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What impact has the introduction of the ongoing achievement record and sign off mentor had on the robustness of mentors' assessment practices?

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Abstract

This study investigated the impact of two changes on the assessment of student nurses in practice in one University in England; the introduction of the ongoing achievement record and the development of the sign off mentor role (NMC, 2008). As contemporary literature showed nurse mentors were failing to fail student nurses, these changes to assessment in nursing practice were introduced (Duffy, 2003; Gainsbury, 2010). A literature review was conducted to identify key themes in the nurse mentoring literature and led to the research question for the study;

What impact has the introduction of the ongoing achievement record and sign off mentor had on the robustness of mentors' assessment practices?

Using a qualitative interpretive methodology, a two phase study firstly examined forty six assessment records for forty students who had failed in practice. These were examined for common issues and themes before semi structured interviews with eight mentors were completed as phase two, to ascertain links between what assessment documents showed and how the mentors felt these changes had affected the assessment of student nurses.

Four themes were drawn from data from both phases of the research: Using the assessment documents, failing a student, accountability and the sign off mentor and finally mentor assessment of behaviours and levels of progress. Data was used to support a discussion on each of these themes.

It was found that the introduction of the ongoing achievement record (OAR) has had a positive impact on mentors and the quality of assessment practices as mentors use prior records to inform their role. This was reliant

however on prior mentors' commitment to completion of the document accurately, which was variable.

The introduction of sign off mentors was shown to have a negative impact on the robustness of assessment practice. Mentors were reluctant to become sign off mentors due to the perception of the increased accountability. Mentors interviewed identified that mentors earlier in the programme were delegating the assessment decision to the sign off mentor as the accountable gatekeeper. This reduced the reliability of the mentorship process and it is recommended that this role should be removed and instead support for novice mentors should be given by experienced mentors to ensure robust assessment takes place.

An emerging theme showed that mentors assess students throughout their nursing programme for key values and behaviours required to be a nurse. This strengthens the profession at a time when it has been under fire in the media for lack of compassion and care (The Patients Association, 2011). It is reassuring for the profession and the public to see that student nurses are assessed consistently against these values as part of their course.

Use of the OAR alongside the impact of sign off mentors and assessment of values and behaviours had not been found in prior literature. This study presents these findings as new knowledge and they will be used to guide local strategy on mentorship models and ensure new mentors have access to experienced mentors. They will also be disseminated nationally to enable other educators and the Nursing and Midwifery Council to become aware of this evidence base for the OAR and sign off mentor in order that they can explore changes that may be needed as they revise their mentor standards to improve the assessment process and mentor support for nursing education.

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Glossary of Abbreviations Used

Dip / BSc.   Diploma in Nursing / Bachelor of Science in Nursing – the academic programme studied by the students in this research study

DoH   Department of Health – UK Government Department

HEE   Health Education England – public body who commissioned nursing programmes involved in this study

NMC   Nursing and Midwifery Council – the professional regulatory body who set UK standards for nursing and midwifery education

OAR   Ongoing Achievement Record - practice assessment document introduced by the NMC in 2007 and used by some of the students in this study

SLAiP   Standards to Support Learning and Assessment in Practice – NMC 2006 standards (2nd edition 2008 used in this study) which give detail on the regulatory framework for mentor preparation and ongoing standards for supporting student nurses and midwives

UKCC   United Kingdom Central Council for Nursing Midwifery and Health Visiting – a prior regulatory body replaced by the NMC in 2002

Chapter One – Introduction.

This thesis presents research on mentorship in nurse education in the
United Kingdom (UK), and specifically the impact on the assessment
practice of mentors from changes made in 2007 by the professional
regulatory body. This chapter will present the rationale for the research
and outline the role of the mentor in nurse education in the UK since the
move into higher education during the 1980s. Nurse education in the UK at
the time of the study was delivered mainly as a three year 'pre-
registration' course leading to a minimum of a diploma level qualification.

Standards from the regulatory body, the Nursing and Midwifery Council
(NMC) state that 50% of a UK nursing course should take place in practice
(NMC, 2004; NMC, 2010). Assessment in practice contributes to
registration as a nurse with the NMC at the end of the course, alongside
achievement of the academic award. Assessment of the student during
their learning in the practice setting is carried out by a mentor and it is
vital that the quality of this assessment is high.

The quality of assessment in practice is important as there are concerns
about the professional standards of nurses both in the news following the
2012 Francis Inquiry (The Kings Fund, 2013; Hayter, 2013) and in criticism
of the NMC by the Council for Healthcare Regulatory Excellence (CHRE,
2012). If the profession and the public do not have confidence in nurses to
care for them competently and compassionately, this affects the
confidence of the profession and the registered nurses' perceptions of their
role (The Patients Association, 2011; Wilson, 2014a).

The Francis Inquiry took place after serious concerns were raised about the
poor quality of care delivered at Mid Staffordshire Hospital Trust between

2005 and 2009. The inquiry found a series of failings in nursing care where patients were left to suffer and compassion was not evident. The published report had 290 recommendations based on transparency in care delivery, improved compassion and care standards and stronger health leadership.

Passing students who should fail was referred to as 'professional cowardice' by Macdonald (1998). Black, Curzio and Terry (2014) question if nurses are failing in their duty of care when they do not fail incompetent students. As the regulator for nursing and midwifery in the UK, the NMC has protection of the public as its priority and the focus of the statutory obligation it upholds (Ilott and Murphy, 1999; Moore, 2005; CHRE, 2012). Doubts about newly registered nurses' fitness to practice are not restricted to the UK (Moore, 2005; Dall'Alba, 2009). A significant increase of nearly 50% in fitness to practice cases with the NMC since 2009 (CHRE, 2012) shows a need to ensure newly registered nurses are equipped with the knowledge, competency and decision making skills to enable fitness to practice at the point of registration.

Nursing is still struggling to gain public recognition as a profession (Hart, 2004; Girvin, 2015). Nursing has had statutory professional registration since 1919 but public recognition of nursing as a profession has not been visible, making it difficult for nurses to be seen as credible in strategic policymaking (Gough and Walsh, 2000; Hart, 2004). From the 1960s the role of nurses has changed from that of doctors' assistants, to a specific role with its own knowledge base and values and is controlled by nurses themselves (Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010). According to Eraut (1994) this makes nursing a profession, although nurses remain poor at demonstrating their specific role and expertise to the public or stakeholders (Gough and Walsh, 2000; Girvin, 2015). Watson (2006) argues that as nurses are accountable for

their practice, this aspect alone makes them aligned to other professions. Ilott and Murphy (1999) concur and add that self-regulation is a characteristic of a profession. As the largest professional group in the National Health Service (NHS) (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), 1999) with 692,000 nurses and midwives on the NMC register (NMC, 2017) it is therefore vital that we can have confidence in the nurse education system and ensure that assessment produces practitioners that are fit for practice in order to protect the public (Dall'Alba, 2009; Royal College of Nursing, 2012).

Criticism of the profession by the public (The Patients Association, 2011; Aitken, Rafferty and Sermeus, 2014) and the press (Watson and Shields, 2009; Girvin, 2015) has highlighted failings in the education system (Cook and Spouse, 2002; Watson, 2006; Health Education England/ Nursing and Midwifery Council, (HEE/NMC) 2015) and especially since the NMC agreed that nurse education would become a degree level programme from 2013 (NMC, 2010; Aitken et al, 2014). With nurse education in transition during the course of this research, moving towards all degree exit curricula and concurrent criticism of the quality of care provided by nurses and other practitioners in the news, this was timely research to explore assessment in nursing practice.

Registered nurses within their mentor role assess student nurses moving through the education programme prior to entry to this profession. By requiring 50% of the students' course to be based in practice with continuous assessment, the NMC recognise the quality of this assessment within the mentor system is vital. This thesis focused on the mentor role in assessing the students' clinical practice and specifically mentor assessment decisions which enable student nurses to qualify and enter the NMC register. If the assessment in practice is not rigorous and objective we

cannot be assured that nurses emerging from the education programmes are competent, fit to practice and fit to register as a nurse, nor be confident in the quality of the system that demands so much resource to ensure students meet the demands of the nursing role.

From my own perspective as research student I was also a nursing lecturer in a large School of Nursing in England during this study. My primary role had a specific focus on mentor and practice teacher preparation and support for practice learning. I specialised in teaching others to teach in the clinical area, immersed in the practice, policy and literature central to this study. During my time in this role I witnessed a move away from focusing on the mentor as a teacher and facilitator of learning, towards a role that has more emphasis on assessment and accountability. This created a change in the mentor role which I wanted to explore further, specifically as the NMC introduced new requirements for assessment in 2007 which were embedding during the timespan for data collection in this study (NMC, 2007).

Alongside the demands of this role, my own motivation in learning more about the underlying theory and principles supporting mentorship over this time also meant my learning changed, from one focused on teaching and learning theory to one focused on assessment theory and strategy within a professional course. This knowledge underpins this study which contributes research on the impact the changes bought into mentorship assessment in 2008. There was little published research on these changes at the start of the study and I hoped to increase the literature and evidence base through researching the impact of the changes. This also gave me the personal opportunity to stop and focus on the wider picture revealed through mentorship, rather than being contextualised within my own local understanding emerging from my work role. I was able to

examine strategic policy and wider influences and look up from the localised picture I held prior to the study.

1.1   Rationale for This Study

New standards affecting mentor practice were introduced by the NMC in 2006 with a second edition in 2008. Implementation of these 'Standards to Support Learning and Assessment in Practice' (SLAiP) (NMC, 2008) appeared to have been relatively successful locally, but created significant unforeseen workload and complexities. This required investment of time and demanded new support mechanisms from both university staff and practice partners. Research into these changes looking specifically at the mentor perspective on assessment was timely and could inform future work locally and the current review of the SLAiP standards by the NMC.

When strategic changes are made in mentorship that impact on partnership work between the School of Nursing and local healthcare Trusts, evaluation of these is key to educate and inform future direction as policies evolve and settle. The School of Nursing for this research supports approximately 1500 pre-registration student nurses, utilising 3000 mentors locally for practice learning and assessment (McGown, 2015; Boyer, 2015). It has another centre providing nurse education too, with an approximate total of 2100 nursing students and estimates of approximately 5000 mentors overall. This is a large School of Nursing, within a Russell Group university and has many national and international links for nursing and healthcare.

Mentor preparation and support is a key element of the success of our pre-registration nursing course. I co-ordinated the provision of mentor preparation from an academic perspective and liaised with academic and

practice based colleagues to ensure the quality of practice based learning overall. Staff are employed specifically to support practice based learning and assessment with mentors and students. This is a significant staffing resource for the University. Ensuring we get the quality of assessment right for pre-registration students in practice means that we have confidence in the quality of our graduates, many of whom work locally after qualifying and that we have confidence in their ability to be fit for practice on graduation.

Nationally there is significant investment from universities and the National Health Service (NHS) in supporting practice learning to improve the quality of healthcare education (Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010; HEE / NMC, 2015). This thesis aimed to offer new knowledge regarding impact upon practice assessment quality for the future delivery of nurse education.

Changes to assessment documentation were implemented by the NMC (2008) following Kathleen Duffy's landmark study (2003). These were intended to eradicate the poor assessment practices Duffy identified, including the concept of mentors failing to fail students who did not achieve. Duffy's qualitative study was funded by a scholarship from the United Kingdom Central Council for Nursing Midwifery and Health Visiting, (which was the professional body at the time) and aimed to explore mentors' and lecturers' experiences of failing nursing students in placement. Using grounded theory methodology Duffy interviewed 14 lecturers and 26 mentors from 3 universities in Scotland. She found that mentors were reluctant to fail students, even when there are doubts about their competence. Mentors gave the benefit of the doubt making it difficult for lecturers to take action when students were struggling.

As a result of this study which confirmed concerns held by the profession regarding the quality of practice assessment from mentors, the Nursing and Midwifery Council revised their standards for mentors and published new standards in 2006. These included changes to the assessment documents with the introduction of the ongoing assessment record and the introduction of the sign off mentor role. Significant resources have been invested to implement these required changes since 2007, to support mentors in using the new assessment documents and introduce the sign-off mentor within the assessment process (Hutchinson and Cochrane, 2014). I doubted however that the impact of the changes had been realised on two points; firstly the intention of changing to an ongoing achievement record (OAR) and the introduction of the sign off mentor were never clearly stated by the NMC. Their primary function is protection of the public (NMC, 2015; CHRE, 2012) and the assumption was therefore made by stakeholders that these changes were designed to improve the quality of practice based assessment, as a response to anecdotal concerns and also the findings of Duffy (2003). This was never formally confirmed by the NMC in any publication at the time of the introduction. There were limited national guidelines for implementation of these changes after the standards were published and therefore systems and practices differ across the United Kingdom, which in turn offered opportunity for inconsistency in quality and rigour of assessment procedures, documentation and implementation of the SLAiP standards on a national scale. Secondly, within the local context, mentors have so many other demands on their time whilst in practice, that the quality of assessment relied heavily on the individual characteristics and commitment of the mentor to their mentor role and the results of these changes are not transparent to staff in practice and the University. Reliance on personal characteristics of the mentor is still high. Consideration of these two points questions why the

changes were made initially and whether they impacted on strengthening assessment practice from all mentors, as would appear to be the intention.

The aim of this study was therefore to:

Explore what impact the prescribed changes had on the quality of the assessment process for nurse mentors.

Key objectives in this study were to:

1) Identify the reasons why students failed in practice and if these were recorded differently by mentors before and after the changes to the assessment documents

2) Ascertain if the introduction of the sign off mentor role (NMC, 2008) was perceived by mentors to improve the quality of the assessment process

3) Develop a deeper understanding of the key issues facing mentors with students who struggle to achieve in practice and the subsequent challenges for their assessment decisions.

Reflection on my early assumptions as the study progressed enabled an interpretive methodology to emerge where I was situated as the researcher, with prior understandings and assumptions, centrally within the methodology. In this way a hermeneutic interpretation for the study emerged, with past experience providing context to this study throughout. My prior understandings and assumptions were not distanced from the research in order to aim for objectivity but were included and acknowledged in order to inform the study as it developed.

Mentoring in nursing practice is a complex and multi-faceted role. As contemporary literature discussed whether nurse mentors are failing to fail

student nurses (Duffy, 2003; Gainsbury, 2010; Black, Curzio and Terry, 2014), these policy changes to assessment in nursing practice were established (NMC, 2008; Veeramah, 2012b). The remainder of this chapter sets the context of the change for nurse education as it moved into higher education and the development of the role of the mentor which is central to this study.

1.2 An Overview of Nursing Curriculum

The role of a mentor was introduced into UK nurse education in the late 1980s with a new nursing curriculum referred to as 'Project 2000' (UKCC, 1986; Allen, Smith and Lorentzon, 2008). At this time, nurse education was integrating into higher education in the UK, away from smaller local National Health Service (NHS) nurse training schools attached to hospitals (Gray and Smith, 2000; Rolfe and Gardner, 2006). For the first time student nurses were not employed on an apprentice style course but were supernumerary university students (Hart, 2004; Fulton, 2015). Nurse education was based in universities, with student nurses usually studying a 3-year course leading to a minimum of a diploma in nursing, alongside registration with the regulatory body. Regulation of the nursing profession transferred in 2002 from the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) to the Nursing and Midwifery Council (NMC).

Nurses completing the Project 2000 curriculum were expected to demonstrate a higher level of theoretical knowledge alongside their competency in practice and were labelled 'knowledgeable doers' (Morle, 1990; UKCC, 1999). However, nursing and the public rejected the idea that nurses needed academic awards (Lord, 2002; Hart, 2004) and one

outcome of the implementation of this curriculum was an increased

concern that registrants were not fit for practice at the point of

registration, despite demonstrating higher level thinking skills and

increased evidence-based practice than their predecessors (UKCC, 1999).

Following evaluation of the curriculum (UKCC, 1999) it was replaced by a

new model for nurse education known as 'Making a Difference' from 2000

(Department of Health, (DoH) 1999).

The Making a Difference curriculum responded to criticism of the Project

2000 programme (UKCC, 1999; Lord, 2002) with an increased emphasis

on learning in clinical practice and meeting the requirements for practice,

rather than the academic qualification being the primary driver of nurse

education policy. This provided a programme with outcomes based

competencies developed in partnership with practice and the universities

(Taylor, Irvine, Bradbury-Jones et al, 2010). This led however to nursing

students experiencing a tension between the need to achieve the academic

assessments in order to meet the university award and also to achieve the

NMC competencies in practice in order to gain professional registration.

(Ilott and Murphy, 1999; Girot, 2000; Veeramah, 2012b)

Since the Project 2000 curriculum, students were based in clinical practice

as supernumerary and therefore not expected to be counted as part of the

workforce staffing requirements. They would work alongside the healthcare

team in practice and be continually assessed by a nurse mentor. This shift

in focusing teaching and assessment roles away from teaching staff

employed by the schools of nursing and towards a mentor role conducted

by registered nurse staff employed in practice was a feature of the

introduction of Project 2000 courses (Chow and Suen, 2001). It was

recognised during evaluation of the Project 2000 curriculum that this shift

required a significant level of increased support from practice organisations

to resource the teaching and assessment of student nurses in practice that had been planned (UKCC, 1999), with a huge increase needed in the number of nursing staff involved in the assessment of students in these new mentor roles (Fisher and Webb, 2008). With the introduction of the 'Making a Difference' curriculum the time spent in practice was designated at 50%, specified at 2300 hours, and remains so today (NMC, 2010). In 2004 the programme competencies (UKCC, 1999) were altered to 'standards of proficiency' (NMC, 2004) and it is these that mentors in this study have used for the assessment of the student nurses.

