCP 4*

"Your using the document daily and you are highlighting problems as they arise with the student…there's no surprises then and that's definitely good for students". PCP 6

The findings indicated the importance of timing regarding the utilisation of action plans/development plans/learning support plans;

"We're actually very slow to do it, but like that I found there's been a couple of students, I've never thankfully had to put anyone on an action plan, but just from experience that maybe they're heading towards their last couple of weeks and the next minute there's this action plan…it's not fair to leave it near the end to put someone on an action plan. That has to be identified much earlier but I suppose the fact that it is here now maybe highlight it a bit earlier on". PCP 5

The findings publicised that the use of action plans/development plans/learning support plans and the decision to fail a nursing student can be related to the relationship of the nursing student and preceptor;

"Sometimes it can be a personality thing, you know the student may not get on with their preceptor". PCP 5

"You obviously build a relationship with you nurse and they can realise you can do this and you can do that…so supervising me doing this then I can do it on my own to be become and expert". STD 5

"It could be personalities as well, you know if you have a student who has gotten on extremely well with their preceptor, they could come out with an excellent mark, but they could actually go to the next placement and if you're really fair about it the might not achieve as high a mark". PCP 4

"Sometimes it can be a personality thing, you know the student may not get on with their preceptor but these competences, these domains are broken down to such an extent that you can't justify failing someone unless they deserve to fail". PCP 1

The findings also revealed the views of participants relating to the responsibilities on nursing students and identification of their expectations;

"Well I think to, they document their own expectations… now there is clarity and if a student wants to have a successful placement and not to fail well then I do think we need to know what your expectation was, well this is our expectation you know and how can we come to some sort of agreement". PCP 2

"I think it puts some onus on the student as well to make them realise they're got responsibilities for their own learning and I think it will help the preceptors as they will have some idea where the student is coming from… and discuss prior experience with the student". CPC 3

"The document goes through all of the domains for each placement rather than a student focusing on a domain per placement. It goes through all of them, so if a student was to fail one particular aspect of a domain, of course they will be on an action plan, but they'll have a chance with their second placement to rectify it and prove themselves… they have failed but they are learning from it because of the supports in place". PCP 1

4.31.3 Feedback

Within the sub theme feedback, the findings overlapped with the requirement to implement an action plan. Participants highlighted the importance of appropriate and timely feedback;

> *"I think the whole point of where the improvement needs in the interview is to try an increase the amount of feedback that is given to the student and the amount they document". CPC 8*

> *"Especially with the middle interview, if there are many issues, to be able to give feedback is important". PCP 3*

> *"I think it removes the surprise element that's going to be there if somebody is going to fail because you have processes in place at the intermediate interview, if you're giving feedback… but giving continuous feedback I know is what we're aiming for but sometimes with the busy environment it mightn't always be there but at least you do know you're going to get the feedback at the intermediate interview". NPC 1*

> *"I had my intermediate last week and I did get feedback, we discussed my weaknesses at the start, that was discussed in the intermediate and then there was little goals that they put out for me". The intermediate should stay in place…especially if you have weaknesses and that's discussed and you can really focus on that". STD 9*

> *"Students need to accept constructive feedback because we do think it's important for the student to see that as being acceptable and that's it's not a form of punishment". PCP 1*

> *Like often it is very positive feedback…it is constructive criticism". NL 1*

4.32.4 Protected time

The subtheme of protected time and its importance in facilitating competence development and reflection was evident in the findings. Participants supported the NMBI standard requiring protected time for preceptor supervision and their comments reflected the importance of this as an enabling structure;

> *"Staff should be afforded protected time for the formal interviews to insure a fair and consistent process for the student and it would take the pressure off so people would not just tick boxes… they need time to question the student on what they may have written, observed or their understanding of the rationale". CPC 6*

"I do think some form of protected time needs to be allocated to the preceptor for the formal interviews". CPC 3

"It's a standard isn't it that preceptors will be given protected time". PDC 2

4. 31.5 Support structures and roles

The findings identified the role, particularly of the Clinical Placement Co-ordinator is outlined by NMBI with specific reference to the findings of two major Irish studies which defined and evaluated the role (Drennan, 2002 and McNamara, 2007). The CPC is a knowledgeable nurse who is supernumerary to care delivery, and provides committed support and guidance to student nurses, preceptors and clinical nurse managers to ensure that assessments are effective and fair, and facilitate competence attainment among undergraduate nursing students through reflective practice (NMBI, 2016 p 130). This study found that the CPC plays a pivotal role in the student experience and the competence process. Participants were positive about the role of the CPC in the development of learning outcomes in partnership with students and their preceptor;

"…the learning outcomes on the first placement, we would really agree with the CPC and the student… what learning outcomes are we going to achieve by the end of the first placement". PCP 8

The role of the CPC in supporting failing students was also highlighted. This role involves monitoring, clarifying, guiding and supporting:

"As CPC, we actually aren't involved in the assessments because we're there to support staff and student, so whether it be a positive that they're going to pass, we do obviously follow up to ensure that yes, the student has passed, we are obviously are aware if a student is going to fail, if they're going to be put on an action plan, we don't sit in on them either because we kind of feel as a CPC that that's unfair, you know we support both the student and the staff if that happens". CPC 12

"I see my role as a CPC … I'm here to facilitate the process, to oversee it and support both of you". CPC 9

"The CPC came to me first highlighting concerns so I knew that this person needed working with… but it is better not stating what they failed on, but there has been an issue". PCP 3

"The student would see the CPC doing up the development plan, and we were disempowering the staff, the preceptor, but we still support them… we should not be seen as the ones doing the development plan". CPC 11

4.31.6 Placement difficulties, resources, time and staffing

The sub theme placement difficulties yielded similar findings to that of failing students. However, further analysis suggested the need to support the student to achieve competence. Participants were clear that they were willing and committed to supporting students, however organisational and resource issues constrained their ability to so robustly. Thee constraints included, time, staffing and demands in patient care;

"With the best will in the world, we do try to get the students with the same preceptor but obviously things change and it's really unfair to the student… if they have a different preceptor for the last week". FG 5

"It's when you have time to grab time and grapping time might be 5 minutes, it could be 10 minutes at the desk, right show me the book, what have you done today? That's the reality of it". PCP 9

"But we're working in an environment where we're barely getting breaks". PCP 8

Nursing students identified similar issues;

"Having a preceptor… it depends on how busy they are on the day". STD 4

"You wouldn't have time, you'd be constantly saying things like I discussed with my preceptor, where the preceptor barely has time to even sign them never mind actually going through them practically as well as write in the documents". STD 5

"If you've assigned one, they should be your one for the placement". STD 2

"That's another thing, you're meant to have the same preceptor for all stages…it doesn't happen". STD 3

Some suggestions were made to ameliorate some of the preceptor challenges including the allocation of 2 preceptors and more flexibility in who can be allocated as a preceptor;

"Student should have two preceptors". STD 3

"It's not feasible to have to wait for people to be a year qualified, then we would have no preceptors". CPC7

"There's very positive feedback from students that work with the newly qualified especially because they're still thinking like a student and they include them". PCP 8

The following conclusions were drawn from the data:

In conclusion, this section of the study generated valuable data in relation to the national standardised documentation to incorporated theoretical frameworks for the assessment of competence, reflective practice, competence assessment process which informed the overall development of the framework and documentation. In addition, there are six overarching themes evident from these findings of the focus groups that are feedback, protected time, support structures and placement difficulties.

4.32 Evaluating action

The competence framework to include documentation is completed based on three sets of findings, SWOT analysis, survey questionnaire and focus groups. The next step is dissemination to initially the Head of Departments in each of the HEI's for comment who will then distribute the documentation to AHCP's.

DISCUSSION OF THE ACTION RESEARCH CYCLES, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction:

This chapter provides a comprehensive discussion of the main study findings, with implications and recommendations for nurse education, professional practice and regulation and provides direction for future research. This chapter will provide discussion on the main conclusions drawn from the findings taking cognisance of previous research studies and current education policy and standards and requirements.

A nurses' level of competence is influenced by his/her educational preparation, frequency of clinical exposure and duration of experience in a particular clinical setting. In essence, NMBI is mindful that the need for professional nurses to maintain competence in a rapidly changing healthcare environment is fundamental to the creation of a safe therapeutic environment for patients, clients, service users and residents. Therefore, the system in place to facilitate the competence assessment of nursing students is paramount and is central to this research. The current research will follow Coghlan and Brannick's model for action research (2014). The steps include constructing/diagnosing, planning action, taking action and evaluating action. The research questions for the overall research project are as follows:

- What theoretical framework/model for the assessment of competence should underpin the national competence assessment framework?
- What are the key elements of a national system to facilitate the competence assessment of nursing students in Ireland?
- What assessment documentation and assessment processes should be developed?

5.2 Pre step stage

As outlined in chapter 1, this research was initiated as a result of a review of degree programme in 2012, by the Department of Health who then issued a Report of the *Review of the Undergraduate Nursing and Midwifery Degree Programme (2012).* The Report recommends that:

> The Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/Health Service will review student clinical assessment processes including documentation to promote standardisation of clinical assessment in line with competence goals for the four nursing programmes (p 61).

In line with this a national approach to competence assessment was recommended. This arose from reported weaknesses (Department of Health 2012, C10.1 p 15) in the assessment of nursing student's clinical learning. The approach aims to ensure standardisation and to reduce variation between competence schemes, documentation and the process of assessment. The literature also supports this requirement. Therefore, there is a requirement to develop a national evidence based standardised competence framework to include assessment tools for application, and guidelines for pre-registration nurse education programmes. Also, the responsibilities and duties of NMBI are defined by the provisions of the Nurses and Midwives Act, 2011. NMBI's primary mission is public protection and this is maintained through its principal functions of; establishing and maintaining a register, providing education and training, providing guidance for the professions of nursing and midwifery and inquiring into complaints.

As previously stated nursing in Ireland has been heavily influenced by the European Union (EU), the European Higher Education Area (EHEA) the Bologna Process, Tuning Process and European Directives. These directives ensure mutual recognition of qualifications and are explicit requirements of the training programme related specifically to 'nurses responsible for general care', that is the Registered General Nurses (RGN) in Ireland. In 1989 a further European Directive was agreed by the member states regarding the balance of theoretical and clinical instruction in nurse

education programmes (Fealy, 2006; European Commission 2005, 2011, 2013). The responsibility for ensuring that these directives are met rested with the regulatory body (NMBI) and NMBI has developed a quality assurance framework and standards and requirements (NMBI, 2016) and the European Union Directives are embedded in the standards. The Tuning principles were to inform both the curriculum content and the skills, learning outcomes and domains of competence at baccalaureate degree level in the signatory nations. Such realignment aimed to ensure that the revised learning outcomes would adequately prepare the student nurse with the competences for safe, effective, skilled knowledgeable and ethical practice yet with an adaptive skill set suited to Ireland's changing health service. The revised *Requirements and Standards for Nurse Registration Education Programmes* (NMBI, 2016) take this into account. The latter has been mapping against Section 23 (g) competences of the Directive 2013/55/EU of the European Parliament and Council of 20 November 2013 to ensure compliance. However, now a standardised competence assessment framework is now required to support the revised standards and the new Domains of Competence (Appendix 4).

Central to its remit for education, NMBI is committed to ensuring the integrity of the practise of nursing through the promotion of high standards of professional education, training and practice (Government of Ireland, 2011). To achieve this, NMBI, as the regulatory authority has re–developed Standards and Requirements for Nurse Registration Education Programmes (NMBI, 2016), revising and updating the previous standards developed in 2005 (ABA, 2005). The primary purpose of these new standards is to develop flexible, innovative, practice-oriented registration programmes for undergraduate nursing programmes at the 13 Higher Education Institutions (HEIs) In Ireland and their associated health care partners (AHCP). This pre step stage gives the rational for the current study and is the precursor to the first step of cycle 1 that is the diagnosing/constructing stage.

5.3 Discussion of findings

The fundamental aim of action research is to improve practice rather than produce knowledge (Elliott, 1991) therefore certain findings are unique and specific to the study. The nature of this study, an examination of regulatory processes regarding a national framework for the assessment of competence is a first step to acknowledge the need to underpin regulatory practice with evidence by developing a national competence framework, documentation and process to ensure that the current diversity of approaches being used nationally will cease and all HEI's and AHCP will met the Nurse Registration Programmes Standards and Requirements (NMBI, 2016).

The purpose of this discussion is to identify key findings and relate these to the literature. This work is important as it will ensure standardization and reduce variation between competence schemes, documentation and the process of assessment in pre-registration nursing thus meeting not only the requirements of then Minister for Health and the Department of Health, but the mission of NMBI, public protection and patient safety.

This chapter discusses the study findings and expands upon these findings in the context of contemporary literature in accordance with the theoretical framework introduced in Chapter 2 and the research questions with a view to formulating recommendation for research, education and clinical practice. Data, in the previous chapter, presented in themes and subthemes, underpin this discussion, which focuses on the main findings, which are theoretical framework/model for the assessment of competence, the competence assessment process and the role of those involved, reflection and self-evaluation. The utilization of action research allows for the findings to be unique and specific and therefore not always related to the theoretical framework outlined earlier. All of the themes and subthemes will inform the national framework and documentation for first year nursing students, the primary purpose of this research study. Finally, a national framework to incorporate documentation is put forwarded.

5.3.1 Theoretical framework/models for the assessment of competence

Data to address this component of the study was collected using a SWOT analysis, survey questionnaire and focus group interviews. The findings were integrated to provide the stakeholder's views of including a theoretical model/framework for the assessment of competence and which framework this should be. Across all cycles of the study the findings indicated a dual approach to the underpinning theoretical framework with both Benner's model and Steinaker and Bell model identified as the preferred approaches for undergraduate nurse education as a result of this study.

Across all three sets of findings respondents indicated that Benner's model of practice experience was the most relevant to the Irish context. This finding was unsurprising and can be attributed to the fact that this model is used in the majority of HEIs (61%, *n*=8) and is widely used internationally (Meretoja *et al,* 2004; Lyneham et al 2008; Flinkman *et al* 2016). Benner's (1984) seminal work on competence development among nurses, particularly in the context of skill and proficiency enhancement among expert nurses, has provided a strong theoretical framework for competence acquisition nationally and internationally. Whilst the model was originally designed for post registration development, the respondents highlighted the two components of the model were particularly relevant to pre- registration nursing in Ireland. This approach is commensurate with Fordham's (2005) assertion that a competence based approach to assessment determines the effective application of knowledge and skills in practice and that assessment is critical to ensure the maintenance of professional standards. However, is should be noted that a substantial number of HEIs (n=5) combined Benner's model with another as they perceived a lack of completeness in using the model a singular approach. Reasons cited for this included a concern that the model was originally developed for post registration nurses and a concern that the issue of competence relates to registered practitioners and not student nurses. This is at odds with Meretoja *et al* (2004) who found Benner's model to be robust and sufficient in the development of their scale of competence. However, their study focussed only on registered nurses and not undergraduate nurses. This compared with the findings of this study further suggests that assumptions of universal application of

Benner's model across under and post graduate nursing cannot be made. Benner's model of developing competence where the process of skills acquisition proceeds from novice to expert practice has been critically examined from both a theoretical and operational perspective and the writer of this study suggests that the use of this model is a suitable model because of its incremental stages along a continuum from novice to expert. In addition, the writer of the current study believes that the four levels of beginner (novice), advanced beginner, competent and proficient, empower the nursing student to achieve the appropriate level of independent practice. It will enable the nursing student to develop their knowledge, skills and attitudes incrementally over the four years and first level of beginner is appropriate and useful for first year nursing students.

The absence of literature around merging theoretical frameworks indicates that combining theoretical models is unique to Ireland in respect of pre–registration nursing. However, the data revealed that many of the HEIs did not consider any one model to be sufficient for pre-registration nurse education and therefore the findings reflected this. This is an important finding as it is the first internationally in this regard. Although the data did not explain the merging of underpinning theoretical models, the final two models are complementary in the sense that they each fulfil a critical aspect absent in the other. Specifically, the fact that Benner's model is competence based and Steinaker and Bell's model is assessment based. This suggests that the current suite of models used internationally may not be sufficient in their own right for the contemporary assessment of undergraduate nurse education.

Findings suggest, secondly, that Steinaker and Bell (1979) experiential learning taxonomy be included in the national competence document. It is used as an approach to teaching and learning and experiential learning follows in a sequence of categories, each comprising of five levels. Firstly, Steinaker and Bell (1979 p. 22) define exposure as the consciousness of an experience. Exposure is where a student has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the clinical placement. Secondly, participation has been described as the level at which one decides, on the basis of data already received to become

physically a part of the experience (Steinaker and Bell, 1979 p. 24). Participation is where a student becomes part of the experience, transitioning with the support of a preceptor to participant rather than an observer. The student takes more responsibility for their own learning and initiates appropriate action and evaluates same as identified by De Montfort University (2017). Thirdly, according to Steinaker and Bell (1979 p. 29) identification occurs when the student actively participates in the experience and uses earlier learned knowledge and experience. In order words, identification is where a student takes more responsibility for their own learning and participation and initiates appropriate action and evaluates same (De Montfort University, 2017). Next, internalisation is where a student applies experience to other situations Steinaker and Bell (1979). In a similar vein, a student makes informed decisions based on the information available and works as an autonomous practitioner and finally dissemination is where a student informs and influences others regarding their experience (Steinaker and Bell, 1979), and the student uses critical analysis to determine the outcomes of their actions and can give rationale for their action to others (De Montfort University, 2017). In summary, the taxonomy begins when the student is exposed to a teaching-learning experience and develops to the point where the student has internalised the experience and is disseminating the experience to others.

In clinical nursing practice, the criteria outlined by Steinaker and Bell (1979) experiential learning taxonomy are exposure, participation, identification, internalisation and dissemination. These are utilised to determine the students' overall performance on each clinical placement. In year one and two the levels of exposure and participation are used and expected and by third year and fourth year the levels utilised are identification, internalisation and dissemination to determine the achievement of competence. In summary, in clinical practice, the assessment of competence from year 1 to year 4 and 4/5 correlates to the theory of experiential learning and the taxonomy of exposure, participation, identification, internalisation and dissemination represent the level the student has reached and at the end of the degree programme, students will be able to work at the level of dissemination to be enabled to register as a nurse. The writer of this study identified the first two levels,

exposure and participation as suitable for first year nursing students because firstly, the nursing student observes an activity or situation and can discuss the core elements and relates to theoretical knowledge. Secondly, the nursing student safety participates under direct supervision and demonstrates knowledge which links to the first stage of Benner's model, novice for first year nursing students.

Furthermore, the writer of this study interpreted the findings regarding the SWOT analysis and found that no one theoretical model should be used in isolation and the findings, furthermore indicated that a combination of models would be beneficial as part of the assessment documentation to ensure completeness. Therefore, for the purposes of this study, the components of theoretical frameworks/models for the assessment of competence are utilised as the NCAD relates to first year nursing students only. The utilisation of Benner's (1984) levels of practice and experience and Steinaker and Bell (1979) experiential learning taxonomy ensures that the requirement of NMBI as outlined in the Nurse Registration Programmes Standards and Requirements (NMBI, 2016, p 17) are met. These requirements stipulated that staged learning outcomes be guided by a framework to show gradual and incremental acquisition of skills, knowledge and professional attributes. No one model was identified, hence the writer included this important question regarding theoretical frameworks/ models in all three data collection methods, to determine the views of nurses in education and clinical practice who guide, support and assess the competencies of nursing students.

Benner (1984) – Novice - The student nurse has no/limited experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The student nurse is taught rules to help them apply theory to clinical situations and to perform tasks.

Steinaker and Bell (1979) - Exposure - The student nurse has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the practice placement.

Steinaker and Bell (1979) – Participation - The student nurse becomes a participant rather than an observer with the support of the preceptor where learning opportunities are identified in partnership.

5.3.2 The competence assessment process

The purpose of the registration education programme is to ensure that on successful completion of the programme the graduate is equipped with the knowledge, understanding and skills necessary to practise as a competent and professional nurse. Therefore, the maintenance of competence using a defined competence assessment framework and process is explored and discussed as related to the findings of the current research study.

Data to address this component of the study was collected using a survey questionnaire and focus group interviews. The findings were integrated to provide the stakeholder's views of the assessment process and the role of those involved in assessing nursing students in clinical practice. This was important because clinical practice placements continue to be a fundamental component of the degree programme as stipulated by NMBI (2016) and European Directives (2013). Previously, competence was assessed using a competence based assessment strategy utilising five domains of competence and performance indicators identified by NMB (2005). Each HEI in partnership with AHCP's was responsible for developing competence assessment documentation/tools based on these requirements until the introduction of the National Competency Assessment Documentation (NCAD) in September 2018 for first year nursing students.

The vast majority of participants identified across two sets of contributions, acknowledged the importance of the assessment process related to the use of three interviews regarding a placement of six weeks are more in duration.

These findings were nor surprising and can be contributed to the fact that firstly, the introduction of competence assessment process was advocated by NMBI as part of the move to degree status education for nursing students in 2002. This was a significant change and critical driver from a regulatory perspective to change the then assessment of competence tool known as the Proficiency Assessment Form (PAF) as discussed in chapter 1. The interview process as introduced in 2002, supports the assessment of the nursing students throughout each placement duration with the support of preceptors and CPC's (An Bord Altranais, 2002). Contemporary views on nursing situate the adult learner within the social environment and in nursing this is the clinical placements in each AHCP's. Nursing students engage with their preceptor through social interaction during the three interview process. The utilisation of this interview process for nursing students with the support of nurses situates the learner within the social environment, therefore social leaning is an important and vital component of degree programme. The process of learning using the three interview process is through social interaction as linked to the theory of situated learning. This theory is particularly relevant for practice-based learning and is therefore central to nursing as the majority of learning in the current undergraduate degree programme is situated in clinical practice. McSharry (2012) and McSharry and Lathlean (2017) claim that the situational learning theories of Lave and Wenger (1991) and Vygotsky's (1978) theory of social constructivism provides a suitable educational foundation for clinical learning when applied to nursing. In practice this theory situates the preceptor and/or CPC's as the 'Most Knowledge Others' (MKO's) and the student nurse as the learner. This distance between the nursing student's ability to undertake the function competently without supervision and their need for supervision can be referred to as the zone of proximal development (ZPD). It is important to note that the writer of this study, intrinsically links this to the choose frameworks/models to assess competence included in the NCAD, that of Benner's (1984) levels of practice and experience and Steinaker and Bell (1979) experiential learning taxonomy.

The three interview process was articulated in the findings and also the participants reiterated that the interview process was structured, fair and the three interview process was welcomed for placements of six weeks are more. Furthermore, all HEI's

and AHCP's continue to use this interview process since 2002 and continuous to date. The findings also advocated that many participants suggested that the process should continue as it works well and is understood by those involved in the assessment of competence for nursing students. Many Irish studies identified the requirements of the preliminary, intermediate and a final interview as part of the process and advocated the positive views of particularly preceptors, who guide, support and assess nursing students and overall preceptors completed all three interviews which is support in the Irish literature (McCarthy and Murphy 2010; Butler *et al*, 2001; Fahy *et al* 2011) as advocated by NMBI. Internationally, particularly from the United Kingdom perspective the use of the three interview process is supported by the NMC in their standards and universities are provided with a degree of flexibility as to how the process is operationalised. The necessity of the process was highlighted in the literature by Duffy (2007); Stuart (2007) and Hunt *et al* (2012) and by Baumgarter *et al* (2017) in Sweden. The importance of the interview process related to the necessary support mechanism and the important role of those involved in assessment. The writer of the current research thesis was mindful of the requirements and importance of the three interview process and included in NCAD and an explanatory note of the process in the accompanying guidelines document.

Participants, particularly identified the importance of the first interview allowing students to determine their learning needs and expectations and to decide learning outcomes and timeframes for interviews in partnership with the preceptor. This validates previous research, that the process of assessment needs to begin early during clinical placements and assessors need to be aware that learning takes place throughout the trajectory of the complete clinical placement as supported by Price (2012) and Hunt (2012). Both stated that assessment is not a single event, highlighting that it involves observing students throughout their placement across the trajectory of the degree programme and making a decision about their performance both at a specified intervals and at the end.

5.3.3 The concept of failure and action plan/development plan

Another aspect of the findings regarding the assessment process relates to the concept of failure. The participants contextualised the data and provided valuable insights into the dynamics associated with the concept of failure as linked to the participants' views regarding the necessary intervention of the action plan/development plan as linked to the interview process. The findings outlined the importance of the action plan/development plan as related to the interview process which can augment the decision for the preceptor regarding a fail grade.

A surprising finding regarding the use of action/development plan was related to reluctance to utilise same which is linked to the difficult of some preceptors to fail a nursing student. Findings suggests that some preceptors lack courage and accountability regarding the decision to fail a student. The significance of this finding is supported from an Irish context by McCarthy and Murphy (2010) and an international context by Duffy (2003) and Luhanga *et al* (2008). From an international perspective, Duffy (2003) and Luhanga *et al* (2008) argued that assessors in clinical practice regularly find it difficult to fail nursing students. These findings are supported, within the Irish context by McCarthy and Murphy (2010) found that more than three-quarters of the sample of preceptors in their study had never failed a nursing student in clinical practice because to so might be construed negatively by nurse mangers as evidence of poor supervision. It is important to add, that the findings linked the concept of failure with the utilisation of learning support plan/ actions plans. The participants suggested that the reluctance to place a nursing student on a learning support plan/action plan because there is a perceived belief that there are possible conflicting role for the preceptor in firstly, supporting and encouraging the student and secondly, related to the assessment and making a decision to fail a nursing student. This is augmented by McSharry (2012) findings when preceptors identified that the 'caring relationship' affected their ability to assess the student accurately' (p 112). This was related to preceptors not feeling at ease, when giving negative feedback as they were fearful of the reaction of the nursing student. The writer of the research thesis believes that the use of standardised process and documentation will support

preceptors going forward to have courage in their decisions regarding deemed nursing students not competent and utilising a development plan.

5.3.4 The support structures

The participants acknowledged the need to support nursing students to achieve competence, however organisational and resources issues inhibited their ability to so robustly. This is acknowledged by Couper (2018) in a study in the Unites States of America found that it was difficult to fail students because of lack of organisational support along with role stress and concluded that it is essential that those in senior roles retain effective communication and provide the necessary support for those who assess nursing students. The findings suggested that it was difficult to ensure that continuity regarding preceptors working continuously with the nursing student and that in certain circumstances, the allocation of time to complete documentation maybe limited. Other constraints included time as ascertained by Mallick and McGowan (2007), as nurse preceptors necessitate the allocation of a time allowance to support and access nursing students. Other findings suggested that there are competing demands regarding the role of the nurse preceptor particularly regarding the need for preceptors to provide patient care. This was predominantly acknowledged by Gidman *et al* (2011) and Cassidy *et al* (2012) who ascertained that in addition, while it was recognised in the literature the importance and the requirement for preceptors to support nursing students, it was suggested that the perceived nursing student's supports in practice in United Kingdom identified that some nursing students encountered negative attitudes among preceptors who argued that their primary role was patient care rather than mentoring students. From the Irish perspective, Cassidy *et al* (2012) found that, preceptors reported feeling torn between the competing demands of caring for patients whilst the staffing resource was under provisioned and of inadequate time for supervision and clinical assessment of competence among their allocated nursing students. Worryingly, these findings suggested that at times, the operation of the preceptorship model is not possible because of competing demands and therefore nursing students are not supported in practice by preceptors, as identified by Fitzgerald *et al* (2012) who postulated that

specific areas of concern are not discussed formally with the nursing student in partnership with the CPC. This finding warrants further investigation to ensure nursing students are fit for purpose to ensure patient safety as advocated by Hughes *et al* (2016).