In 2010 the NMC published 'Standards for Pre-Registration Nurse Education' which marked a policy shift to graduate exit nursing. From 2013 all nursing education programmes are a minimum of degree level (NMC, 2010; Ali and Watson, 2011). This caused much debate in the national press and nursing press about the requirement for nurses to study to degree level (Watson and Shields, 2009; Shields, Watson and Thompson, 2011). This study focused on aspects of the assessment process using the NMC 2004 standards and contributes towards the evidence base on assessment in practice emerging after implementation of the NMC SLAiP standards (2008) and the more recent nursing degree courses (NMC, 2010). With 692,000 nurses and midwives on the professional register in the UK (NMC, 2017) and over 20600 commissioned places for student nurses and midwives in 2009 at a cost of almost 1 billion pounds (Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010) getting effective high quality education is vital for public protection and for the future of the profession.

1.3 Local Context of This Study

This thesis focused on the assessment of student nurses on a Diploma /
Batchelor of Science in Nursing (Dip/BSc) programme at a large University
in England, commencing between 2006 and 2010. Changes to the
assessment process in practice from 2007 (NMC, 2008) are researched in
this study. This provides information covering that change period when the
assessments in practice and documentation were amended with the aim of
improving the quality of assessment in practice within the newer graduate
nurse programmes and curricula.

1.4 Mentors in Practice

Placements are locations where healthcare practice is delivered and
student nurses are allocated for education purposes. The student nurse will
move between placements during their programme to gain experience in a
variety of settings and explore different models of healthcare delivery. All
placements used for student learning need to be audited to meet the
quality standards prescribed in 'Placements in Focus' (English National
Board /Department of Health (ENB / DoH), 2001). One of the requirements
is to have sufficient staff prepared as mentors to support a student's
learning and assess them in practice. A mentor is defined by the NMC as;
"a registrant who has met the outcomes of stage 2 and who facilitates
learning and supervises and assesses students in a practice setting." *(*NMC,
2008, p45.)

The outcomes of stage 2 mentor are the NMC standards for mentors
(Appendix 1), alongside a list of requirements that mentors will meet
during formal approved mentor preparation courses studied at university
after qualification as a nurse (NMC, 2008). These include the need for

mentors to have been qualified for a year before undergoing mentor preparation and once qualified as a mentor, to have annual mentor updates for professional development purposes. Nursing and Midwifery mentors are required to meet these standards, however this study focused only on nurse mentors and the student nurses' assessment in practice, as models of mentorship in midwifery and assessment strategies differ.

Lengths of time spent in placements vary from a few weeks to three months and each new placement brings a new mentor to assess the student. There is no continuity of mentor support between placements. It becomes vital that mentors can quickly form a helping relationship with the student to meet their individual learning needs in the context of that placement, then move toward assessing them against the required NMC standards (NMC, 2004; NMC, 2008). The skills required by the mentor make this a complex and important role in nurse education (Myall, Levett-Jones and Lathlean, 2008; Veeramah, 2012b). Without mentor assessment in practice environments no nursing student would qualify and graduate.

Nursing mentors are members of staff in clinical practice. They are employed with a primary role delivering patient care with the mentor role secondary to this, although often a requirement of the job description, but with no recognition of the time required when allocating workload (Cook and Spouse, 2002; Nettleton and Bray, 2008). This causes a conflict at times when nurses may be incredibly busy with patient care and therefore not always have the time to devote to mentoring the student in practice (Webb and Shakespeare, 2008; Holland, 2010). The NMC require all registrants to practice according to the 'The Code: professional standards of practice and behaviour for nurses and midwives' and this clearly states that all registrants "support students and colleagues learning to help them develop their professional competence and confidence" (NMC, 2015, p9),

thereby prescribing the duty to teach and mentor despite the demands, complexities and conflicts of the role (Myall, et al, 2008; Cassidy, 2009; Holland, 2010). Continuing professional development, alongside achievement of the mentor standards is required before a registered nurse can act as a mentor and assess the student nurse (NMC, 2008).

The NMC sets the mentor standards. Initially they were advisory standards, but in 2006 the NMC introduced the 'Standards to Support Learning and Assessment in Practice' (SLAiP) with a 2nd edition published in 2008. These standards offer a four stage developmental framework for registrants to support learning and assessment (NMC, 2008). Stage one contains a set of standards to be met by all registrants and integrates with the requirements of the code (NMC, 2015). Stage two lists the mandatory mentor outcomes for all mentors to achieve during their studies for mentor preparation and maintain through on-going professional development (Appendix 1). Stages three and four set the standards for practice teachers and teachers respectively. SLAiP standards define the requirements for mentor preparation including the quality assurance of approved mentor preparation through short modular courses no less than ten days in length, delivered by an approved educational institution usually within a university setting. The standards have significantly strengthened the profile of mentorship for learning and assessment in practice (Gidman, McIntosh, Melling, et al, 2011) although Fisher and Webb (2008) make the point that these standards have also increased the financial and workload implications for organisations involved in supporting mentors, both within universities and the NHS.

Once qualified as mentors, registered nurse mentors are listed on a local mentor register in order to practice as a mentor, and undergo a triennial review with their employer to ascertain their right to stay on that register

and be able to function in practice as a mentor. In 2015 there were 3000

mentors on these local registers across the main placement areas used by

the university where this study took place (McGown, 2015; Boyer, 2015).

Training, updating and supporting this number of mentors is a huge

workload demanding dedicated staffing resource from both the NHS Trusts

and the local universities. Any change to mentor assessment in practice

brings increased demand on that resource and workload. Investment to

support mentors and practice learning is a key requirement for the School

of Nursing and is a benchmark measure of quality assurance used during

review.

These NMC SLAiP standards emphasised the accountability of the mentor's

assessment decision, which in turn highlighted the responsibility that

mentors have for the assessment of student nurses and midwives (NMC,

2008; Andrews, Brewer, Buchan et al, 2010). Whilst the standards deliver

a quality assured system for initial mentor preparation there is less

structure for supporting mentors with their role once qualified as mentors

and supporting them with protected time alongside their students to fulfil

the mentor role fully. This limitation of time is one area frequently

identified as a key barrier to effective mentoring (Cook and Spouse, 2002;

Nettleton and Bray, 2008; Veeramah, 2012a).

Achievement of the NMC mentor standards (2008) during mentor

preparation is intended to ensure that all mentors start their role with the

same baseline of competence. However, once they start the role in

practice, support for them can be variable, with no dedicated time for the

role and an expectation that they will support and mentor students with no

reduction in workload for patient care (Hyrkas and Shoemaker, 2007).

Individual university schools of nursing work in conjunction with their

practice partners to offer practice learning support, but systems vary

across the country and often mentors are operating at a distance from the university, short term mentoring a student who is on placement with them for weeks rather than months (Duffy, Docherty, Cardnuff et al, 2000). This can affect the quality of assessment when novice mentors have to rely solely on their own judgements when facilitating the student's learning and assessing them (Elcock and Sookhoo, 2008; Veeramah, 2012b). Locally, mentorship practice has been previously reported by students as variable (Quality Assurance Agency, 2006). The quality of mentorship is reported as an issue in Australia, Canada and the United States too by Moore (2005) in his policy review.

A quantitative research study, previously completed for my masters' degree (Royal, 2007), examined mentors' perception of their achievement of the NMC mentor standards and identified that mentors believed they did achieve the standards overall, however assessment and educational audit were their weaker areas of confidence (Royal, 2007; The University of Nottingham, 2007). Whilst findings from this study were generalizable, one limitation of this research was the lack of depth in the findings as the study was quantitative, collecting data via a questionnaire completed by 193 mentors with no qualitative comments collected. As assessment practice and documentation has altered significantly in nursing education since this research was completed, with more emphasis on assessment seen in the NMC standards (2008) and the contemporary literature and in light of other research regarding assessment issues (Duffy, 2003; Gainsbury, 2010; Veeramah, 2012b; Black (2011); Hunt (2014) this thesis aimed to add to that literature.

This thesis continues with a review of the contemporary literature that was considered during this study (Chapter Two). It then moves on to detail the methodology underpinning the study with discussion of the data collection

methods and rationale (Chapter Three). Findings are then discussed, with themes identified and analysed (Chapter Four). Discussion of these themes and the implications for practice follow (Chapter Five) prior to the conclusion, revisiting the aims of the study and the emerging findings from analysis of the data (Chapter Six).

Chapter Two - Literature Review.

Chapter one considered the rationale for this study within the wider context of changes in nurse education and the mentor role in the United Kingdom (UK). This chapter will synthesise published work through a literature review, relating to policy and research on assessment in professional education, focusing on the context of nursing and assessment of competency in practice settings.

A literature review is undertaken in order to establish what is already known. Through synthesis of published works strengths and weaknesses in relation to assessment in practice and gaps in knowledge can be identified. It can also serve to provide context and rationale to the issue under research, providing an evidence base for practice (Booth, Papaioannou and Sutton, 2012). Much of the literature in mentorship and assessment is pragmatic and practical in nature. This literature and empirical research does not have a tradition using specific underpinning theoretical frameworks but instead deals with practicalities of the issue. For this reason it was imperative that the review was managed in a rigorous way.

A strategy for searching was devised based on a systematic approach (Aveyard, 2007; Booth, Papaioannou and Sutton, 2012) to ensure thorough consideration of the topic under investigation. The intention is to provide an overview of the literature on nursing mentoring and move onto identifying the gaps for further research study without recourse to an underpinning theoretical framework.

The review focused specifically on assessment in the workplace; in nurse education this is termed the practice setting or placement. There is a plethora of published work around nurse education including focus on teaching nursing, assessment within the university setting and assessment of simulation activities. These areas were not the focus for this study and therefore were excluded from the review. Within this review I also wanted to focus on assessment related to adults rather than children and specifically on competency assessment as this is the assessment method used for nursing students in practice. In nursing this assessment is done by mentors, however other assessor roles in the workplace were initially included as a full understanding was required.

Four databases were reviewed in order to collate literature from a breadth of education and health care sources; The British Educational Index (BEI), Applied Social Sciences Index and Abstracts (ASSIA), Educational Resource Information Centre (ERIC) and Cumulative Index to Nursing and Allied Health Literature (CINAHL). These were revisited during the course of the study to ensure findings were updated and available literature considered. Alongside this, literature already held by the researcher was revisited and reviewed in order to determine the relevance for this study.

Keywords used for the searches on these databases focused primarily on 'assessment' and 'competence' with further searching using the keywords 'mentor' and 'assessment' to ensure full coverage of the literature related to the mentor role in assessment of competence in the workplace. Initial searching combining these three keywords of assessment, competence and mentor returned nothing. After further investigation and search attempts, the most effective way to ensure literature was found across these elements was to search each database twice. The first time keywords of 'assessment' and 'competence' were used and on the second occasion

'mentor' and 'assessment' were used. This ensured a full search of the relevant literature was completed and identified a broad scope of assessment literature beyond the mentor role.

Timescale for publication was defined from 1993 when the mentoring concept was established and introduced into nursing in the UK. Only publications in English were reviewed as the first language of the researcher. Full text was included in the search criteria. Where possible on the database criterion, age groups were selected as adults and education levels to those for adults. Once the database created this initial search result list, the title and abstract were reviewed. Only literature that appeared to be relevant to this study were included for further reading. Both empirical papers and non-empirical work such as discussion papers and expert opinion pieces were reviewed in order to provide insight into the overall context from the literature (Aveyard, 2007). In reviewing the titles and abstracts some themes were excluded and these are detailed on the tables below; for example if an article discussed competency in a specific clinical task or skill this was excluded, or if it was evident that the assessor was not workplace based, for example a tutor led assessment within the workplace. As each database was reviewed, literature for further reading and consideration emerged as follows:

Table 2.1 Literature Search Strategy (BEI).

Database	**British Educational Index (BEI)**
Search 1: Keywords	Assessment and Competence
Dated	After 1993
Language	English
Age Group	Adults
Education level	All

Initially provided	33 results
Titles and abstracts reviewed; excluded references to-	Cultural competence, clinical competence, academic assessment, simulation assessment, communication competence, development of competence through learning.
Selected for reading of full text	1 article
Search 2: Keywords	Mentor and Assessment
Dated	After 1993
Language	English
Age Group	Adults
Education level	All
Initially provided	47 results
Titles and abstracts reviewed; excluded references to-	Peer-assessment, pupil assessment in schools, coaching, peer mentoring, self-assessment, youth development, functional skills.
Selected for reading of full text	4 articles
After reading full text - excluded	1 article
Included in literature review	3 articles

Table 2.2 Literature Search Strategy (ASSIA).

Database	**Applied Social Sciences Index and Abstracts (ASSIA)**
Search 1: Keywords	Assessment and Competence
Dated	After 1993
Language	English
Source Type	Scholarly Journals
Initially provided	1404 results
Titles and abstracts reviewed; excluded references to -	Post graduate, continuing professional development, self-assessment, academic assessment, simulation assessment (OSCE), cultural competence, legal competence, children's competence, competence and mental health capacity, patient capacity, competence for consent, grading of assessment, portfolio assessment, functional analysis, development of the fitness to practice curriculum.
Selected for reading of full text	25 articles
After reading full text - excluded	4 articles
Included in literature review	21 articles
Search 2: Keywords	Mentor and Assessment
Dated	After 1993
Language	English
Source Type	Scholarly Journals
Initially provided	123 results

Titles and abstracts reviewed; excluded references to -	Coaching, interprofessional assessment, peer mentor, peer assessment, self-assessment.
Selected for reading of full text	26 articles
Duplicates removed	10 articles
Selected for reading of full text	16 articles
After reading full text - excluded	4 articles
Included in literature review	12 articles

Table 2.3 Literature Search Strategy (ERIC).

Database	**Educational Resource Information Centre (ERIC)**
Search 1: Keywords	Assessment and Competence
Dated	After 1993
Language	English
Selected	Full text, peer reviewed, journal articles
Publication type	all
Education level	Adult education
Initially provided	47 results
Titles and abstract reviewed; Exclude references to -	Academic assessment, comparison of assessment modes, educational competence levels, self-assessment, clinical competence, capability and performance competency, health education, interpersonal competence, needs assessment,

Selected for reading of full text	3 articles
After reading full text - excluded	2 articles
Included in literature review	1 article
Search 2: Keywords	Mentor and Assessment
Dated	After 1993
Language	English
Selected	Full text, peer reviewed, journal articles
Publication type	all
Education level	adult
Initially provided	33 results
Titles and abstract reviewed; Exclude references to -	None selected, as the mentor was not the assessor in these articles. In many the mentor was a coach or had a CPD role in supporting employees.
Selected for reading of full text	0 articles

Table 2.4 Literature Search Strategy (CINAHL).

Database	**Cumulative Index to Nursing and Allied Health Literature(CINAHL)**
Search 1: Keywords	Assessment and Competence
Dated	After 1993
Selected	Full text
Language	English

Initially Provided	179 results
Titles and abstracts reviewed; Exclude references to -	Self-assessment, peer assessment, clinical competence, continuing professional development, cultural competence, academic assessment,
Results for reading full text	15 articles
Remove duplicates from earlier searches	9 articles
Selected for reading full text	6 articles
After reading full text - excluded	5 articles
Included in literature review	1 article
Search 2: Keywords	Mentor and Assessment
Dated	After 1993
Selected	Full Text
Language	English
Initially Provided	37 results
Titles and abstracts reviewed; Exclude references to -	Peer assessment, coaching roles, professional development.
Results for reading full text	8 articles
Remove duplicates from earlier searches	0 articles
Selected for reading full text	8 articles

After reading full text - excluded	4 articles
Included in literature review	4 articles

Sixty three papers were selected for full reading. Whilst reading these articles and research papers some of them were not suitable for inclusion in the study after reading in full, as the content was not as expected: for example; articles focusing on the mentors' own portfolio, assessment based in higher education and not in practice and articles that did not focus on mentoring or competency in the main body. This excluded twenty papers from the total. Therefore forty three papers were found and used in this literature review.

Whilst reading this literature, where repeated references to other literature and policy documents emerged, these were also included in the themed discussion of the literature as synthesis of themes progressed. This results in a literature review that includes policy papers, published research, contemporary articles and opinion pieces and more recent published articles discussing the impact of the changes emerging from the introduction of the SLAiP standards (NMC, 2008). I was also aware of theses published by others on the subject of mentors' assessments in practice, namely Duffy (2003), Black (2011) and Hunt (2014). They are included here too with detail of the methods used and key findings. From synthesis of the published literature, themes emerged that impact on this study and inform the research question.

The topic is mapped through this reading into a timeline and analysis of the issues that link to mentorship in nursing. It is then grouped into eight themes of:

- Models of mentorship,

- Terminology for the role,

- The mentor as assessor,

- Assessment of competence,

- Continuous assessment in practice,

- Failure to fail,

- The introduction of the ongoing achievement record (OAR),

- The introduction of the sign off mentor.

Each of these themes will now be presented sequentially with inclusion of the associated literature.