The findings revealed other factors, lack of trained therefore unprepared preceptors and educated preceptors, perceived lack of support from an organisation perspective. These findings are supported in the literature by O'Connor et al (2009) who concluded that their findings were consistent with other studies regarding the preparation of assessors, the need for considerable time to use the documentation. Three Irish studies (McCarthy and Murphy, 2008; Fahy *et al* 2011 and Butler *et al* 2011) identified many factors that impact on the assessment of nursing students in practice to include, process not standardised, lack of continuity when it became to preceptorship, and time constraints. Findings, also reported by Dobbs (2017) related to the preparedness of the preceptor regarding the assessment of students particularly with regard to the management of failing students.

5.3.5 The role of those involved in the assessment process

The role of the preceptor and CPC is crucial to student learning and is advocated in the Code of Professional Conduct and Ethics (2014) developed by NMBI, that states that the registered nurse role involves 'supporting, learning, teaching, supervising, assessing practice and taking action to address concerns where they are identified' (Principle 5, Standard 5). Findings suggest that many preceptors felt that the nursing students deserved this support and was a key component of their role as preceptors. However, linked to this was the issue of no constant preceptor working with the nursing student for the duration of the clinical placement as identified by Butler *et al* (2011) who found that preceptors reported a lack of continuity with particular nursing students in the conduct of initial, mid-point and final interviews, variability on the length of time allocated to differing students.

The findings also revealed that the current timeframe from an organisational perspective to allow registered nurses to act as preceptors needs to be reviewed and newly qualified registered nurses should not be excluded from this important role because of their expertise and their recent experience of their role as nursing students. This is something that the writer of the thesis can influence going forward. Academic staff have been identified as being central in the assessment process through their support of nursing students, preceptors, CPC's and CNM's. However certain findings identified that this important role is not operationalised in practice and if so it is ad hoc. This important role is illuminated by McSherry *et al* (2015) who suggest that engagement of academics in the practice setting will ensure partnership and support for staff and nursing students and will have transparent outcomes for students' practice and education. Likewise, Carney (2017) argue that the nature and frequency of communication between the HEI's and ACAP's, can impact on student teaching and learning positively or negatively. This reflects the support structures required for collaborative working between the HEI's and AHCP's as supported by a quality clinical learning environment where Nolan (1998) believes that there is a requirement for effective communication between the HEI's and AHCP's. A quality learning environment is where students learn to integrate the theory and practice of nursing and the most important people responsible for the development of a quality clinical learning environment are staff nurses, clinical managers, and lecturers (Seshan *et al* 2011). It was also further established and related, that the success of a nursing student may be influenced by the relationship with their preceptor and the dynamics of the clinical learning environment regarding attitudes and interaction not only with staff but also patients, and if the students felt valued and as part of the team. This is supported by Dunn and Hansford, (1997) Hart (1992); Saarikoski and Leoino-Kilpi, (2000) Seshan, *et al*, (2011) who purported that the quality of the staff and student relationship particularly between preceptor and student was important. In addition, Sword (1994) identified the requirement of a quality student-patient relationship was required to ensure a successful placement for nursing students. Furthermore, an international study by Chuan and Barrett (2012) that positive factors that influence the student experience included the friendliness of the clinical learning environment,

attitudes of staff nurses towards student learning and variations of learning opportunities.

In addition to the preceptor role, the current degree programme in Ireland is reliant on additional clinical support staff to include the CPC's. The findings of the study revealed that the role of the CPC was to facilitate the interview process and support both the student and preceptor particularly if action plan/development plan is required. This supportive role is unique to Ireland and Drennan (2002) defined the Clinical Placement Co-ordinator (CPC) as "an experienced nurse who provides dedicated support to nursing students in a variety of clinical settings" (p 428). The primary functions of the role include guidance, support, facilitation and monitoring of learning and competence attainment among undergraduate nursing students through reflective practice.

5.3.6 Feedback

The current study interconnected the concept of failure with the important theory of feedback. Three significant findings emerged, in relation to the theme of feedback. The first, relates to the interview process. It was viewed that the three interview process not only allowed for formal feedback early and during placements but ensured continuous feedback which was not always possible before, using the existing documentation utilised by HEI'S and ACHP's as identified in the findings. In addition, linked to the process was the identification of learning outcomes at the beginning of the placement to ensure that the student is aware of what they need to achieve by the end of the placement as identified by Flanagan *et al* (2000) and Rust (2002) who assert that assessment criteria related to all modules and are clearly related to the learning outcomes, and it is important to map the learning outcomes of the modules to the programmes subject requirements.

The second, relates to the role of the preceptor in the provision of feedback and how this links to the identification of expectations. The latter was not only linked to the role of the nursing student, but also particularly to the one aspect of the role of the preceptor. The literature identifies the importance of preceptors in the provision of

feedback and is recognised by Collins *et al* (1991) when exploring the concept of cognitive apprenticeship. Also the findings purported that the expectations of the preceptor and what is required of preceptors when assessing students is clearly delineated. The idea that nursing students are required to identify their expectations was viewed as important and this was related to the idea the nursing students are adult learners who need to take responsibility and prepare themselves before commencing a clinical placement as purported by Knowles (1984).

The third, relate to the relationship between feedback and failure and again there is a link with the interview process as findings, suggested that feedback is crucial especially during the middle interview because issues should be addressed by the preceptor and the nursing student. Moreover, the important role of feedback regarding the concept of failure, now only for the student but also those involved in the assessment process was acknowledged. Other findings address the concept of continuous feedback which identified that if the method of feedback was utilised, it required appropriateness and to be given in a timely manner. It is noteworthy that *Collins et al* (1991) posit that the preceptor can employ techniques to ensure the nursing student moves along the learning continuum, thereby developing both performance, clinical reasoning and thinking competence. The first three focus on developing the nursing student's ability to perform in practice including: modelling where the preceptor demonstrates the object to be learned; coaching which involves delegating and guiding the nursing student's activity and observation of the performance and finally by providing ongoing appropriate feedback.

It was also suggested in the findings that the amount of feedback should be increased and is a crucial, particularly during the third interview. If appropriate and timely, feedback will ensure that no nursing student will be surprised if a fail placement is inevitable. These findings are contextualised by Heaslip and Scammell (2012) purport that feedback should be ongoing and not just at the end of a clinical placement to ensure further development of skills and confidence for the student and preceptor and confidence was a key skill when deciding to fail a student. Interestingly, certain

findings of the current study can be related to the latter point identified by Heaslip and Scammell (2012) regarding the concept of confidence.

5.3.7 Reflection and self-evaluation

Reflection and self-evaluation were emergent theme that was repeatedly highlighted by the participants of both the survey questionnaire and the focus groups. It was evident that the concept of reflection in the form of written reflections on practice experiences or/and reflective notes needs to be included in practice and the assessment documentation, as the use of reflective notes may inform the assessment process. The significance of these findings is augmented by Johnston and Fells (2017) regarding the importance of reflection-in-action as critical for effective practice and for the development of competence in nursing. Findings also outlined the need to have a model of reflection and the importance of commencing reflection on practice in first year using a model from a theoretical perspective. Some participants identified the need and the importance, that the model identified from a theoretical perspective is utilised throughout the trajectory of the degree programme. In addition, it appeared that the findings identified, that nursing students in 4th year may not be aware of the model in used. Findings suggested that the lack of understanding by nursing students regarding the use of a model of reflection can only lead to this important strategy not been utilised by nursing students and preceptors, not only from an assessment process but also regarding the specific competencies required for successful completion of the degree programme and ultimately registration. The importance of these findings is augmented by Henderson (2012) who proposed that engaging in reflective practice through the process of clinical supervision can develop the quality of the student/preceptor relationship which will allow effective objectivity more possible (p 35). In addition, nursing students should have the opportunity to reflect on their care delivery in an analytical way within the milieu of practice, in order to identify how they can achieve best practice in line with current professional standards (Mc Sharry, 2012; Mc Sharry and Lathlean, 2017). In conclusion, the findings identified that the use of reflective models were perceived as useful and valuable and notability Gibbs model predominated and the current Standards and Requirements for Nurse

Education (NMBI, 2016) make provisions for reflection and Gibb's model of reflection is prescribed. The use of this model is supported by Atkins and Murphy (1993) as it is cyclical, simply to apply in practice and has a focus on self-awareness.

In the findings, participants, illuminated the common difficulties when ensuring reflection occurs in practice particularly regarding time constraints and support for reflection. Participants questioned the learning that occurs because reflection-in-action is not embedded in clinical practice. The facilitation of reflective practice is proposed by Cassidy (2009) to be embedded in phenomenology where the student immerses themselves in practice. Participants stated that if the documentation increased the necessity to include a reflective component, it will ensure that reflection is related to practice as the nursing student in partnership with the preceptor reflects on what happen on a particular day where the nursing student self-reflects that is reflection-on-action (Schon, 1983). Here reflection, occurs after the experience where the nursing student with the preceptor may explores the rationale and consequences of their actions through a documented reflection of the situation. The latter findings are disappointing as nursing students are currently allocated protected reflective time to facilitate this learning strategy and the structures in place for the implementation of protected reflective time are agreed formally between HEI's and AHCP's (NMBI 2016 p 127).

Findings regarding the concept of self-evaluation was twofold relating to learning needs and expectations and the value based enquiry model (McLean, 2012). The findings articulated that self-evaluation of learning needs would ensure that adult learning styles are utilised and learning opportunities specific to placement would ensure that nursing students would identify their learning needs and take ownership for their learning. This can be related to humanist theory advocated by Bates (2016) as it suggests that learners are individuals who should determine the nature of their own learning and reflects the idea of the adult learner adoption of andragogy (Knowles, 1984). However, some findings identified that the use of self-evaluation particularly outlined in the value based enquiry model, may be difficult for first year student nurses and therefore suggested that this self-evaluation should take the form of self-reflection as discussed earlier.

5.3.8 National documentation

Findings of the current study, overwhelming suggest that the introduction now of a national standardised framework is welcomed to ensure safe nurses as indicated by Bradshaw and Merrimen (2008), Licen and Plazar (2015) and finely, Saleh *et al* (2017). This will ensure that nursing competence is maintained and is of increasing importance to professional regulators, employers, nurses and most importantly patients. The introduction of a national framework and documentation and therefore appropriate assessment methods will enhance the transparency of the nursing workforce competences going forward as advocated by Helminen *et al* (2016). In addition, the vast majority of participants acknowledge that the national standardised documentations are welcomed and the significance of this finding is that it would promote consistency regarding assessment.

The findings related to language and it was identified that for the most part the language was concise, straight forward and inclusive compared to previous assessment documents used in clinical practice. This was reiterated in research findings in three Irish studies (McCarthy and Murphy, 2008; Fahy *et al* 2011 and Butler *et al* 2011) who identified that difficulties in understanding language impact on the assessment of nursing students in practice before the development of national documentation as part of this study. However, certain findings identified that the language for the most part represented the individual discipline of nursing with the exception of psychiatric division and this related to the fact that the language was not person centred and did not reflect the core values related to mental health. The findings put forward a solution and that the term mental health was more appropriate. The current language of the title 'psychiatric nursing' is utilised in line with the Nurses and Midwives Act (2011) and on successful completion of the degree programme, the student nurse registers as a 'registered psychiatric nurse (RPN)'. This title is a protected title because of legislation. Nationally, the idea of the title 'registered psychiatric nurse' needs to be considered in light of international findings such as the use of the title 'mental health nursing' by international regulatory bodies such as the United Kingdom, Canada, New Zealand and Australia. Nationally, there is

a degree of evidence to support the change in title with the establishment in 2018 of a National Strategic Psychiatric/Mental Health Nursing Group to guide and support the development of professional mental health nursing in line with policy and legislation. This includes supporting the implementation of recommendations originating from the 'Vision for Change Review Group' and the publication of A Vision for Change (2006) and recommendations included the change to the professional title from 'Psychiatric Nurse' to 'Mental Health Nurse' and states; "an inclusive consultation process is required to review the title of Registered Psychiatric Nurse to reflect the role related to the health component of the mental health spectrum of care" (Cusack and Killoury, 2012: 53). In light of the findings of the current study, the use of the title of 'Mental Health Nurse' now needs to be considered but will have consequences regarding the Nurses and Midwives Act (2011), Nurses Rules (2017) and Nurse registration Programme Standards and Requirements (2016) and will require considerable consultation with the nursing profession as advocated in current legislation.

In relation to the use of focus groups, there can be unintended consequences which was not the intention of the researcher as certain findings did not relate to focus group guide or the literature review but were viewed as important concepts for some of the participants. The researcher included these concepts because of the strong opinions of the participants but suggested a further review of the literature is required. These concepts included protected time, the inclusion of clinical skills in the documentation and importance of confidentiality regarding the assessment documentation utilised by nursing students.

5.3.9 Protected time

Participants identified the important role again of assessment of competence for nursing students and welcomed the standard set out by NMBI which states that 'protected time policy/arrangements are in place for preceptor supervision and examining of undergraduate students' (NMBI, 2916 p 127). In addition, this protected

time was related to the interview process in place and was viewed as a mechanism to insure a fair and consistent meaningful process, not just a tick box exercise.

5.3.10 Confidentiality

There is a paucity of literature regarding the concept of confidentiality. However, the subtheme of confidentiality of information in the findings arose in many ways, particularly in relation to failing nursing student and action plans. It was gleaming from the findings that the relationship between the nursing student and preceptor was associated with the concept of trust and the importance of confidentiality regarding the action plan. One of the main reasons for this related to new preceptors in the next clinical placement may be influenced by previous decisions and new outcomes should be based on the new evaluation by the preceptor working with and assessing the nursing student. Interestingly, findings differ regarding the confidentiality of the information as it was perceived by others that this information needed to be shared when the nursing student goes forward to the next placement but only when the nursing student and the preceptor discussed this and ultimately it was suggested that it is the decision of the nursing student and in reality, there is a need to take a pragmatic stance taken regarding the confidentiality of assessment decisions by the preceptor in partnership with the nursing student. It may be of benefit the nursing student and help in the process of gaining confident and becoming competent with the support of different preceptor in the a different clinical learning environment. As identified in the findings, it is important that the process of assessment is dealt with in a professional manner and outcomes of assessment is discussed with the relevant personnel and not discussed out of context. The writer of the current study has outlined in the current documentation that NCAD is shared with the preceptor throughout the practice experience as it forms the basis of regular discussion of learning needs and also ensures records of achievement are completed regularly.

5.4 Conclusion

The discussion commenced with a review of theoretical/framework/models for the assessment of competence in clinical practice and the rationale for the inclusion of

Benner's (1984) levels of practice and Steinaker and Bell (1979) experiential taxonomy in the NCAD. The discussion highlighted the importance and the reasons to maintain the current competence assessment process and the use of three interviews in clinical practice. The process was aligned to the concept of social learning and the role of the nursing student and preceptor regarding the requirements of supervision as related to the choose framework/model used in the NCAD. Another aspect of the discussion related to concept of failure and the utilisation of action plan/development plan and sometimes the reluctance to use a plan which is one of important aspects of competence assessment currently and is a critical part of the process to guide and support students and is part of the national framework and NCAD going forward. The support structures necessary to support nursing students such as adequate numbers of trained preceptors was highlighted and linked to the supports are the preceptor and CPC's. The concept and importance of feedback was highlighted again in relation failure. The discussion illuminated the importance of reflection and a model of reflection in the NCAD AND Gibb's model of reflection was the one put forward. The introduction of a national standardised framework and the language inherent in the documentation was discussed. Two important concepts relating to the interview process, protected time and confidentiality were included in the discussion as these two concepts were viewed as important aspects regarding the assessment process by the participants.

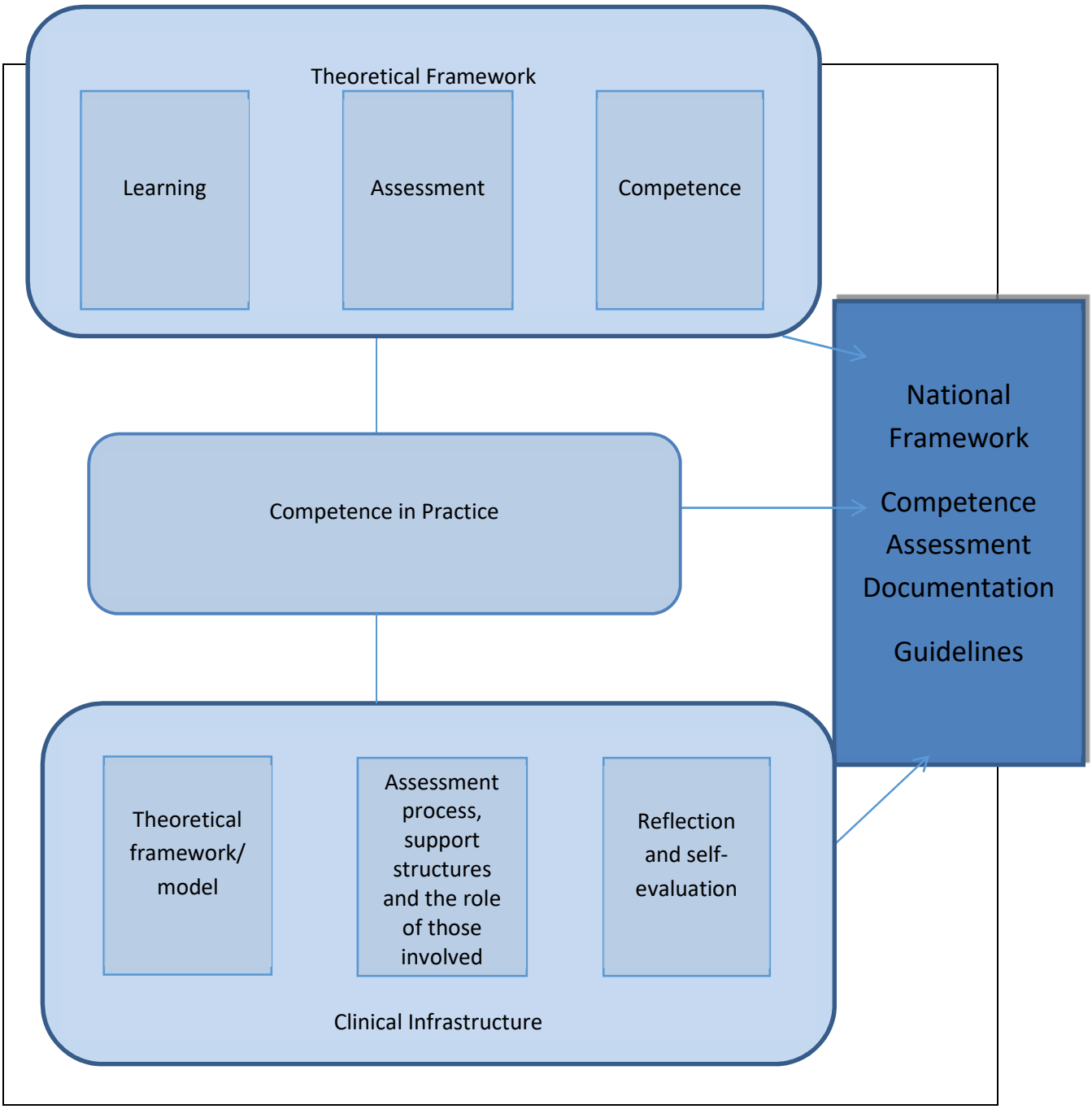


Figure 5.1: The common themes discussed linked to the theoretical framework

5.5 Overall conclusion of the research study

The desired outcome of this study was to develop and implement a national competence framework to facilitate the assessment of first year nursing students undertaking the four year/four and half year degree programme in the four disciplines of nursing. This national framework and documentation will be implemented in the Higher Education Institutions in the Republic of Ireland. This research was initiated as a result of a review of the degree programmes in 2012, by the Department of Health, who then issued a Report of the *Review of the Undergraduate Nursing and Midwifery Degree Programme (2012).* The Report recommends that:

> The Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/Health Service will review student clinical assessment processes including documentation to promote standardisation of clinical assessment in line with competence goals for the four nursing programmes (p 61).

Therefore, the current study focused on developing a national evidence based standardised framework incorporating the process of assessment, national assessment documentation and guidelines for first year nursing students undertaking degree programmes in nursing. The research questions for the overall research project were as follows:

- What theoretical framework/model for the assessment of competence should underpin the national competence assessment framework?
- What are the key elements of a national system to facilitate the competence assessment of nursing students in Ireland?
- What assessment tools, documentation and assessment processes should be developed?

As action research involves the purposive redrafting of projects while they are in process, a new framework and documentation were developed and refined through each action research cycle. Consulting with the stakeholders through each stage in the development of framework and documentation contributed to a high level of engagement with

stakeholders in this important national initiative. The consultation process allowed stakeholders to identify the key features of the national framework and documentation going forward. The framework and documentation were developed based on best practice which set out clear expectations for nursing students, academic partners, preceptors and CPC's.

The study findings are beneficial for the following distinct reasons as related to the research questions. Firstly, it provides a national framework incorporating the process and documentation. This will ensure that the responsibilities and duties of NMBI as defined by the provisions of the Nurses and Midwives Act, 2011, and the mission of public protection are met by providing a robust mechanism regarding the assessment process and the documentation used for first year nursing students. Most importantly, inherent in the documentation are the necessary components for comprehensive fair assessment of clinical competence for nursing students undertaking the nursing degree programmes in Ireland. The journey taken by NMBI regarding assessment has evolved over the years particularly in light of the degree programme in 2002 and the utilisation at the time of the Requirements and Standards for Nurse Registration Education Programmes (2000) which were updated in 2005. Both these documents used domains of competence for entry to the Register. As a result of the review these domains of competence were reviewed in 2016, taking cognisance of national and international standards. These new standards and requirements constitute an important development regarding its role in public protection and the domains of competence are inherent in the NCAD. These national documents will ensure consistency of assessment and will benefit the HEI's and AHCP's as prior to the NCAD, different documents were in use with differing content and many AHCP's support nursing students from different HEI's. The use of the NCAD and the framework will help in the standardisation of the process and provide a basis for preceptorship training which will be consistent for all those who guide, support and assess nursing students.

Previously, a collaborative approach to the assessment of competence among nursing students was developed based on the domains of competence (ABA, 2000) in three

universities as many AHCP's were clinical placement sites for nursing students coming from the different universities (O'Connor *et al* 2009). The documentation was implemented in the AHCP's in 2004 and evaluated in 2006. This evaluation was positive regarding the benefits of 'inter-institutional collaboration' in competence assessment with recommendations for practice. The writer of this research study believes it is now important and timely to introduce the NCAD supported by the guidelines documentation from a tripartite perspective with the regulatory working with HEI's and AHCP'S. Furthermore, it is suggested that the national focus regarding competence assessment is unique in the Irish and the international context where other regulatory bodies have not defined a system or standards to introduce a standardised national process and documentation for competence assessment of students. The writer of this research thesis would like to share the journey travelled with those who may like to introduce a national framework and documentation for the assessment of students, both nationally and internationally.

As outlined in the literature review, many of the HEI's utilised many differing theoretical framework/models for the assessment of competence and used a combination of frameworks/models, including Benner's (1984) levels of practice and experience, Bloom's taxonomy of educational objectives for knowledge based goals, Steinaker and Bell (1979) experiential learning taxonomy and Bondy (1983) criterion-referenced definitions for rating scales in clinical education. Other frameworks/models were identified by certain HEI's but a full review of the evolution of differing theoretical frameworks/models is beyond the remit of this research. The identification of two theoretical frameworks namely Benner's (1984) Levels of Practice and Experience and Steinaker and Bell's (1979) Experiential Learning Taxonomy to underpin the NCAD is unique to the Irish context but also will ensure consistency, standardisation from a national perspective for all HEI's and AHCP's. In addition, the writer of this research thesis suggests that the introduction of known frameworks/model to assess competence is helpful from an educational and clinical perspective as the utilisation of both frameworks/models are in place and are mostly, known to those involved in assessment of nursing students. Furthermore,

education programmes have been developed by the HEI's in partnership with AHCP's, therefore this standardisation will not place a burden on those involved in assessment going forward in contrast to introducing a new framework/model. The writer recommends a review and an evaluation of these frameworks/models before the first cohort of undergraduate nursing students complete the degree trajectory as this will highlight issues for development and knowledge generation.

The utilisation of the self-evaluation of learning needs and expectation is a new component in the framework and documentation regarding assessment of nursing students in Ireland. This component is to be completed by the undergraduate nursing student prior to practice placement, incorporating theory and clinical skills learned to date if appropriate for their stage along the first year trajectory. Mixed views were identified by participants regarding this component particularly for first year nursing students on their first placement, but for the most part the section was welcomed because it will allow student nurses to bring their life experiences to practice and focus them to identify their learning needs and be aware of the learning outcomes before completing the first interview with the preceptor. The completion of the self-evaluation of learning needs and expectation is supported by inclusion of the Southampton values based model (McLean, 2012), which provides prompt questions designed to encourage the nursing student to question. This will form the basis of learning both from a theoretical and clinical perspective and particularly give assistance when completing the self-evaluation and expectations. The model emphasises that 'self-awareness, awareness of others and the values of care and compassion are central to both education and practice' (Southampton University 2012; McLean, 2012). Other aspects of a values based curriculum model were not explored for this study but the writer endorses a review of the related components going forward.

Inclusive in the NCAD for all disciplines of nursing is the three stage interview process of preliminary interview, mid interview and final interview and these interview are augmented with progress notes which are individual to each HEI's and used according to

local policy as it was difficulty to standardisation all aspects of the NCAD. Many of the HEI'S have standard policies which have been validated by academic council.

Reflection and reflective practice have been a critical component of the undergraduate degree programme since its introduction in 2002 and the use of protected time for reflection is central to the operationalisation of reflective practice during clinical practice for all nursing student across the trajectory of the undergraduate degree progamme. The utilisation of protected time and reflection is not without its problems, usually related to time constraints, busy work environments and not a standardised policy for protected time. The inclusion of reflective practice using a known model of reflection such as Gibbs model of reflection (1988) in the NCAD will reinforce this important requirement as related to and relevant to learning that has to be achieved by the nursing student during clinical practice as linked to the learning outcomes. Reflection must relate to situations encountered by the nursing student in clinical practice.

As outlined in the NCAD documentation for all disciplines of nursing, the assessment of competence are based on the six domains of competence as developed as part of the standards and requirements in 2016. Each domain is outlined and the preceptor ensures that each indicator is achieved when supervising the nursing student in practice as related to the theoretical framework/model identified for first year nursing students as discussed earlier.

The guidelines for those who assess nursing students in clinical practice reflects the components of the NCAD. In addition, this document incorporates guidance based on situational learning theories, the supervision requirements for the totality of the undergraduate degree programme, the assessment process relating to the three interviews and the requirements regarding reflective practice. This document will give guidance to preceptors in practice when guiding, supporting and assessing nursing students. Furthermore, the document outlines guidance and requirements regarding the undergraduate nursing student.