2.1 Models of Mentorship

Within the general literature for education there is a vast amount on mentoring overall. Most is based on a business model of mentoring used for supporting career and personal development. This mentoring role is long term, with the mentor often chosen by the mentee and used as a developmental coaching role to enable growth and achievement. This model of mentoring is popular in management and teaching roles (Connor and Pakora, 2007; Lawy and Tedder, 2011). Mentoring in this way can be informal and not documented, with the mentor acting as a stable influence over time (Murray and Owen, 1991; Fulton, 2015).

At the introduction of mentoring in nurse education there were no published guidelines to the role or requirements for preparation, training or standards and as Morle (1990) discusses, this left the role open to

interpretation of what the mentor should actually do. Jones and Straker (2007) report that the implementation of mentoring in teacher education was also done without clear guidelines, leading to a dependence on "personal assumptions of what the role entailed" (p.166). This lack of clarity in further education teacher development is also commented upon by Lawy and Tedder (2011). Their study used semi structured interviews with 9 teacher mentors, 10 trainee teachers and 9 managers. They identified that the mentor role in teacher education had been formalised during changes to teacher training, but there was a lack of clarity between the teacher and assessor role which created tension in the relationship. In nurse education, teaching roles in practice placements previously sat with clinical teachers, employed by the school of nursing, who would visit placements to spend time with student nurses on duty and ensure their practice was developing (Morle, 1990).

The mentor role emerging in nursing in the UK was not the mentor model emerging from the United States (US) and seen in business (Morle, 1990; Gray and Smith, 2000). This US version was long term, nurtured for career development and progression with senior colleagues acting as mentors. Morton-Cooper and Palmer define this role as 'classical mentoring' (2000, p.61). Morle (1990) discusses the difficulties in interpretation of the mentor role and is critical of the ready adoption of this role into nurse education in the UK without adequate definition stating,

"The different contexts in which mentorship is operational make it inevitable that different emphasis is placed upon the various facets of the role ranging from nurturing to teaching and guiding to career facilitator" (Morle 1990, p.67).

Darling, an early US writer on mentoring, is often quoted in mentoring literature (Andrews and Wallis, 1999; Gray and Smith, 2000; Chow and

Suen, 2001; Kinnell and Hughes, 2010). Her key paper (Darling, 1985) titled "what nurses' want in a mentor" presented her work in the US interviewing healthcare professionals about their mentors. However, Darling is describing the coaching and supporter 'classical mentoring' role and therefore comparisons made later with the UK nurse mentor role are not accurate. The key characteristics she outlined for mentors in her measurement scale (Darling, 1985) are quoted in later UK literature without recognition of the different approaches to the role (Gray and Smith, 2000; Huybrecht, Loeckx, Quaeyhaegens et al, 2011; Kinnell and Hughes, 2010).

Chambers (1998) and Andrews and Wallis (1999) discuss the difficulty in establishing the role when no clear definition was available from the policy makers, leaving universities to interpret the role and decide if a mentor merely supervised a student in practice or also carried out their assessment. In some areas this was an integrated role, but in others different staff took on the separate roles (Morle, 1990; Neary, 2000; Bray and Nettleton, 2007).

A clear early definition of the mentor role not taken up by any official body came from Gray and Smith in 2000, "The mentor is a staff nurse who has the responsibility for facilitating the student's application of theory to practice and for assessing the student's progress." (p.1544). It was not until a clear definition emerged with the 2001 advisory standards for mentors within the publication on 'The Preparation of Mentors and Teachers' (ENB / DoH, 2001) that the mentor role was consistently defined and implemented.

Mentor support for students is now accepted as mandatory with current NMC standards (2010) stating all pre-registration students should be allocated a mentor and work alongside a mentor for at least 40% of their

time in placement. The Royal College of Nursing provide a definition in their guidelines that mentors

"will support learning and assessment in practice, and make judgements relating to a student's fitness for practice and registration. Mentors are accountable to the NMC for such judgements." (2007, p.6).

The document also advises that "As a mentor supporting students, you undertake the responsibility of assessing competence/incompetence and should be able to defend assessment decisions made about students in practice. As 50% of pre-registration nursing and midwifery programmes are embedded in the practice setting, the role of the mentor as a teacher, supervisor and assessor has never been more important" (RCN, 2007 p.5).

It is interesting to see literature from the teaching professions, where the mentor role is being formalised and assessment of the trainee in-service teacher by the mentor is becoming a prominent element of the role (Cullimore and Simmons, 2010). Their paper describes a shift from the coaching and critical friend culture of mentoring outlined by earlier literature, toward a role increasing the focus on the mentor as an accountable assessor in the workplace and the tensions this may bring, especially when mentoring someone who may have been a colleague. However although this work states questionnaires were sent to mentors and mentees, detail on these is absent. In further education Lawy and Tedder (2011) discuss this mentor role as a transition from the formative coaching role of a mentor, toward a performative mentor role where public scrutiny is involved including a judgement of achieving standards. These papers seems to indicate a pathway for the mentoring role in teaching that nurse education has already travelled.

Mentors in nursing are not selected by the student and the role is valid only during the student's placement. This becomes a short term relationship requiring the mentor to establish a working relationship, assess learning needs, provide opportunities to meet that learning and then assess the student against the prescribed NMC standards for pre-registration nursing within that timescale (NMC, 2008). There is a pressure for all these activities to be facilitated by the mentor during the student's short placement.

2.2 Terminology for the Role

A definition of mentoring has been affected by the use of different terms attributed to the same role (Morton-Cooper and Palmer, 2000; Andrews and Wallis, 1999; Hyrkas and Shoemaker, 2007). In the UK context a mentor will support a pre-registration nursing or midwifery student. However, in Ireland the same role is called 'preceptor' (Cassidy, Butler, Quillinan et al, 2012) and this term is also used in US and Australian literature and had been used in earlier UK definitions of the role (Andrews and Wallis, 1999; Mallik and McGowan, 2007; Webb and Shakespeare, 2008). In the UK context a mentor would support a pre-registration student and a preceptor would support a newly qualified nurse, or a nurse new to that clinical area (Nash and Scammell, 2010).

In other professions students are also supported in practice by healthcare practitioners rather than academic staff. Terminology for this role differs. In physiotherapy this role is known as clinical educator (Trede, Mischo-Kelling, Gasser et al, 2015) whilst in occupational therapy it is referred to as a practice placement educator (Duke, 2004). This can present issues when participating in interprofessional education and assessment in practice to ensure students are paired with the appropriately skilled

practice educator within the interprofessional care team (Mallik and McGowan, 2007).

Another difference between professions is the required hours that a nursing student should study in the practice environment before registration, which are greater than for other healthcare programmes (Andrews et al, 2010). In Nursing and Midwifery this is set at 2300 hours minimum, however in physiotherapy and in occupational therapy, students on the undergraduate course are required to do 1000 hours in assessed practice placement learning which Meldrum et al (2008) state is equivalent to a year of full time study. For social work students their undergraduate degree includes a required 200 days in placement for their registration, equivalent to 1500 hours (Health Care Professions Council, 2016) whilst for speech and language students it is 400 hours. (Andrews et al, 2010).

With nursing and midwifery requiring 50% of their programme in the practice setting it can be expected that their competency on registration should be clear (Girot, 2000). However, Moore's (2005) study showed that employers had concerns about the newly qualified nurses' fitness to practice. The findings of his report did however show that whilst nurses did not show the competency expected upon qualifying, their skills had improved sufficiently within 6 months to meet employer standards. Roberts (2009) debates this issue as a lack of confidence in the newly qualified nurse, rather than a lack of competence.

All registered nursing staff are expected to mentor student nurses during their career (Watson, 2004; Holland, 2010) and it is a descriptor of effective practice in many newly qualified nurse job descriptions (Nottingham University Hospitals (NUH), 2016; Great Ormond Street Hospitals, 2016).

Watson published a quantitative study in 2004 where 115 mentor students completed a questionnaire in class about their reason for attending mentor preparation. For many it was seen as an option for their professional development as the course was required for promotion, especially for junior registered nurses. Mentor students came onto the module primarily because they had been told to and this impacted on both their motivation to study and also longer term on their motivation in the mentor role. This concurs with my experience. This was also found in work published on mentoring by the National Nursing Research Unit (2015). An interesting point made in Lawy and Tedder's (2011) paper based in further education teacher development was the assumption by trainee teachers that to be a mentor you had to be passionate about your role. In nursing, when the expectation of the mentor role is almost compulsory, it means we cannot choose nurse mentors who are all passionate about nursing and in this difficult context of healthcare delivery (The Patients Association, 2011; Aitken et al, 2014; Wilson, 2014a) it does mean that motivation to be a mentor may not always be present.

Mentors are allocated to the student and may not always be notified until the students arrive at placement. This can mean that students can be faced with staff who are mentors but are unprepared when the student arrives or who do not bring enthusiasm to the role and this can impact on their learning (Nettleton and Bray, 2008; Huybrecht et al, 2011; Gidman et al, 2011). Spouse (2001; 2003) stated that mentors are key to the success of student learning and this has been supported by other authors (Andrews and Wallis, 1999; Chow and Suen, 2001; Royal College of Nursing, 2007). Recent work by the National Nursing Research Unit (2015), suggests that consideration should be given to whether all nurses should be mentors, instead identifying those who want the role in order to provide commitment and motivated support to students on placement. Lord Willis,

in his shape of caring review (HEE/NMC 2015) makes this point and asks that the NMC reviews current models of mentorship.

2.3 The Mentor as Assessor

Earlier literature on mentoring in nursing focused primarily on the teaching and learning aspects of the role and less on the assessment role (Morton Cooper and Palmer, 2000). Bray and Nettleton (2007) used questionnaires and semi structured interviews to explore mentoring roles. They identified that mentors in nursing struggled with being the teacher as well as the assessor, which they felt was a complex task. Issues with the role boundary were identified as assessment was not always well defined. They concluded that clear definition of the mentoring role was required.

Jokelainen, Turunen, Tossavainen et al (2011), published a systematic review of mentoring literature 1986-2006 and this focused heavily on the teaching element of the mentor role with scant mention of the assessment role. Chambers (1998) cites work by Lankshear (1990) who suggested mentors may give students the benefit of the doubt and fail to fail them. This early work was developed further by Duffy (2003) who published a qualitative research project with data collection via interviews with lecturers and mentors, which was supported with a scholarship from the NMC. Whilst her findings supported the anecdotal evidence surrounding student assessment, the effects have been far reaching across thousands of mentors supporting students across the UK.

Duffy's thesis (2003) focused specifically on mentors' assessment practices with students who were struggling to show competence. Using grounded theory methodology she interviewed 14 lecturers and 26 mentors from 3 universities in Scotland about their concerns and identified that mentors

were 'failing to fail' incompetent students in practice. Mentors identified they were unwilling to make this assessment decision as they were cognisant of the impact of a fail decision on the student's progress. Mentors also identified this was an emotional and challenging thing to do and they gave students the benefit of the doubt. Lecturers identified that where mentors did not take action to fail students they were unable to follow key processes to remove students from the programme without this evidence of judgement. Implications for the profession when there is acknowledgement that failing to fail takes place was evident and more literature on this subject has emerged following Duffy's study (Hand, 2006; Wilkes, 2006; Holland, 2010; Andrews et al, 2010). Emphasis on assessment has also increased in the NMC mentor standards (NMC, 2008).

Taking on both the role of teacher and assessor is unusual in mentoring in other professions and it clearly brings difficulties with conflict and tensions existing in the role (Andrews and Wallis, 1999; Bray and Nettleton, 2007; Nash and Scammell, 2010; Huybrecht et al, 2011). Jones and Straker (2007) researched teacher education where mentors are also the assessors and found there were tensions within this dual role, as did Trede and Smith (2014) in their qualitative research with physiotherapy students and educators, stating the complexity this adds to the relationship between teacher / assessor and student. Trede and Smith (2014) completed a qualitative study to examine Australian physiotherapist educators' interpretation of their workplace assessment practice using semi structured telephone interviews, followed by discussions with 9 physiotherapy educators. They found a tension between the educators practice based judgements and documentation of competence. The educators reflected on their confidence in making assessment decisions when they had no preparation for the role. They concluded that assessors should be encouraged to engage with these tensions to develop their own

assessment practices based on their own interpretations. This may however have an implication for the inter assessor reliability in this situation.

Further qualitative research by Trede, Mischo-Kelling, Gasser and Pulcini (2015) used focus groups where 24 physiotherapy students identified the relationship with their clinical educator from the first day as pivotal to their placement and assessment. They also included 19 physiotherapy educators in their focus groups. Students and educators identified the assessments were challenging and they were dissatisfied with the process. Students felt assessments were subjective. Educators felt early investment in their relationship with the student, including giving the student responsibility for their own patient workload, improved the relationship between educator and student..

A case study of workplace assessment in motor vehicle apprentices on NVQ programmes interviewed 18 staff and 23 trainees in addition to workplace observation (Colley and Jarvis 2007). They discussed whether the mentor should also be the assessor and especially if the trainee did not know the answers at assessment, there was a tendency for assessment to turn into teaching episodes bringing a tension in to this dual role. They conclude that when the student and assessor have worked together it can be a benefit for the assessment process, reducing the stress of assessment on students and allowing a more natural performance to be seen reliably at work which included attitudes and behaviours enabling holistic assessment to take place.

Research in teacher training education by Smith (2008) and Cullimore and Simmons (2010) identified tension in the role when the mentor is teacher and assessor. Mentors took responsibility for their trainee but needed to fail them at assessment if sufficient improvement was not seen.

Research by Lord, Atkinson and Mitchell (2008) reviewed the research evidence around mentoring in teacher education. The report defined a number of models for mentoring, many of which do not contain an assessment element and appeared to be focused on mentoring qualified teachers as a professional development growth activity. These models refer to experienced teachers guiding and coaching novice teachers. Only one model which they term the 'competency model' referred to an assessment and gatekeeper role. This is in contrast to nursing where the mentor is a mandatory element of the pre-registration assessment structure, mandated by the professional body. Whilst mentors are qualified practitioners, as they can become a mentor after one year of registration they may not always feel they have sufficient experience to take on the assessor role, but workforce pressures mean they are required to do so as insufficient mentors are available in their placement area. Lord, Atkinson and Mitchell (2008) do however note the tensions with insufficient time and lack of commitment to the role.

Spouse (2003) studied the experience of student nurses with regard to mentorship finding the quality of the relationship between student and mentor was significant on influencing the student's progress. Yet students are aware that their mentor who teaches and facilitates their learning also has the power of assessment for them and they aim to ensure their relationship with the mentor is positive and the mentor is happy with their progress (Webb and Shakespeare, 2008).

Moore (2005) conducted a policy review commissioned by the NMC in order to explore issues around assuring fitness for practice. This review collated information from eight health professions in the UK as well as twenty nurse regulators in Australia, Canada, New Zealand and the Republic of Ireland. It concluded that assessors were not always well

prepared for their role in practice and are "sometimes reluctant to refer or fail students" (p23). It also questioned the use of competency based assessment in nursing. Summarising the findings of the review, Moore (2005) found no evidence to confirm there was a failing by the NMC policies to ensure fitness for practice at the point of registration, but did highlight weaknesses in the assessment structures in practice assessment. The focus of these were outlined as the pressure on clinical placements from the number of student nurses allocated for practice experience and the insufficient preparation and numbers of mentors. Standardisation of assessment documents would also have increased the reliability in the assessment of competence in practice.

Further work from Fitzgerald, Gibson and Gunn (2010) supported Duffy, identifying failure to fail. However their small scale qualitative research with one group of child field nursing students, which analysed the data in assessment documentation, varied from Duffy's findings in identifying that mentors' feedback directly to students differed from that given anonymously. The method of data collection here is unusual as many studies rely on interviews or questionnaires to mentors and this used assessment documents to collect data. They identified that there were inconsistencies in feedback recorded and mentors lacked ability to give accurate feedback on behaviours rather than on skills directly to students. This point was identified in Duffy and Hardicre (2007a) and subsequently raised in research conducted by Jervis and Tilki (2011) who state that "mentors wanted explicit tools that would help them judge attitudinal and behavioural achievement" (p.586). Their qualitative study used focus groups and semi structured interviews exploring mentors' reluctance to fail students who underperformed in practice. Mentors identified using objective assessment alongside intuition in assessment decisions to fail a student. They highlight the difficulties for mentors in assessing attitudes

and values. Their work shows mentors are committed to the mentor role but need to have more confidence in their decisions and recommends further support and training for mentors in this aspect.

Working closely with the student over a number of weeks enables continuous assessment in nurse education, offering nurse mentors observational assessment and opportunity to ask questions to check knowledge as they work alongside students, over a period of time rather than at a predetermined time as in episodic assessment (Watson, Stimpson, Topping et al, 2002; Wu, Enskar, Lee and Wang, 2015). In this way knowledge, skills and attitudes can be assessed reliably and validly as the student provides direct patient care under the supervision of the mentor.

Research by Bray and Nettleton (2007) shows mentors and students in nursing, midwifery and medicine do not focus on the assessment element of the mentor role, describing key elements of the role focusing on teaching and support instead. When assessment of competency for practice is a vital part of practice placements in nurse education (Girot, 2000; NMC, 2010), the lack of priority seen in this element of the role is worrying and links further into the 'failure to fail' debate. Huybrecht et al (2011) sent a questionnaire to Flemish nurse mentors asking them to identify key elements of their role. Their findings show the assessor role was not rated highly, supporting the earlier work of Bray and Nettleton (2007) and Royal (2007) and that teaching was more frequently identified than assessment. Andrews et al (2010) states that mentors are most troubled by the assessment aspect of their role. Veeramah (2012b) identified that mentors in her study were most concerned with the assessment process and specifically with completion of the assessment documents. This is an issue as sign off mentors rely on clear assessment

documentation from previous mentors, to support their own role as the final assessor prior to the student's registration.

Wolf (1995) in her book on competency based assessment, identifies that having practitioners assessing students in the workplace after providing support to them can be a threat to the quality of that assessment process. The issue of the teacher becoming the assessor in mentorship can cause problems with objectivity and bias in the assessment decision (Ilott and Murphy, 1999; Bray and Nettleton, 2007). Neary (2000) and Watson et al (2002) note the socialisation process may bias the ongoing assessment role when the teacher becomes the assessor, however when continuous assessment is required then the assessor must, by definition, work closely with the student in order that assessment can take place.

Supporting mentors in their assessment role in practice has gained prominence since Duffy's report (2003). Organisations have developed roles based in the health service or in the university to support mentors (Fisher and Webb, 2008). Elcock and Sookhoo (2008) discuss the development of such a role and identify that the biggest challenge for mentors was failing students and support was required at this time. Literature shows practice time is restricted (Veeramah, 2012a; Sandy, 2014), patient workload demands are high (Aiken et al, 2014) and nurses struggle to provide adequate mentorship to students placed with them (Duffy, 2003; Nettleton and Bray, 2008). Combine this with changes in the assessment documentation and requirements for assessment in practice (NMC, 2007; NMC, 2008; O'Connor, Fealy and Kelly, 2009) and the role becomes increasingly difficult. Holland (2010, p.249) refers to these demands as a "constant juggling exercise".

2.4 Assessment of Competence

Competency assessment in practice for entry to the NMC register began with 'Project 2000' where the newly developed mentor roles would assess students in practice. There were however no defined curriculum standards or objective strategies for measurement of assessment for competence (Bradshaw, 1997; Chambers, 1998; Farrand, McMullan, Jowett et al, 2006). The introduction of the 'Making a Difference' curriculum (DOH, 1999), which was an outcomes based model, aimed to enable objectivity for assessment through development of professional standards for assessment of competency (Farrand et al, 2006; Murrells, 2009). This continued with implementation of the Standards of Proficiency for pre-registration nursing education (NMC, 2004; Moore, 2005). This move towards competency based assessment was in line with national policy moves within vocational education and introduction in the 1990s of National Vocational Qualifications (NVQ's) in many vocational domains (Colley and Jarvis 2007, Gonczi and Hagar, 2010).

I recognise there is a wider debate on competency assessment used in education, but for the purposes of this thesis the focus of this section will be situated in nursing education. As Gallagher, Smith and Ousey state, "the notion of competence has greatly influenced pre-registration nurse education" (2012, p.301) despite competency based assessment remaining difficult to define since the emergence of the mentor role in practice (Worth-Butler, Murphy and Fraser, 1994; Bradshaw, 1997; Dolan, 2003).

Assessment of competency has been criticised as being reductionist and focusing on tasks (Worth-Butler, Murphy and Fraser, 1994; Hagar, Gonczi and Athansou, 1994; Watson et al, 2002; Taylor, Irvine, Bradbury-Jones et al 2010). Competency based assessment is complex (Dolan, 2003; Butler, Cassidy, Quillinan et al, 2011). By its nature the assessment by a mentor

of a student in practice will be subjective (Neary, 2000; Webb and Shakespeare, 2008; Gallagher, Smith and Ousey, 2012) and must depend on more than the behavioural tasks performed by the student (Hagar et al, 1994; Murrells, 2009; Trede and Smith, 2014). It should also include the attitudes displayed by students and confirm the knowledge base required for achievement of the task (Worth-Butler, Murphy and Fraser, 1994; Dolan, 2003; Cassidy et al, 2012). Without defined standards, this holistic assessment of nursing competency provoked debate and its suitability in nurse education was challenged (Hager et al, 1994; Moore, 2005; Gallagher, Smith and Ousey, 2012).

Continuous assessment meant assessment tools needed to be redesigned (Moore, 2005) and suitable for use by mentors. A later systematic review of clinical assessment (Wu et al, 2015) explored literature from 2000 to 2013 focusing on 6 quantitative and 8 qualitative papers. Most assessment tools are criterion referenced using national standards and a holistic assessment model was seen to be emerging. There was an increasing demand on clinical nurses to be the assessor / mentor / preceptor, however support for the process was needed from academic staff as there were issues with the reliability and validity of assessment tools. Poorly designed assessment tools have led to criticism of the assessment process overall (Watson et al, 2002; Jervis and Tilki, 2011). The assessment tool used locally emerged from work by Bondy (1983) and is used by other local Universities, however the ongoing achievement record is not in the same format. The issue of consistency and ease of use in the assessment documents is also reported as an issue in other countries (Gallagher, Smith and Ousey, 2012; Butler, Cassidy, Quillinan et al, 2011; Zasadny and Bull, 2015).

Eraut (1994) discusses the need for all professions to have available information on what it is they do. For many professions however this emerges as a list of tasks and does not show the full extent of the associated knowledge and values required to demonstrate the individual quality of the professional (Hager et al, 1994). If this cannot be defined, how can mentors then confidently assess and how can the public have trust in the profession?

"The reputations of professions in this age of mass media are increasingly dependent on their weakest members: can the public be guaranteed that even the least capable can provide a satisfactory service?" (Eraut 1994, p.117).

As recent enquiries have shown (Francis, 2013; Aiken et al, 2014) public trust in nursing is affected and the profession's ability to demonstrate reliably assessed competence at the point of registration is more vital than ever.

Literature returns frequently to the issue of the definition of competence (Watson et al, 2002). The NMC definition of, "the skills and abilities to practise safely and effectively without the need for direct supervision" (2008, p.45) is widely used. However, this does not fully capture the elements of behaviours and attitudes expected of a professional (Eraut, 1994) and which require skilled holistic assessment by a mentor (Murrells, 2009). Much of the literature discusses competency assessment as more than observation of performance and assessment of skills, but that it should be holistic and include the application to practice of knowledge and attitudes too (Worth-Butler, Fraser and Murphy, 1994; Hager et al, 1994; Watson et al, 2002; Duke, 2004; Wu et al, 2015). Cowan, Norman and Coopamah (2005) conducted a literature review on the concept of competence in nurse education from 1995-2005. They identified it was a

complex issue and found a lack of consensus on the definition of competence in nursing with some contradiction. They favoured the holistic view of competence to include knowledge, performance, values and attitudes.

Hager, Gonczi and Athansou (1994) argue for integrated assessment of competence which they also term holistic assessment, then outline the following aspects that need to be included as part of this holistic assessment within the situated context of practice.

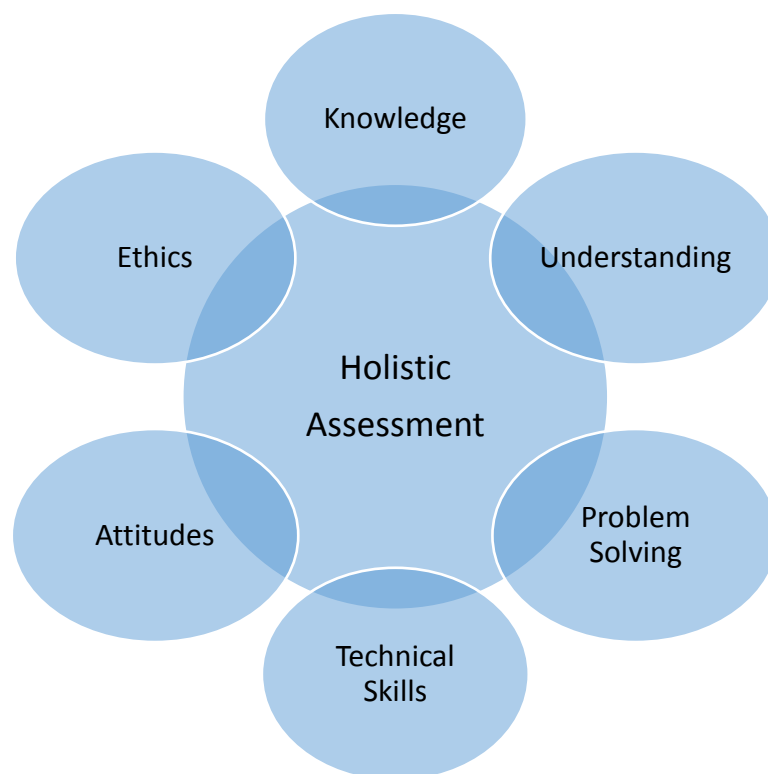**Figure 2.1 Holistic Assessment Components.**

Figure 2.1: Taken from Hager et al. 1994, page 8.

The 1994 paper by Hager et al. became seminal work for the emerging debate about competency based assessment. Their writing focused on Australian and American education systems. The debate has since included the UK context where assessment of vocational courses, whether delivered in further or higher education settings, adopted a competency based approach to assessment using criterion rather than norm referenced assessment for both assessment in practice and in education (Gonczi and Hager, 2010). In nursing education in the UK the pre-registration nursing competencies are set by the Nursing and Midwifery Council (2004; 2010) and therefore this use of standardised competencies enables reliability for employers when all UK pre-registration nurse students have achieved the same competencies during the programme and also ensures validity in the assessment process as the competencies are assessed holistically within practice settings.

An evaluation study in Scotland in 2009 found that newly qualified staff were competent and fit for practice with some deficit in clinical skills at the point of registration, which was soon overcome as confidence increased once they started working (Holland, Roxburgh, Johnson et al, 2010). Cowan et al (2005) make the point that whilst we struggle to define competence it is clear that the alternative – incompetence – is not acceptable.

More recently the issue of competency assessment in nursing has been debated alongside public concern about the lack of care and compassion shown by nurses (Taylor et al, 2010; Francis, 2013; Hayter, 2013; Aiken et al, 2014). One response to this which has had impact nationally, was the publication from the English Chief Nurse and her Director of Nursing (Department of Health, 2012) on 'Compassion in Practice' emphasising a framework of the 6Cs which has been used extensively in the NHS to

underpin education of values and behaviours. In turn aspects of these are starting to be used in student assessment documents to ensure students are assessed against these values (Duffy, 2015). This ensures that not only are knowledge and skills assessed, but that attitudes are also central to this process. This responds to the concern from mentors in earlier publications that assessment tools did not clearly identify attitudinal assessment (Gonczi and Hager, 2010; Jervis and Tilki, 2011)

2.5 Continuous Assessment in Practice

A student nurse's primary objective whilst in practice is to learn to deliver competent high quality care to patients, providing evidence for mentors to meet the specific standards for pre-registration nurse education (NMC, 2004; 2010; Gidman, McIntosh, Melling et al, 2011). For the mentor however, their primary objective in practice is managing their patients and the associated workload in leading the care team to ensure nursing care is delivered (Andrews et al, 2010). Within the constraints of current care delivery, financial shortfalls and shortage of skilled staff it is easy to see how mentoring a student cannot be top priority (Sherrat and Chambers, 2011; Wilson, 2014b) and time for assessment becomes an issue (Dolan, 2003; Duffy and Hardicre, 2007a; Veeramah, 2012a).

Girot (2000) makes the point that mentors have far less experience of assessment than academic colleagues for their summative assessment. This can mean that qualifying students may achieve the minimum for the NMC standards or may even not meet the required standards, but as their mentor has assessed them at a pass level they go on to qualify and register. This clearly has a subsequent effect on the profession when nurses go on to provide poor quality care (Ilott and Murphy, 1999; Black,

Curzio and Terry, 2014) or lack the knowledge and skills to effectively practise and lead care in the future (Taylor et al, 2010).

With the changes to nursing curricula since the introduction of Project 2000, came a change in the methods of assessment for practice. Calman, Watson, Norman et al (2002) asked universities in Scotland about how students demonstrate competence for assessment. They used questionnaires and follow up interviews with nursing and midwifery education directors and key stakeholders. They also completed 12 group interviews with students from 7 of the universities from all branches of nursing. Their report found that the mentor role brought with it continuous assessment in practice for student nurses, moving away from episodic assessment where staff from the education provider rather than staff from practice were responsible for assessment. They identified that each university had developed its own assessment document and some assessors were prepared for the role but the study discovered they did not all know how to use the competency assessment tool correctly and felt it was too much paperwork. Students identified a lack of consistency in the assessors and the way the tool was used in practice and they wanted to have more contact with academic staff whilst in practice. This move toward continuous assessment aimed to provide consistency in criterion referenced assessment for the student and decrease subjectivity in assessment (Gonczi, 1994).

Development of the student – mentor relationship becomes key to assessment in a system of continuous assessment. It is vital that when students are working alongside their mentors in practice that assessment is planned so that it becomes a continuous exercise and not an episodic event (Holland, 2010; Duffy, 2015). Wilkes (2006) stated that although the role of the mentor has changed, the relationship between student and

mentor is vital to the student's learning and achievement. It is also vital that mentors lead responsibility in planning the student placement to ensure all teaching and assessing is completed during the placement timeframe (Gopee, 2008).

2.6 Failing to Fail

Ilott and Murphy (1999) explored issues affecting occupational therapy assessors in failing students and discuss the phenomenon of 'failing to fail'. Calman et al (2002) found that nursing students rarely failed their practice placements. In 2003 the NMC published Duffy's landmark study and 'failing to fail' has since become a contemporary issue for discussion in mentoring for nursing (Rutkowski, 2007; Cassidy, 2009; Gainsbury, 2010; Jervis and Tilki, 2011; Black, Curzio and Terry, 2014).

Duffy (2003) found that nursing mentors were failing to fail students and did not act on their own judgement of a student's weakness after developing a working relationship with them, when the "action could have serious personal consequences for the student" (p.52). When the student was nearing the end of the course this was specifically identified as an issue and supports findings reported by Ilott and Murphy (1999).

The report found mentors lacked confidence in the use of competence assessment tools (Duffy, 2003). This had previously been identified in her earlier work (Duffy et al, 2000) "their paperwork is often excessive, confusing, time consuming and vague" (p.37). Mentors still identify that the assessment documentation is difficult to use (Taylor et al, 2010; Fitzgerald, Gibson and Gunn, 2010; Veeramah, 2012a; Black, Curzio and Terry, 2014). Clynes and Raftery (2008) make the point that mentor preparation focuses on the completion of the assessment documentation

required, often to the detriment of sufficient information on how to give feedback. Interestingly though their article makes no mention of documenting any feedback decisions in the assessment documents, focusing instead only on verbal feedback. Contrasting this, respondents in Veeramah's (2012b) study evaluated if the new mentor preparation courses following the NMC standards for mentors (2008) met the needs of mentors. Questionnaires were sent to 346 mentors, with a 57.5% response rate. Respondents felt ready to take on the role of mentor with increased confidence in the process. The lack of protected time for mentor preparation was identified as an issue and more support on completing the assessment documents was suggested as completion of the assessment documents gave them concern.

Duffy's study heavily influenced the development of the NMC mentor outcomes and provided a clear emphasis on the mentor's accountability in failing students within the NMC SLAiP standards (Duffy and Hardicre 2007b, NMC 2008) where outcome 3.3 states mentors should

"Manage failing students so they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future". (NMC, 2008 p.20).

Mentor preparation modules since 2007 have emphasised the requirement for mentors to take action when a student is struggling (NMC, 2008) and to seek support for both the student and for themselves. Giving specific feedback to the student is vital and especially so at a formative assessment with a struggling student (Duffy, 2015).

The study by Duffy (2003) led to later work by Gainsbury (2010) surveying nearly 2000 nurse mentors, which found 37% stated they had passed students when competency or attitudes had concerned them and 69%

stated they struggled with the paperwork in assessment. The significance of the Gainsbury survey results were that this was completed seven years after Duffy's publication and three years after the new NMC mentor standards were introduced (NMC, 2008) and yet the same issues were still reported. However, this was a survey done for publication in a popular nursing journal and the research methodology of the study, including selection of the respondents, was not published in any detail. This was also prior to the full implementation of the OAR documentation occurring in 2010 and may not provide an accurate reflection from the change to ongoing achievement documents.

Veeramah's (2012a) study conflicts with Gainsbury (2010), when 88.4% of the mentors completing postal questionnaires reported they had not passed a student when they had concerns, however Sandy (2014) reported his research with mentors found failing to fail remains an ongoing issue.

Brown, Douglas, Garrity et al (2012) distributed a postal questionnaire to mentors in Scotland which repeated the Gainsbury (2010) study. 52% of mentors responding admitted failing to fail students as they felt the university would overturn their decision and 29% reported failing to fail because they lack the confidence to do so. The authors recommend support for mentors is required with the assessment of failing students.

Wells and McLoughlin (2014) conducted a literature review on published papers since Duffy's (2003) study, focusing on mentorship and feedback, identifying that a struggling student needs a confident mentor to support and assess them and they must both have access to support structures provided either by the university or the NHS Trust. Time was a key barrier to giving feedback and the consequences of not giving effective feedback were identified with students unaware of their weak areas and poorly performing students progressing through to registration.