In summation, the development and structure of a standardised national framework, associated processes and documentation will fulfil regulatory requirements, standardise disparate practices and provide an evidence based approach to the process. Furthermore, it will bridge the existing gap for a standardised approach to competence assessment for undergraduate nurse education programmes. The national framework and documentation no longer exists only in theory, it has become a lived experience for stakeholders in the HEI's and AHCP's since September 2018. As a result, NMBI can quality assure their mechanisms to safely enter a name on the Register of nurses as maintained under the Nurses and Midwives Act (2011) and fulfil the mission to protect the public.

5.6 Limitations

While the study has developed a competence framework and national assessment documentation, there are number of limitations, which must be acknowledged. Limitations apply to all cycles and are related to the constraints associated with available resources in terms of researcher time. This study was undertaken while the researcher was in full time employment and gained promotion with added responsibilities and accountability for the Education Department of the regulatory body who provides advice, guidance to all stakeholders involved in the education of nursing students and registrants. In addition to the above generic limitation, a number of other limitations are related specifically to action research cycles.

1. Constraints associated with recruitment for cycle 3 of for the study resulted in a sample which may not have been representation of the overall education group that guide, support and assess nursing students in clinical practice.
2. The composition of the initial focus group interviews may have resulted in a degree of group thinking and this may have influenced the initial findings to some extent.

5.7 Recommendations

5.7.1 Research

1. The redevelopment of the Competence Framework to include the process and documentation should follow a similar action research process as was used in its original development to inform the competence framework for year 2, 3, 4 and 4.5 of the undergraduate nursing programme.
2. It is recommended that the lessons learned from the study become a focus of research in the education department of NMBI within a two-year timeframe.
3. NMBI needs to revisit the definition of competence from a national regulator perspective and influence the European agenda regarding a pan European accepted definition of competence.
4. It is recommended that the title of 'psychiatric nurse' is reviewed in consultation with the profession.

5.7.2 Education

1. The developed first year documentation as a result of this research needs to be reviewed to ensure that it is fit for purpose going forward within a three year timeframe as the utilisation of the process and documentation was instigated in September 2018.
2. It is recommended that NMBI undertake a review of the Nurse Registration Programmes Standards and Requirements (NMBI, 2016) with key stakeholders and patient groups because of certain findings of this study.
3. It is recommended that guidance to support preceptors in their role regarding failure to fail be developed.
4. It is recommended that an online education programme in relation to the competence assessment framework should be developed from a national perspective by NMBI.

5. It is recommended that the role and the operationalisation of preceptorship and reflective practice is reviewed regarding the undergraduate nursing programme to meet the responsibilities of the HEI's and AHCP's to meet the standards defined by NMBI.
6. It is recommended that the values based model developed by McLean (2012) and utilised in the University of Southampton be reviewed to inform further development of NCAD.
7. It is recommended that the timeframe to allow new qualified nurses act as preceptors be reviewed in conjunction with HEI's and AHCP's.

5.7.3 Clinical Practice

1. It is recommended that the regulatory body for nursing in Ireland utilise information technology and develop on-line systems regarding the national documentation to be utilised by the HEI's and AHCP's.
2. It is recommended that NMBI review and re-develop the guidelines document to particularly meet the needs of the preceptor and CPC's.
3. It is recommended that a programme of professional development for those involved in the assessment process be implemented.

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Appendix 1 - PAF – Proficiency Assessment Form

An Bord Altranais
(NURSING BOARD)

PROFICIENCY ASSESSMENT FORM

Surname.....

Forename.....

Date of entry to present training .....

Ward/Department.....

Speciality ..... Day/night duty

From ..... To .....

No. of weeks.....

Preliminary interview date .....

Signature .....
Ward Sister/Charge Nurse

Signature .....
Student Nurse

Intermediate interview date.....

Signature .....
Ward Sister/Charge Nurse

Signature .....
Student Nurse

Please rate section below by placing "X" in appropriate box:
1 = Very Good. 2 = Good. 3 = Fair. 4 = Unsatisfactory.

APPLICATION TO NURSING CARE	1	2	3	4
1. Uses all opportunities to increase knowledge and skills				
2. Has responsible attitude to attendance/ punctuality				
3. Works well without undue supervision having regard to level of training				
4. Shows dependability, self reliance and initiative				
GENERAL RATING – APPLICATION TO NURSING CARE				

ATTITUDE TO PATIENTS	1	2	3	4
1. Demonstrates ability to assess, meet and evaluate patients' needs.				
2. Develops good nurse/patient relationships				
3. Shows good understanding of patient as an individual				
4. Gains confidence and co-operation of patient				
GENERAL RATING – ATTITUDE TO PATIENTS				

QUALITY OF STUDENT'S PERFORMANCE	1	2	3	4
1. Is accurate in performing duties				
2. Adapts well to changed conditions				
3. Learns new duties well without undue repeated instructions				
4. Plans work effectively				
5. Has ability to cope with pressure				
6. Shows high degree of observation and accurately reports all relevant information				
7. Maintains high standards when carrying out nursing procedures				
8. Applies theoretical knowledge to nursing practice				
GENERAL RATING – QUALITY OF STUDENT'S PERFORMANCE				

RELATIONSHIP WITH CO-WORKERS	1	2	3	4
1. Works well as a member of the team				
2. Has a positive attitude to direction and supervision				
3. Shows willingness to guide junior colleagues				
4. Has ability to work with other disciplines				
5. Is tactful in working relationships				
GENERAL RATING – RELATIONSHIP WITH CO-WORKERS				

ATTITUDE TO RELATIVES AND VISITORS	1	2	3	4
1. Shows consideration, tolerance and tact				
2. Is approachable				
GENERAL RATING – ATTITUDE TO RELATIVES AND VISITORS				

ABILITY TO COMMUNICATE IN WRITING	1	2	3	4
1. Has ability to define essentials on which to plan and report				
2. Demonstrates ability to present clear and accurate reports				
3. Can always be relied upon to record clinical data accurately and promptly				
GENERAL RATING – ABILITY TO COMMUNICATE IN WRITING				

PROFESSIONAL BEHAVIOUR	1	2	3	4
1. Upholds the generally accepted standards of the nursing profession				
2. Has reponsible attitude to importance of confidentiality				
GENERAL RATING – PROFESSIONAL BEHAVIOUR				

ABILITY TO COMMUNICATE VERBALLY	1	2	3	4
1. Has ability to communicate well through verbal expression				
2. Is clear, accurate and positive when giving verbal reports				
GENERAL RATING – ABILITY TO COMMUNICATE VERBALLY				

OVERALL PERFORMANCE RATING

Indicate overall rating by signing appropriate line below. If it is the assessor's intention to sign line 3 or 4, please discuss with the Matron/Chief Nursing Officer and Principal Tutor/Tutor.

1. Very good (performs very well) 1 .....

2. Good (performs moderately well without serious short-comings). 2 .....

3. Fair (does not function adequately without constant supervision) 3 .....

4. Unsatisfactory (does not function even with constant supervision) 4 .....

I have discussed this complted form with the student nurse.

Signature .....
Ward Sister/Charge Nurse

Date .....

I have read this form and understand the contents.

Signature .....
Student Nurse

Date .....

ACTION PLAN FORM

Action plan form must be completed by the matron/chief nursing officer and principal tutor/tutor for all student nurses who receive an overall number 3 or number 4 rating in a proficiency assessment form.

Student nurse's name .....

Commenced training .....

Overall performance rating given on proficiency assessment form .....

Date .....

Ward/Department .....

ACTION PROPOSED .....

.....

.....

Signature .....

Matron/Chief Nursing Officer

Date .....

Signature .....

Principal Tutor/Tutor

Date .....

I have read this form and understand the contents.

Signature .....

Student Nurse

Date .....

Appendix 2 - Domains of Competence (NMBI 2016).

Domain 1: Professional values and the role of the nurse competences

Demonstrates the capacity to:

1.1 Practise safely

• Ensure the safety of the person whilst protecting the public, through the delivery of safe, ethical, reliable and competent nursing care.

• Practise with integrity, honesty and within the law to uphold the professional values of nursing.

• Practise within her/his scope of professional practice with due regard for regulatory and statutory requirements.

• Practise with due regard for ethical and professional guidance governing the role.

1.2 Practise compassionately

• Practise in a caring, kind, sensitive, holistic, impartial, and non-judgmental manner.

• Assist the person to maintain needs for hydration, nutrition, elimination, personal hygiene, rest, sleep and activity.

• Practise compassionately to facilitate, promote, support and optimise the health, wellbeing and comfort of persons whose lives are affected by ill health, distress, disability or life-limiting conditions.

1.3 Practise accountably

• Identify personal responsibility, level of authority and lines of accountability.

• Take personal and professional accountability for own decisions, actions and for the completion of delegated tasks

• Accept responsibility for the maintenance of clinical competence through the undertaking of continuing professional development

Domain 2: Nursing practice and clinical decision making competences

Demonstrates the capacity to:

2.1 Assess nursing needs

• Take a nursing history using relevant frameworks to organise clinical information and the person's experience of altered health, ability and developmental or life stage needs.

• Analyse information collected to reach an accurate assessment of a person's nursing needs.

• Recognise and interpret signs of normal and changing health care needs.

2.2 Plan nursing care:

• Develop a person-centred plan that incorporates the person's experience of altered health and expectation for recovery.

• Plan nursing interventions applying current theoretical and clinical knowledge based on principles of quality and safety.

• Prioritise the person's nursing care needs taking into account relevant physical, psychological, social, spiritual, cultural and environmental factors.

• Communicate plan of care and rationale for interventions clearly to the person, primary carer and other health professionals.

2.3 Deliver nursing skills, clinical interventions and health activities:

• Obtain consent from the person to deliver nursing care.

• Deliver person-centred nursing care safely in accordance with the person's plan of care.

• Make sound clinical judgements to adapt interventions to changing health needs.

• Maintain the person's dignity, rights and independence.

• Apply principles of health and safety including moving and handling, infection control and emergency procedures.

• Assess risk, hazards and adverse outcomes and take relevant actions to manage risks identified.

• Recognise and respond to early warning signs of critical changes in a person's health status.

• Initiate life preserving measures in response to critical changes in a person's health status or in emergency situations.

• Recognise and refer accordingly when the complexity of a person's needs requires specialist expertise.

• Administer medicines and other therapeutic interventions safely.

• Utilise nursing techniques and procedures, medical devices and technologies and clinical equipment safely, with awareness of correct usage, limitations and hazards associated.

• Utilise information management technology safely to record personal data for clinical decision making.

• Support and facilitate the person to promote health and physical and emotional well-being including access to health screening.

2.4 Evaluate nursing care:

• Synthesise a range of clinical observations, feedback and other sources of information to adjust the plan of nursing care through ongoing evaluation of its effectiveness.

• Gather additional data to evaluate priorities, goals, time frames and interventions based on changes to the person's condition, responses, or situational needs.

• Review nursing interventions against evidence of best practice.

Domain 3: Knowledge and cognitive competences

Demonstrates the capacity to:

3.1 Practise from a competent knowledge base

• Apply current and relevant aspects of concepts and theory of nursing to care planning, nursing interventions and health settings.

• Apply principles of quality and safety to audit and evaluate nursing and healthcare practice.

• Recognise common physical, developmental, emotional and behavioural signs, vulnerabilities and co-morbidities within their division of nursing.

• Apply current and relevant aspects of national and international policies that influence nursing practice and health care delivery.

• Apply current and relevant knowledge of the structure and function of the human body from the health and life sciences to in day to day nursing practice situations.

• Apply current and relevant knowledge from the social and behavioural sciences to nursing practice situations and settings.

• Apply reasoning and relevant knowledge from the ethical theory to moral dilemmas in day to day nursing practice

• Demonstrate knowledge of legislation relevant to nursing practice situations and settings.

• Apply current and relevant aspects of principles of health information technology and nursing informatics to nursing practice.

• Appraise, and apply as relevant, aspects of the nursing research process to enhance the evidence base of nursing practice interventions.

3.2 Use critical thinking and reflection to inform practise

• Develop analytical skills for problem-solving, reasoning, evaluation, synthesis for application to nursing practice situations and interventions.

• Develop personally and professionally through reflection to enhance resilience and own nursing practice.

Domain 4: Communication and inter personal competences

Demonstrates the capacity to:

4.1 Communicate in a person-centred manner

• Communicate in an effective, compassionate, age-appropriate, respectful and non-discriminatory manner with the person and her/his primary carer.

• Provide emotional support to the person undergoing nursing care and health procedures/interventions, whilst respecting professional boundaries.

• Assist the person and primary carer to express concerns about their experience of nursing and health procedures/interventions.

• Support and empower the person to make health and life choices for health promotion, recovery, resilience, self-management, wellbeing and social inclusion.

• Respect the diversity, dignity, integrity and uniqueness of the person through a collaborative partnership that recognises her/his autonomy.

• Utilise communication techniques and technologies to assist a person with physical, emotional, behavioural or cultural communication difficulties to express their needs.

• Recognise and refer when a person requires language interpreters or specialist communication supports communication technologies to assist persons with communication difficulties to express their needs.

4.2 Communicate effectively with health care team

• Accurately report, record, document and refer observations and information received in the nursing care giving process.

• Communicate clearly and coherently with other health and social care professionals.

• Negotiate with other health care and other professionals to ensure that the rights, beliefs and wishes of the person are not compromised.

• Respect the privacy of the person and confidentiality of information in the health setting.

• Use standardised professional nursing language terms when reporting, documenting and communicating to nursing and health care teams.

• Share information with others in accordance with legal and professional requirements in the interests of protection of the public.

Domain 5: Management and team competences

Demonstrates the capacity to:

5.1 Practise collaboratively

• Work for the person's wellbeing, recovery, independence and safety through recognition of the collaborative partnership between the person, family and health care team.

• Collaborate effectively with other health care disciplines and members of the nursing team to prioritise, coordinate and monitor care provision for effective health outcomes.

5.2 Manage team, others and self safely

• Assess risk to a person's safety, security, well-being and health status through, promotion of a safe environment for each person, self and others.

• Assess priorities, manage time and resources safely and effectively.

• Participate in audit and quality improvement processes within the health service setting.

• Foster a supportive clinical work environment that facilitates a culture of interprofessional trust, openness, respect, kindness and safe standards of health care.

• Contribute to the learning experiences of other colleagues through provision of support, supervision and facilitation of learning.

• Demonstrate personal organisation and efficiency in undertaking nursing care.

Domain 6: Leadership potential and professional scholarship competences

Demonstrates the capacity to:

6.1 Develop leadership potential

• Articulate the purpose and function of leadership and accountability for effective clinical health and social care.

• Lead and co-ordinate a team, delegating, supervising and monitoring nursing care provision.

• Exhibit awareness of self and of the impact of personal values and feelings in relation to attitude development, professional comportment, response and reaction to events and the development of personal coping mechanisms and resilience.

• Enhance personal performance of professional role through constructive use of feedback, supervision and appraisal.

• Reflect on and apply insights derived from aspects of daily nursing practice and from critical incidents in health care delivery.

6.2 Develop professional scholarship

• Develop professional scholarship through self-directed learning skills, critical questioning/reasoning skills and decision-making skills in nursing as the foundation for lifelong professional education, maintaining competence and career development.

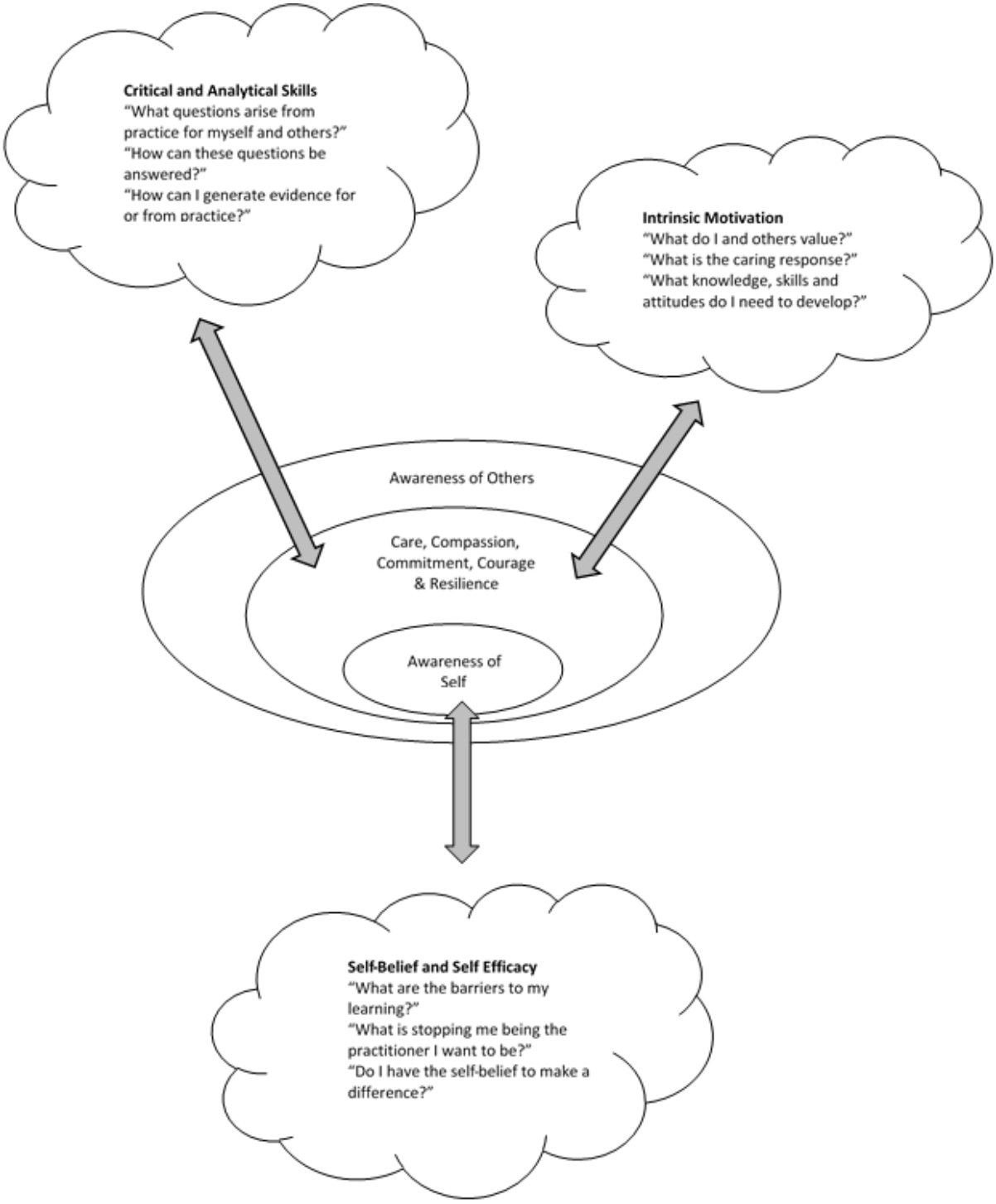
• Recognise and respond to situations requiring to be shared with experienced colleagues, senior managers and other health care professionals.

• Demonstrate a capacity to adapt nursing interventions and to update competence in response to dynamically altering health environments and population focus.

Appendix 3 – Common theoretical models used in the HEI's for the assessment of competence.

Higher Education Institute.	**Benner (1984).**	**Bloom (1956).**	**Steinaker and Bell (1979).**	**Bondy (1983).**
	Novice to expert	**Taxonomy of educational objectives**	**Experiential learning taxonomy**	**Criterion–referenced definitions for rating scales in clinical evaluation**
AIT			√	
DCU		√		
DKIT	√	√		√
GMIT	√			√
ITT	No	No	No	No
LYIT	√			
NUIG	√			
STACS			√	
TCD				√
UCC	√		√	
UCD	√			
UL	√		√	
WIT	√		√	√

Appendix 4- The Southampton Values Based Model



The Value Based Enquiry Model – McLeon (2012)

Values for Nurses and Midwives in Ireland – (NMBI 2016)

Appendix 5 - Correspondence 1.

Dr Mary Gobbi

Senior Lecturer in Nursing
Faculty of Health Sciences
University of Southampton
Highfield, Southampton
SO17 1BJ United Kingdom

14th December 2016

By email and post

Re: NMBI Competence Assessment Tool for Nursing and Midwifery Students

Dear Mary,

As you are aware the Nursing and Midwifery Board of Ireland has developed Nurse Registration Programmes Standards and Requirements.

We are now developing a competence assessment tool for nursing and midwifery students based on the nurse registration programme competencies.

I'm writing to request whether we might be permitted to adopt some of the principles in the section of your assessment of practice adult nursing document.

If it is permitted we would acknowledge and credit the source of the information.

Yours sincerely,

Judith Foley
Chief Education Officer

Appendix 6 - Correspondence 2.

Health Sciences

UNIVERSITY OF Southampton

19th December 2016

Ms J Foley
Acting Chief Education Officer
Nursing and Midwifery Board of Ireland (An Bord Altranais)
18/20 CArysofrt Avenue, Blackrock
County Dublin,
Ireland

Dear Ms Foley

Re NMBI Competency Assessment Tool for Nursing and Midwifery Students

Thank you for your letter to Mary Gobbi requesting that you adopt some of the principles outlined in our assessment of practice document for adult nursing students.

I am delighted to provide permission for NMBI to adopt the relevant sections, with due acknowledgement and credit to the Faculty of Health Sciences. We are very pleased that the work undertaking by our nursing education staff can assist mentors and students elsewhere in the world.

May I take the opportunity to wish you and NMBI the Season's Greetings.

Yours sincerely,

Professor Mandy Fader
Dean, Faculty of Health Sciences

Faculty of Health Sciences
Building 67, Faculty of Health Sciences, University of Southampton, Highfield Campus, Southampton SO17 1BJ United Kingdom
Tel: +44(0)23 8059 7979 Fax: +44(0)23 8059 7900 www.southampton.ac.uk/healthsciences

Athena SWAN Bronze Award

Appendix 7 - Letter of Invitation

Education Department,

Nursing and Midwifery Board of Ireland.

25th January 2017

Dear

I invite you to participate in a research study that I am undertaking. I attach an information leaflet that outlines the background and aim of the study, which I am doing as part of the Professional Doctoral Programme in Education, at the School of Education, Dublin City University.

My interest in Competence Assessment for Nursing and Midwifery Students stems from the need to developemnt of a national competence tool supports NMBI's mission to ensure patient safety and protection of the public as set out in the Nurses and Midwives Act 2011. The project takes cognisance of recommendations (C 6, C6.2, C10.1, C12) made by the Department of Health in it's *Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes* (DOH, 2012).
"*The Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/ Health Service will review student clinical assessment processes including documentation to promote standardisation of clinical assessments in line with competence goals for the four nursing programmes and the Midwifery programme" (p 61).*

I may contact you again over the coming weeks and months to discuss the study further. If you wish to participate in the study, please sign the attached 'Informed Consent Form'

Please do not hesitate to contact me if you have any queries regarding the study.

Yours sincerely,

_____

Judith Foley

Appendix 8 - Information Leaflet

WORKING TITLE OF THE STUDY

A research project to implement a national system to facilitate the competence assessment of nursing students in Ireland.

INTRODUCTION

My name is Judith Foley and I am undertaking further studies in Dublin City University.

BACKGROUND

The project takes cognisance of recommendations (C 6, C6.2, C10.1, C12) made by the Department of Health in it's *Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes* (DOH, 2012).
"*The Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/ Health Service will review student clinical assessment processes including documentation to promote standardisation of clinical assessments in line with competence goals for the four nursing programmes and the Midwifery programme" (p 61).*

PROCEDURES

Being part of this study means that you are willing to share your views and opinions of Competence Assessment and what this means to you as Head of Department. This will involve engaging in a focus group with other Heads of Department who facilitate nursing and midwifery registration programmes. The focus group will last approximately one hour. The methodology is action research; hence I may need to have further focus groups or individual interviews.

This is an opportunity for you to share and contribute to the development of National Competence Tool for Nursing Students and a National Competence Tool for Midwifery Students.

RISKS

There is no foreseeable risk to you being involved in this study. Should you decline to answer any questions, your decision will be respected. You will not be asked for an explanation for your decision.

CONFIDENTIALITY

At all times your identity will be protected. Information that might identify you will not be used in any presentation or publication resulting from the study. If you wish to talk to people about the study, you are free to do so.

VOLUNTARY PARTICIPATION

There is no obligation on you to participate in this study. If you choose to participate you are free to withdraw your consent at any time without obligation to anyone. This means that you can opt out before, during or after the interview, refuse to answer any question, turn the tape off, or request to exit the focus group at any time. If you decide not to participate, or if you withdraw, you will not be penalised in any way.

PERMISSION

This research has been granted ethical approval from Dublin City University.

Appendix 9 - Informed Consent Form

WORKING TITLE OF THE RESEARCH STUDY:
A research project to implement a national system to facilitate the competence assessment of nursing students in Ireland.

RESEARCHERS CONTACT DETAILS:

Judith Foley Telephone 01 6398560 Email: jjjjjjjjjjjjjjjjjjjj

BACKGROUND AND PROCEDURES
The project takes cognisance of recommendations (C 6, C6.2, C10.1, C12) made by the Department of Health in it's Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes (DOH, 2012).
"*The Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/ Health Service will review student clinical assessment processes including documentation to promote standardisation of clinical assessments in line with competence goals for the four nursing programmes and the Midwifery programme" (p 61).*

DECLARATION

I have read the information leaflet and this consent form	**Yes**	**No**
I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction:	**Yes**	**No**
I understand that my participation is voluntary and that I may withdraw from the study at any time:	**Yes**	**No**
I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential:	**Yes**	**No**
I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights:	**Yes**	**No**
I have received a copy of this agreement and I understand that the results of this research may be published:	**Yes**	**No**
I understand that the focus groups (if using) will be audio taped:	**Yes**	**No**

PARTICIPANT'S NAME (Block Capitals):_____

CONTACT TELEPHONE NUMBER:_____

PARTICIPANT'S SIGNATURE:_____

DATE:_____

Appendix 10 - Ethics Approval form DCU

Dublin City University

RESEARCH ETHICS COMMITTEE

OTIFICATION FORM FOR LOW-RISK PROJECTS

Application No. *(office use only)* DCUREC/2016/____

Section A: Applicant Details

PROJECT TITLE:	A research project to implement a national system to facilitate the competence assessment of nursing students in Ireland.
APPLICANT NAME:	Judith Foley.
SCHOOL/UNIT:	School of Education, Dublin City University.
APPLICANT EMAIL:	judith_foley@hotmail.com
If a student applicant, please provide the following additional information:	
Programme of Study:	Professional Doctorate: Leadership in Education and Training.
Supervisor Name:	Dr, Shivaun O'Brien.
Supervisor Email:	Shivaun.obrien@dcu.ie

Section B: Questions

1. Notification Review is reserved for low-risk social studies that fall under the following classifications. Please indicate your project type below:

Please mark as appropriate:	
/	Anonymous Survey (the topic will not elicit significant difficulties for participants)
	Observation (without audio or visual recording) of a public setting
	Questioning participants regarding their opinions on products or services
	Questioning students about standard educational practices
	Study will monitor the impact of participants' daily activities
/	Questioning public figures/professionals in their professional capacity regarding their professional activities
/	Analysis of existing anonymised data which has been provided to the researcher by a third party
	Collection of biological samples which are anonymised and do not require invasive techniques (e.g. hair, nails).
	Other ***Please explain:*** Documentary analysis of existing tools used to measure competence. Focus groups with lecturers who use tools. In depth interviews with nurses who support students in practice. Questionnaires.

2. Please provide a justification for why your study is considered to be low-risk?

The sample for the project will be adults who will be able to determine their own participation. Informed consent will be utilised in all aspects of data gathering process to ensure protection of the rights of those participating in the research. Participants will be informed about the nature of the study and that participation is voluntary. Therefore the voluntary nature of participation and in addition the right to

withdraw from the study without providing rationale will be emphasised. Complete anonymity and confidentiality will be assured.

3. Please describe how your participants will be recruited?

I propose sending a letter of invitation to lecturers working in School of Nursing and Midwifery in Higher Education Institutions (HEIs) and Associated Health Care Providers (AHCPs) who support nursing students in practice. Each letter will inform participants of the details of the study, time commitment and voluntary participation, right to withdraw without prejudice and assurance of confidentiality (Appendix 1). If a person is willing to participate in the study, he or she will be asked to sign an Expression of Interest Form (Appendix 2) which will be returned to me in an enclosed stamped address form. Depending on the number of forms received, I will randomly choose the participants. I will contact the participants and answer any questions and ensure that each participant is aware of the study, time commitment. Each participant will be asked to sign a consent form prior to data collection and a copy of the consent form will be given to each participant (Appendix 3).

Participant's identities or any personal information given during data collection will be anonymised using pseudonyms and their identities will not be cited in the final thesis.

4. Informing your participants – Plain Language Statement

A Plain Language Statement (PLS) should be used in all cases. This is written information in plain language that you will be providing to participants, outlining the nature of their involvement in the project and inviting their participation. The PLS should specifically describe what will be expected of participants, the risks and inconveniences for them, and other information relevant to their involvement. Please note that the language used must reflect the participant age group and corresponding comprehension level – if your participants have different comprehension levels (e.g. both adults and children) then separate forms should be prepared for each group. The PLS can be embedded in an email to which an online survey is attached, or handed/posted to individuals in advance of their consent being sought. ***A copy of the PLS should be attached to this application****. See link to sample templates on the website:*
http://www4.dcu.ie/research/research_ethics/rec_forms.shtml

Please confirm whether the following issues have been addressed in your plain language statement for participants:

	YES or NO
Introductory Statement (PI and researcher names, school, title of the research)	**YES**
What is this research about?	**YES**
Why is this research being conducted?	**YES**
What will happen if the person decides to participate in the research study?	**YES**
How will their privacy be protected?	**YES**
How will the data be used and subsequently disposed of?	**YES**
What are the legal limitations to data confidentiality?	**NO**
What are the benefits of taking part in the research study (if any)?	**YES**
What are the risks of taking part in the research study?	
Confirmation that participants can change their mind at any stage and withdraw from the study	**YES**
How will participants find out what happens with the project?	**NO**
Contact details for further information (including REC contact details)	**YES**

If any of these issues are marked NO, please justify their exclusion:

5. Capturing consent – Informed Consent Form

In most cases where interviews or focus groups are taking place, an Informed Consent Form is required. This is an important document requiring participants to indicate their consent to participate in the study, and give their signature. If your participants are minors (under 18), it is best practice to provide them with an assent form, while their parents/guardians will be given the Informed Consent Form. In cases where an anonymous questionnaire is being used, it is enough to include a tick box in the questionnaire (underneath the information section for participant), where the participant can indicate their consent. See link to sample templates on the website: http://www4.dcu.ie/research/research_ethics/rec_forms.shtml. ***A copy of the Informed Consent Form should be attached to this application.***

Note – IF AN INFORMED CONSENT FORM IS NOT BEING USED, THE REASON FOR THIS MUST BE JUSTIFIED HERE:

Important Notes:

- **Please ensure you attach any *additional* relevant documentation to your application: E.G.** copy of Survey/Questionnaire, copy of Interview/Focus Group schedule, copy of permission/approval from external sources (i.e. approval to access individuals in an organisation, school, community group)
- **The application should consist of one electronic file only.** The completed application must incorporate the plain language statement, informed consent form and all supplementary documentation
- **All sections of the application form must be answered**. The completed application must be proofread and spellchecked before submission to REC
- **Your application must be e-mailed to the DCU Research Ethics Committee at rec@dcu.ie . Student applicants must cc their supervisor on that e-mail** – this applies to *all* student applicants (masters and postgraduate). **The form should be approved and signed by the supervisor in advance of submission to REC.**

Applications which do not adhere to these requirements will not be accepted for review and will be returned directly to the applicant. The administrator to the Research Ethics Committee will assess, on receiving such notification, whether the information provided is adequate.

Please note: Project supervisors have the primary responsibility to ensure that students do not take on research that could expose them and the participants to significant risk, such as might arise, for example, in interviewing members of vulnerable groups such as young children. In general, please refer to the REC

Guidelines for further guidance on what research procedures or circumstances might make a higher level of ethical approval necessary.

See https://www4.dcu.ie/researchsupport/research_ethics/guidelines.shtml

DECLARATION BY PRINCIPAL INVESTIGATOR(S)
In the case of student applicants the Principal Investigator is their supervisor.

The information contained herein is, to the best of my knowledge and belief, accurate. I have read the University's current research ethics guidelines, and accept responsibility for the conduct of the procedures set out in the attached application in accordance with the form guidelines, the REC guidelines (https://www4.dcu.ie/researchsupport/research_ethics/guidelines.shtml), the University's policy on Conflict of Interest, Code of Good Research Practice and any other condition laid down by the Dublin City University Research Ethics Committee. I have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my obligations and the rights of the participants.

If there exists any affiliation or financial interest for researcher(s) in this research or its outcomes or any other circumstances which might represent a perceived, potential or actual conflict of interest this should be declared in accordance with Dublin City University policy on Conflicts of Interest.

I and my co-investigators or supporting staff have the appropriate qualifications, experience and facilities to conduct the research set out in the attached application and to deal with any emergencies and contingencies related to the research that may arise.

Electronic Signature(s):

Principal investigator(s):

_____

Print Name(s) here:

_____

Date: _____

Appendix 1

Letter of Invitation to Participants

Whiteriver

Collon

County Louth

A92E2C7

Dear Participant

My name is Judith Foley and I am undertaking a Doctorate in Education at School of Education in Dublin City University.

I invite you to participate in a research study that I am undertaking and I attach an information leaflet that outlines the background and aim of the study.

Having read the attached information leaflet, and if you wish to take part in this research, please complete the “Expressions of Interest Form” and return same in the envelope provided. The decision to participate is your choice and confidentiality and anonymity of information will be assured by the researcher.

Please do not hesitate to contact me if you have any questions regarding the research study.

Yours sincerely

_____

Judith Foley

Telephone 087777777

Appendix 2

Expressions of Interest Form.

A research project to implement a national system to facilitate the competence assessment of nursing students in Ireland.

Please complete this form and return same in the envelope provided if you are interested in taking part in this research.

Name _____

Telephone _____

Email _____

I will contact you to discuss the research in detail and to answer any questions you may have and to organise a time and date for data collection if you are happy to take part in the research project.

Thank you for taking the time to read this information.

Appendix 3

Consent Form.

Working title of the research study

A research project to implement a national system to facilitate the competenceassessment of nursing students in Ireland.

Researchers contact details

Ms Judith Foley

Telephone 087777777

Email Judith foley'gmail.com

Background

The aim of the research is to implement a national system to facilitate the competence assessment of nursing students in Ireland. This proposed research regarding the development of a national competence tool is a recommendation of the Department of Health (2012) based on a review entitled Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes (2012).

Declaration

I have read the information provided Yes No

I have had the opportunity to ask questions Yes No

I understand that all the information gathered will be treated as confidential

and that my identity will not be shared Yes No

I understand that my participation is voluntary and that I may withdraw at

any time Yes No

I understand that this research maybe published Yes No

PARTICIPANT'S NAME (Block Capitals) _____

CONTACT TELEPHONE NUMBER _____

PARTICIPANT'S SIGNATURE _____

DATE _____

Appendix 4

Plain Language Statement / Information Leaflet.

TITLE OF THE STUDY

A research project to implement a national system to facilitate the competence assessment of nursing students in Ireland.

INTRODUCTION

My name is Judith Foley and I work as the Chief Education Officer in the Nursing and Midwifery Board of Ireland. I am conducting this research as part fulfilment of the Taught Professional Doctoral Programme (Education) in Dublin City University (DCU). My supervisor is Dr Shivaun O'Brien and contact details are shivaun.obrien@dcu.

BACKGROUND

A review by the Department of Health entitled *Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes (2012, 61)* recommended that the

> "Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/ health service will review student clinical assessment processes including documentation to promote standardisation of clinical assessments in line with competence goals for the four nursing programmes".

This proposed research will address this recommendation and will explore clinical assessment current structures and how they contribute to the learning outcomes/competencies required for clinical practice by registrants. The draft objectives of the research study are:

1. To determine and map the range of clinical assessment processes currently in use in the assessment of clinical competence of undergraduate nursing students in Ireland.
1. To identify the contribution of such clinical assessment processes to the development of clinical competence among undergraduate nursing students as perceived by a sample of preceptors, clinical placement coordinators and link nursing lecturers.
2. To develop and pilot an instrument and process for a national scheme of clinical competence assessment for undergraduate nursing students in Ireland.
3. To evaluate the instrument and make recommendations.

The design will explore action research with multi stakeholder involvement to map current systems and explore new possibilities to achieve evidence based nationally agreed assessment methodology that allows for standardisation of clinical assessments and early intervention for student competence problems. In the programme of study I will explore a number of methodologies and theories, educational research that supports policy development. Initial ideas will involve a four stage approach beginning with the development of a survey of key stakeholders involved in undergraduate nursing clinical competence assessment to map current strategies and instruments utilised. This will be followed by a small number of interviews with a sample of preceptors who are representative of each of the four divisions of nursing. Thirdly, based on an analysis of the survey results, an instrument and will be developed and tested in a small sample of higher education settings to evaluate its robustness, reliability and validity for clinical competence assessment of nursing students using the revised Standards and Requirements competences. Because the methodology is action research many cycles of data collection will occur.

RISKS

There is no foreseeable risk to participants and if participants decline to answer questions or withdraw from the study, there decision will be respected and no explanation will be needed.

BENEFITS

Those involved may benefit as the tool used to assess nursing students will be standardised in all Higher Education Institutions (HEI's) and Associated Health Care Providers (AHCPs). The participants all work, supervise and assess nursing students to determine their competence to register with the Nursing and Midwifery Board (NMBI).

CONFIDENTIALITY

At all times the identity of the participants will be protected and no one will be informed of their participation in the study. Information that might lead to identification of participants will not be used in presentations or published. Data will be locked in a filing cabinet and the office will be locked when not occupied by myself. All data will be destroyed within one year of completing the research.

VOLUNTARY PARTICIAPTION

The researcher (Judith Foley) will ensure that the participants are told that there is no obligation to participate in the study. If one chooses to take part, they will be assured that they can withdraw at any time with no consequences.

THE OBJECTIVE OF THE RESEARCH

1. To support the mission of the Nursing and Midwifery Board of Ireland (NMBI) to ensure patient safety and protection of the public as set out in the Nursing and Midwifery Act 2011.

1. To determine and map the range of clinical assessment processes currently in use in the assessment of clinical competence of undergraduate nursing students in Ireland.

2. To develop and implement an instrument and process for a national scheme of clinical competence assessment for undergraduate nursing students in Ireland.

3. To evaluate the instrument and process and determine its effectiveness.

KEY QUESTIONS

1. Is there an established competence tool that could be tested nationally or internationally? (literature review / focus groups/ document analysis/ review of annual reports).

1. What kind of quality assurance mechanism should be developed (is the tool valid and reliable) to measure the competence of nursing students undertaking a degree programme?

2. What are the components of an effective system to determine competence of nursing students?

3. How will the system be developed?

4. How will the system be implemented?

5. How will the system be evaluated?

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000, e-mail rec@dcu.ie

Appendix 11- SWOT analysis questionnaire regarding theoretical models.

Competence Assessment Framework for Nursing Students and Midwifery Students.

Background

NMBI has been mandated to develop, implement and evalaute a national competencetool, which will be used by all Higher Education Institutions (HEIs) and their Associated Health Care Providers (AHCPs) in the assessment of nursing and midwifery students' clinical competencies. This will be in parellel with the developement of programmes in the HEIs taking cognisance of the Nurse Registration Programme Standards and Requirements (2016) and the Midwife Registration Programme Standards and Requirements (2016). These pre-registration programmes will commence in September/October 2018.

The principles underpinning a Competence Assessment Framework for Nursing Students for the purposes of assessing undergraduate nursing students undertaking General Nursing (RGN), Psychiatric Nursing (RPN), Intellectual Disability Nursing (RNID), Children's Nursing (RCN) students. This paper is informed by

- Nurses and Midwives Act (2011).
- Nurse Registration Programmes Standards and Requirements (NMBI, 2016).
- Midwifery Registration Programmes Standards and Requirements (NMBI, 2016).
- Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes (Department of Health, 2012).
- The EU Directive 2005/36/EU and EU Directive 2013/55/EU.

The developemnt of a national competencee framework and tool, supports NMBI's mission to ensure patient safety and protection of the public as set out in the Nurses and Midwives Act 2011. The project is also taking cognisance of recommendations (C 6, C6.2, C10.1, C12) made by the Department of Health in it's *Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes* (DOH, 2012).

> "*The Nursing and Midwifery Board, Higher Education Institutions and the Health Service Executive/ Health Service will review student clinical assessment processes including documentation to promote standardisation of clinical assessments in line with competencegoals for the four nursing programmes and the Midwifery programme" (p 61).*

The tools will reflect the competencedomains as outlined in the *Nurse Registration Programmes Standards and Requirements* (NMBI, 2016, Section 2.2, pp 17-23) and

the *Midwifery Registration Programmes Standards and Requirements* (NMBI, 2016, Section 2.2, pp 17-23 and Section 2.6, pp 16 -31. The measurement of clinical competenceis a multidimensional and complex task. In 2015, NMBI commenced a process to develop standards and requirements for Nurse and Midwifery Registration Programmes and this included the defining of competenceand the resultant domains will provide clearer goals for planning the outcomes of the education programme in the HEI's.

Theoretical Models.

1. Bloom's (1956) taxonomy of educational objectives.
2. Benner's (1984) levels of practice and experience.
3. Steinaker and Bell (1979) experiential learning taxonomy.
4. Bondy (1983) Criterion-referenced definitions for rating scales in clinical evaluation.

Bloom's (1956) taxonomy of educational objectives.

Bloom's Taxonomy of learning behaviours was developed in 1956 with colleagues, by Dr Benjamin Bloom an educational psychologist. Three domains were identified, cognitive (knowledge), affective (attitude of self), and psychomotor (skills). These domains are often referred to in the literature as KSA that is Knowledge (cognitive), Skills (psychomotor) and Attitudes (affective). He hoped that this taxonomy would ensure higher order thinking such as applying, analysing, synthesising and evaluating knowledge rather than rote learning among students. The cognitive domain (knowledge-based) is often used to structure curriculum learning objectives and assessment processes and involves knowledge and the development of intellectual skills (Bloom 1956). The categories commence with the simplest to the complex that is knowledge, comprehension, application, analysis, synthesis and evaluation. Subsequently, Anderson and colleagues revised the cognitive domain to reflect active thinking by changing the names of the six categories to remembering (knowledge), understanding (comprehension), applying (application) analysing (analysis), evaluating (synthesis) and creating (evaluation). This taxonomy of educational objectives uses a scale to express the level of expertise required to achieve measurable learning outcomes which will allow one to choice appropriate assessment methods (Quinn, 2013: Bloom *et al*, 1956).

Level of Expertise	Description of Level
1. Knowledge (Basic knowledge)	Recall, or recognition of terms, ideas, procedure, theories.
2. Comprehension (Understanding)	Translate, interpret, extrapolate, but not see full implications or transfer to other situations, closer to literal translation.
3. Application	Apply abstractions, general principles, or methods to specific concrete situations.
4. Analysis	Separation of a complex idea into its constituent parts and an understanding of organisation and relationship between the parts. Included realising the distinction between relevant and extraneous variables.
5. Synthesis	Creative, mental construction of ideas and concepts from multiple sources to form complex ideas into a new integrated and meaningful pattern subject to given constraints.
6. Evaluation (Valuing)	To make a judgement of ideas or methods using external evidence or self-selected criteria substantiated by observations or informed rationalisations (Bloom *et al,* 1956).

2. Benner's (1984) Levels of Practice and Experience.

Benner (1984) identified five levels of practice ranging from novice to expert based on the work of Dreyfus and Dreyfus (1981) to which she refers to extensively. Stuart Dreyfus and Hubert Dreyfus developed a model of skills acquisition based on the study of chess players, air force pilots and army tank drivers and commanders. Benner (2004) states that the Dreyfus model is 'developmental, based on situated performance and experiential learning' (p 188). She describes the main characteristics of the different stages or levels of practice and identifies five levels of proficiency in clinical nursing practice.

- Stage 1: Novice

The nurse has no experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The student is taught rules to help them apply theory to clinical situations and to perform tasks.

- Stage 2: Advanced beginner

The nurse demonstrates acceptable performance based on previous experience gained in real clinical situations.

- Stage 3: Competent

A nurse who has undertaken the job for a number of years has gained experience and therefore can plan actions with a view to achieving efficiency and long term goals. She/he has the ability to manage the complexity of clinical situations.

- Stage 4: Proficient

The nurse perceives and understands the situation as a whole and continuous to learn from experience in certain clinical situations and can determine if plans require modification.

- Stage 5: Expert

The expert no longer relies on rules, guidelines or principles to determine actions. The nurse has a large repertoire of intuitive experience in clinical situations and is extremely capable and skilful (Benner, 1984: pp 20-32 and Benner 2004).

3. Steinaker and Bell (1979) Experiential Learning Taxonomy.

The Experiential Taxonomy Learning Theory was developed by Norman Steinaker and Robert Bell in 1979. The process is made up of five levels:

- Exposure

The student has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the clinical placement.

- Participation

The student becomes a participant rather than an observer with the support of the preceptor where learning opportunities are identified in partnership.

- Identification

The student takes more responsibility for their own learning and participation and initiates appropriate action and evaluates same.

- Internalisation

The student makes informed decisions based on the information available and works as an autonomous practitioner.

- Dissemination.

The student uses critical analysis to determine the outcomes of their actions and can give rationale for their action to others (De Montfort University. 2017).

In summary, the taxonomy begins when the student is exposed to a teaching-learning experience and develops to the point where the student has internalised the experience and is disseminating the experience to others. Steinaker and Bell perceived this taxonomy as "*a functional vehicle for providing the complete classification of human activity from the moment the learner is exposed to the possibility of an experience to its highest level of completion"* (Steinaker and Bell, 1979:19).

4. Bondy (1983) Criterion-referenced Definitions for Rating Scales in Clinical Evaluation.

Bondy (1983) argues that the evaluation of competence can be subjective and unreliable (p 376) and therefore developed a criteria using a five point rating scale to evaluate the clinical performance of nursing students. Five levels of competence are identified across three evaluation areas:

1. Professional standards and procedures for the behaviour
2. Quality aspects of the performance
3. Assistance needed to perform the behaviour (p 378).

EFFECT: "Effective refers to achieving the intended purpose of the behaviour" (ibid).

AFFECT: "Affective refers to the manner in which the behaviour is performed and the demeanour of the student (ibid).

Bondy (1983) Criterion-referenced Definitions for Rating Scales in Clinical Evaluation.

Scale Label	Standard Procedure	Quality of Performance	Assistance
Independent	Safe Accurate Effect (each time) Affect (each time)	Proficient, coordinated, confident. Occasional expenditure of excess energy. Within an expedient time period.	Without supporting cues.
Supervised	Safe Accurate Effect (each time) Affect (each time)	Efficient, coordinated, confident Some expenditure of excess energy Within a reasonable time period	Occasional supportive cues.
Assisted	Safe Accurate (each time) Effect (most of the time) Affect (most of the time)	Skilful on parts of behaviour Inefficiency and incoordination Expands excess energy Within a delayed time period	Frequent verbal and occasional physical directive cues in addition to supportive cues.
Marginal	Safe but not alone Performance at risk Accurate (not always) Effect (occasionally) Affect (occasionally)	Unskilled, inefficient Considerable expenditure of excess energy Prolonged time period	Continuous verbal and frequently physical cues.
Dependent	Unsafe Unable to demonstrate behaviour	Unable to demonstrate procedure/behaviour Lacks confidence, coordination and efficiency	Continuous verbal and physical cues.
X	Not observed		

Source: Kathleen Nowak Bondy (1983).

Application of Bondy (1983) Scale - University of Minnesota School of Nursing.

Levels of Student Performance in Clinical Practice

University of Minnesota School of Nursing

Student criterion-referenced performance standards are defined in this way for levels of student competence. Read the standard for each level of competence carefully:

INDEPENDENT

- Performs safely and accurately each time* behaviour is observed without supportive cues*from the preceptor/instructor.
- Demonstrates dexterity.*
- Spends minimal time on task.*
- Applies theoretical knowledge accurately each time.
- Focuses on clients while giving care.*

SUPERVISED

- Performs safely and accurately each time* behaviour observed.
- Requires a supportive or directive cue occasionally during performance of task.*
- Demonstrates coordination, but uses some unnecessary energy* to complete behaviour/activity.
- Spends reasonable time on task.*
- Appears generally relaxed and confident; occasional anxiety may be noticeable.
- Applies theoretical knowledge accurately with occasional cues.
- Focuses on client initially; as complexity increases, focuses on task.*

ASSISTED

- Performs safely and accurately each time* observed.
- Requires frequent supportive and occasional directive cues.*
- Demonstrates partial lack of skill and/or dexterity* in part of activity; awkward.
- Takes a long time* to complete task; occasionally late.
- Appears to waste energy due to poor planning.
- Identifies principles, but needs direction to identify application.
- Focuses primarily on task or own behaviour, not on client.*

PROVISIONAL

- Performs safely under supervision,* not always accurate.
- Requires continuous supportive and directive cues.*
- Demonstrates lack of skill; uncoordinated* in majority of behaviour.
- Performs tasks with considerable delay; activities are disrupted or omitted.*

- Wastes energy* due to incompetence.
- Identifies fragments of principles; applies principles inappropriately.
- Focuses entirely on task or own behaviour.*

DEPENDENT

- Performs in an unsafe* manner; unable to demonstrate behaviour.
- Requires continuous supportive and directive cues.*
- Performs in an unskilled manner; lacks organisation.*
- Appears frozen, unable to move, non-productive.
- Unable to identify principles or apply them.
- Attempts activity or behaviour, yet is unable to complete.*
- Focuses entirely on the task or own behaviours.*

_____

*distinctive features of the level of competence.

Developed by Krichbaum, K. from Bondy, K. N. 1983. *Criterion-referenced definitions for rating scales in clinical evaluation*. Journal of Nursing Education, 22, pp 376 – 382.

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S.W.O.T Analysis.

Bloom's (1956) taxonomy of educational objectives.

Strengths	**Weaknesses**
Opportunities	**Threats**

S.W.O.T Analysis.

Benner's (1984) levels of practice and experience.

Strengths	**Weaknesses**
Opportunities	**Threats**

S.W.O.T Analysis.

Steinaker and Bell (1979) experiential learning taxonomy.

Strengths	**Weaknesses**
Opportunities	**Threats**

S.W.O.T Analysis.

Bondy (1983) Criterion-referenced definitions for rating scales in clinical evaluation.

Strengths	Weaknesses

Appendix 12 – Survey Questions

In what capacity are your responding to this survey?

Which of the following best describes your employer?

Which of the following best describes your current occupation?

Please tick the box for the document you are commenting on.

What are your views regarding the suitability of the competence assessment document?

In relation to the language used, do you think that it is to understand and did it provide clear description?

Did you think the structure of the document in terms of quality and fitness for purpose is satisfactory?

Do you think the document adequately assesses the competence of a 1st year nursing student?

Can you comment on the sections regarding self-evaluation of learning needs and expectations in terms of whether or not they are useful?

Which theoretical frameworks should be included in the document? (if any)

How would you improve the competence assessment documents/any other comments?

What do think of the current process used to assess competence in your area of practice?

What are the issues with its implementation in your opinion?

How far do you think the current interview schedule is manageable regarding time, clarity and ease of use for preceptors and students?

How far does the guidance document provide clear direction for preceptors in their role?

What aspects of the guidance document do you find most helpful?

How will the document help you in your role?

Do you have any comments in relation to the guidelines for document?

Appendix 13 – Focus group guide

Questions, guide and prompts.

Competence Assessment Document (CAD).

1. What are your views regarding the suitability of the Competence Assessment Document?
2. Can you comment if the language in the booklet?
    a) is easy to understand
    b) if it provides a clear description of what is required?
3. To what extent do you agree that this competence assessment booklet adequately assesses student's competence in your discipline of nursing?
    a. Does the tool adequately assess the competence of 1st year nursing students?
4. Do you think the sections regarding self-evaluation of learning needs and expectations useful?
    a. Why is it useful?
    b. Will it be of benefit to students?
    c. Will it be of benefit to you as preceptors/CPC?
5. Is there information in the document not required?
6. Do you see problems/issues with its implementation?

7. Do you think the document adequately assesses knowledge, skills and behaviours?

8. The use of a theoretical framework with levels of learning is used to reflect the level expected of the student for each year of the programme. What theoretical frameworks should be included?

   Bloom's (1956) taxonomy of educational objectives.

   Benner's (1984) levels of practice and experience.

   Steinaker and Bell (1979) experiential learning taxonomy.

   Bondy (1983) Criterion-referenced definitions for rating scales in clinical evaluation.

9. How would you improve the competence assessment document?

10. Does the document benefit preceptor and students?

11. Is there anything you would like to add to the competence tool?

Competence Assessment Process.

What do you think of the current process used to assess competence?

Do you think that the interview schedule is manageable for preceptors and students?

Guidance for preceptors

1. How does this document provide clear direction for preceptors?

2. What aspects of the guidance document do you find most helpful?

3. How will the document help you in your role?

4. Have you any suggestions or additions?

Appendix 14 - NCAD – General nursing

General Placement

National Competency Assessment Document for the Undergraduate Nursing Student

2018

Record of on-going achievement

This competence assessment Document constitutes my record of competence development in practice placement settings for **YEAR ONE** of the programme.

I consent to allow the processing of confidential data about me to be shared between successive preceptors and with the relevant education providers in the process of assessing my development of clinical competence.

I understand that this is a requirement Higher Education Institute and its associated healthcare provider(s) for progression through the programme of study in General Nursing and in compliance with the Standards and Requirements of the Nursing and Midwifery Board of Ireland (NMBI).

Student signature		Date	
HEI Link Person		Date	
CPC		Date	

National Competency Assessment Document – YEAR ONE: Registrant Signature Sheet

Registrant Signature Sheet

All health care professionals signing student documentation should insert their details below, as indicated.