Black's thesis (2011) focused specifically on mentors who failed a student in their final practice placement. Her interpretive hermeneutic phenomenological study explored and interpreted mentors' understanding and experience of failing students at the final placement in the programme. Her work was completed prior to the implementation of the newer sign off mentor role (NMC, 2008) and gave detail on the situation faced by 19 mentors from 7 different organisations. The nature of the subjective assessment was explored and the mentors' sense of refining the student's practice (referred to as 'polishing the rough diamond') was discussed. There was also recognition of the personal impact on the mentor of the fail decision alongside their professional accountability. This thesis by Black in 2011 is the only piece of prior research that explored a final placement fail decision prior to the implementation of the sign off mentor role in the final placement, which took place from 2010.

One key factor affecting the ability of a mentor to give the correct feedback to a struggling or failing student is that this feedback is face to face. This has an emotional impact on mentors (Colley and Jarvis, 2007; Trede and Smith, 2014; Black, Curzio and Terry, 2014). Having to inform a student that you have worked with that you are going to fail them is very demanding of the mentor's emotional energy and something they do not forget (Duffy, 2003; Clynes and Raftery, 2008). Sandy (2014) conducted focus groups with 30 mentors focusing on factors that affect student nurse assessment. Mentors identified issues in understanding NMC outcomes for assessment. Factors affecting assessment included mentors' anxiety of assessment, duration of placement, and mentors needed time and support from the university to conduct assessments correctly. Time for mentor updating and assessing students was identified as a constraint.

Fulton makes the point that the current focus on failing to fail highlights the deviant situation of "the failing students and the mentors who are failing to carry out their role by passing such students" (2015, p.47). There is certainly a lot of time and support offered to these few students (Carr, Heggarty, Carr et al, 2010; Hunt, McGee, Gutteridge and Hughes, 2012) and support for mentors who fail students is recommended by Carr et al (2010) in their reflection on mentor experiences and by Sandy (2014), to ensure that a negative experience does not significantly impact on the mentor's future assessment experiences.

The thesis completed by Hunt in 2014 focused specifically on the support mentors required to fail an underperforming student in practice. Her phase one study identified that fail rates in practice were at a proportion of 1 practice fail decision for every 5 fail grades awarded in theoretical assessments. Following on, her phase two study used grounded theory to explore the experiences of 31 participants who had failed student nurses in practice. She identified key factors supporting those who made the fail decision with a key determinant that mentors need to feel secure in their role. Formal support offered to mentors faced with a struggling student enables decisions to be made which reflect the situation and need. These structures are often not present or offered informally and therefore subject to chance. Hunt makes a number of recommendations to key stakeholders including that mentor preparation should contain more detail on the difficult situation when failing students and the support required for mentors in this situation.

2.7 Introduction of the Ongoing Achievement Record

At this stage of the literature review the literature regarding the introduction of the OAR and the sign off mentor resulted in far less published material on the topic than had been found for earlier themes discussed and very few published research studies. For this reason these next two sections have more explanation based on my understanding and context, using supporting literature rather than primary research in the discussion on these issues. The literature review has therefore identified a lack of published literature and specifically rigorous research publications on these topics and demonstrates the timeliness of this study.

A significant change within the SLAiP standards (NMC, 2008) was the introduction of an 'Ongoing Achievement Record' (OAR). This was introduced from 2007 as an assessment document that travels with the student from placement to placement. Prior to this, student nurses had an assessment document only for individual placements, which did not offer any information on the student's previous achievements. Mentors would rely on the student's verbal report of how prior placements had gone. This individual record of assessment aimed to help students by maintaining confidentiality and removing any potential assessment bias and increasing objectivity in assessment (Stuart, 2003; Ball, 2006; Kinnell and Hughes, 2010). However, from the mentor perspective each student was unknown and they only had student self-reports of prior success or otherwise to help them plan learning for this placement. Where students were struggling this was often not recognised until later in the placement, leaving limited time for mentors to take action, feedback to the student and develop an action plan for improvement (Duffy, 2003; Rutkowski, 2007).

Prior to this change in assessment documentation, myself and a few colleagues thought that some students passed placements with the

minimum skills and 'scraped through' placement initially, but during their final placement these weaknesses would be highlighted and mentors would fail them. This meant students could be almost at the end of the course, on their final placement, which was 12 weeks long, when they were failed by mentors (NMC, 2004; 2010). During this placement students are expected to work with less supervision prior to completion of the course and entry to the register. Whilst this point of a higher fail rate was anecdotal, it links with research by Ilott and Murphy (1999) and Duffy (2003) which found that mentors were reluctant to fail students earlier in the course but also identified the difficulty in failing students in their final placement due to the impact of the fail on the student personally (Jervis and Tilki, 2011). Subsequent work by Black (2011) and Black, Curzio and Terry (2014) focused specifically on mentors who fail students in their final placement identifying the moral courage this requires.

In development of the SLAiP standards, the NMC (2008) were keen to increase transparency in practice based assessment and the introduction of the OAR enables mentors to see the student's practice based assessment document throughout the course as they progress from placement to placement. Responses to the NMC consultation on fitness for practice proposals (Ball, 2006) identified that mentors felt information of ongoing achievement would be really valuable when dealing with borderline students.

Mentors consistently reported difficulty in completing the individual assessment documents (Duffy et al, 2000; Duffy, 2003; Moore, 2005), "criticising its non-user friendly format, with repetitive and lengthy sections which made it difficult and time consuming to complete" (Myall, Levett-Jones and Lathlean, 2008, p.1839). Introduction of the OAR therefore required time to develop a user-friendly assessment document that

reduced these concerns, whilst incorporating all of the NMC standards of competency and assessment progress records for each placement on the student's course. This inevitably meant that the OAR became a bigger document and therefore mentors continued to have concerns about repetition, size and complexity of the OAR. This documentation of progress by the mentor is the only written feedback the student receives from their practice component of the course. It is vital that feedback is documented accurately, and this is especially relevant when a student is struggling, to show that action has been taken and the student was aware prior to summative assessment (NMC, 2008; Wells and Mcloughlin, 2014; Duffy, 2015)

Students reported issues with complex assessment documents in research by Calman et al (2002) looking at the validity and reliability of practice assessment documents. Students found that mentors did not understand the documents and they were completed inconsistently.

Neary (2001) published work from her research which examined the assessment of clinical competence of students by practitioners and the impact on nursing practice. She used qualitative and quantitative methods of semi structured interviews with 70 students and 80 assessors and questionnaires to 155 practitioners and 300 students plus non participant observation; she identified mentors were struggling with the assessment documents when students and assessors were confused by them and they took time to complete. Assessors felt it was difficult to fail a student with so much paperwork to complete and they identified they needed support from the university but they often thought the university staff would not support their fail decision. Whilst assessment has moved on since Neary's work more recent publications by Duffy and Hardicre (2007a) confer with these points. Although the OAR was introduced in 2007 the complexity of

the documentation is still an issue for mentors with many stating it is difficult to understand (Veeramah, 2012a)

The requirement for mentors to document their feedback and assessment decision continues to be identified as time consuming. O'Connor, Fealy and Kelly (2009) evaluated the implementation of a new competence assessment tool for nursing in Ireland. They sent a questionnaire to 29 BSc Nursing students and 29 preceptors in Ireland. Findings identified the dissatisfaction with time it took to use the tool and the preparation needed prior to using the tool. Whilst the study enabled development of a subsequent tool and links into findings in other literature, the small sample size is identified as a weakness.

Veeramah (2012a) in her study identified that 70% of her respondents identified time as a key barrier to fulfilling the mentor role adequately and 67% reported conflict between the mentor role and the clinical workload. 22% reported having insufficient time to study the assessment documentation. This links to mentors reporting taking the documents home to complete (Myall, Levett-Jones and Lathlean, 2008). Jones and Straker (2007) also identified a lack of time and volume of paperwork as a barrier in the assessment of trainee teachers. Mentors are required to provide written objective, honest and accurate feedback (Duffy, 2013; Walsh, 2014), yet this can be difficult with limited time.

Fitzgerald, Gibson and Gunn (2010) identified in their study analysing the practice assessment documents that there was inconsistency in the way they were completed. Limitations or strengths identified at the midpoint were not always followed up at the summative interview. They concluded this highlights a lack of ability on the part of these mentors to give clear feedback on professional values and behaviours. Duffy (2013) identified that feedback in the assessment document should contain specific

examples to aid the student's progression and in the case of failing students, so that review by the university can see the exact issues that have led to the practice fail decision. Mentors would usually need support during this process if it is available (Carr et al, 2010; Sandy, 2014; Zasadny and Bull, 2015).

2.8 The Introduction of Sign Off Mentors

Alongside the documentation was the concurrent introduction of a sign off mentor for the student's final placement. This role was introduced following concerns raised by Duffy's study (2003) about the consistent quality of mentorship and new nurse registrants (Andrews et al, 2010). A sign off mentor is an experienced mentor with current clinical practice, who has met additional criteria and can assess a student in practice at the end of the programme (NMC, 2008). From 2007, all student nurses must be assessed by a sign off mentor in their final practice placement which is 12 weeks long (NMC, 2010). Interestingly in midwifery each student midwife needs a sign off mentor at the end of each part of the programme, not just at the end of the programme (Fisher and Webb, 2008). This discrepancy between professions regulated by the same professional body has no public explanation and this sign off mentor role was not specifically outlined in the consultation paper on the NMC standards (Burke and Saldanha, 2005), therefore the evidence base for emergence of the differing sign off mentor role between professions in the final document (NMC, 2008) is unknown, although reference to a sign off point for competency is seen in the consultation on a review of fitness to practice (Ball, 2006). It is noted there however that 45% of NMC approved institutions responding to the consultation disagreed with the sign off point suggested (Ball, 2006).

Rooke (2014) evaluates the sign off mentor role in nursing and midwifery. Questionnaires were sent to sign off mentors after attendance at a preparation workshop (95% response rate), mentor students in the mentor preparation course (not sign off mentors yet) (44.6% response rate) and nursing and midwifery lecturers (28% response rate). Findings were that the accountability for signing off a student was seen as daunting.

Practitioners felt the role would lead to fewer fail to fail incidents, adding more rigour to the assessment process and would add value to the mentoring and assessment process. Negative findings were based around time needed for the role and workload reduction needed. It was felt it was difficult to do the role well when mentors were busy and had no time. There were also concerns about the accountability of the sign off mentor as it was seen as an increased responsibility. Midwifery sign off mentors were however more anxious about this assessment role at the final part of the programme than earlier in the midwifery programme. This links to the anxiety identified in nursing around the accountability of the sign off role at the final assessment point (Jervis and Tilki, 2011; Middleton and Duffy, 2013; Black, Curzio and Terry, 2014)

As sign off mentors were introduced it was left to the individual NHS Trusts to determine who could become a sign off mentor (Barker, Blacow, Cosgrove et al, 2011). The SLAiP standards (NMC, 2008) define these as experienced mentors, however during the NMC fitness to practice consultation and in the detail of the final SLAiP standards there was no definition for what constitutes an 'experienced mentor' (Ball, 2006; NMC, 2008). In most cases this was decided in liaison with the university so that consistency across NHS Trusts was seen. Between 2007 and 2010 (when the first sign off process occurred locally) a significant amount of work was done to ensure sufficient numbers of suitably experienced sign off mentors

were prepared for the assessment of the final year nursing students in 2010.

Many existing mentors were unsettled by the introduction of the sign off role (Jervis and Tilki, 2011; Black, Curzio and Terry, 2014). The emphasis in the role was on the assessment and accountability of the decisions made by the sign off mentor because for the first time they would be signing off a student's practice assessment and declaring them 'fit to enter the register' (NMC, 2008). This emphasis meant that sign off mentors became the 'gate keepers' for professional registration for nursing (Bennett and McGowan, 2014). Whilst this was not significantly different from the accountability of the assessment for any mentor, this transparency of the role linking to register entry made mentors concerned that they would be accountable for any student who qualified and went on to make a mistake (Middleton and Duffy, 2013).

Barker et al (2011) describe a system of using sign off mentors alongside mentors to make assessment on overall proficiency. Their Trust invested time into the sign off assessment process for 66 sign off mentors. A report by Robinson, Cornish, Driscoll, Knutton, Corben and Stevenson (2012) on behalf of the National Nursing Research Unit states that the introduction of sign off mentors required significant work to develop and establish the role in the areas where they studied.

The NMC (2008) stated that sign off mentors should have one hour per week for the role, to review the students' evidence for assessment and document assessment decisions. This was a step forward and the first time the NMC formally stated mentors should have any protected time for their role. For NHS Trusts this presented challenges of providing consistent support across all placement areas and protected time. Whilst Barker et al (2011) note their Trust invested in the assessment process for the final

placement, in many areas this is still an unresolved issue and inconsistency of protected time remains an issue (Rooke, 2014; Wells and McLoughlin, 2014). Andrews et al (2010) raise the point that time for additional mentor support for students in their final placement may already be too late. In a system of continuous assessment it also seems odd that one practitioner takes accountability for the student entering practice, based on the prior assessment decisions from others alongside their own assessment and they make the point that if the assessment practice is working well then we would not need sign off mentors (Andrews et al, 2010).

Bennett and McGowan (2014) identified sign off mentors were concerned that previous mentors would not feel the same accountability for their assessments in a system using a sign off mentor. Hutchison and Cochrane (2014) published findings of phenomenological research, using semi structured interviews with six sign off mentors. The mentors identified anxiety about their accountability, time and commitment for the role. Some mentors discussed issues when senior students arrive at this final placement without the expected skill level and the emotion and frustration this brings for the mentor. One respondent linked the accountability from assessment of student nurses to dealing with poorly performing registered nurses highlighting the role of the sign off mentor to make difficult decisions. Time to perform the role was difficult to protect. They recommended that the sustainability of the sign off mentor role requires organisational investment and protected time must be given for the role. Mentors should not be expected to be a sign off mentor too frequently and should have a limited number of students when they are also a sign off mentor.

2.9 Chapter Summary

The introduction in 2007 of the Standards to Support Learning and Assessment in Practice (NMC, 2008) required planning between universities and practice partners in order to implement the appropriate practice based documents, including the OAR, and to ensure mentors were clear on their role as mentor or sign off mentor (The University of Nottingham, 2007; Andrews et al, 2010). This partnership between practice and the university is pivotal for programme delivery (Lord, 2002). Introducing these changes required a significant investment of time and energy for many staff employed by the NHS or a university (Andrews et al, 2010). This support and training for mentors, sign off mentors, maintaining the local mentor database and providing mentor and student support in placement areas is an ongoing requirement and resource issue for both practice and the universities.

The impact of these changes on the students themselves was minimal, as the changes produced two systems for mentoring and assessment documents and students were either on the old set of documents and systems, or using the new ones. However, the workload on mentoring, both for initial preparation and ongoing practice learning support was significant. At the time of writing, the SLAiP standards have been operating for eight years and overall there is a sense of improvement in the quality of mentorship. Assessment and accountability within the mentor role has been highlighted in practice (Andrews et al, 2010). Evaluation through this study of the key changes with the implementation of the OAR and the sign off mentor will enable nursing education locally to take stock and assess the benefits and challenges at a point where the mentor standards are due for review again.

Whilst there has been research published since Duffy identified that mentors were failing to fail in 2003, and standards do seem to be driving up quality of mentorship overall (NMC, 2008; Andrews et al, 2010) there are still issues with the role and the system (Hunt et al, 2012; HEE/NMC, 2015). This literature review has identified a lack of published research in the impact of the introduction of the sign off mentor and the ongoing achievement records. This study will add to evidence on the impact of changes introduced in the NMC SLAiP standards (2008).

The research question posed for this study therefore was:

What impact has the introduction of the ongoing achievement record and sign off mentor had on the robustness of mentors' assessment practices?

Nursing is developing as a profession (Royal College of Nursing, 2012) with more research studies now being done to provide an evidence base for nursing practice (Koch, 1995; Avis, 2003). It is imperative that alongside this an evidence base for nurse education is also developed (Holland, 2010) in order that changes that impact on the public expectation of the profession are evaluated to ensure the safety of the public. This study does this in order to respond to the question above.

Chapter Three – Methodology.

Following review of the literature, the research methodology evolved from reflection on the research question alongside related prior research in this area (Duffy, 2003; Fitzgerald, Gibson and Gunn, 2010). Consideration of the underpinning philosophy of the research, together with examination of my own views led to decisions on the methodology to use. This chapter provides a rationale on methods used to collect data, consideration of the ethical issues and the approval process required for this study, followed by detail on how the study was conducted.

As stated earlier the research question for this study was:

What impact has the introduction of the ongoing achievement record and sign off mentor had on the robustness of mentors' assessment practices?

This question should ascertain if the changes introduced through the SLAiP standards (NMC, 2008) have had an impact on assessment in nursing practice. The two elements of the OAR and the sign off mentor were chosen as they were new processes introduced with these standards and were designed to counteract the weak assessment practice identified by Duffy (2003).

3.1 Deciding on the Approach for the Research

I felt from the start that I wanted to be able to research with depth and evaluation of the issues identified. Prior research completed as part of my Master's degree investigated mentor's achievement of the NMC Mentor standards (Royal, 2007; The University of Nottingham, 2007). That research used a quantitative paradigm. Questionnaires, using closed

questions and a Likert scale response, were sent to 334 mentors at one hospital asking them how confident they felt about achieving each of the NMC's mentor standards. The questionnaire received a 58% response rate (n=193). Whilst this met the aims of the research and requirements of the Master's degree, I was personally frustrated at the limitation of the questionnaire used that did not encourage any comments or qualitative data from mentors. Whilst findings were seen to be generalizable, lack of depth in the results left me disappointed in being unable to fully explore individual reasons for responses. This was also commented on by colleagues when the research was disseminated.

That study found that mentors perceived they were weak in achievement of the assessment standards in practice. This concurs with Duffy's (2003) research, which led to the NMC making the changes to the assessment practice researched in this study. Embarking on this doctoral research I wished to explore mentor responses more fully, to obtain depth of analysis within the local context from mentors about their own perceptions of the changes to the assessment of student nurses. This was situated within the timeline of changes to assessment documents imposed by the NMC from 2007 and also in light of the limitations of my previous research. For this reason from the start I was drawn to a qualitative study as it aims to find a deeper understanding of the subject being studied and to get closer to the data in a more focused way (Silverman, 2010).

Kirk and Miller (1986) state that qualitative research consists of observing people in their normal settings and communicating with them in ways they understand using language they understand. I am very experienced in mentoring in nursing education. I hold assumptions about reality, developed over time, that I wished to acknowledge whilst analysing the data to ascertain what mentors may interpret as their individual reality

during their assessment of student nurses. This followed an interpretive phenomenological perspective advocated by Heidegger (McConnell-Henry, Chapman and Francis, 2011). This aims to uncover deep understanding of human behaviour in an effort to understand it more fully (Bryman, 2001). Mentors may develop norms and assumptions about the nature of assessment. I wished to understand these in order to research how the assessment documentation may impact on changes in their practice or attitudes to assessment. The purpose of this study was not to provide a generalizable account of mentor behaviour based on a representative sample, but to develop a theory based interpretation of mentor behaviour within my context locally that may have transferable application to mentors in other contexts.

3.2 Research in Nursing

Research is an established element of the profession of nursing, becoming more prevalent over the last twenty years and has supported the development of nursing as a profession (Koch, 1995; Speziale and Carpenter, 2003). Historically, research in nursing had concentrated on developing a scientific basis for practice. Arguably this has been driven by an ambition among nurse academics to be seen as a research profession in its own right, based within a positivist quantitative research paradigm (Koch and Harrington 1998; Avis, 2003; Speziale & Carpenter, 2003). Nursing research is seen as necessary in order to define the unique role that nurses have within a team of health professionals (Polit and Hungler, 1995) and to demonstrate nursing's worth and impact. Qualitative research from an interpretivist position has increasingly been used in nursing research (Avis, 2003; Speziale & Carpenter, 2003; Watson and Girard, 2004) as the profession develops confidence in research skills and methods

alongside definition of the nursing role and the use of nursing models such as Carper (1978) which shows nursing both as a science and an art (Speziale and Carpenter, 2003). This has led in turn to increased confidence and acceptance in qualitative research methods being used within the nursing research community overall (Denzin and Lincoln, 2005; Pratt, 2012). Koch (1995) and Maggs-Rapport (2001) state that interpretive phenomenology has been used widely in nursing research as one methodological approach.

An interpretive paradigm is linked to an epistemology that recognises that many research questions in social sciences study people and social groups and focus on these interactions (Standing, 2009). Therefore it is not possible to plan an interpretive research study based on rules of replicability and measurement. Some social science researchers have been critical of applying positivist scientific research methods to the study of humans and behaviours (Koch and Harrington, 1998; Bryman, 2001; Avis, 2003) suggesting different research methodologies are required. The ontology of interpretivism recognises that individuals hold different assumptions and beliefs about their reality (Standing, 2009; McConnell-Henry, Chapman and Francis, 2011). It therefore uses the findings of research in order to develop theory (Cohen, Manion and Morrison, 2000).

Research on mentorship often followed a qualitative methodology (Duffy, 2003; Jones and Straker, 2007; Webb and Shakespeare, 2008) with interviews with mentors and students, questionnaires and focus groups frequently used as methods for obtaining data. Few studies on mentorship use a quantitative methodology (Watson, 2004).

3.3 Validity and Reliability in Interpretivist Research

Validity in research was a term used when trying to argue that qualitative research had the same qualities as quantitative research. It was defined as how much the research describes or measures what it is meant to (Bell, 1993). Criticism of interpretivist research often focuses on weak validity (Kirk and Miller, 1986). Murphy and Dingwall (2003) argue that attempting to show validity and reliability in qualitative research in the way it is shown in quantitative studies is unachievable. Instead there is a need to show that studies are rigorous and methods used are appropriate for the subject under study. As data collection is usually taken from a much smaller sample in qualitative research, it may produce findings that are so contextual, even though they are in depth, they cannot be generalised to a wider population but they remain credible within the population under study (Koch and Harrington, 1998; Murphy and Dingwall, 2003; Pratt, 2012).

Reliability in research refers to the replication of results, asking if the research were to be repeated, would the same result occur? Bryman (2001) states that reliability is difficult to achieve in qualitative research as similar responses cannot be guaranteed in human responses, even if using a larger population sample. Results then may not be replicable within other contexts or populations and therefore the findings can be criticised as weak and unreliable. Avis (2003) disagrees with this perspective arguing that qualitative research is reliable and it can be justified as reality to those within the context that is studied. These issues are discussed in the paper by Graneheim and Lundman (2004), who summarise that the underpinning concepts have the same meaning and it is merely the given name that changes. Their paper focuses on trustworthiness in qualitative research and states this needs to show detail of how the data was interpreted and

the researcher's view on this to enable alternative interpretations to be seen or alternatively to allow for transfer to other settings.

3.4 My Values and Beliefs

My research interest for this study emerged from my area of practice (Burgess, Sieminski, Arthur, 2006). As an experienced registered nurse and a nurse lecturer I have a strong interest in practice based assessment. Whilst I had mentored in clinical practice for a number of years, frequent reflection enabled me to develop my own assumptions on issues in practice assessment. It was intended that this research study should further my own knowledge and explore if my reflections and understandings matched mentors' expectations and experiences, within their context of practice, since the change in the assessment documentation. By aligning my views and expert knowledge of practice assessment in nursing as a personal and subjective experience I demonstrated an interpretive epistemology (Cohen, Manion and Morrison, 2000; Wilson, 2014a).

Epistemology is defined as the relationship between the researcher and what can be known and communicated (Cohen, Manion and Morrison, 2000). My prior experience as a practitioner enabled me to develop experience in assessment as a mentor. Subsequently my education role in mentorship built on that knowledge and included many informal conversations (Murphy and Dingwall, 2003) and a shared understanding with mentors about their assessment decisions on whether or not to fail students. As a lecturer for mentor preparation I have an in depth understanding of the mentor role and the requirements of the NMC and understand that this often produces a tension within the context of clinical practice, where mentors have a priority to a demanding clinical workload,

balancing this with professional expectations and standards of mentoring. This role is by necessity secondary to their patient care workload and the quality of mentorship is reliant on the individual mentor. They need to be committed to the mentor role and the student to capture time for mentoring the student (Veeramah, 2012a). I recognised my beliefs and perceptions impacted on this research and I needed to be cognisant of this throughout the study. My epistemological knowledge was acquired over time and subjective because of my experiences. This doctorate offered the opportunity to structure research around these informal conversations and situate my past experiences, enabling research into the impact of the changes on the mentor assessments in practice.

Within the research literature on nurse mentorship a shared frame of reference (Cohen, Manion and Morrison, 2000) can be identified as detailed in the literature review. For many experienced educators in nurse mentorship, their ontological perspectives are framed by this experience and the culture of mentorship in nursing. As previously discussed, the origins and evidence base for the policy changes introduced by the NMC appeared weak, centred on Duffy's (2003) research and suggestions made during the NMC consultations on the standards (Burke and Saldanha, 2005). My ontological perspective around the essence of mentoring meant I was unsure if the planned impact on assessment was evident and realised over time, despite the significant investment of staff time and mentor energies in implementation. Mentors are still failing to fail students. Two key factors influencing this are lack of time for the assessment process within the clinical setting (Veeramah, 2012a) and the variable commitment of some mentors to their mentoring role (Nettleton and Bray, 2008). During informal discussions it appeared that some colleagues locally and nationally agreed with this view although this can be seen as relativist ontology (Denzin and Lincoln, 2005) as reality differs for everyone.

Articulating researcher values and beliefs strengthens procedural objectivity (Speziale and Carpenter, 2003), ensuring data collection and analysis methods are not unduly influenced by researcher bias. As this study topic was chosen due to personal interest and experiences in practice assessment, there was early recognition that I should not strive to be distanced from the context of this research. By maintaining rigorous reflexivity during data collection (Koch and Harrington, 1998; Finlay 2012) I strived to reduce subjectivity by declaring my assumptions, enabling readers to ascertain if my account is valid and trustworthy (McConnell-Henry, Chapman, Francis 2009; Wilson, 2014a).

Throughout, I considered what effects my values had on the study (Bryman, 2001) in order to be open and questioning to all possibilities of emerging findings (Murphy and Dingwall, 2003). I recognised that the assumptions I hold about mentoring in practice from my past experience meant my ontology and beliefs about reality applied to nurse mentoring may impact on this study. I needed to focus on looking for unseen results and themes to ensure my ontology did not bias me toward unanticipated aspects of assessment that have changed as a result of policy initiatives (Murphy and Dingwall, 2003).

3.5 Interpretive Phenomenology

Methods used in qualitative research aim to capture reality as perceived by individuals and to explain their behaviours (Cohen, Manion and Morrison, 2000; Bryman, 2001). Focusing this study on the lived experiences of mentors in order to reveal meaning to their assessment practice follows an interpretive phenomenological philosophy (Speziale and Carpenter, 2003; Flood, 2010). Phenomenology is used to identify how individuals make

sense of the world around them (Bryman, 2001), typically using bracketing to eradicate any influence the researcher brings to the research from their own values that could affect their interpretation. The aim is to interpret findings from the participants' point of view (Gubrium, Holsteim, Marvasti and McKinney, 2012). This follows a Husserlian approach where the researcher's values are suspended and 'bracketed' during the study (Koch, 1995; McConnell-Henry, Chapman and Francis 2009; Dowling and Cooney, 2012). I was not aiming to bracket and achieve this level of objectivity. I could not adopt the stance of an independent researcher as I needed to recognise my pre-existing beliefs and understanding and my perspective of 'situated knowing' (Tebes, 2005) and instead used an interpretive approach that acknowledged my past experience and knowledge of mentoring advocated by Heidegger (Wilson, 2014a). By detailing the methods and rational used, the structure can be seen (Avis, 2003). In this I aimed to be reflexive, enabling the research findings to develop throughout the study (Mason 1996). Using the themes identified in the survey of assessment documents to frame the questions for interview allowed my own thoughts and reflections on assessment to develop, with assessment from the mentor perspective interpreted following the interviews.

In designing this study I wanted to focus on assessment decisions and how mentors record them, within timeframes before and after the changes to assessment documentation with the introduction of the OAR. It was identified in the literature review there was a gap in the literature on this topic. The intention was to identify any change to mentor practice when completing assessment documents. The method chosen for this was analysis of the assessment documents held on file in the School of Nursing where I worked, which became phase one of the study.

During the planning of this research I believed that analysing the assessment documents would not give me the full picture and would not provide information on the mentors' perspective of the impact of the introduction of the sign off mentor on assessment. I therefore chose to follow up from analysis of the assessment documents by conducting semi structured interviews with mentors, designed to replicate and capture the informal conversations I have mentioned. This was phase two of the study. This aimed to investigate mentor values and beliefs on changes to assessment documentation focused on themes emerging from the documents and to ascertain if their perceptions of assessment had altered with the introduction of the ongoing achievement records and the sign off mentor role. Interviews provided opportunity for the mentors' lived experiences to be shared through analysis of the mentor voice and phenomenon of their experience (Speziale and Carpenter, 2003; McConnell-Henry, Chapman and Francis 2009; Wilson 2014a). This provided a strong dataset where multi-methods were used to inform the next stage of the research through corroboration, increasing understanding on the topic by using both sources of data (Denscombe, 2003).

This study used these two methods to explore the reality from the mentor perspective compared with their assessment documents. Familiar themes may have confirmed anecdotal evidence of the changes to assessment practice which I had knowledge of from my informal conversations with mentors, but there is also the possibility that new knowledge is uncovered that illuminates the situation and provides unanticipated findings, to explain mentor perspective on the changes and impact on the quality of practice assessment.

This need for depth of data can be determined from my past research experience alongside a desire to explore any behaviour change and impact

of changes from different data sources within the same context using multi-methods to improve depth of understanding and interpretation within this context (Denzin and Lincoln, 2005). It is important to note that this study was set within my local context where I have considerable understanding. Foucault (1988, in Denzin and Lincoln, 2005) refers to this as a discourse. The diversity of assessment documentation across the UK means that a study based on analysis of documentation alone would be impossible and not generalizable, as each university is responsible for developing their assessment documents (NMC, 2008). An interpretative approach that attempts to obtain an in depth insight into mentors use of the assessment documentation in one setting may generate theories on how mentors assess students that could have wider application. My intention at the start of the study was that any significant results found could be disseminated locally and nationally and be used to influence future review of standards by providing an evidence base for the NMC. Generalisation to other professions within the context of assessment in professional education may be possible too, but this was not my primary intention for the study. It is only through interpreting the meanings attributed to human behaviour and experiences, from the perspective of the participant, that contextual findings emerge that might be transferable to other settings away from the location of this research (Pratt, 2012).

3.6 Influence of the Researcher

In planning this study and exploring the methodology I needed to consider influence during interviews with mentors (Cohen, Manion and Morrison, 2000). As a lecturer I have been perceived by some mentors to have a senior position to them due to their perception of my increased knowledge (Foucault, 1988). My interactions with mentors needed to minimise any

influence and emphasise positive interactions without becoming too social or informal. Reflexivity during interviews was essential, however I did recognise that I would not remove this influence completely. Participating mentors were made comfortable during interviews and gave written consent. As the researcher I aimed not to impose my values onto their responses, with non-verbal gestures for example. Mentors needed to feel confident that I analysed their responses accurately and drew the correct meaning from them in order that this study is judged as robust and has integrity (Watson and Girard, 2004). The nature of interviews as a face to face activity means they are not neutral objective interactions (Fontana and Frey, 2005). From a positive perspective mentors may have felt able to share experiences in detail as my expertise enabled me to understand the context and situations they described more than if I were an independent researcher with no situated knowledge of the subject (Gubrium et al, 2012). As Finlay (2012) points out however, this influence may also mean mentors may want to convince me of their own ability and competence as a mentor and tailor their responses accordingly. Whilst I had a shared understanding of the context of mentorship in nursing I could not assume these as shared experiences when analysing the data (Finlay, 2012, Gubrium et al, 2012)

3.7 Ethical Issues

Within any research study consideration needs to be given to the ethical implications for the participants. Any research should respect the people involved and the truth (Burgess, Sieminski and Arthur, 2006). All researchers must be aware of the ethical limitations and aim to do no harm to the participants, to have consent for research where possible and to provide benefits to the study population (Denscombe, 2003; Aagaard-

Hansen and Johansen, 2008). As a registered nurse I also have individual professional accountability to ensure any research does no harm and to operate within the NMC Code (NMC, 2015). As a student in the School of Education I was also bound by the 'Statement of Research Ethics Form' which is underpinned by the British Educational Research Association Ethical Guidelines for Educational Research (2011). All requirements needed to be in place to protect the safety and reduce potential risks to research participants prior to any data collection.

Within this study it was vital that privacy and confidentiality were maintained for both the students whose documents were analysed and the mentors, whose assessment decisions were analysed in the documents and through the interviews. Individuals and places of work are not identified in any way through the data collected and transcribed, and confidentiality will be maintained throughout this thesis, subsequent discussions and dissemination. All identities were coded for the documents analysed and interview respondents were allocated pseudonyms. Handwritten data summary sheets from analysis of the assessment documents were stored in a locked filing cabinet in a locked office and electronic data was stored securely on a password protected computer. No reference to respondent names was stored electronically thereby ensuring compliance with the Data Protection Act (The Stationary Office, 1998). Prior to any data collection, ethics approval was sought and obtained from the School of Education where I am a student (Appendix 2). Approval was also given by the School of Nursing in order to gain access to student nurses' assessment documents, in my capacity as research student (Appendix 3).

For the second phase of the semi structured interviews NHS Research and Development approval was required, which included completion of Integrated Research Application System requirements (IRAS), seeking

University sponsorship agreements, in order that I could recruit mentors for the interviews. This was obtained from the two local NHS Trusts where mentors were recruited for the study (Appendix 4 and 5). Detailed information of the study and how it was to be conducted were required for each of these approval processes to enable the two phase data collection to take place.

Figure 3.1 The Two Phase Research Design.

Phase 1	Analysis of Practice Assessment Documents

- Obtain assessment results of nursing students from 2 cohorts pre change and 2 cohorts post change. Later added in 2 cohorts 3-years post change to assessment document (n=921).

- Examine results, identify all students who have no assessment result recorded (n=151).

- Identify which of these were placement fails (n=46).

- Analyse the 46 assessment documents stored for key words and phrases, record on individual document summary sheets.

- Analyse summary sheets using Thematic Analysis, identify areas impacting on questions to be asked at phase 2.

- Amend interview schedule.

Phase 2	Interviews with mentors

- Conduct in depth semi structured interviews with mentors (n=8).

- Transcribe interviews.

- Analyse interview transcripts using thematic analysis.

- Define and name themes.