Name of Preceptor (PRINT NAME)	Signature	Contact phone	Practice Placement Area

Clinical Placement Details for YEAR ONE of the Programme

Practice Experience 1

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 2

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 3 (if applicable)

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	

Academic Link Person	

Practice Experience 1: Self-evaluation of learning needs and expectations*

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

*see appendix 1

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews (Reflection - Gibb's (1988) model of reflection)

Reflection must relate to situations encountered by the nursing student in this practice placement

Description – What happened?
Feelings – What were your thoughts and feelings during the experience?
Evaluation – What approaches worked and which ones did not work?
Analysis – What sense can you make of the situation?
Conclusion – After evaluating the situation, what conclusions can you come with?
Action Plan – What would you do differently?

Nursing Student Signature		Date:	
Preceptor/Associate Preceptor Signature		Date:	

National Competency Assessment Document – YEAR ONE: Six Domains of Competency

NMBI have determined that to practice safely and effectively as a Registered Nurse, a nursing student must demonstrate competence in the following Six Domains of Competence:

1. Professional Values and Conduct of the Nurse Competences
2. Nursing Practice and Clinical Decision Making Competences
3. Knowledge and Cognitive Competences
4. Communication and Inter Personal Competences
5. Management and Team Competences
6. Leadership Potential and Professional Scholarship Competences

Competence is defined as the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a Registered Nurse. To assist in determining if a nursing student has met the required level of competence, NMBI have detailed performance criteria for each domain and relevant indicators which demonstrate if the performance criteria have been met.

Novice
The nursing student has no experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The nursing student is taught rules to help them apply theory to clinical situations and to perform tasks.

Exposure
The nursing student has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the practice placement.
Participation
The nursing student becomes a participant rather than an observer with the support of the preceptor where learning opportunities are identified in partnership.

In year 1, at the end of each practice placement, nursing students have to achieve all domains and all indicators at exposure and/or participation level.

National Competency Assessment Document – YEAR ONE: Progression Criteria

GENERAL NURSING

Domain 1: Professional values and conduct of the nurse

Criteria related to practising safety, compassionately and professionally under supervision of a Registered Nurse

1.1.1 Demonstrates safe, person-centred care		✓ or ✗
a.	Clarifies with supervisor instructions that s/he does not understand	
b.	Applies principles of safe moving and handling	
c.	Adheres to principles of safe hand washing	
d.	Adheres to principles of infection control	
e.	Identified actions to be taken in emergency situations	
f.	Recognises and responds to situations of risk to vulnerable persons	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.1.2 Demonstrates compassion in providing nurse care		✓ or ✗
a.	Shows respect, kindness, compassion towards service users and their families	
b.	Acts in a professional manner that is attentive, sensitive and non-discriminatory towards other people	
c.	Assists service users to maintain their dignity in all nursing and health care interventions	
d.	Demonstrates respect for diversity and individual preferences	
e.	Seeks help and guidance when a service user's needs are not being met	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.1.3 Demonstrates responsible and professional practice		✓ or ✗
a.	Adheres to and works within the Scope of Nursing and Midwifery Practice Framework as it applies to the nursing student	
b.	Practises honestly and with integrity in accordance to the Code of Professional Practice and Ethics for Registered Nurses and Registered Midwives as it applies to the nursing student	
c.	Adheres to local policies, procedures and guidelines	
d.	Adheres to reporting policy in respect of any untoward incidents or near misses	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed

PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Progression Criteria

GENERAL NURSING

Domain 2: Nursing practice and clinical decision making

Criteria related to delivering effective, person-centred nursing care under supervision of a Registered Nurse

1.2.1 Assesses the person's nursing and health needs		✓ or ✗
a.	Monitors and records a person's vital signs accurately and reports observations	
b.	Gathers information and records and reports it in a systematic way	
c.	Seeks information on a person's health status in a person-centred manner	
d.	Takes part in an assessment or re-assessment of a person's nursing and health needs	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.2 Plans and prioritises person-centred nursing care		✓ or ✗
a.	Identifies how information gathered is structured using an appropriate framework	
b.	Assists a Registered Nurse to plan an aspect of nursing care	
c.	Reviews with preceptor the structure of goals for a plan of care	
d.	Identifies with preceptor actual and potential goals	
e.	Identifies with preceptor interventions to meet a nursing or health goal	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.3 Undertakes nursing interventions		✓ or ✗
a.	Ensures consent of the person prior to giving nursing care	
b.	Maintains the person's dignity, rights and independence when undertaking nursing care	
c.	Uses clinical equipment safely, showing awareness of limitations and associated hazards in usage and disposal	
d.	Assists service users to meet their essential daily needs: • Comfort and wellbeing • Personal hygiene • Respiration • Fluid management • Nutrition • Elimination care	

	• Skin integrity • Safety and security • Sleep and rest	

1.2.3 Undertakes nursing interventions		✓ or ✗
e.	Records nursing interventions, observations and feedback from the person accurately and concisely	
f.	Assists the Registered Nurse in the safe administration and management of medicines	
g.	Carries out instructions responsible and timely manner in accordance with local policies, procedures and guidelines	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Progression Criteria

GENERAL NURSING`

Domain 2: Nursing practice and clinical decision making

Criteria related to delivering effective, person-centred nursing care under supervision of a Registered Nurse

1.2.4 Evaluates person-centred nursing care		✓ or ✗
a.	Gathers and records information in accordance with a person's nursing care plan	
b.	Assists the Registered Nurse to review a person's plan of nursing care in light of observations, feedback from the person and health care team	
c.	Assists the Registered Nurse to review and revise as necessary the planned outcomes or interventions of a person's plan of nursing care	
d.	Assists the Registered Nurse to carry out a re-assessment of a person's nursing and health care needs	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.5 Utilises clinical judgment		✓ or ✗
a.	Recognises and reports if a service user appears to be at risk	

b.	Recognises and reports if a service user's physical or psychological condition is deteriorating	
c.	Demonstrates how to act in an emergency and to administer essential life-saving intervention	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 3: Nursing knowledge and cognitive competence
Criteria related to application of knowledge and understanding of the health continuum and of principles from health and life sciences underpinning practice

1.3.1 Practises from a competent knowledge base		✓ or ✗
a.	Monitors and records the changes in sensory, physical, emotional, behavioural or developmental signs of a person in the practice setting	
b.	Applies knowledge from the health and life sciences to the nursing care needs of a person in the practice setting	
c.	Safely and accurately carries out medication calculations and management	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.3.2 Uses critical thinking and reflection to inform practice		✓ or ✗
a.	Sources information relevant to a nursing intervention in the practice setting	
b.	Applies knowledge of local policies, procedures and guidelines to an aspect of nursing intervention encountered in the practice setting	
c.	Safely and accurately carries out to medication calculations and management	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 4: Communication and interpersonal competence
Criteria related to effective communication and empathic interpersonal skills

1.4.1 Communicates in a person-centred manner		✓ or ✗
a.	Demonstrates the ability to listen, seek clarification and to carry out instructions safely	
b.	Demonstrates respect for service users' rights and choices	
c.	Ensures that confidential information is maintained securely according to local health care policy	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Progression Criteria
GENERAL NURSING

Domain 4: Communication and interpersonal competence
Criteria related to effective communication and empathic interpersonal skills

1.4.2 Communicates accurately with the health care team		✓ or ✗
a.	Communicates clearly with other health care team members	
b.	Demonstrates safe and effective communication skills, in oral, written and electronic modes	
c.	Accurately reports, records and documents clinical observations	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 5: Nursing management and team competence
Criteria related to application of management and team working competence

1.5.1 Practises in a collaborative manner		✓ or ✗
a.	Interacts with members of the health care and multi professional team in a manner that values their roles and responsibilities	
b.	Develops a professional relationship by working in partnership with members of the multidisciplinary health care team	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.5.2 Manages team, others and self safely		✓ or ✗
a.	Promotes a safe and therapeutic environment for nursing care	
b.	Recognises and responds appropriately to situations that challenge self or others	
c.	Recognises risks and hazards associated with nursing interventions and escalates these to Registered Nurse as appropriate	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

DOMAIN 6: LEADERSHIP POTENTIAL AND PROFESSIONAL SCHOLARSHIP COMPETENCES

Criteria related to effective leadership potential and self-awareness under the supervision of a Registered Nurse

1.6.1 Develop leadership potential		✓ or ✗
a.	Demonstrate the constructive use of feedback supervision and appraisal on the development of self-awareness and competence as a nurse	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.6.2 Develop professional scholarship		✓ or ✗
a.	Communicate an example of self-directed learning used to enhance professional performance in practice	
b.	Communicate with the multidisciplinary team regarding to the plan of nursing care intervention	
c.	Identify the use of relevant opportunities for learning in the practice setting	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	

Proposed date for final interview	
CPC signature	

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Mid Placement Review

Student's review of progress during placement to date
Preceptor's review of student's progress during placement to date
Preceptor's summary of student progress during placement to date
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*

Student signature	
Preceptor signature	
CPC signature	

Academic link person signature	

Practice Experience 1: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature	
Academic link person signature	

Placement Result (✓or ✗)		**Preceptor Signature**	**Date completed**
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Competency Development Action Plan

Practice Experience 1: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	
Academic link person signature	

Practice Experience 2: Self-evaluation of learning needs and expectations

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

Practice Experience 2: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 2: Mid Placement Review

Student's review of progress during placement to date	
Preceptor's review of student's progress during placement to date	
Preceptor's summary of student progress during placement to date	
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*	
Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Practice Experience 2: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Placement Result (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

Practice Experience 2: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

Academic link person signature	

Practice Experience 3: Self-evaluation of learning needs and expectations

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

Practice Experience 3: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

Practice Experience 3: Mid Placement Review

Student's review of progress during placement to date
Preceptor's review of student's progress during placement to date
Preceptor's summary of student progress during placement to date
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*

Student signature	
Preceptor signature	
CPC signature	
Academic link person signature	

Practice Experience 3: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Placement Result (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Competency Development Action Plan

Practice Experience 3: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	
Academic link person signature	

Appendix 15 – NCAD Children's nursing

Children's Placement

National Competency

Assessment Document for the

Undergraduate Nursing Student

2018

Record of on-going achievement

This competence assessment document constitutes my record of competence development in practice placement settings for **YEAR ONE** of the programme.

I consent to allow the processing of confidential data about me to be shared between successive preceptors and with the relevant education providers in the process of assessing my development of clinical competence.

I understand that this is a requirement Higher Education Institute and its associated healthcare provider(s) for progression through the programme of study in Children's Nursing and in compliance with the Standards and Requirements of the Nursing and Midwifery Board of Ireland (NMBI).

Student signature		Date	
HEI Link Person		Date	
CPC		Date	

National Competency Assessment Document – YEAR ONE: Registrant Signature Sheet

Registrant Signature Sheet

All health care professionals signing student documentation should insert their details below, as indicated.

Name of Preceptor (PRINT NAME)	Signature	Contact phone	Practice Placement Area

Clinical Placement Details for YEAR ONE of the Programme

Practice Experience 1

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 2

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 3 (if applicable)

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	

Academic Link Person	

Practice Experience 1: Self-evaluation of learning needs and expectations*

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

*see appendix 1

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews (Reflection - Gibb's (1988) model of reflection)

Reflection must relate to situations encountered by the nursing student in this practice placement

Description – What happened?			
Feelings – What were your thoughts and feelings during the experience?			
Evaluation – What approaches worked and which ones did not work?			
Analysis – What sense can you make of the situation?			
Conclusion – After evaluating the situation, what conclusions can you come with?			
Action Plan – What would you do differently?			
Nursing Student Signature		Date:	

Preceptor/Associate Preceptor Signature		Date:	

National Competency Assessment Document – YEAR ONE: Six Domains of Competency

NMBI have determined that to practice safely and effectively as a Registered Nurse, a nursing student must demonstrate competence in the following Six Domains of Competence:

1. Professional Values and Conduct of the Nurse Competences
2. Nursing Practice and Clinical Decision Making Competences
3. Knowledge and Cognitive Competences
4. Communication and Inter Personal Competences
5. Management and Team Competences
6. Leadership Potential and Professional Scholarship Competences

Competence is defined as the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a Registered Nurse. To assist in determining if a nursing student has met the required level of competence, NMBI have detailed performance criteria for each domain and relevant indicators which demonstrate if the performance criteria have been met.

Novice
The nursing student has no experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The nursing student is taught rules to help them apply theory to clinical situations and to perform tasks.

Exposure
The nursing student has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the practice placement.
Participation
The nursing student becomes a participant rather than an observer with the support of the preceptor where learning opportunities are identified in partnership.

In year 1, at the end of each practice placement, nursing students have to achieve all domains and all indicators at exposure and/or participation level.

National Competency Assessment Document – YEAR ONE: Progression Criteria
CHILDREN'S NURSING

Domain 1: Professional values and conduct of the nurse
Criteria related to practising safety, compassionately and professionally under supervision of a Registered Nurse

1.1.1 Demonstrates safe, person-centred care		✓ or ✗
a.	Clarifies with supervisor instructions that s/he does not understand	
b.	Applies principles of safe moving and handling	
c.	Adheres to principles of safe hand washing	
d.	Promotes a safe and therapeutic environment for children, young people and their families, staff and visitors	
e.	Recognises and responds to situations of risk to protect children and young people	
f.	Demonstrates how to act in an emergency and to administer essential life-saving intervention	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.1.2 Demonstrates compassion in providing nurse care		✓ or ✗
a.	Shows respect, kindness, compassion towards children, young people and their families	
b.	Acts in a professional manner that is attentive, empathetic and non-discriminatory towards children, young people, their families respecting diversity in culture, faith and social background	
c.	Supports children, young people and their families with sensitivity during periods of emotional distress or when undergoing diagnostic, nursing or medical procedures	
d.	Seeks help and guidance when a child or young person's needs are not being met	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.1.3 Demonstrates responsible and professional practice		✓ or ✗
a.	Adheres to and works within the Scope of Nursing and Midwifery Practice Framework as it applies to the nursing student	
b.	Practises honestly and with integrity in accordance to the Code of Professional Practice and Ethics for Registered Nurses and Registered Midwives as it applies to the nursing student	
c.	Adheres to local policies, procedures and guidelines	
d.	Adheres to reporting policy in respect of any untoward incidents or near misses	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Progression Criteria

CHILDREN'S NURSING

Domain 2: Nursing practice and clinical decision making

Criteria related to delivering effective, person-centred nursing care under supervision of a Registered Nurse

1.2.1 Assesses the person's nursing and health needs		✓ or ✖
a.	Monitors and records the changes in sensory, physical, emotional, behavioural or developmental status or responses of a child or young person in the clinical setting	
b.	Gathers information systematically in a child-centred manner	
c.	Documents and reports observations accurately	
d.	Participates in risk assessment with a child or young person	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.2 Plans and prioritises person-centred nursing care		✓ or ✖
a.	Assists in the gathering and recording of clinical information using an appropriate child and family- centred framework	
b.	Assists a Registered Nurse to plan an aspect of nursing care	
c.	Reviews with preceptor the structure of goals for a plan of care	
d.	Identifies with preceptor actual and potential goals	
e.	Identifies with preceptor interventions to meet a child or young person's developmental, nursing or health goal	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.3 Undertakes nursing interventions		✓ or ✖
a.	Ensures consent of the child, young person and family member prior to undertaking nursing interventions	
b.	Builds relationships with children, young people and their families to meet their developmental and health needs Demonstrates respect for the welfare, human rights and individuality of the child and young person Builds on a child or young person's personal preferences, capabilities and abilities	

	Promotes the child or young person's autonomy and self-management of health care to the maximum degree Provides a supportive presence for the child and young person and family members in their response to and experience of altered health Affords protection to the child and young person throughout their health care experience in any setting	

1.2.3 Undertakes nursing interventions (continued)		✓ or ✗
c.	Promotes the child and young person's health, recovery and optimal functioning	
d.	Participates in a group or social activity with children, young people and their families	
e.	Assists children, young people and their families to maintain their dignity in all nursing and health care interventions	
f.	Records nursing interventions, observations and feedback from the child, young person or family members and interprofessional colleagues accurately and concisely	
g.	Uses clinical equipment safely, showing awareness of limitations and associated hazards in usage and disposal	
h.	Assists the Registered Nurse in the safe administration and management of medicines	
i.	Safely and accurately carries out to medication calculations and management	
j.	Carries out instructions in a responsible and timely manner in accordance with local policies, procedures and guidelines	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 2: Nursing practice and clinical decision making
Criteria related to delivering effective, person-centred nursing care under supervision of a Registered Nurse

1.2.4 Evaluates person-centred nursing care		✓ or ✗
a.	Gathers and records information in accordance with a child or young person's nursing care plan	
b.	Assists the Registered Nurse to review a child or young person's plan of nursing care in light of observations, feedback from the person and health care team	
c.	Assists the Registered Nurse to review and revise as necessary the planned outcomes or interventions of a child or young person's plan of nursing care	
d.	Assists the Registered Nurse to carry out an evaluation of a child or young person's nursing and health care needs	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.5 Utilises clinical judgment			✓ or ✗
a.	Recognises and reports if a child or young person appears to be at risk		
b.	Demonstrates how to act in an emergency and to administer essential life-saving intervention		
Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 3: Nursing knowledge and cognitive competence
Criteria related to application of knowledge and understanding of the health continuum and of principles from health and life sciences underpinning practice

1.3.1 Practises from a competent knowledge base			✓ or ✗
a.	Applies knowledge of the philosophical underpinnings to child and family centred nursing to care of the child and young person		
b.	Applies knowledge from the social and life sciences to the nursing care of a child or young person in the practice setting		
c.	Safely and accurately carries out medication calculations and management recognising the particular risks to children and young people		
Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.3.2 Uses critical thinking and reflection to inform practice			✓ or ✗
a.	Sources information relevant to a nursing intervention in the practice setting		
b.	Applies knowledge of local policies, procedures and guidelines to an aspect of nursing intervention encountered in the practice setting		
Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 4: Communication and interpersonal competence
Criteria related to effective communication and empathic interpersonal skills

1.4.1 Communicates in a child-centred manner		✓ or ✖
a.	Demonstrates ability to listen, seek clarification and observe non-verbal cues	
b.	Demonstrates respect for children, young people and their families' rights and choices	
c.	Engages in a collaborative manner with the child, young person and family member in all aspects of nursing intervention	
d.	Utilises age-appropriate nonverbal and verbal strategies to facilitate effective communication with the child and young person	
e.	Acts as an advocate for the child, young person and family whilst accessing health care	
f.	Demonstrates awareness of power imbalances between children, young people and their families and health care professionals	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

1.4.2 Communicates accurately with the health care team		✓ or ✖
a.	Communicates clearly with other health care team members	
b.	Demonstrates safe and effective communication skills, in oral, written and electronic modes	
c.	Accurately reports, records and documents clinical observations	
d.	Ensures that confidential information is maintained securely according to local health care policy	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 5: Nursing management and team competence
Criteria related to application of management and team working competence

1.5.1 Practises in a collaborative manner		✓ or ✗
a.	Interacts with members of the health care and multi professional team in a manner that values their roles and responsibilities	
b.	Develops a professional relationship by working in partnership with members of the multidisciplinary health care team	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.5.2 Manages team, others and self safely		✓ or ✗
a.	Promotes a safe and therapeutic environment for nursing care	
b.	Recognises, reports and responds appropriately to a change or deterioration in a child or young person's sensory, physical or emotional state or behaviour	
c.	Recognises risks and hazards whilst undertaking therapeutic or clinical interventions and escalates these to Registered Nurse as necessary	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 6: Leadership potential and professional scholarship competences
Criteria related to effective leadership potential and self-awareness under the supervision of a Registered Nurse

1.6.1 Develop leadership potential			✓ or ✗
a.	Demonstrate the constructive use of feedback supervision and appraisal on the development of self-awareness and competence as a nurse		
Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.6.2 Develop professional scholarship			✓ or ✗
a.	Communicate an example of self-directed learning used to enhance professional performance in practice		
b.	Communicate with the multidisciplinary team regarding to the plan of nursing care intervention		
c.	Identify the use of relevant opportunities for learning in the practice setting		
Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Mid Placement Review

Student's review of progress during placement to date	
Preceptor's review of student's progress during placement to date	
Preceptor's summary of student progress during placement to date	
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*	
Student signature	
Preceptor signature	
CPC signature	
Academic link person signature	

Practice Experience 1: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature	
Academic link person signature	

Placement Result (✓or ✖)		**Preceptor Signature**	**Date completed**
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Competency Development Action Plan

Practice Experience 1: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	
Academic link person signature	

Practice Experience 2: Self-evaluation of learning needs and expectations

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

Practice Experience 2: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 2: Mid Placement Review

Student's review of progress during placement to date	
Preceptor's review of student's progress during placement to date	
Preceptor's summary of student progress during placement to date	
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*	
Student signature	
Preceptor signature	
CPC signature*	

Academic link person signature	

Practice Experience 2: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Placement Result (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Practice Experience 2: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	
Academic link person signature	

Practice Experience 3: Self-evaluation of learning needs and expectations

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

Practice Experience 3: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

Practice Experience 3: Mid Placement Review

Student's review of progress during placement to date
Preceptor's review of student's progress during placement to date
Preceptor's summary of student progress during placement to date
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Practice Experience 3: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature *	
Academic link person signature	

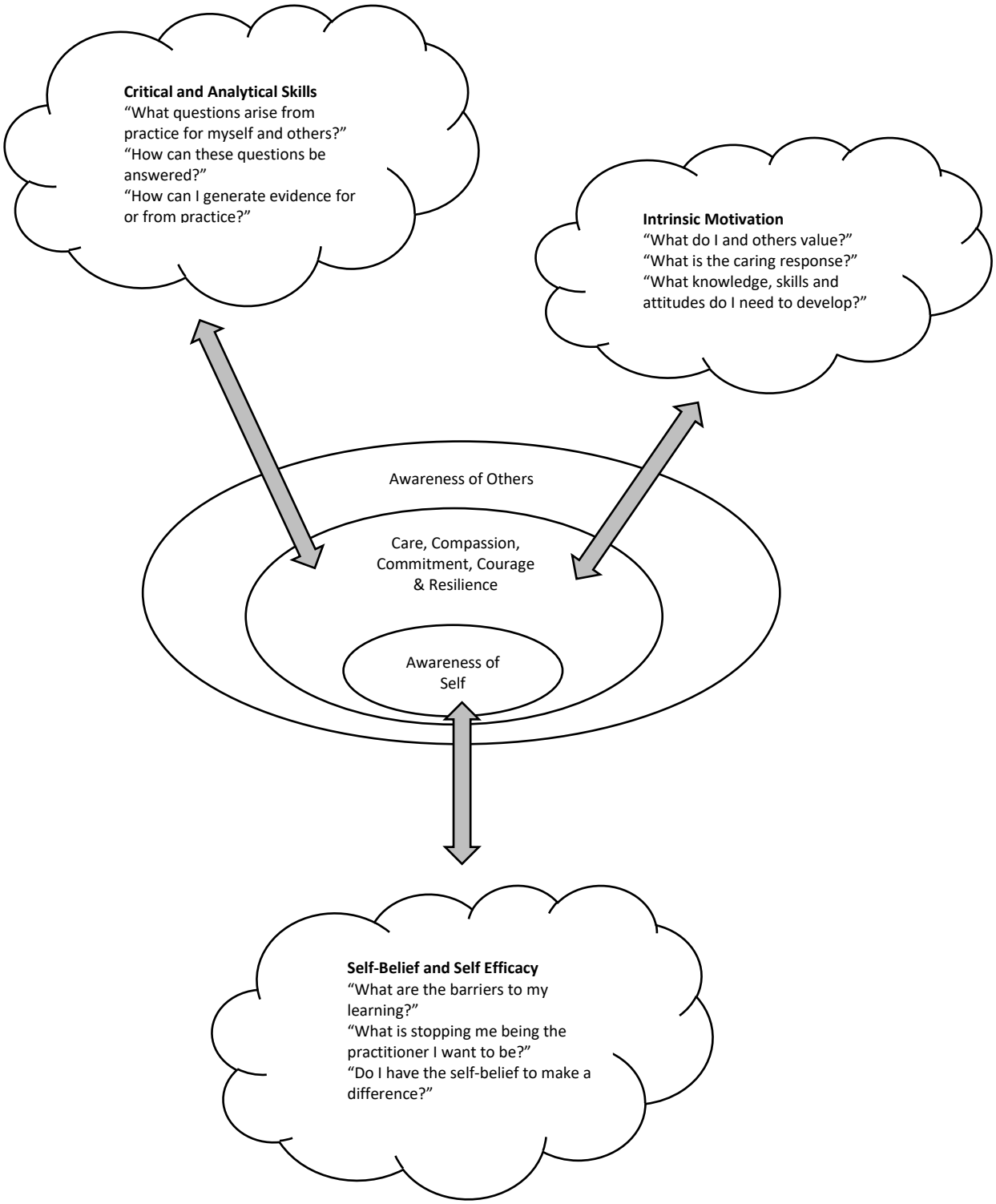
Placement Result (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Competency Development Action Plan

Practice Experience 3: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	
Academic link person signature	

Appendix 1 - A Guide to help you with your Self-evaluation



The Value Based Enquiry Model – McLeon 2012
Values for Nurses and Midwives in Ireland – NMBI 2016

Appendix 16 – NCAD Intellectual Disability nursing

Intellectual Disability Placement

National Competency Assessment Document for the Undergraduate Nursing Student

2018

Record of on-going achievement

This competence assessment Document constitutes my record of competence development in practice placement settings for **YEAR ONE** of the programme.

I consent to allow the processing of confidential data about me to be shared between successive preceptors and with the relevant education providers in the process of assessing my development of clinical competence.

I understand that this is a requirement Higher Education Institute and its associated healthcare provider(s) for progression through the programme of study in Intellectual Disability Nursing and in compliance with the Standards and Requirements of the Nursing and Midwifery Board of Ireland (NMBI).

Student signature		Date	
HEI Link Person		Date	
CPC		Date	

National Competency Assessment Document – YEAR ONE: Registrant Signature Sheet

Registrant Signature Sheet

All health care professionals signing student documentation should insert their details below, as indicated.

Name of Preceptor (PRINT NAME)	Signature	Contact phone	Practice Placement Area

Clinical Placement Details for YEAR ONE of the Programme

Practice Experience 1

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 2

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 3 (if applicable)

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	

Academic Link Person	

Practice Experience 1: Self-evaluation of learning needs and expectations*

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

*see appendix 1

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews (Reflection - Gibb's (1988) model of reflection)

Reflection must relate to situations encountered by the nursing student in this practice placement

Description – What happened?
Feelings – What were your thoughts and feelings during the experience?
Evaluation – What approaches worked and which ones did not work?
Analysis – What sense can you make of the situation?
Conclusion – After evaluating the situation, what conclusions can you come with?
Action Plan – What would you do differently?

Nursing Student Signature		Date:	
Preceptor/Associate Preceptor Signature		Date:	

NMBI have determined that to practice safely and effectively as a Registered Nurse, a nursing student must demonstrate competence in the following Six Domains of Competence:

1. Professional Values and Conduct of the Nurse Competences
2. Nursing Practice and Clinical Decision Making Competences
3. Knowledge and Cognitive Competences
4. Communication and Inter Personal Competences
5. Management and Team Competences
6. Leadership Potential and Professional Scholarship Competences

Competence is defined as the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a Registered Nurse. To assist in determining if a nursing student has met the required level of competence, NMBI have detailed performance criteria for each domain and relevant indicators which demonstrate if the performance criteria have been met.