3.8 Phase One –Analysis of Practice Assessment Documents

A practical issue in deciding methods to use, was consideration of what

was already available and whether access could be obtained to this existing

data. The route chosen was analysis of the practice assessment documents created during placement assessment. Students submit these to their mentors in practice, who use them to assess the student against competency standards (NMC, 2004) and give written feedback to the student on their professional behaviours. This is the only record of assessment and feedback the student has for the practice component of their programme. On returning to the university, the student meets with their personal tutor when a copy is made and stored in the student files. These files are stored for 50 years in line with professional body requirements (The University of Nottingham, 2011).

Phase one of this study analysed the assessment documents pre and post changes in the documentation. As the study focused on NMC changes, in response to prior research on failing students (Duffy, 2003), the decision was made to analyse the assessment documents of students who failed in practice to ascertain what mentors documented and to interpret these findings in order to identify themes for failing that could be explored further in the mentor interviews in phase two.

At the start of the study the intention was to analyse assessment records for two cohorts of students prior to the documentation change and two post change using the OAR format. However, within the timeframe of the analysis of assessment records, colleagues felt that a higher number of students were failing in practice once the sign off mentor role was established. With this in mind a decision was made to analyse a further two cohorts of students starting three years later, when the change had been established. This amendment meant six cohorts of student practice assessment records were included in the study, with a total number of 921 students included in phase one of the study. This change also demonstrated the reflexivity used during the study. Assessment records

were not copied or held by myself. Analysing the assessment documents enabled comparison and identification of similar issues and differences to be highlighted between the two versions of the assessment documents regarding the mentor assessment decisions recorded and written feedback. This enabled recurring themes to be uncovered and patterns of failure to be determined through follow up analysis of these summary sheets, using the six stage thematic analysis framework proposed by Braun and Clarke (2006). This approach uses critical hermeneutic analysis (Flood, 2010) as it relies on the researcher interpreting the documents and extracting the themes using their own knowledge of the organisation; Documents were analysed within their context where "the analyst is fully conversant with the context" (Bryman, 2001, p.383)

This enabled me to analyse assessment practices recorded by the mentors, to ascertain if the numbers of students failing in practice had altered with the introduction of the OAR and reasons why. Anecdotally prior to this research, colleagues and I believed more students failed practice in their final placement when mentors realised they were not ready to qualify and enter the professional register. Therefore, this was explored during this study through noting the semester when the student failed in the final year and comparison of the timing of fail decisions on final year students in order to provide findings for this anecdotal thinking.

These documents were naturally occurring as a product of the assessment process and not created for the purpose of any research (Bryman, 2001). They were therefore authentic and genuine documents accessible for this research (Mason, 1996). Reliability of this method of data gathering is high, as these documents are available to subsequent researchers. By ensuring my interpretation focused wholly on analysing the assessment records from practice and not on other information stored in the student

files this gave the research rigour in focusing solely on the subject under study.

Involving student nurses in order to capture their views of assessment in practice was considered when planning this study. However, this was ruled out as each student nurse only has their own experience of assessment within practice, alongside one version of assessment documents, either pre or post change. As they would have no comparison to discuss, it was decided that their views on the changes to the assessment documents would be limited to their experiences and perspective. This would not enable the comparison of the assessment documents in the same way that research using the documents themselves would. All the documents in this study are from student nurses who have now completed the programme. Those who were successful have commenced employment and I did not wish to raise any concerns for them as individuals about the quality of the assessment process. At the time of their achievement this process was approved as a valid and reliable method for assessment and I would not wish to suggest any other perspective to them. Mentors interviewed may have been assessors for both sets of the documents and expressed their perspective on this comparative experience during interview.

3.9 Sampling Strategy and Consent for Analysis of Assessment Documents

Probability sampling was used to select which documents to analyse (Bryman, 2001) where each student in the population had equal chance of being selected at the start of the process (Burgess, Sieminski and Arthur, 2006). Selecting students that had failed placement or had incomplete results reduces the sample and a sampling strategy was not required.

When accessing the records and in discussion regarding ethics approval for this stage of the study, the issues of student consent arose. Informed consent was not sought from all students for permission to access their records due to difficulty in tracking all the students who have completed their courses and as it was also not required as part of the ethics approval. Consent to retain their records is given by students during the course as a requirement of the professional body. No student records were removed and the data collection took place where the records were stored. Codes were used on document summary sheets so no identification of student or mentor was recorded to ensure confidentiality.

Document summary sheets were collated and analysed for recurring themes and issues (Appendix 6). Checking and rechecking also occurred to ensure all themes were exposed, in line with thematic analysis (Braun and Clarke, 2006). Any themes identified that affected the interview schedule were added to the interview schedule prior to interviews. I also reflected during analysis to ensure phase two of the research was valid or required any alteration before proceeding.

The constraint in analysing these records was the time taken to access and analyse the documents within their location. There were also issues in accurate storage of files for all students and this became an issue when incomplete records were found. Time was then taken to ensure full documents were collated where possible. In only two cases did I need to approach a member of academic staff to find out the progress of the student after a failed placement and the assessment documents were then located and filed as per process.

To explore the wider context during the study, I discussed early findings with colleagues internally and from other schools of nursing. I also met with a representative of the NMC during the study with the aim of

discussing the study and confirming NMC intentions in implementing the policy changes and to identify if they perceive that any impact has occurred through their national monitoring work. This informed exploration of results and themes during phase one and prior to the second phase of data collection and demonstrates the reflexiveness needed to ensure I gave consideration to all possible findings as the study progressed (Murphy and Dingwall, 2003, Finlay 2012).

3.10 Phase Two - Recruiting for the Interviews

In order to explore local mentor perceptions, in depth semi-structured interviews offered the best method for the second phase of data collection, generating knowledge between humans through conversation, using an interview schedule (Cohen, Manion and Morrison, 2000; Bryman, 2001). Questionnaires offer limited interaction between the researcher and participant (Cohen, Manion and Morrison, 2000) as found in prior research (Royal 2007). Mentors were recruited as participants for this research via flyers distributed at mentor updates and practice learning activities. Mentors then had opportunity to read the information and consider whether or not they wished to participate. There is recognition that mentors could have individual motivations to come forward and this may affect responses by offering a skewed sample (Cohen, Manion and Morrison, 2000), however it would have been difficult to coerce mentors by using a formalised random sampling technique. A gift voucher was offered to all participants to recompense time for taking part in the interview, but there was reliance on goodwill too and in many ways this reflects the core premise of mentoring; relying on mentor goodwill to operate effectively.

Criteria for inclusion in interviews were stated in the flyer. Mentors needed to be:

- a registered nurse;

- currently working as a mentor;

- assessing students in practice;

- and maybe have experience of failing students.

This followed a purposive sampling strategy where criteria for inclusion are outlined on the flyer and participants are able to choose whether to participate or not (Silverman, 2010). I had five mentors respond to the call for recruitment via the flyer. This was insufficient and I contacted colleagues to ask for names to email mentors directly. I attached the recruitment flyer from the study for their consideration. Following this I had a list of fifteen mentors who agreed they would take part in the research. Arrangements were made via email for interviews to be held at a mutually convenient time. Written consent for interviews was required prior to the recording and all participants were asked to read the participant information sheet. At the start of the interview participants had the opportunity to ask further questions before signing the consent sheet. Consent sheets were subsequently stored with the research data in a locked cabinet in a locked office.

3.11 Interviews with mentors

Data taken from the analysis of assessment documents was used to create a baseline analysis of assessment practices of mentors generating a framework for questions linked into my own perceptions. This enhanced the interview questions used to interpret mentor views on documentation

and aimed to generate new theory on assessment in practice (Mason, 1996). The questions were a mix of open and closed questions (See table 3.1), beginning by asking them about their experience as a mentor before asking about the changes in assessment documents, any experience of failing a student and moving onto the introduction of the sign off mentor with questions 16 and 17 added following the completion of phase one. The final question was used for participants to open up about their views on assessment more generally. During interviews I aimed to achieve consistent responses through a consistent use of the interview schedule (Gubrium et al, 2012). At the interview I guided the mentor by asking the planned questions and then letting them fully respond, in order to reduce bias. This enabled them to give their perspectives on assessment experiences fully (McConnell-Henry, Chapman and Francis, 2011). It was vital I could establish a rapport with these mentors, some of whom I had not met before, and quickly move to asking them in depth questions about their assessment to enable the respondents to feel secure and able to open up without fear of judgement (Gubrium et al, 2012). In this I was reminded of my role as a registered nurse, when it is necessary to meet someone and quickly move on to asking personal questions in order to assess their needs. I concluded the interviews by thanking the participants and encouraging them to ask any questions they may have.

Table 3.1 Mentor Interview Schedule Questions.

	Introductory Questions
1	Thank you for attending this interview, can I ask you to confirm you consent to this interview and to the recording of the interview on the tape please?
2	Can I ask you how long have you been a mentor?

3	Are you a sign off mentor assessing students in their final management placement?
4	And what kind of care area do you work within?
	Interview Main Questions
5	This interview aims to explore mentor's practice in the assessment of students. Have you assessed student nurses in practice including completing their assessment documents?
6	Have you completed both the old style individual Assessment of Practice Record (APR) and the newer Ongoing Achievement Record (OAR)?
6a	(If Yes Answered above): Have you found any differences in your practice when assessing the students using these different assessment documents?
7	What are your thoughts on the assessment of students in practice?
8	Do you have time to document your assessment decisions as fully as you would like to?
9	When using the OAR document do you look back at other mentor assessments to help guide you at all?
10	Have you ever had difficulty assessing, when a student has not been at the expected level?
10a	If Yes – did you use the assessment records to review the student's past placement assessments?
11	Have you felt able to give that student verbal feedback and to record your feedback in the documents?
12	Have you ever failed a student on placement?
13	On a scale of 1-10 where 1 is 'none' and 10 is 'high'; What impact do you think the introduction of the sign off mentor has had on your own assessment practice?
14	On a scale of 1-10 where 1 is 'none' and 10 is 'high'; what impact do you think the introduction of the sign off mentor has had on the assessment of student nurses more widely?
15	On a scale of 1-10 where 1 is 'none' and 10 is 'high'; What impact do you think the introduction of the ongoing achievement record has had on mentor assessment in practice?
16	In a 3-year programme, does the student's year and stage of progress mean you assess them on different things depending on

	their year of the programme?
17	Do you assess students' behaviour and characteristics alongside their competence and skills?
17a	If yes, why is this important?
18	Do you feel that mentor assessment in practice is valid and ensures that only competent students qualify at the end of the programme?

I anticipated that common themes would emerge from talking to mentors based on my past experience and informal conversations with mentors in the course of my work, and therefore to establish depth of data there would not be a need to interview large numbers before data saturation was reached. Questions were devised from recognising and integrating this past experience within the context of findings from the literature review. These structured questions may therefore appear to lead the respondent in a directive manner (Cohen, Manion and Morrison, 2000) using some closed questions. The intention here was not to limit the information communicated at interview but to ensure that interviews were structured with comparable questions asked of each respondent, although variation occurred in response to respondent answers and linked to the next element of the questions and interview. Use of these directive questions alongside open questions provides opportunity to gain comparable data across the mentors interviewed and enable depth of response around individual experiences of mentor assessment. This may not however be achieved if mentors felt the questions were so directive they did not give lengthier responses to the questions.

In order to minimise disruption to the participants' workplace and comply with ethics requirements, six of the interviews took place on university premises. This was near to the participants' workplace on the same site. In

two instances it was not possible for the participant to meet at the university and so I travelled to meet them in their workplace in a booked meeting room away from any clinical area. This met the requirements of ethics and ensured that mentors were not disturbed from their workload in order for the interview to take place.

The room had a 'do not disturb' sign on the door to ensure no interruptions during the interview. Water was available and seating was arranged informally where it was possible, or on opposite sides of a desk when the room layout was not conducive to removing the desk. There was a voice recorder used to capture the interview data, placed between us on the table or the arm of the chair. This all demonstrated to the participant that I valued their participation and was focused on them.

At the start of each audio recording I also asked each participant to confirm their consent to the interview and the recording. This process formalised the setting to some extent, setting the pace and tempo for the subsequent interview.

During interviews I ensured respondents had time to prepare responses and allowed silence to occur where needed (Walker, 2011). There were also times where I probed more deeply to ensure my interpretation matched the mentor responses and ensured depth of data (McConnell-Henry, Chapman and Francis, 2011). I concentrated on my non-verbal expressions with their responses, offering encouraging nods and smiles to get them to continue when further detail was required from them. I was cognisant of the mentor responses and used reflection in action to draw their experiences and thoughts out with subsequent questions when needed. This meant all interviews contained variations away from the interview schedule as expected in semi structured interviews (Walker, 2011). Where mentor responses drifted away from focusing on

assessment, for example they started talking about wider issues in the workplace affecting staffing levels, it was necessary to make a decision on whether to interrupt the participant in order to re-focus the response, or to allow them to speak.

The time taken for the interviews varied, from 11.39 minutes to 32.55 minutes. I made no notes during the interviews as I did not want to affect the flow of speech, however immediately following each interview I made notes to capture some of the themes contemporaneously (Braun and Clarke, 2006). Use of the interview framework for each interview enabled a structure to be consistently followed, however as mentors were sharing their own individual experiences through interviews it was important that additional questions were asked when needed to explore a response and ensure their meaning in their responses was clear to me. This enabled my interpretation of their experiences to be clearer. Using the interview schedule gave consistency in the flow of responses and replicated the informal conversations I have with mentors in the course of my job. Taking more time on the interviews would have reduced this replication and I also felt that the key questions were answered in the timeframe of the short interviews.

Others may feel these questions were very structured and led the mentors to specific responses. However the initial questions checked the applicability of the mentor to participate in the interviews and subsequent questions were drawn from themes identified in the analysis of assessment documents. In hindsight more use of open questions may have meant mentors responded with more detail and shared further experience as the use of closed questions meant their responses were too specifically related only to that question and may have limited the depth of information in

their response. Bell (1993) notes that standardising the interview by use of scheduled questions makes analysis of the responses manageable.

Reliability is an issue as respondents' answers are not replicable for each interview. My role as interviewer in each interview was to elicit the thoughts of each participant during the interview when they have not had prior sight of the interview questions and to listen attentively to their responses and follow up as necessary to gain full description of experiences. This gave an immediate response from each participant, thereby increasing inter-respondent reliability as each respondent answered questions in this way.

I began phase two with a pilot interview using the interview schedule. This enabled me to test participant understanding of the questions. The feedback from the participant and my supervisors following this pilot interview was positive and very encouraging and a minor change was made to the structure of the schedule to ensure clarity following this pilot. This interview was included in the final set of interviews for the study.

Following the conclusion of all interviews, four of the interview files were transcribed by myself and four by a paid transcriber. All spoken words were captured. All participants were given their pseudonym at this point to enable anonymity to be maintained for the remainder of the research. These were allocated in alphabetical order reflecting the order of the interviews. Names created for the participants were Ann, Bill, Cath, Diana, Erica, Flora, George and Helen. A profile of each mentor is given in table 4.8.

3.12 Data Analysis

By combining two methods of research, with interviews building on themes identified from analysis of the assessment records, I aimed to improve the strength of the study and rigour of the findings by building from one data source into another (Murphy and Dingwall, 2003).With both sets of data I used a six stage framework using thematic analysis advocated by Braun and Clarke (2006) (Table 3.2) to identify themes and develop understanding.

Table 3.2. Six Stage Framework for Thematic Analysis.

Phases of Thematic Analysis	
1	Familiarising yourself with your data
2	Generating initial codes
3	Searching for themes
4	Reviewing themes
5	Defining and naming themes
6	Producing the report
	Taken from Braun and Clarke (2006) page 87.

Thematic analysis is used by social scientists in interpretive research to examine data obtained and identify themes and concepts by reading and re-reading the data using this framework (Braun and Clarke, 2006). It was important that I did not assume common understanding with the data (Finlay, 2012) but I was reflexive in order to ensure that I was open to all possible themes that may emerge (Gubrium et al, 2012) ensuring the rigour during interpretation. These interviews presented opportunity to challenge preconceptions and 'taken for granted' assumptions I held, by

collecting perspectives from mentors that I had not considered (Murphy and Dingwall, 2003). In the process of thematic analysis the researcher is not a passive role (Braun and Clarke, 2006) and data was interpreted over a period of time to consider and identify themes. This enables meanings to be interpreted and goes beyond descriptions of responses (Gubrium et al, 2012). Themes identified from interviews were coded and compared between participant responses to enable cross referencing (Murphy and Dingwall, 2003).

It was intended that mentor views should be corroborated by feedback and comments already seen in assessment records (Denscombe, 2003). Therefore one method increases confidence on what is found in the other (Cohen, Manion and Morrison, 2000). This ideally works in the opposite direction too, with mentor interviews supporting themes identified in assessment documents. Initially the framework above was applied separately to each dataset and then analysis was integrated between findings from both the records and the interviews. If this did not correlate and findings presented another view, it may have been the case that what mentors report verbally and what they choose to record on the documents may not be the same. Using two sources of data enabled the different perspectives to be gathered and to see if they conferred or not and offered an informed set of results (Denscombe, 2003).