Novice
The nursing student has no experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The nursing student is taught rules to help them apply theory to clinical situations and to perform tasks.

Exposure
The nursing student has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the practice placement.
Participation
The nursing student becomes a participant rather than an observer with the support of the preceptor where learning opportunities are identified in partnership.

In year 1, at the end of each practice placement, nursing students have to achieve all domains and all indicators at exposure and/or participation level.

National Competency Assessment Document – YEAR ONE: Progression Criteria

INTELLECTUAL DISABILITY NURSING

Domain 1: Professional values and conduct of the nurse

Criteria related to practising safety, compassionately and professionally under supervision of a Registered Nurse

1.1.1 Demonstrates safe, person-centred care		✓ or ✗
a.	Clarifies with supervisor instructions that s/he does not understand	
b.	Applies principles of safe moving and handling	
c.	Adheres to principles of infection control	
d.	Promotes a safe and therapeutic environment for service users, staff and visitors	
e.	Recognises and responds to situations of risk to vulnerable persons	
f.	Identifies actions to be taken in emergency situations	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.1.2 Demonstrates compassion in providing nurse care		✓ or ✗
a.	Shows respect, kindness, compassion towards service users and their families	
b.	Acts in a professional manner that is attentive, empathetic and non-discriminatory towards other people	
c.	Supports service users with sensitivity during periods of emotional distress or when expressing behaviour of concern	
d.	Assists service users to maintain their dignity in all nursing and health care interventions	
e.	Seeks help and guidance when a service user's needs are not being met	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.1.3 Demonstrates responsible and professional practice		✓ or ✗
a.	Adheres to and works within the Scope of Nursing and Midwifery Practice Framework as it applies to the nursing student	
b.	Practises honestly and with integrity in accordance to the Code of Professional Practice and Ethics for Registered Nurses and Registered Midwives as it applies to the nursing student	
c.	Adheres to local policies, procedures and guidelines	
d.	Adheres to reporting policy in respect any untoward incidents or near misses	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Progression Criteria

INTELLECTUAL DISABILITY NURSING

Domain 2: Nursing practice and clinical decision making

Criteria related to delivering effective, person-centred nursing care under supervision of a Registered Nurse

1.2.1 Assesses the person's nursing and health needs		✓ or ✗
a.	Monitors and records the changes in sensory, physical, emotional, behavioural or developmental signs of a person in the practice setting	
b.	Gathers information systematically in a person-centred manner	
c.	Documents and reports observations accurately	
d.	Participates in risk assessment with a service user	
e.	Participates in assessment or re-assessment of a person's physical, psychological or developmental health state	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.2 Plans and prioritises person-centred nursing care		✓ or ✗
a.	Identifies how information gathered is structured using an appropriate framework	
b.	Assists a Registered Nurse to plan an aspect of nursing care	
c.	Reviews with preceptor the structure of goals for a plan of care	
d.	Identifies with preceptor actual and potential goals	
e.	Identifies with preceptor interventions to meet a developmental, nursing or health goal	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.3 Undertakes nursing interventions		✓ or ✗
a.	Ensures consent of the person prior to undertaking nursing interventions	
b.	Builds relationships with service users to meet their developmental and health needs: • Demonstrates respect for human rights, social inclusion and individuality • Builds on a person's personal preferences, strengths and abilities • Promotes independent living to the person's maximum degree • Provides a supportive presence for the person • Promotes optimum physical health • Provides psychosocial support for optimum mental health/resilience	

	• Promotes physical, emotional and sensory health • Affords protection to vulnerable persons	
c.	Undertakes an education or training session with a service user	

Continued Page 11

Domain 2: Nursing practice and clinical decision making
Criteria related to delivering effective, person-centred nursing care under supervision of a Registered Nurse

1.2.3 Undertakes nursing interventions (continued)		✓ or ✗
d.	Undertakes a group or social activity with service users	
e.	Maintains the person's dignity, rights and independence when undertaking nursing care	
f.	Records nursing interventions, observations and feedback from the person or carer and interprofessional colleagues accurately and concisely	
g.	Uses clinical equipment safely, showing awareness of limitations and associated hazards in usage and disposal	
h.	Assists the Registered Nurse in the safe administration and management of medicines	
i.	Carries out instructions responsible and timely manner in accordance with local policies, procedures and guidelines	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.4 Evaluates person-centred nursing care		✓ or ✗
a.	Gathers and records information in accordance with a person's nursing care plan	
b.	Assists the Registered Nurse to review a person's plan of nursing care in light of observations, feedback from the person and health care team	
c.	Assists the Registered Nurse to review and revise as necessary the planned outcomes or interventions of a person's plan of nursing care	
d.	Assists the Registered Nurse to carry out a re-assessment of a person's nursing and health care needs	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.5 Utilises clinical judgment		✓ or ✗
a.	Recognises and reports if a service user appears to be at risk	
b.	Recognises and reports if a service user's physical or psychological condition is deteriorating	
c.	Demonstrates how to act in an emergency and to administer essential life-saving intervention	

Assessment Decision (✓or ✗)	Preceptor Signature	Date completed

PASS			
FAIL			

Domain 3: Nursing knowledge and cognitive competence
Criteria related to application of knowledge and understanding of the health continuum and of principles from health and life sciences underpinning practice

1.3.1 Practises from a competent knowledge base		✓ or ✗
a.	Applies knowledge of the philosophical underpinnings to intellectual disability nursing to everyday practice	
b.	Applies knowledge from the health, social and life sciences to the nursing care needs of a person in the practice setting	
c.	Safely and accurately carries out medication calculations and management	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.3.2 Uses critical thinking and reflection to inform practice		✓ or ✗
a.	Sources information relevant to a nursing intervention in the practice setting	
b.	Applies knowledge of local policies, procedures and guidelines to an aspect of nursing intervention encountered in the practice setting	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 4: Communication and interpersonal competence
Criteria related to effective communication and empathic interpersonal skills

1.4.1 Communicates in a person-centred manner		✓ or ✗
a.	Demonstrates ability to listen, seek clarification and observe non-verbal cues	
b.	Demonstrates respect for service users' rights and choices	
c.	Engages service user as an active partner in nursing intervention	
d.	Responds empathetically to a service user's expressive language	
e.	Uses assistive / augmentative technology to support communication	
f.	Challenges negative stereotypes, beliefs and stigma	
g.	Demonstrates awareness of power imbalances between service users and health care professionals	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			

FAIL			

National Competency Assessment Document – YEAR ONE: Progression Criteria
INTELLECTUAL DISABILITY NURSING

Domain 4: Communication and interpersonal competence
Criteria related to effective communication and empathic interpersonal skills

1.4.2 Communicates accurately with the health care team		✓ or ✗
a.	Communicates clearly with other health care team members	
b.	Demonstrates safe and effective communication skills, in oral, written and electronic modes	
c.	Accurately reports, records and documents clinical observations	
d.	Ensures that confidential information is maintained securely according to local health care policy	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 5: Nursing management and team competence
Criteria related to application of management and team working competence

1.5.1 Practises in a collaborative manner		✓ or ✗
a.	Interacts with members of the health care and multi professional team in a manner that values their roles and responsibilities	
b.	Develops a professional relationship by working in partnership with members of the multi-professional care team	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.5.2 Manages team, others and self safely		✓ or ✗
a.	Recognises and responds appropriately to situations that challenge self or others	
b.	Recognises, reports and responds appropriately to a change or deterioration in a service user's sensory, physical or emotional state or behaviour	
c.	Recognises risks and hazards whilst undertaking therapeutic or clinical interventions and escalates these to Registered Nurse as necessary	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

DOMAIN 6: LEADERSHIP POTENTIAL AND PROFESSIONAL SCHOLARSHIP COMPETENCES

Criteria related to effective leadership potential and self-awareness under the supervision of a Registered Nurse

1.6.1 Develop leadership potential			✓ or ✖
a.	Demonstrate the constructive use of feedback supervision and appraisal on the development of self-awareness and competence as a nurse		
Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

1.6.2 Develop professional scholarship			✓ or ✖
a.	Communicate an example of self-directed learning used to enhance professional performance in practice		
b.	Communicate with the multidisciplinary team regarding to the plan of nursing care intervention		
c.	Identify the use of relevant opportunities for learning in the practice setting		
Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	

Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Mid Placement Review

Student's review of progress during placement to date
Preceptor's review of student's progress during placement to date
Preceptor's summary of student progress during placement to date
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*

Student signature	
Preceptor signature	
CPC signature	
Academic link person signature	

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Placement Result (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

National Competency Assessment Document – YEAR ONE: Competency Development Action Plan

Practice Experience 1: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

Academic link person signature	

Practice Experience 2: Self-evaluation of learning needs and expectations

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

Practice Experience 2: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

Practice Experience 2: Mid Placement Review

Student's review of progress during placement to date	
Preceptor's review of student's progress during placement to date	
Preceptor's summary of student progress during placement to date	
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*	
Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Practice Experience 2: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature	
Academic link person signature	

Placement Result (✓ or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Practice Experience 2: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

Academic link person signature	

Practice Experience 3: Self-evaluation of learning needs and expectations

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

Practice Experience 3: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews

Practice Experience 3: Mid Placement Review

Student's review of progress during placement to date
Preceptor's review of student's progress during placement to date
Preceptor's summary of student progress during placement to date
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Practice Experience 3: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

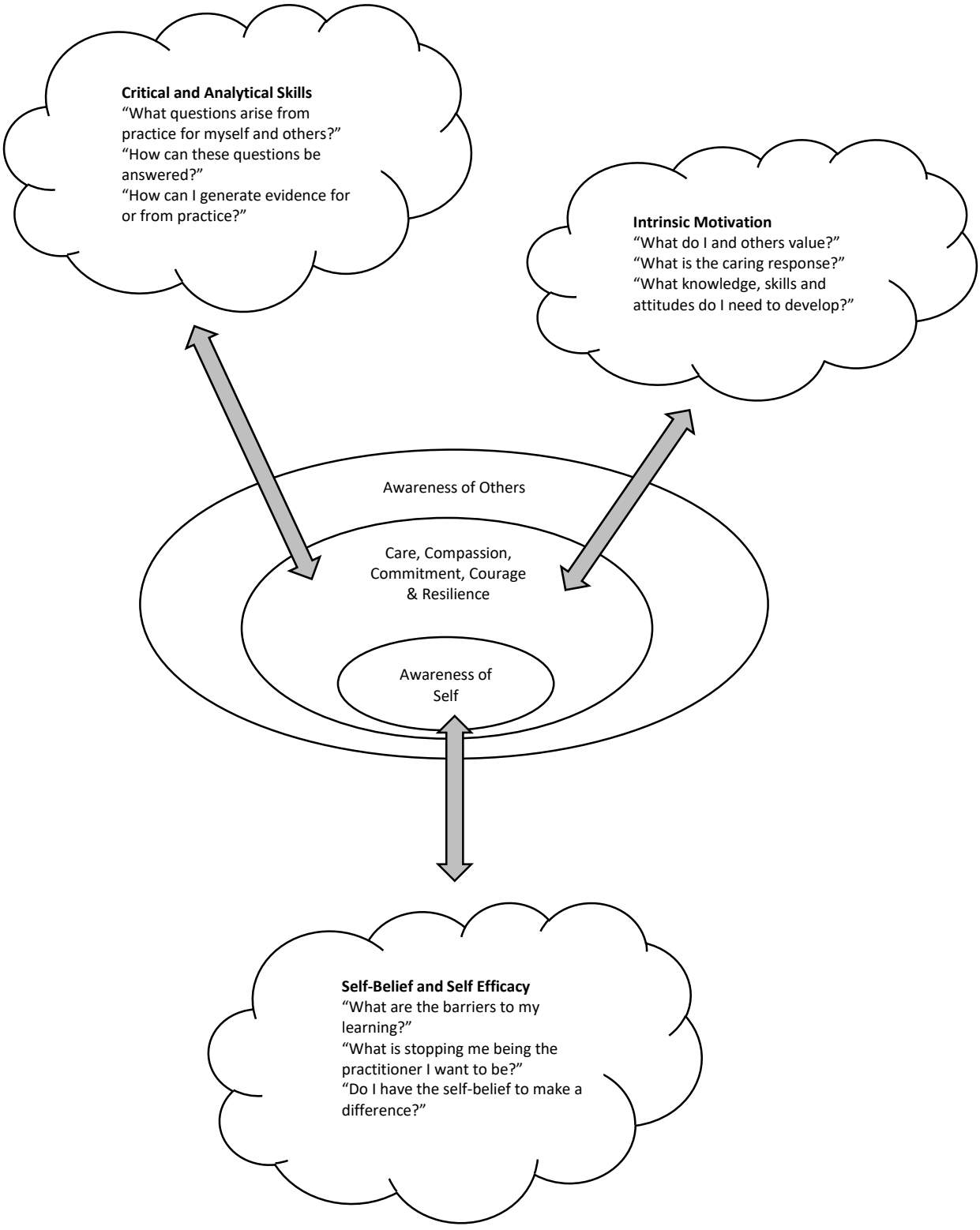
Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Placement Result (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Practice Experience 3: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	
Academic link person signature	

Appendix 1 - Guide to help you with your self-evaluation



The Value Based Enquiry Model – McLeon 2012
Values for Nurses and Midwives in Ireland – NMBI 2016

Appendix 17 – NCAD Psychiatric Nursing

Psychiatric Placement

National Competency
Assessment Document for the
Undergraduate Nursing Student

2018

National Competency Assessment Document – YEAR ONE: Registrant Signature Sheet

Registrant Signature Sheet

All health care professionals signing student documentation should insert their details below, as indicated.

Name of Preceptor (PRINT NAME)	Signature	Contact phone	Practice Placement Area

Record of on-going achievement

This competence assessment Documentation constitutes my record of competence development in practice placement settings for **YEAR ONE** of the programme.

I consent to allow the processing of confidential data about me to be shared between successive preceptors and with the relevant education providers in the process of assessing my development of clinical competence.

I understand that this is a requirement Higher Education Institute and its associated healthcare provider(s) for progression through the programme of study in Psychiatric Nursing and in compliance with the Standards and Requirements of the Nursing and Midwifery Board of Ireland (NMBI).

Student signature		Date	
HEI Link Person		Date	
CPC		Date	

Clinical Placement Details for YEAR ONE of the Programme

Practice Experience 1

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 2

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 3 (if applicable)

Name of Practice Placement	
Name of Health Service Provider	
Phone number of Placement	
Clinical Nurse Manager	
Name of Preceptor	
Name of Associate Preceptor	
Clinical Placement Coordinator	
Academic Link Person	

Practice Experience 1: Self-evaluation of learning needs and expectations*

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

*see appendix 1

National Competency Assessment Document – YEAR ONE: Competency Assessment Interviews (Reflection - Gibb's (1988) model of reflection)

Reflection must relate to situations encountered by the nursing student in this practice placement

Description – What happened?			
Feelings – What were your thoughts and feelings during the experience?			
Evaluation – What approaches worked and which ones did not work?			
Analysis – What sense can you make of the situation?			
Conclusion – After evaluating the situation, what conclusions can you come with?			
Action Plan – What would you do differently?			
Nursing Student Signature		Date:	

Preceptor/Associate Preceptor Signature		Date:	

National Competency Assessment Document – YEAR ONE: Six Domains of Competency

NMBI have determined that to practice safely and effectively as a Registered Nurse, a nursing student must demonstrate competence in the following Six Domains of Competence:

1. Professional Values and Conduct of the Nurse Competences
2. Nursing Practice and Clinical Decision Making Competences
3. Knowledge and Cognitive Competences
4. Communication and Inter Personal Competences
5. Management and Team Competences
6. Leadership Potential and Professional Scholarship Competences

Competence is defined as the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a Registered Nurse. To assist in determining if a nursing student has met the required level of competence, NMBI have detailed performance criteria for each domain and relevant indicators which demonstrate if the performance criteria have been met.

Novice
The nursing student has no experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The nursing student is taught rules to help them apply theory to clinical situations and to perform tasks.

Exposure
The nursing student has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the practice placement.
Participation
The nursing student becomes a participant rather than an observer with the support of the preceptor where learning opportunities are identified in partnership.

In year 1, at the end of each practice placement, nursing students have to achieve all domains and all indicators at exposure and/or participation level.

National Competency Assessment Documentation – YEAR ONE: Progression Criteria

PSYCHIATRIC NURSING

Domain 1: Professional values and conduct of the nurse

Criteria related to practising safety, compassionately and professionally under supervision of a Registered Nurse

1.1.1 Demonstrates safe, person-centred care		✓ or ✗
a.	Clarifies with preceptor instructions that s/he does not understand	
b.	Applies principles of safe moving and handling	
c.	Adheres to principles of infection control	
d.	Promotes a safe and therapeutic environment for service users, staff and visitors	
e.	Recognises and responds to situations of risk to vulnerable service user	
f.	Identified actions to be taken in emergency situations	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.1.2 Demonstrates compassion in providing nurse care		✓ or ✗
a.	Shows respect, kindness, compassion towards service users and their families	
b.	Acts in a professional manner that is attentive, empathetic and non-discriminatory towards other people	
c.	Supports services users with sensitivity during periods of mental distress	
d.	Assists service users to maintain their dignity in all nursing and health care interventions	
e.	Seeks help and guidance when a service user's needs are not being met	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.1.3 Demonstrates responsible and professional practice		✓ or ✗
a.	Adheres to and works within the Scope of Nursing and Midwifery Practice Framework as it applies to the nursing student	
b.	Practises honestly and with integrity in accordance to the Code of Professional Practice and Ethics for Registered Nurses and Registered Midwives as it applies to the nursing student	
c.	Adheres to local policies, procedures and guidelines	
d.	Adheres to reporting policy in respect of any untoward incidents or near misses	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 2: Nursing practice and clinical decision making

Criteria related to delivering effective, person-centred nursing care under supervision of a Registered Nurse

1.2.1 Assesses the person's nursing and health needs		✓ or ✗
a.	Monitors and documents a person's mental state, mood and behaviour accurately and systematically	
b.	Gathers information and records and reports observations in a person-centred manner	
c.	Participates in risk assessment with a service user	
d.	Participates in assessment or re-assessment of a person's mental health state	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.2 Plans and prioritises person-centred nursing care		✓ or ✗
a.	Identifies how information gathered is structured using an appropriate framework	
b.	Assists a Registered Nurse to plan an aspect of nursing care	
c.	Reviews with preceptor the structure of goals for a plan of care	
d.	Identifies with preceptor actual and potential goals	
e.	Identifies with preceptor interventions to meet a nursing or health goal	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.3 Undertakes nursing interventions		✓ or ✗
e.	Uses clinical equipment safely, showing awareness of limitations and associated hazards in usage and disposal	
f.	Assists the Registered Nurse in the safe administration and management of medicines	
g.	Carries out instructions responsible and timely manner in accordance with local policies, procedures and guidelines	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.3 Undertakes nursing interventions		✓ or ✗
a.	Ensures consent of the person prior to undertaking nursing interventions	
b.	Builds therapeutic alliances with service users to meet their recovery needs: • Engages interpersonally in a collaborative manner • Demonstrates respect for diversity, choice and human rights • Builds on a person's personal preferences, strengths and abilities • Promotes social inclusiveness • Supports the person to find hope, meaning and personal growth • Provides a supportive presence for the person • Promotes personal health and resilience • Actively supports and promotes a recovery ethos	
c.	Records nursing interventions, observations and feedback from the person accurately and concisely	
d.	Maintains the person's dignity, rights and independence when undertaking nursing care	

Domain 2: Nursing practice and clinical decision making
Criteria related to delivering effective, person-centred nursing care under supervision of a Registered Nurse

1.2.4 Evaluates person-centred nursing care		✓ or ✗
a.	Gathers and records information in accordance with a person's nursing care plan	
b.	Assists the Registered Nurse to review a person's plan of nursing care in light of observations, feedback from the person and health care team	

c.	Assists the Registered Nurse to review and revise as necessary the planned outcomes or interventions of a person's plan of nursing care	
d.	Assists the Registered Nurse to carry out an evaluation of a person's nursing and health care needs	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

1.2.5 Utilises clinical judgment		✓ or ✖
a.	Recognises and reports if a service user appears to be at risk	
b.	Recognises and reports to an RPN if a service user's physical or psychological condition is deteriorating	
c.	Demonstrates how to act in an emergency and to administer essential life-saving intervention	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 3: Nursing knowledge and cognitive competence
Criteria related to application of knowledge and understanding of the health continuum and of principles from health and life sciences underpinning practice

1.3.1 Practises from a competent knowledge base		✓ or ✖
a.	Applies knowledge of the philosophical underpinnings to mental health psychiatric nursing to everyday practice	
b.	Applies knowledge from the health, social and life sciences to the nursing care needs of a person in the practice setting	
c.	Safely and accurately carries out medication calculations and management	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

1.3.2 Uses critical thinking and reflection to inform practice		✓ or ✖
a.	Sources information relevant to a nursing intervention in the practice setting	
b.	Applies knowledge of local policies, procedures and guidelines to an aspect of nursing intervention encountered in the practice setting	

Assessment Decision (✓or ✖)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 4: Communication and interpersonal competence
Criteria related to effective communication and empathic interpersonal skills

1.4.1 Communicates in a person-centred manner		✓ or ✗
a.	Demonstrates ability to listen, seek clarification and observe non-verbal cues	
b.	Demonstrates respect for service users' rights and choices	
c.	Engages service user as an active partner in nursing intervention	
d.	Responds empathetically to a service user's personal narrative and experience	
e.	Cultivates hope, self-worth and meaningful dialogue and understanding	
f.	Challenges negative stereotypes, beliefs and stigma	
g.	Demonstrates awareness of power imbalances between service users and health care professionals	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 4: Communication and interpersonal competence
Criteria related to effective communication and empathic interpersonal skills

1.4.2 Communicates accurately with the health care team		✓ or ✗
a.	Communicates clearly with other health care team members	
b.	Demonstrates safe and effective communication skills, in oral, written and electronic modes	
c.	Accurately reports, records and documents clinical observations	
d.	Ensures that confidential information is maintained securely according to local health care policy	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Domain 5: Nursing management and team competence
Criteria related to application of management and team working competence

1.5.1 Practises in a collaborative manner			✓ or ✗
a.	Interacts with members of the health care and multi professional team in a manner that values their roles and responsibilities		
b.	Develops a professional relationship by working in partnership with members of the multidisciplinary health care team		
Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.5.2 Manages team, others and self safely			✓ or ✗
a.	Recognises and responds appropriately to situations that challenge self or others		
b.	Recognises, reports and responds appropriately to a change or deterioration in a service user's mood, mental state or behaviour		
c.	Recognises risks and hazards whilst undertaking therapeutic or clinical interventions and escalates these to Registered Nurse as necessary		
Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

DOMAIN 6: LEADERSHIP POTENTIAL AND PROFESSIONAL SCHOLARSHIP COMPETENCES

Criteria related to effective leadership potential and self-awareness under the supervision of a Registered Nurse

1.6.1 Develop leadership potential			✓ or ✗
a.	Demonstrate the constructive use of feedback supervision and appraisal on the development of self-awareness and competence as a nurse		
Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

1.6.2 Develop professional scholarship		✓ or ✗
a.	Communicate an example of self-directed learning used to enhance professional performance in practice	

b.	Communicate with the multidisciplinary team regarding to the plan of nursing care intervention	
c.	Identify the use of relevant opportunities for learning in the practice setting	

Assessment Decision (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Competency Assessment Documentation – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	

Proposed date for final interview	
CPC signature	

Competency Assessment Documentation – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Mid Placement Review

Student's review of progress during placement to date	
Preceptor's review of student's progress during placement to date	
Preceptor's summary of student progress during placement to date	
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*	
Student signature	
Preceptor signature	
CPC signature*	

Academic link person signature	

National Competency Assessment Documentation – YEAR ONE: Competency Assessment Interviews

Practice Experience 1: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature**	

Placement Result (✓or ✖)		**Preceptor Signature**	**Date completed**
PASS			
FAIL			

National Competency Assessment Documentation – YEAR ONE: Competency Development Action Plan

Practice Experience 1: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

Practice Experience 2: Self-evaluation of learning needs and expectations

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

Competency Assessment Documentation – YEAR ONE: Competency Assessment Interviews

Practice Experience 2: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature*	

Practice Experience 2: Mid Placement Review

Student's review of progress during placement to date	
Preceptor's review of student's progress during placement to date	
Preceptor's summary of student progress during placement to date	
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*	
Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

Practice Experience 2: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature**	

Placement Result (✓or ✗)		Preceptor Signature	Date completed
PASS			
FAIL			

Competency Assessment Documentation – YEAR ONE: Competency Development Action Plan

Practice Experience 2: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	
Academic link person signature	

Competency Assessment Documentation – YEAR ONE: Self Evaluation

Practice Experience 3: Self-evaluation of learning needs and expectations

To be completed by the undergraduate nursing student prior to placement incorporating theory and clinical skills learning to date.

The life and previous experience of practice that I bring with me to this placement is…
The learning opportunities that I hope to achieve during this placement are…
Any concerns that I have about this placement are…
The relevant theoretical learning that I bring to this placement…

Practice Experience 3: Preliminary Interview

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning needs identified by Student	
Learning plan agreed with Preceptor for placement	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	

Practice Experience 3: Mid Placement Review

Student's review of progress during placement to date
Preceptor's review of student's progress during placement to date
Preceptor's summary of student progress during placement to date
Please state any actions needed to enhance or maintain student's competency development action plan *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

NMBI Competency Assessment Documentation – YEAR ONE: Competency Assessment Interviews

Practice Experience 3: Final Placement Interview

Student's review of progress during placement
Preceptor's review of student's progress during placement
Preceptor's summary of student progress during placement
Please state any actions needed to enhance or maintain student's competence *(if applicable)*

Student signature	
Preceptor signature	
CPC signature*	
Academic link person signature	

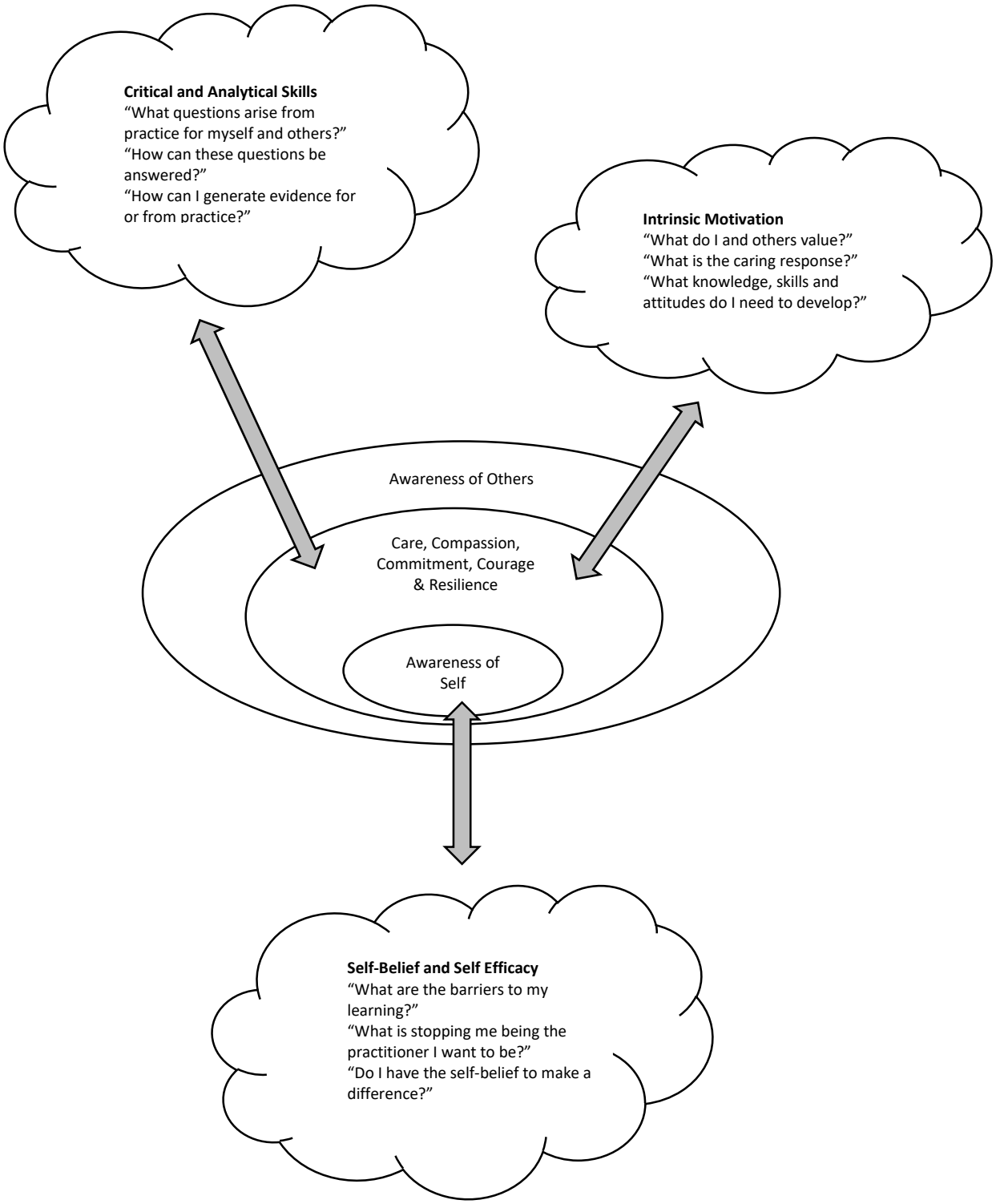
Placement Result (✓or ✗)		**Preceptor Signature**	**Date completed**
PASS			
FAIL			

NMBI Competency Assessment Documentation – YEAR ONE: Competency Development Action Plan

Practice Experience 3: Competency Development Action Plan (if required)

Date	
Welcome to Practice Placement Area	
Orientation to Practice Placement	
Name of Preceptor	
Name of Associate Preceptor	
Name of Clinical Placement Coordinator	
Name of Clinical Nurse Manager	
Name of Academic Link Person for Placement	
Learning plan agreed between Student and Preceptor for Placement: *Specify goals, activities proposed and date(s) for review*	
Student signature	
Preceptor signature	
Proposed date for mid placement review	
Proposed date for final interview	
CPC signature	
Academic link person signature	

Appendix 1 - A Guide to help you with your Self-evaluation



The Value Based Enquiry Model – McLeon 2012
Values for Nurses and Midwives in Ireland – NMBI 2016

Appendix 18 - Guidelines regarding the components of the assessment process and competence assessment documents.

Guidelines for those who assess nursing students in clinical practice

2018

REFERENCES

Collins, A., Brown, J., & Holum, A. (1991). Cognitive apprenticeship: Making thinking visible. *American Educator: The Professional Journal of the American Federation of Teachers*, 15(3), 6-11, 38-46.

Drennan, J. (2002). An Evaluation of The Role of the Clinical Placement Co-ordinator in Student Nurse Support in the Clinical Area. *Journal of Advanced Nursing, 40*(4), 475-483.

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NMBI. (2015). *Scope of Nursing and Midwifery Practice Framework.* Dublin.

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Introduction

This guide has been developed to help nursing students and those involved in their assessments complete their Competency Assessment Document. Please read and become familiar with these pages. We recommend that they are read in conjunction with the Higher Education Institute regulations and guidelines for assessment.

Clinical practice represents 50% of the undergraduate nursing programme and the development of skills, knowledge, professional behavior and attitudes represents a key component in the undergraduate nursing students' attainment of competency to practice as a registered nurse. In keeping with the requirements of the Nursing and Midwifery Board of Ireland (NMBI), the competency assessment document(s) acts as the record of on-going achievements that is NMBI's requirement for registration. It is also a fundamental component for the successful progression through the undergraduate nursing programme.

Competency for Entry to the Register[1]

The Nursing and Midwifery Board of Ireland (NMBI) defines competency as the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a Registered Nurse. Competency relates to the nurse's scope of practice within a division of the register and is maintained through continuing professional development. The nurse may need to upskill, update or adapt competency if s/he works in a different practice setting or with a different profile of service user.

There are five domains of competency that the undergraduate nursing student must reach upon completion of the education programme for entry to the Nursing Register held by the Nursing and Midwifery Board of Ireland. These comprise of:

Domain 1: Professional values and conduct of the nurse competences

Knowledge and appreciation on the virtues of caring, compassion, integrity, honesty, respect and empathy as a basis for upholding the professional values of nursing and identity as a nurse.

Domain 2: Nursing practice and clinical decision-making competences

Knowledge and understanding of the principles of delivering safe and effective nursing care through the adoption of a systematic and problem solving approach to developing and delivering a person centred plan of care based on an explicit partnership with the person and his/her primary carer.

Domain 3: Knowledge and cognitive competences

Knowledge and understanding of the health continuum, life and behavioural sciences and their underlying principles that underpin a competency knowledge base for nursing and healthcare practice.

Domain 4: Communication and interpersonal competences

Knowledge, appreciation and development of empathic communication skills and techniques for effective interpersonal relationships with people and other professionals in healthcare settings.

[1] Adapted from Nurse Registration Programmes Standards and Requirements (NMBI, 2016:17)

Domain 5: management and team competences

Using management and team competences in working for the person's well-being, recovery, independence and safety through recognition of the collaborative partnership between the person, family and multidisciplinary health care team.

Assisting Undergraduate Nursing Students to Develop Competency

The purpose of the registration education programme is to ensure that upon successful completion of the programme, the graduate is equipped with the knowledge, understanding, professional attributes and skills necessary to practise as a competent and professional nurse. Undergraduate nursing students vary widely in their life experience on entry to an education programme. They normally develop their confidence and competency to practice as a nurse over the duration of their programme but at different rates of progress. This depends on their prior knowledge and experience in healthcare, and also the rate at which they begin to apply knowledge and skills and professional values to clinical practice as they encounter patients, service users, interdisciplinary colleagues and family members.

Situational learning theories such as the cognitive apprenticeship model and the self-efficacy theory provide a suitable educational foundation for clinical teaching learning and assessment (Mc Sharry 2012; Mc Sharry and Lathlean 2017). In the first instance it is essential that students are facilitated to participate in all the activities of the nursing team on the unit where students feel a sense of belonging and part of the community of practice and students move along a continuum of learning started with observation (Mc Sharry 2012). The teaching methods posited by Collin *et al* (1991), that the preceptor can employ involves six techniques to ensure the student moves along this continuum and develops both performance and clinical reasoning and thinking competency. The first one is **modelling** where the preceptor demonstrates the object to be learned. This is followed by **coaching** which involves delegating and guiding the student's activity and observation of the performance (Collins *et al* 1991). The preceptor provides ongoing appropriate feedback. Mc Sharry and Lathlean 2017) purport that the preceptor should try to verbalise their thought processes while participating in practice so that student uses their problem solving and clinical reasoning skills. The **scaffolding** technique accesses what level the student is at and plans activities to process the student along the learning continuum. This teaching strategy is akin to continual assessment.

The aforementioned techniques focus on developing the student's ability to perform in practice the next three strategies focus on developing the students' thinking skills. The first one is **articulation**. This is where the preceptor questions the students to illicit their problem solving skills. It involves the preceptor questioning the student on their rationale for care and why they have chosen one action over the other

or indeed challenge them with “what if” scenarios to access what action the student may have taken if the practice situation became more complex (Collins *et al*, 1991; Mc Sharry 2012). Reflection in practice is another technique that accesses the students’ cognition. The preceptor at the end of the shift or following a learning opportunity encourages the student’s self-reflection or assess their performance on their performance; that is their strengths and their weaknesses. Finally the teaching technique of **exploration** is where the preceptor encourages the student to set their future learning goals and practice more independently (Collins *et al*, 1991; Mc Sharry 2012; Mc Sharry and Lathlean 2017).

It is important that preceptors have the ability to articulate and dialogue practice, carry out contextual questioning, encouraging student’s self-evaluation, provide situational, context specific feedback and be aware of strategies that build the students’ self-efficacy and confidence to practice and learn. Students should have the opportunity to reflect on their care delivery in an analytical way within the milieu of practice, in order to identify how they can achieve best practice in line with current professional standards Mc Sharry 2012; Mc Sharry and Lathlean 2017). Students are currently allocated protected reflective time in clinical practice to facilitate this learning strategy and this can be facilitated or directed by the Preceptor, Clinical Placement Co-ordinator; Academic Link Tutor (NMBI 2016).

The overarching aim of the programme is to ensure that the graduate acquires the competences for critical analysis, problem-solving, decision-making, collaborative team-working, leadership, professional scholarship, effective interpersonal communication and reflection that are essential to the art and science of nursing. Safe and effective practice requires a sound underpinning of theoretical knowledge that informs practice and is in turn informed by practice. Within a complex and changing healthcare service and population focus, it is essential that preceptors facilitate students to achieve these outcomes and that practice is informed by the best available evidence and that graduates develop a capacity for continuing professional development to maintain competencyover a potentially long professional career.

Levels of Competency for National Competency Assessment

Competency is defined as the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a Registered Nurse. To assist in determining if a nursing student has met the required level of competence, NMBI have detailed performance criteria for each domain and relevant indicators which demonstrate if the performance criteria have been met.

(Benner, 1984)
Novice
The nursing student has no/limited experience and understanding of the clinical situation therefore they are taught about the situation in terms of tasks or skills taking cognisance of the theory taught in the classroom. The nursing student is taught rules to help them apply theory to clinical situations and to perform tasks.
Advanced beginner
The nursing student demonstrates acceptable performance based on previous experience gained in real clinical situations.
Competent
A nursing student who has gained experience and therefore can plan actions with a view to achieving efficiency and long term goals. She/he has the ability to manage the complexity of

(Steinaker & Bell, 1979)
Exposure
The nursing student has the opportunity to observe a situation taking cognisance of the learning objectives of the programme and the practice placement.
Participation
The nursing student becomes a participant rather than an observer with the support of the preceptor where learning opportunities are identified in partnership.
Identification
The nursing student takes more responsibility for their own learning and participation and initiates appropriate action and evaluates same.
Internalisation
The nursing student makes informed decisions based on the information available and works as an autonomous practitioner.
Dissemination.
The nursing student uses critical analysis to determine the outcomes of their actions and can give rationale for their action to others.

Supervision for Undergraduate Nursing Students

Existing standards for undergraduate nursing education programmes

Supervision requirements of undergraduate nursing students by preceptors throughout the four years of the programme are explicitly defined within the Standards and Requirements for Nurses (2016) document in two places. Firstly, within the Explanation of Terms (Page 135) which describes indirect and direct supervision with the context of the Scope of Nursing and Midwifery Practice Framework. There is an adjacent paragraph applying these principles of direct and indirect supervision to the four years/four and a half years of the undergraduate nursing programmes.

Supervision

Supervision is defined by the Board as "the provision of oversight, direction, guidance or support by a nurse or midwife to students or unregulated health care workers (HCW). Supervision may be direct or indirect" (NMBI, 2015: 2)[2]. "Direct supervision means that the supervising nurse or midwife is actually present and works with the student or unregulated HCW undertaking a delegated role or activity. Indirect supervision implies that the nurse or midwife does not directly observe the student or the regulated or unregulated HCW undertaking a delegated role or activity. Both direct and indirect supervision can include oversight, direction, guidance and support and evaluation" (NMBI, 2015: 14).

During Years 1 to 3, the level of direct and indirect supervision varies according to the year of the programme, confidence, experience and level of skills and proficiency as judged by the Registered Nurse. The preceptor will assess what level of supervision the student requires based on their teaching technique of scaffolding which involve continuous assessment of the students' performance and thinking (Mc Sharry 2012). When the student has acquired the competencies and learning outcomes in the elements of nursing practice set for each stage of the programme they will facilitated to move along the continuum of learning and supervision will be tailored accordingly (Mc Sharry and Lathlean 2017). In some cases, the student will shadow the Registered Nurse during nursing interventions; in other circumstances the Registered Nurse may undertake nursing interventions at arm's length and report back on and document the process and outcomes. During the final year placements, within the 36 weeks internship, students continue to need guidance, support, prompting, feedback and evaluation to enable them achieve the level of clinical competency expected within the practice placement environment.

Nursing & Midwifery Board of Ireland*, Scope of Nursing and Midwifery Practice Framework.* 2015 Blackrock Co. Dublin

This definition is further amplified within the body of the Nurse Registration Programmes Standards and Requirements in Section 2: Learning levels towards achieving practice-based competency (Pages 22-23). It is proposed that these definitions be expanded to clarify the terms for different levels of supervision with the insertion of the text in bold as follows:

Level 1/Year 1: This level recognises that the undergraduate nursing student is a novice to the world of nursing and requires exposure to all aspects of practice. It is expected that a Registered Nurse will *directly supervise* the nursing student when s/he is participating in care provided to people in the practice setting across the life continuum. **Direct supervision is defined as the preceptor being present and working continuously with the undergraduate student whilst s/he provides delegated nursing care to patients/service users**. It is further expected that the nursing student will have a basic understanding of the broad concepts underpinning such care. The undergraduate nursing student may require continuous prompting in the provision of person-centred nursing care, and considerable direction in identifying her/his learning needs.

Level 2/Year 2: This level recognises that the undergraduate nursing student has had some exposure and participation in the provision of care in the practice environment. The undergraduate nursing student needs both the assistance and *close supervision* of the Registered Nurse while s/he participates in the provision of person-centred nursing. **Close supervision is defined as the presence or close proximity to the undergraduate student whilst s/he provides delegated nursing care to patients/service users and supports family members.** Frequent prompting may be required to support the student in the provision of person-centred nursing and in identification of its underpinning evidence. The student begins to identify her/his learning needs through discussion with her/his preceptor.

Level 3/Year 3: At this level, under the *indirect supervision* of the Registered Nurse, the undergraduate nursing student can identify the needs of persons and primary carers in practice and begins to adopt a problem solving approach to the provision of safe nursing care. **Indirect supervision is defined as the preceptor being accessible to the undergraduate student for guidance and support whilst s/he provides delegated nursing care to patients/service users and supports family members**. The undergraduate nursing student actively participates in the assessment, planning, delivery and evaluation of person-centred nursing and is able to provide a rationale for her/his actions. It may be difficult for the student to prioritise care in particular or complex situations. The student demonstrates awareness of the need for best practice, and can identify her/his learning needs from clinical experience. Year 3 Practice Learning

Outcomes cover the requirements for the Supernumerary placements which may include part of Stage 4 (the fourth year of study for the BSc Nursing Children's and General Integrated Programme only.)

Level 4/Year 4/5: At this level the undergraduate nursing student will be expected to competently apply a systematic approach to the provision of person-centred practice to an allocation of 4-6 patients under the *distant supervision* of a Registered Nurse. **Distant supervision is defined as the undergraduate nursing student providing safe and effective delegated nursing care to patients/service users and supporting family members. The undergraduate nursing student accepts responsibility for the provision of delegated care and recognises when s/he requires the guidance and support of the preceptor and Registered Nurse and seeks such assistance in a timely manner**. The student must demonstrate evidence based practice and critical thinking. S/he is capable of supporting the person and their primary carers and to work collaboratively with professional colleagues within the clinical environment. The competent practitioner possesses many attributes including practical and technical skills, communication and interpersonal skills, organisational and managerial skills and the ability to perform as part of the healthcare team, demonstrating a professional attitude, accepting responsibility and being accountable for one's own practice.

National Competency Assessment Documentation

Each undergraduate nursing student has competency assessment documentation that is shared with the preceptor throughout the practice experience. This forms the basis of regular discussion of learning needs and also ensures records of achievement are completed regularly. Each practice experience requires a clinical assessment. A qualified preceptor who has relevant expertise in assessment must carry out the assessment. The assessment should usually involve one assessor (preceptor) and one student but may include other assessors (e.g. a new preceptor being supervised). Sufficient time should be set aside to complete the assessment.

Assessments should be carried out within the context of practice so that evidence of skills, professional behaviour and knowledge is captured. While facilitating the students' learning using the teaching methods of coaching and articulation the preceptor will use a combination of assessment methods e.g. questioning and/or direct observation. Questioning allows the preceptor to assess the students' knowledge, problem solving and clinical reasoning skills while also assessing the student's attitudes such as respect, compassion care and commitment to the patient, Observation measures accuracy of practice demonstration of affective skills such as caring and compassion and level of autonomy.

The fundamental requirement of each registered nurse is to support and facilitate students the meeting their learning needs during practice experience. As a preceptor, there is additional requirements not only to support and facilitate the student but also to take part in their assessments of practice. Students undertaking the registration education programme do so under the supervision of a Registered Nurse who has been designated as his/her preceptor and under the wider supervision and direction of a team of Registered Nurses within each practice setting. In some cases, an undergraduate nursing student will require clear guidance and support to achieve aspects of his/her practice which have been identified to them as being below the required standard. In such cases, it is helpful to have the support of both the clinical practice coordinator for the area and the academic link tutor to ensure that the student clearly understands what it is that he/she is required to achieve, for instance, initially a Learning Support Plan which may still require the instigation of a Competency Development Action Plan.

The preceptor should remember as both a registered nurse and as a qualified preceptor, although it is a student's responsibility to learn, you are responsible for the assessment process and will need to have confidence in your judgement. Please ensure that the undergraduate nursing student has achieved the appropriate level of competency before awarding a pass judgement. If you are concerned that the student may not be able to achieve the required level confidence during or by the end of the placement, please ensure that the clinical practice coordinator and academic link tutor are informed.

Towards the end of the practice experience, a summative assessment is completed of the specified competences identified with the undergraduate nursing student at the commencement of the placement. Results should be discussed with the students at the time of completion to ensure timely feedback. Where learning needs are identified feedback should be delivered with sensitivity in the manner that will enhance learning. Comments should be written by the students and the preceptor following assessment. If a referral or fail is recorded, the student's additional learning needs must be documented and made explicit in a competency development plan agreed with the clinical placement coordinator and the link academic tutor.

Assessment decision	Criteria
PASS	The undergraduate nursing student has consistently demonstrated achievement of all of the specified assessments and demonstrates safe practice.
FAIL	The undergraduate nursing student has failed to consistently demonstrate achievement of any the specified criteria and/or demonstrates unsafe practice.

Guidance for the Undergraduate Nursing Student

Remember, this is your assessment document and you must accept responsibility for its accurate completion

The nursing student is required to:

- Prior to the start of your first practice experience, review your learning needs; it may be helpful to review any earlier experience you may have had of practice settings and to make a list of the areas for achievement that you have in mind. The following are suggestions to enhance your learning in the practice setting:
- Prior to the placement, check the location and travel implications and find out from your allocations officer, allocations liaison officer and or link academic tutor what type of practice experience and learning opportunities you are likely to undertake;
- Contact the practice setting to identify your hours of attendance and the day/date of your first day of placement;
- Aim to arrive a little earlier on your first day to ensure that you arrive in good time to familiarise yourself with the entrance and place of reporting;
- Undertake an orientation to the practice setting on the first day with your preceptor or co-preceptor;
- Actively participate in your preliminary, mid-placement and final interviews with your preceptor;
- At the your preliminary meeting in the placement site, identify and affirm your learning needs with your preceptor, and agree a plan of action to make the most of the learning opportunities available in the placement site;
- Take advantage of every opportunity to work with your preceptor and to engage with all the learning opportunities available;
- Maintain your competency assessment booklets securely throughout placements and throughout the programme;
- Provide your preceptor and clinical placement coordinator with evidence and examples from your practice as to how you are working to achieve competencies and skills;
- Make your competency assessment document(s)available to your preceptors, clinical placement coordinators and academic link staff on request;

- Discuss with your preceptor, clinical placement coordinator and academic link tutor how your learning is going during the placement;
- Work collaboratively with your clinical placement coordinator, preceptor and other clinical staff to ensure that the assessment of your competency is completed by the date specified;
- Submit the competency assessment document(s)to the designated School/Department office by the date specified;
- Ensure that all sections are fully completed before you submit it competency assessment document(s)with the requisite signatures;
- Undertake an online or off-line evaluation of each practice experience.

Competency Assessment Process

Competency in practice

As an undergraduate nursing student, competency to practise as a nurse is acquired gradually and successively across your programme of study as you gain knowledge, skills and professional acumen and apply these in practice placements. Achievement of competency for entry to the NMBI professional register is assessed continuously throughout each stage of your programme and you will be deemed competent when you have met all theory and practice requirements of your programme.

Progression

For each year/stage of the programme, there is a Competency Assessment Document(s) to be completed during the one or more practice placement experiences you undertake. Within each document(s) you will find a number of indicators related to the five domains of practice that must be achieved to progress clinically and to achieve the practice elements of your studies for that year. In order to provide your preceptor with the evidence of your achievement of clinical competence, you will need in some cases to demonstrate skills, undertake activities, discuss, answer questions, prepare written notes or undertake reflection on situations you have encountered. Certain proficiencies may be met through simulation either in a practice setting or in a clinical skills laboratory as part of your theoretical studies.

In the majority of settings you will be able to develop your knowledge, skills and competency through interactions with patients, service users, nursing colleagues and members of the multidisciplinary team. It is necessary to both acquire and maintain competency hence your preceptors will be reviewing with you at initial, mid-point and final interviews your learning needs as well as your proficiency in nursing. This will encompass the development of professional values, your interpersonal communication, team working, self-management, decision-making, professional scholarship and leadership potential.

Assessment process – Initial Interview

In most practice placement in of four weeks or longer, you will undertake usually within the first two days of commencing an initial interview with your preceptor. At this interview you will both review your learning needs, discuss learning opportunities available to you in that setting and identify how these can be related to achievement of the indicators and competences in your clinical assessment booklet.

Mid-point Interview

The mid-point interview provides you and your preceptor with an opportunity to review your achievement to date and for her/him to provide you with feedback on what areas of your practice need further development and to identify priorities and opportunities for their achievement. Feedback on your learning with both your preceptor and clinical placement coordinator should be competed in a supportive manner to provide you with adequate time to reflect on your achievements to date and to adapt your schedule of activities and demonstration of professional knowledge and values in the practice setting. It is important that at this mid-point interview, a note of your learning needs and progress is completed and agreed with you by your preceptor. The competency statements and indicators have been designed to be applicable to all practice settings. Please discuss with your preceptor and CPC should you encounter difficulties in gaining experience necessary to achieve the competences agreed with your preceptor at the initial interview for a particular practice placement.

Whilst you will be supervised and assessed primarily by your preceptor, you may be allocated a co-preceptor and will be also working alongside other registered nurses and members of the multidisciplinary team during your placements. Only a Registered Nurse who has completed a preceptorship programme may sign off your practice competency achievement. However, your preceptor will discuss your progress with you and with other registered nurses who have worked alongside you and have observed your interactions and interventions in formulating her/his decision. Your preceptor may sign certain sections of you document(s) after witnessing you undertaking certain practice activities on an ongoing basis; other competences may be completed at the mid-point or final interview stages of your practice placement.

Final Interview

The final interview allows for a review of your learning overall and to consider your needs and requirements to progress to the next stage/year of your programme of study. This should be accompanied by a written comment by you and by your preceptor on the overall process and result of the competency assessment to guide your future learning needs.

Should you not achieve a pass in one or more domains or in an individual requirement within your booklet, you would normally be referred. It is important that clear feedback is given and recorded as to how to enhance your learning and to identify the precise areas for improvement in your practice. Your result should be discussed with your academic link person and clinical placement coordinator as soon as possible after the final interview to determine a Competency Development Action Plan to assist your learning. Additional supports may be provided by the higher education institution and associated health service provider in the particular practice setting to assist you to meet the outcomes specified in the competency development action plan.

Undergraduate nursing students who have been referred in a particular aspect of their competency assessment of practice are normally allowed a further attempt to achieve their requirements through a period of additional practice experience. Should this further period of experience be insufficient to achieve and overall pass in the clinical practice element of your programme, undergraduate nursing students are required to meet formally with their academic link person to discuss the potential implications of the result for progression or graduation as a nurse.

Reflective Practice

The current Standards and Requirements for Nurse Education (NMBI, 2016) make provisions for reflection as an integral component of degree programme and currently Gibb's model of reflection is prescribed for use in the competence assessment documents for first year nursing students (NMBI, 2018) and the curriculum documents developed by the HEI's reflect these requirements. The rationale for this choice is that the model is cyclical in nature and is simple to apply in practice and has a focus on self–awareness (Atkins and Murphy, 1993). The model is illustrated in figure 1 and the questions suggested in its application are identified in table 1 which will help the nursing student to undertake reflection in practice.

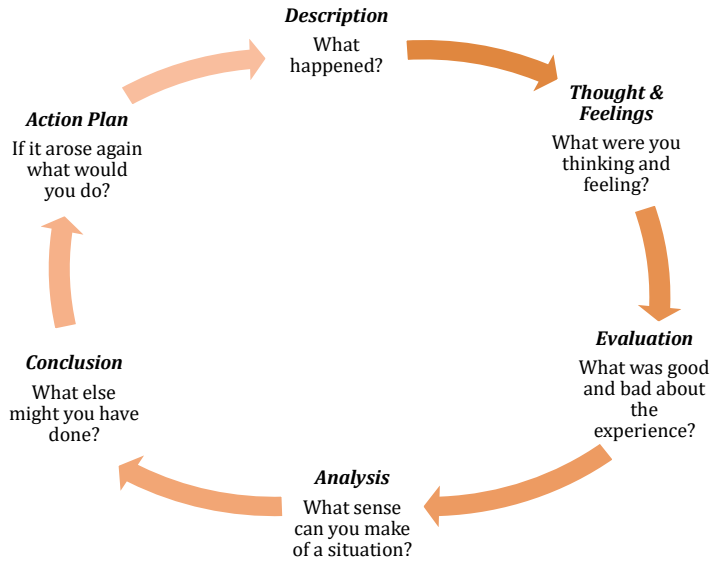

Figure 1 - Gibbs model of reflection (1988)

Stages of the reflective cycle	**Questions**
Description	What happened?
Thoughts and feelings	What were your thoughts and feelings during the experience?
Evaluation	What approaches worked and which ones did not work?
Analysis	What sense can you make of the situation?
Conclusions	After evaluating the situation, what conclusions can you come up with?
Action plan	What would you do differently?

Table 1: Questions to be considered when using Gibbs Model of reflection.

Glossary of terms

Associate Health Care Providers

Hospitals and services that provide practice placement for nursing students.

Assessment of Clinical Practice

The key concepts associated with clinical assessment are that assessment must judge the nursing student's abilities in clinical practice include an opportunity for self-assessment and make explicit the expected outcomes and criteria and include feedback (NMBI, 2016).

Applicant

Applicant refers to an individual who applies to NMBI to have his/her name entered in the relevant Division of the Register as maintained by the Board.

Assessment

Assessment involves determining the extent to which an individual reaches the desired level of competence in skill, knowledge, understanding or attitudes in relation to a specific goal. Assessment measures the integration and application of theory to client care learned throughout the programme, and requires the Candidate Nurse to demonstrate proficiency within practice through the achievement of learning outcomes.

Candidate

A Candidate means a person pursuing a training course leading to entry to a division of the register and whose name has been entered on the Candidate Register.

Candidate Register

The Board shall establish and maintain a Register of Candidates admitted for training on which the name of every such candidate shall be entered.

Competence

The attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a Registered Nurse. Competence relates to the individual nurse's scope of practice with a division of the register, is maintained through continuing professional development and the nurse may need to upskill, update or adapt competence if s/he works in a different practice setting or with a different profile of services use (NMBI, 2016).

Competences

The development of competence for a specified discipline represents the goal of an education programme; competences are specified in a manner that renders them assessable and develop incrementally throughout a programme of study. "Competences represent a dynamic combination of cognitive and meta-cognitive knowledge, intellectual and practical skills and ethical values" (Nursing Subject Area Group (SAG) of the Tuning Project, 2011).

Competence framework

A complete collection of competencies and their indicators that are central to and set the standards of effective performance for a particular client group (Nursing and Midwifery Council, 2010).

Domains of Competence

These are defined as broad categories that represent the functions of the Registered Nurse in contemporary Practice.

Indicators

Statements of the behaviour that would be observed when effective performance of a competence is demonstrated.

Knowledge

The cognitive representation of ideas, events of happenings. It can be derived from practical or professional experience as well as from formal instruction or study. It can comprise description, memory, understanding, thinking, analysis, synthesis, debate and research.

Learning Outcomes

Defined as "statements of what a learner is expected to know, understand and be able to demonstrate after completion of a learner experience and are the expression in terms of the level of competence to be obtained by the learner" (Nursing Subject Area Group (SAG) of the Tuning Project, 2011).

Preceptor/Associate Preceptor

A Preceptor/Associate Preceptor is a Registered Nurse. S/he is responsible for orientating, supervising and assessing the Candidate Nurse. The role involved facilitating learning opportunities and assessing the competence of the Candidate General Nurse on a continuing basis throughout the period of supervised practice. The Preceptor/Associate Preceptor is an experienced Registered Nurse who acts as a role model and resource person for the Candidate Nurse assigned to him/her.

Clinical Placement Coordinator

Drennan (2002) defined the CPC as "an experienced nurse who provides dedicated support to nursing students in a variety of clinical settings." The primary functions of the role include guidance, support, facilitation and monitoring of learning and competence attainment among undergraduate nursing students through reflective practice.

Development plan

When an undergraduate nursing student requires additional guidance and support to achieve the agreed practice placement learning outcomes, a learning support plan will be put in place in line with HEI policy and procedures and in a timely manner.

References

Appendix 19

Excerpt from thematic content analysis of SWOT analysis

Frameworks strengths

Blooms 1 b

Identifies three domains

- Knowledge (cognitive)
- Skills (psychomotor)
- Attitude (affective).

This marries well with what we understand by competence (the combination of knowledge, skills and attitudes), and could be mapped to the differentiated levels we expect our students to be at from 1st yr through 4th yr.

Can be applied to many different learning environments and situations for a variety of purposes.

The clarity and logic makes it easier to apply to the setting and measuring of learning outcomes.

Well known in field of education and nursing and midwifery.

Offers clear structure for writing learning objectives.

Promotes higher order thinking; Emphasis on safe practice.

Useful in assessing the student's cognition and the level of learning they are at in terms of their thinking.

Helpful in writing the curriculum.

Helpful in writing learning outcomes.

Helpful in planning classroom lesson plans.

Helpful to identify which classroom technique are most appropriate for measuring learning outcomes.

Helpful for identifying the types and/or difficulty of test question.

Helpful for Building on knowledge and helping students to begin to apply, analyse, synthesize, and evaluate.

Good structure for educators to use along with list of questions to encourage high order thinking in students.

The cumulative hierarchical framework is easy to understand.

Well established and widely used in educational circles.

Reasonably simple to understand.

Has been updated in recent times to match changes in the educational environment.

Benner 2 b

Benner's terminology is reflected in the current NMBI standards and requirements document.

Focuses on the behaviour of nurses depending on their level of understanding with nursing practice.

Well known.

Easy to follow.

Comprehensible.

Well applied to nursing and midwifery.

The importance of clinical experience in developing expertise is recognised.

Developed from observations of nurse in practice.

Focus on performance and experiential learning.

Acknowledges learning in practice with increasing complexity and competence.

Framework well recognised in nursing and has been applied to assess progression in clinical learning.

Novice to Competent stages sit well overall with transition from Year 1to exiting BSc programme.
Has potential to allow for variation across situations e.g. novice in one situation and advanced beginner in another situation, yet same year of learning.

The strength of this theory is the recognition that all novices need rules and clear instructions when starting to learn
Also that experience is necessary to learn.

From reading Benner's work the strength of her theory is that she found that not all nurses become experts even though they have lots of experience.
They needed experience scientific knowledge technical knowledge ability to reflect excellent inter and intra personal skills and really a high level of emotional and intellectual intelligence.

Very well-known model in nursing circles leading to an ease of implementation if it were used.

Benner's version was actually focused on nurses making it very relevant.

The categories make a certain sense to people on a superficial level, i.e. the progression from novice to expert.

Currently in use

Identified five levels of practice ranging from novice to expert based on the work of Dreyfus and Dreyfus (1981) to which she refers to extensively.
Developed a model of skills acquisition based on the study of chess players, air force pilots and army tank drivers and commanders.
Based on situated performance and experiential learning' (p 188).
Five levels of proficiency in clinical nursing practice.

Benner's theory focuses on the behaviour of nurses depending on their level of understanding with nursing practice.

I believe Benner's five stages are very well defined in her original work, which clearly articulates the progression from novice through to expert…as I recall she does not equate expertise with number of years' experience.

The terms novice, advance beginner, competent, proficient and expert are terms that do relate well to a competence based framework.

Could use the grading to define expected level at different levels of the programme.

Focus more on performance/competencecompared to Bloom's taxonomy.

Use of the term 'competent' in one of the levels.

Spiral/incremental model.

Widely used in nursing and well respected.
It is simple to understand and mirrors well the idea of the student nurse journey from novice to expert.

It is well suited to the clinical learning environment from the delineation of stages perspective.

Steinaker and Bell 3 b

It is based on an experiential theory: students in clinical practice are engaging in experiential learning.

It is student learning based.

Facilitates student application of theory to practice as they progress from initial exposure in practice to dissemination.

Experiential taxonomy fits well for nursing and midwifery practice.

Offers a tool for planning sequencing implementing and evaluating the human experience of teaching and learning.

Used in Queens University as it is a more unified and broadly based taxonomy which encompasses the broader human experience.

Useful for collaborative learning styles.

Offers comprehensive and structured framework.

Emphasis on experiential learn.

Has been used by some Schools in Ireland
and seems to have been generally
acceptable.

This theory takes cognisance of practice learning. It matches many other of the theories of situated learning. I know it's an experiential learning theory however I am not a lover of this theory as Nursing has standards to meet and skills and content that needs to be

learned that are essential therefore clear structure and sequencing are required Situated learning theories align well with the practice discipline of nursing.

Clear descriptors are provided at each level
The sequencing and scaffolding of learning that is required in learning the practice of nursing are mirrored in this theory.

A 'broad based' taxonomy which encompasses the broader human experience of learning – from the moment the learner is 'exposed' to an experience/skill to highest level of completion (autonomous).

It promotes 'active learning' which is meaningful learning.

It allows the student to observe before they participate (under observation) then practice autonomously – gradual steps to build confidence.

'Identification' and 'internalisation' stages also encourages the student to link the skills with the knowledge and rational

The 'exposure' enhances learning so that it supports various individual learning styles – as a student only remembers 10% of what they hear/read, 30% of what they see visually and 45% by doing/ 'participating' thus it enhances/increases learning and consolidation.
It does integrate knowledge, skills and attitudes within the concept of holistic teaching.

Framework focuses on practice-based learning.

Gives good indications to practice-based teachers as to the level of involvement of student in learning activities.

Spiral/incremental model.

This taxonomy is used widely in nursing.

The design of this framework lends itself well to capturing the theory to practice path.

It is based on experiential learning which is one of the more popular theories in vogue in particular in a clinical setting.

Bondy 5 b

Well known and used. The cues under 'Assistance' provide really clear and concise guidance for preceptors (especially with weak students on placement).

It adapts well with other frameworks (Benner and Steinaker and Bell).

Incorporates a five point rating scale to evaluate clinical performance of nursing students.

Unlike checklists which utilize
two-point scales (pass/fail), a five point rating scale can provide more information about the student's performance and differentiate between different learning levels.

Identifies five levels of competence across three evaluation areas.

Assessor's judgements about student's achievement and proficiencies take into consideration the level of performance that is required for the stage of learning.

Provides overall structure and framework Acknowledges progression of learning.

The effect and affect descriptors and criterion are very appropriate and focus on performance and affective domain which would encompass communication skills, compassion, empowerment, caring, confidence, inspiring trust etc.

The rating scale rates levels of supervision required and associated descriptors are clear and I believe accurate which make it easy for the assessor to grade or rate the student performance.

Its hits the right levels of practice for the undergraduate student.

Measures student's single performance and also development over time.
Provides student with diagnostic feedback.
Check list provided with 3-20 scale points rather than pass/fail.

Allows staff to describe and classify more accurately the strengths and limitations of a student's performance.

A common framework exists to discuss student performance.

Captures essence of affective and psychomotor domains by applying the concept of increasing competence varying from dependent to independent.

Assesses level of supervision required but also evaluates accuracy, safety, effect and affect.
Reduces subjectivity and ensures fairness thus the levels appear to be more easily interpreted, with less room for subjectivity.

Assessment of student competence against the practice levels of the skills using the tool-supports the use of a skills escalator for practice teaching, learning and assessment.

Helpful to provide a framework for objective assessment.

Helpful to provide the student with constructive feedback.

Helpful to provide consistency among a variety of evaluators.

Helpful to provide a standardized framework within which to observe student clinical behaviour.

Helpful to describe and classify the strengths and limitations of a student's performance.
Focus on safe practice.

Level of support/supervision from practice-based teacher clear in this model.
Spiral/incremental approach
Focus on practice.

Dependent/unsafe level –makes it clear to students if they are not competent yet.

Specifically constructed for clinical nurse education using nurse educators.

Could be adopted / mapped for / to the domains used in Standards and Requirements.
Has been adopted for use by well-regarded nursing schools elsewhere such as the University of Manchester.

It is very well predisposed as a framework for skill acquisition.

Framework weaknesses

Bloom's 1b

There is a risk that the focus will be on cognitive skills only.

The results of most empirical studies of the underlying assumptions of these models have been inconclusive.

Anti-behaviourists strong criticism of Blooms taxonomy in Curzen (2000) suggest that it is formulated in behavioural terms, that it ignores much of the contemporary analysis of the cognitive processes associated with epistemology and that a disjunction between cognitive and affective objectives it is logically incoherent in education. Oakeshott (1962)

argued in Curzon (2000) that education should be a journey of exploration without restrictive mapping.

As learning is not sequential, Blooms taxonomy is artificially constructed and it is individualistic in its approach to learning.

Linear view of how individuals learn.

Predominately associated with cognitive processes and skills rather than psychomotor and affective learning.

Mainly associated with classroom learning.

Artificial separation between knowledge and understanding- contemporary Pedagogy teaches for understanding from the outset.
Mostly knowledge oriented.

Original taxonomy is dated and has since been developed further- although similar criticisms are levelled at updates.

Very little evidence to illustrate how this taxonomy is effective for learning in practice settings and complex situations.

Does not assess the in action practice of nursing that is the doing.

Does not assess the affective domain that is the care compassion ability to empower the person/patient/ client/service user.

It could constraint looking at certain aspects of nursing practice if used rigidly.

The affective and skills element were never fully developed by Bloom and thus the hierarchy described really only applies to the attainment of knowledge.

It may be difficulty to apply to the practice skill in nursing both psychomotor and affective.

Fails to acknowledge that learners may perform at different levels of proficiency with each type of higher order thinking skill.

The distinctions in the taxonomy make no practical difference in diagnosing and treating learning and performance gaps.

The very structure of the taxonomy moving from the simplest level of knowledge to the different level of evaluation is not supported by research.

There is not always a clear distinction between analysis, synthesis and evaluation. Analysis generally involves some type of evaluation, for example.

In undergraduate Nursing education, there is a strong emphasis on what students 'know'. This is inevitable, given the emphasis on content and acquisition of psychomotor skills in the curriculum. Therefore, what we are often looking for is evidence of having achieved the lower levels of the taxonomy. So, the higher levels are not always relevant.

Relating to my comment above, there is a significant body of evidence to show that knowledge and comprehension are really important foundations for the higher levels. I think this is sometimes overlooked.

Taxonomy, as described in frameworks section leads itself more to cognitive assessment 'checking of knowledge' rather than 'performance-based review of competence'.

Unclear which elements in this framework are to be completed supervised or unsupervised for competence.

Action verbs used could be difficult to understand for practice-based assessors (i.e. preceptors), as the terms are educational.

Other experts in the field and even the authors have stated that the hierarchical nature of Blooms may be restrictive in interpreting how learning really occurs.

Some experts believe its simplistic approach does not really mirror how learning takes place in light of newer research in this domain.

Might not be well suited to the clinical learning environment as a stage delineation framework or as a model for a skills acquisition environment.

Perhaps lacks the granularity that would be useful in clinical education such as that in the Bondy model.

Benner 2b

Benner's research related to the development of expertise in qualified staff and not student nurses.

Linear model, which does not consistently meet student needs in terms of changing to a different practice setting.

Do not take account of the individual student's ability and the range of clinical experience.

Little emphasis on academic learning.

The problem with this theory is it is not suitable as an undergraduate framework as her work studied levels of nurse's performance. She focused mostly on critical care nurses and community nurses which is quite specialised. Her findings while I accept are from the USA which has a different education system for Nurses found that nurses reached level 3 competence after 2 years qualifying. This is not our system or requirements.

The positioning of "competence" in the middle of the hierarchy has obvious problems for the development of a competence tool.

The departure from binary ideas of competencemay also present problems.

Benner's work while influential was has never really developed beyond the intensive care setting in which it was based leading to problems of transferability to other areas.

The categories described by Benner are difficult to measure and rely on mainly subjective qualitative type judgements.

Not supported by grand theory.

More suited to post graduate learner linked with levels of Practice and Experience.

Brenner's five stages (novice, advance beginner, competent, proficient, and expert) are poorly defined in the literature.

The criteria used for assigning nurses to stages (number of years of experience and supervisors' judgements) are not reliable and in fact have been shown to not always correlate with expertise.

The very status of these stages is unclear. If they are meant to imply that individuals can be categorized in one stage, there are plenty of evidences showing that individuals, while fluent in one sub-field, may perform much less fluidly in another sub-field of the same domain.
Benner's model (or at least her adaptation of the Dreyfus and Dreyfus model) is based on her research findings in a particular context i.e. the United States. Her application of the 5 stages relates to qualified / registered nurses and not undergraduates. I don't believe it is commensurate with the model of education in Ireland and yet we continue to apply it.

Terms used to describe levels of competence very vague even with explanations.

I have never met a student, who could tell me what 'advanced beginner' actually means.

Use of the term 'expert' could imply that students use their intuition in practice more often – is this desirable? Can this be assessed?

Level of supervision from practice-based teacher unclear in this model.

Other researchers in this field question for example how we be sure a person is at a certain stage or even how these stages are defined i.e. is there enough quality research backing them up.
Others question the adequacy of Benner in relation to "expert intuition".

Does it need updating for learning in the digital-age?

Is it a good framework for a skills acquisition environment?

Perhaps lacks the granularity that would be useful in clinical education such as that in the Bondy model.

Steinaker and Bell 3b

It would not capture the affective domain of learning by itself.

Does not presume to offer an answer to the question of what is good teaching and learning experience.

Do not take account of the individual student's ability and the range of clinical experience.

Potential to see students as relatively passive in the early phases of learning.

Assumption that students wait to internalisation to take responsibility for learning is too late- this should be happening from the outset in year 1.

Capacity to make informed decisions arrives too late at identification stage.

Differentiating between identification and internationalisation can be challenging for clinical staff.

This theory similar to Blooms is one dimensional and does not reflect the complex nature of what needs to be learned in order to practice nursing.

It focuses only on the thinking or cognitive level at the last two levels, until the last 2 levels.
Students need to know the underpinning theory and rationale before or while doing their practice. Yes often, they find it hard to make links but this must start and be assessed at exposure stage.

Is limited in assessing the full gamut of nursing practice.

May lead to very atomised type of assessment

Not strong for assessing affective skills and communication skills etc.
Appears a linear process – learning is anything but!!

After exposure there is no mention of the term 'reflection/discussion etc prior to 'participation' a large gap.

'Identification' – the term/concept critique/analyse/reflection needs to be included.

'internalisation' the term – 'information available' is very vague/loose/invalidated, maybe this should be replaced with research/evidence based practice/guiding policies and documentation.

If the persons experience is of 'good quality' but the reflection is limited, then the learning will also be limited.

Terms used in this framework do not clearly relate to competenceassessment – what is the required level for BSc students 'identification', 'internalisation'?

Explanations used in framework are vague.

Highest level 'dissemination' – 'can give rationale' seems very basic for degree students.

Level of supervision required from preceptor unclear – not referred to in framework.

Like a lot of these frameworks it may seem abstract in the reality of the clinical learning environment.

Newer clinical assessments such as learning contracts may not sit well with this framework.
Perhaps lacks the granularity that would be useful in clinical education such as that in the Bondy model.

Bondy 4 b
The terms AFFECT and EFFECT may cause confusion amongst staff.

University of Minnesota's adaptation focusses on negative criteria at the he lower levels eg dependent rather than what is expected of a first year.

Do not take account of the individual student's ability and the range of clinical experience.

Does not take into consideration required skill set of preceptors who assess students.

Very behavioural oriented.

Language of 'unsafe' in earlier Dependent phase is a concern... student's needs to be safe within their defined scope of practice.

Seems somewhat stifling to progression multiple levels before independence.

Multiple criteria may make it difficult to use or understand by practitioners.

The model does assess the interpersonal communication and other aspects of performance however there is no reference or measure of the cognitive domain.

Has perhaps an overemphasis on clinical skill development.

Not very widely used or known.

May lead to atomisation in assessment.

May not be strong in assessing more abstract skills

Level of assistance required by student-verbal and physical directive cues.

Time consuming.
Lengthy.

Middle rating sometimes perceived negatively, perhaps as an average scoring.

The preceptor is required to make a judgement that differentiates between levels of achievement.
Required performance level unclear in model - ? different levels required for different years.

Does not really identify theoretical underpinning knowledge behind performance level.

Does not really identify attitudes towards care provided.

It is not a framework that identifies the level / stage of the learner clearly.

Framework opportunities

Bloom 1 b

Could combine well with other frameworks.

None-very taskoriented.

Useful in assessing the level students' are at in relation to their ability to think critically, problem solve be creative be reflective.

Benner 2 b

Framework widely known and has the potential to be adapted.

The advancement of the student from novice to expert depends on the opportunities for experience available to them.

Opportunity to continue on with higher skill proficiency in PG education thereby a coherent framework acknowledging life long and continuity of learning.

Benners' work highlights the need to ensure students on undergraduate programmes have scientific knowledge and develop the skills of critical reasoning and professional communication. This lays the foundation for expertise in practice.

The fact that the Benner model is well known could be used as part of a wider model to great advantage.

By having a standardised framework for learning widely used lead to more consistency, less discrepancies of teaching and learning within the education and practice environments if using new model.

Perhaps, if the levels are more clearly defined, the framework could be more useful.

Steinaker and Bell 3 b

Could be used to inform and outline expectations of students on clinical placement in terms of their level of engagement in experiential learning.

Students have the opportunity for exposure as a participant in the clinical practice setting with the support of a preceptor and whereby learning opportunities are identified in partnership.

Continue to apply a framework already in use in Ireland.

This is very useful in terms of measuring practice perform and where the student is at in terms of supervision required..

An opportunity is that it is 'active learning' so encourages students to engage in learning which enhances skills acquisition.

It reduces anxiety/stress for the student as they have the opportunity to be exposed to and observe first.

It provides the opportunity for increased learning by exposure and participation and then practice.
If reflection/discussion/questioning was implemented after exposure prior to participation this would provide an opportunity to enhance critical thinking skills and problem solving skills.

By having a standardised framework for learning it would lead to more consistency and less discrepancies of teaching and learning within the education and practice environments.

The outcomes of experiential learning appear to be diverse; ranging from skills acquisition of a new skill or personal development right through to social consciousness raising.

Bondy 4 b

Combines well with other frameworks.

Enables assessors to:

- Describe and classify more accurately the strengths and limitations of a student's performance.
- Provide more detailed, specific constructive feedback.

Bondy's criterion referenced definitions are very suitable to an undergraduate program. They get the assessor to focus on what is done and how it is done which will encompass developing the professional identity of the student.

Clinical behaviours can be evaluated; pre-determined range of reference points on rating scale; label for each reference on scale point.

Assessment and evaluation of skill (technical, psychomotor and interpersonal), attitudes and insights, and reasoning.

Students perceive the comments as constructive and positive rather than as critical or negative.

Students learn to self-evaluate and to validate self.

Can identify various strategies to help students improve performance.

Can help weak students with feedback.

Can be adapted to suit needs of college/healthcare areas.

Tool can be audited.

Adaptions of the framework to develop clinical assessment tool offers an opportunity to reflect the conceptual framework and philosophy of the nursing program.

Provides a clear structure for level of support/supervision and for competence assessment.

Provides a good basis for action planning, if performance is unsafe.

Bloom 1 b

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The outcomes of experiential learning appear to be diverse; ranging from skills acquisition of a new skill or personal development right through to social consciousness raising.

Bondy 5 b

Combines well with other frameworks.

Enables assessors to:

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- Provide more detailed, specific constructive feedback.

Bondy's criterion referenced definitions are very suitable to an undergraduate program. They get the assessor to focus on what is done and how it is done which will encompass developing the professional identity of the student.

Clinical behaviours can be evaluated; pre-determined range of reference points on rating scale; label for each reference on scale point.

Assessment and evaluation of skill (technical, psychomotor and interpersonal), attitudes and insights, and reasoning.

Students perceive the comments as constructive and positive rather than as critical or negative.

Students learn to self-evaluate and to validate self.

Can identify various strategies to help students improve performance.

Can help weak students with feedback.

Can be adapted to suit needs of college/healthcare areas.

Tool can be audited.

Adaptions of the framework to develop clinical assessment tool offers an opportunity to reflect the conceptual framework and philosophy of the nursing program.

Provides a clear structure for level of support/supervision and for competence assessment.

Provides a good basis for action planning, if performance is unsafe.

Framework treats

Bloom 1 b

There is an association with Bloom to the cognitive domain primarily.

Less attention is paid to the skills and attitude elements.

Numerous critiques of this model in recent years.

Resistance from educators because of its weaknesses and uncertainty of application in the clinical environment.

Resistance from practitioners already used to another framework and because it lacks practice orientation.

Using this theory on its own would lead to an incomplete assessment of the complexity of nursing practice. Its focuses only on cognition which is extremely important and a necessary component of practice but thinking has to be realised in practice. Therefore students who are not performing to the standard that is required will not be assessed accurately using this theory.

Lack of clarity /mix-up of goals objectives between theoretical and practical part of the BSc curriculum (as we already use this taxonomy for educational objectives).

Needs a lot of preparation for practice-based teachers e.g. understanding action verbs used in framework, knowing what level of intervention is required from preceptor for competence.

Other theories in the field.

Newer research which may question further its suitability / robustness.

Its age may mitigate against its appropriateness into the future.

Can we say it fits well as a framework for say new methods of teaching such as for example

Benner 2 b

Use of the 'Novice' term may lead people to interpret that Benner's framework is being utilised.

Recognising intuition within this model has been critiqued.

Lack of exposure to differing experiences in clinical practice settings could limit learning opportunities for students.

Risk of being applied with rigidity along a linear taxonomy.

Resistance from practitioners already used to another framework.

The theory leads to too high expectation for an undergraduate programme. It does not have enough clear measurable descriptors i.e. outcomes for levels below competence.

More applicable model of learning now available for consideration.
Could cause confusion among practice-based teachers and module co-ordinators if levels of performance are unclear.

Practice-based teachers might be reluctant to award more than 'competent', as students are undergoing BSc programme – when is the use of levels such as 'proficient' and 'expert' relevant?

Other theories in the field.

Newer research which may question further its suitability / robustness.

Steinaker and Bell 3 b

Lack of exposure to differing experiences in clinical practice settings could limit learning opportunities for students.

Student self-esteem/confidence and satisfaction with progression in learning and their perceived competence.

Limiting time factors.

Resistance from practitioners already used to another framework.

The affective and cognitive domain of nursing is not measured in this theory. I would have difficulty with a. student operating autonomous practitioner as described in internalisation Furthermore I would always want them to be able to give rationale for their actions which is considered the highest level.

If the person they are observing in the first instance may not be practising in accordance with evidence based practice, so may not be exposed to current or best practice.

Thus further evidence within the experiential learning taxonomy of research/EBP needs to be apparent earlier in the framework.

As further developments in technology and research.

emerge/change/influences practice the framework needs to take cognisance in allowing/fostering these changes – not evident enough in this taxonomy.

With no reflection mentioned in the framework it leads to 'surface learning' while 'critical reflection' is associated with 'deep learning'.

Experience and reflection should be combined.

Time constraints in a busy ward/unit/environment may compromise the time for observation/ discussion/questioning/rational – and thus hinder/reduce learning.

Confusion of practice-based teachers as to the level of supervision required and the level of competenceto be assessed.

Other theories in the field.

Newer research which may question further its suitability / robustness.

Bondy 5 b

Inappropriate use of clinical evaluation due to confusion over terminology.

While students can be supported to be self-evaluative of their own work more research is required to determine if students subsequent to feedback opt to improve own performance.

Resistance from practitioners already used to another framework.

Risks a return to task oriented approach to learning.

The key treat here is focus on the doing ie performing. Assessors are always very happy with students who can contribute to getting the work done. The "faster" the student may get a higher evaluation. Thinking students may on the other hand be considered to be less competent. There is no measure of understanding what they are doing or thinking of different ways of doing. Clinical reasoning or problem solving skills are not measured or identified in this model. All aspects of nursing practice need to be assessed in practice otherwise theory can be divorced from practice and the focus can occupational competence rather than educational competence.

Adaptions of the framework to develop clinical assessment tools must be manageable in length.

Undefined or vague labels for the scale points for the adaption tool can contribute to lower reliability.

Overreliance on performance assessment without identifying the required level of knowledge and attitude.

Other theories in the field.

Newer research which may question further its suitability/robustness.

Appendix 20 - Excerpt from NVivo nodes of focus group interview