'Member checking' (McConnell- Henry, Chapman and Francis, 2011) by asking mentors to read and agree transcripts was not planned as each mentor would only be interviewed once. I did not wish to give further opportunity for them to reinterpret their original responses in a different context and time. There was no study requirement for transcripts to be validated in this way either, as recordings are stored and available if any interview was contested. There is debate in the literature about the

purpose of member checking and impact on qualitative research

(Bradbury-Jones, Irvine and Sambrook, 2010). My intention was to capture

what was said at the time of the interview only and providing opportunity

for the participants to clarify this may have affected that initial data

capture. Hagens, Dobrow and Chafe (2009) found that asking participants

to review transcripts gave little advantage to the quality of the research.

By also using interpretive phenomenology my intention here was to

present my interpretation of the mentors' lived experience from original

interview transcripts without participant opportunity to clarify or confirm.

Member checking is therefore incongruent with this methodology

(McConnell-Henry, Chapman and Francis (2011). Any clarification I

required should have been completed during the original interview process

and therefore captured in the transcripts. In this way it is more important

that the interview technique used is effective and thorough.

In summary, this chapter has outlined the methodology for the process of

the study underpinned by the key theoretical frameworks I adopted. It also

provides detail on ethical issues considered during the planning of the

research and moved onto detail regarding the two stages of data

collection. From this the next chapter will detail the findings from the

thematic analysis of the multi method data collected.

Chapter Four - Results and Findings.

This chapter will lead the reader through collection and interpretation of the data, from phase one examining the practice assessment records and moving onto phase two mentor interviews. Both sets of data and findings will be detailed prior to analysis. Discussion of findings will follow in the next chapter.

4.1 Phase One – Analysis of Assessment Documents

As outlined in the previous chapter, using the practice assessment documents held at the School of Nursing, six cohorts were examined for this study. Two cohorts were chosen prior to the change in assessment documents (Cohorts A & B). Two cohorts were chosen immediately after the change (Cohorts C & D) and two cohorts were chosen when the change was established, two years after the introduction of the OAR (Cohorts E & F).

Assessment results for each cohort over the three years of their programmes were initially examined to ascertain which students had failed placement. Cohorts included students studying all fields of nursing and across a variety of placements in healthcare. This enabled a wide variety of mentor practice across healthcare organisations to be analysed. The number of records identifying no practice assessment results from 921 students at the end of the year was 193 and at this point each record was given a reference number. Of these, forty two students had submitted late for the assessment, however did not experience any fail in academic or practice assessment. These forty two students were removed from the study at this point and therefore 151 records were examined in greater

detail (See table 4.1). Some students had failed an academic assessment in the course, some were students who had left the course mid-year and there was no end of year assessment, some had taken an interrupt from their studies and again there was no end of year assessment recorded but there were forty six placement fails. Of these forty six, some students failed first attempt placement, some failed second attempt too and six students failed more than one placement, in that same year or in subsequent years. Consequently I examined forty six assessment records where a fail decision was taken, with forty students involved.

Table 4.1 Practice Assessment Documents Examined.

	Cohort	Initial numbers in cohort	Documents surveyed in year 1	In year 2	In year 3
Pre Change to documents	A	158	4	15	7
	B	144	7	12	4
Post change	C	162	13	8	5
	D	140	20	5	8
Change established	E	149	13	5	6
	F	168	10	2	9
	Total population	921	67	47	37
Total student assessment documents analysed			151		

From analysing the one hundred and fifty one student files, reasons were identified why students failed or records were incomplete at the end of year results. This was then categorised into the following reasons and presented in table 4.2.
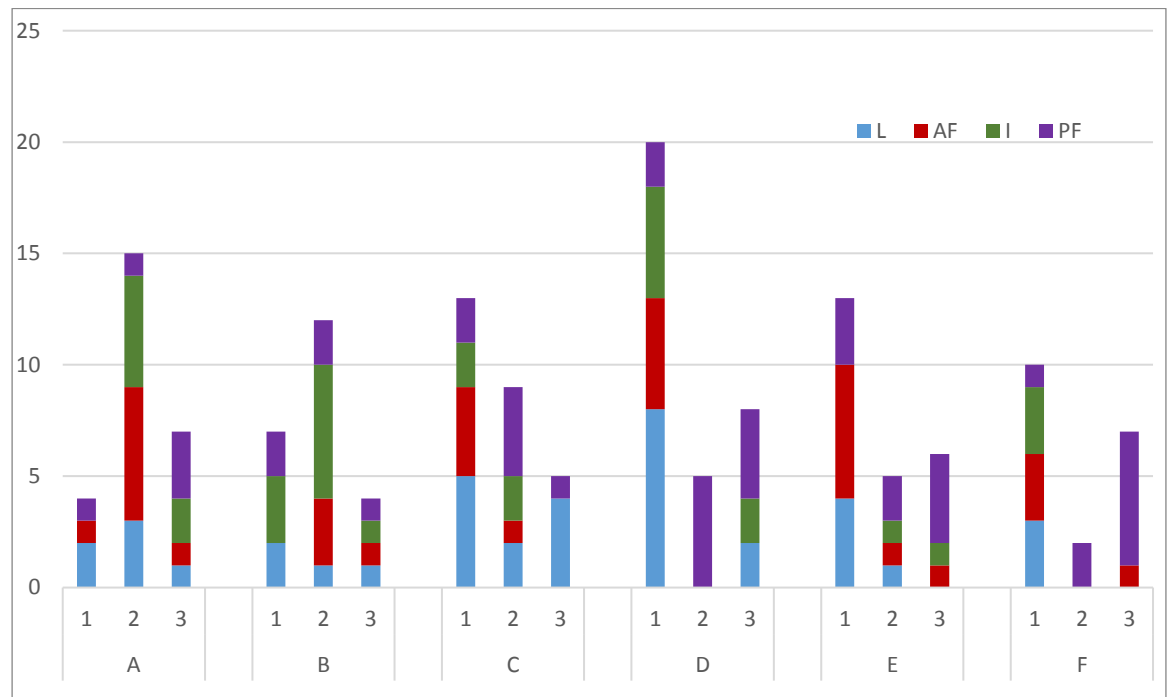
- Failed practice assessment (PF)

- Academic Fail (AF)

- Interrupted study and did not resume in that academic year (I)

- Left by their choice (L)

Table 4.2 Reasons for Students Results Incomplete or Failed.

	Cohort	Year 1		Year 2		Year 3	
Pre Change to documents	A	PF	1	PF	1	PF	3
		AF	1	AF	6	AF	1
	(158 students)	I	0	I	5	I	2
		L	2	L	3	L	1
	B	PF	2	PF	2	PF	1
		AF	0	AF	3	AF	1
	(144 students)	I	3	I	6	I	1
		L	2	L	1	L	1
Post change	C	PF	2	PF	4	PF	1
		AF	4	AF	1	AF	0
	(162 students)	I	2	I	2	I	0
		L	5	L	2	L	4
	D	PF	2	PF	5	PF	4
		AF	5	AF	0	AF	0
	(140 students)	I	5	I	0	I	2
		L	8	L	0	L	2
Change established	E	PF	3	PF	2	PF	4
		AF	6	AF	1	AF	1
	(149 students)	I	0	I	1	I	1
		L	4	L	1	L	0
	F	PF	1	PF	2	PF	6
		AF	3	AF	0	AF	1
	(168 students)	I	3	I	0	I	0
		L	3	L	0	L	0
Practice assessment fails included			11		16		19

By representing this as a bar chart the results across the six cohorts, for

each year from the four categories can be seen more clearly.

Table 4.3 Bar Chart of Reasons for Students Results Incomplete or Failed.

The total fail decisions on practice assessment is forty six with the

breakdown across three categories of cohorts represented below.

Table 4.4 Practice Assessment Fails by Year.

	Practice Assessment Fails.		
	Yr. 1	Yr2	Yr3
Cohorts A & B	3	3	4
Cohorts C & D	4	9	5
Cohorts E & F	4	4	10

Each assessment record for the forty six failed placements was scrutinised for key words or phrases recorded by mentors, using a document summary record sheet to collate the data (Appendix 6). This contained the students' cohort group, year of study and identification number. It noted reasons given for the practice assessment fail and keywords in the assessment records from mentors.

Table 4.5 Document Analysis Summary – example of one record.

Cohort: Yr. 3 Cohorts E & F	**Student Code** ____191_____

Grading   Above required level

                  At required level

                  <u>Below required level</u>

                  Not achieved

Notes on grading and why not achieved if applicable

Communication issues in year one 1st placement – quiet and withdrawn but improved and passed placement.

Year Three management placement – not working at management level or taking learning opportunities.

Conduct and Professional Behaviour – mentor comments

No enthusiasm for this management placement.

Poor communication

Mentor Feedback Comments – keywords / phrases

"Conduct was poor"

"Needs to improve manners, effective communication and interpersonal skills"

Student Comments – keywords / phrases

Semester 6 1st attempt fail. Passed at second attempt.

These summary records of practice assessments for each year were then separated into the three cohorts groups and analysed as detailed below. The numbers in brackets refer back to the student record number used as a method of tracking the students. Only I hold records of which student tallies with each record and this is securely stored and not used at any point, in order to maintain confidentiality of the students and mentors involved.

Using the framework of Thematic Analysis (Braun and Clarke, 2006) as detailed in the previous chapter, all summary sheets were read and re-read, themes were identified and all data was checked and rechecked after initial codes were extracted and again during the naming of themes in order to ensure consistency in the interpretation of the data.

4.2 Year One Assessment Results

There were eleven fails in practice assessment across all six student groups in year one. In cohorts A & B, the three fails were due to issues with the students' professional behaviours, with two students not achieving at the expected level in their first year in practice. Mentor comments include "not at expected level" (2) and "unsafe practice" (1) which occurred when a student had worked beyond their role. The third student appears to have presented fraudulent assessment records and was subsequently terminated from the course.

For cohorts C & D, there were four fails in practice; one student gave cause for concern as "not at the appropriate level" (23) but the other three students all failed first attempt due to no opportunity to provide evidence for assessment. Mentor comments for these students were complimentary; "Professional, reliable" (13), "trustworthy, used initiative" (40) and

"competent under supervision, shows compassion" (41). These fails appear to have occurred because no opportunity for assessment across the breadth of competencies required was available.

In cohorts E & F, four students failed practice assessment; three students due to lack of evidence to support practice but mentor comments were positive "good worker, reliable" (151) and "caring, good communication" (152). One student was identified as having "good communication skills" (125) but failed as they did not provide any written evidence for the assessment. The mentor here gave detailed feedback to the student in the assessment documents. They passed their next placement with support from practice staff. This identified a developmental need for this student to have more understanding of the need to provide both observed and written evidence for their mentor to achieve all the required competencies in practice.

4.3 Year Two Assessment Results

There were sixteen fails for year two assessments in practice. No student who had failed in year one failed again in year two. In cohorts A & B three students failed assessment in practice; all three fails were identified through the student having no opportunity to present evidence for assessment. This is due to the specialist nature of second year placements that students experienced, with less opportunity for the student to demonstrate competence in technical specialist placements such as critical care. All mentor comments are positive in their feedback "very keen, well done" (67) and "worked hard" (76) with no professional issues identified. One mentor only reports that a student "needs to improve confidence" (72).

In cohorts C & D nine students failed practice. Six failed due to no opportunity to provide evidence for assessment, probably again due to the specialist nature of the placements, but three students failed as they were not at the expected level. Mentor comments in the OARs focus on the professional characteristics expected of a nurse and where students have not had opportunity to be assessed, the comments are positive overall; "pleasant student, worked hard" (83), "excellent, enthusiastic, shows patients respect and dignity" (53), "professional and helpful, a pleasure to have" (92). However, where students have failed as they are not at the expected level the mentor comments identify the deficits; "fails to identify risk issues" "lacks confidence" (82), "issues with safety and supervision" "kind and caring but doesn't recognise limitations" (93).

In cohorts E & F where the change in assessment documents to the OAR were established, four students failed placements. None of these students were at the expected level to pass. Feedback from the mentors reflects this. "Cause for concern" (182), "lacks confidence in communication" (183), "needs more confidence, took time to settle in" (174) and this comment from a mentor "Grave doubts over ability to become a safe and competent practitioner, lacks fundamental qualities" (186). This student did not achieve at second attempt and their course was terminated for failure in practice. Notes in student records also indicate that for student 182 and 183 additional support and action planning were given prior to the fail decision in the second year. Further support was given in their reassessment placements and they went on to subsequently pass.

4.4 Year Three Assessment Results

There were nineteen fails for year three assessments in practice. Four of these students had previously experienced a placement fail in year one or two. The third year of the programme has two placements for students and three students failed both of these placements in semesters five and six. Student 152 had failed in year one and subsequently failed both year three placements.

The final semester six placement is called 'management placement' with twelve weeks of continuous practice (NMC, 2004). This is when students have to take responsibility for managing a group of patients and their practice is assessed at a level requiring minimal supervision (The University of Nottingham, 2008). Assessment in management placement for cohorts C & D and E & F was made by a sign off mentor; an experienced mentor who has undergone additional preparation for the role (NMC, 2008), using the Ongoing Achievement Record (OAR). In the earlier cohorts A & B, the mentor assessing students in their final management placement tended to be an experienced mentor, but this was not an explicit requirement prior to the NMC (2008) SLAiP Standards.

In cohorts A & B there were four fails. Two students failed both semesters. In semester five they both failed for lack of opportunity for assessment, but in semester six one failed as they were not at the expected level. The other student left the programme before completion of their second assessment attempt in semester six. For this student (95), their mentor in semester six identified issues relating to the student's attitude and professionalism, along with a poor level of knowledge around clinical skills. The second student (96) failed for unsafe practice on first attempt in semester six, where the mentor identified they were not at the point

needed for qualification at the end of the programme. They went on to pass this at the second attempt and qualify.

The remaining two students in cohorts A & B failed only in their management placement at first attempt but went on to succeed on second attempt. One was identified as not at the expected level (97) and one was ill and did not attend for her final assessment due to sickness (104). Three of these four students passed management placement at second attempt. Mentor comments for year three assessments focus on the expectations of skills in a student nurse, with two students identified as "not competent with medicines administration" (95, 96) and two with a lack of clinical skills (95, 97). Lack of confidence was mentioned in one student (96) and poor communication for one student (95). The student who had been ill and unable to be assessed had no comments or issues raised in their assessment document (104) which suggests they would have passed had they not been absent. One student had positive comments in the documents too despite the fail decision "keen and eager" alongside "cannot prioritise care" (96). This seemed to demonstrate a tension for the mentor in assigning this fail decision to a student who was eager but not yet competent.

In cohorts C & D where students were using the ongoing achievement record (OAR), there were five students that failed practice in their third year. The mentors in these assessments would have been in the newly designated role of sign off mentor. Four students were failed by their sign off mentors as they were not working at the expected level. One student did not attend for final assessment due to ill health and passed on their second attempt. Mentor comments in the OARs mention a lack of confidence in two students (82, 120) and competency with medicines administration in three students (94, 118, and 120). Prioritisation of

workload was mentioned for two students (94, 93) and a skill expected for a student about to qualify. One mentor commented that a student was "unrealistic about own levels of practice" and "unprepared for management placement" (94). One student had positive comments in their assessment document despite the fail decision stating "Caring and compassionate but deviates from tasks" (93). In one the sign off mentor identified that further support would be needed for this student once they had qualified and gained employment (120). All students here passed at second attempt.

In cohorts E & F where the change with the OAR and the sign off mentor was established, ten students failed placements. One student was not at the expected level and failed semester five at their first attempt but passed at reassessment, before being assessed as unsafe and failing their management placement too at their first attempt in semester 6. They were identified here by their sign off mentor as working below the expected level of professionalism (152). Two students were assessed with insufficient evidence to meet all required outcomes with minimal supervision in semester six and one of these had no other issues recorded in their assessment document.

Seven students failed at their management placement as not working at expected level and were permitted another assessment attempt. Of the ten failed students in cohorts E & F, eight passed at second attempt and qualified. One left during her second attempt as she was not meeting the required level (194) and one completed a second attempt but was still assessed below the requirement of working with minimal supervision and therefore her programme was terminated (190). Of these ten students, seven of them experienced their first ever fail grade for practice assessment in their final placement. Mentor comments in the OARs specifically mention communication as an issue with three students (152,

190, and 191). One student's communication was stated as poor with both staff and students "pompous communication to the team especially healthcare assistants" and "struggles to engage with clients" (190). Other comments focused on the lack of professional behaviours "working below the expected level of professionalism" (152), "does not use her initiative" "lacks confidence and skills" (159) and prioritisation of workload was an issue specifically for four students "not able to manage a group of patients" (195) and "needs to prioritise and delegate effectively" (159). Three students received positive comments on their characteristics too in the assessment record despite the fail grade awarded, "shows compassion and respect" (187), "caring and compassionate" (159), "respectful, caring and conscientious" (195).

Three students failed their management placement having failed a placement earlier on the course too. One student had failed in year one, passed at second attempt, had no identified issues in the second year before failing both third year placements (152). The assessment records for year three identified weakness in communication, professionalism and medication administration. Two students failed the second year and their management placement (174, 182). For both of these students the fail in second year was due to illness, however the failure in management placement was due to not working at the expected level with poor documentation and prioritisation skills for student 182 and a lack of motivation with unreliable attendance as feedback to student 174. Both students passed management placement at second attempt, however student 174 received weekly support from the placement and their tutor to ensure they were achieving to the expected level.

4.5 Thematic Analysis of the Assessment Documents of Failed Students

Exploring the forty six student assessment records of those who failed placement uncovers reasons for failing identified by mentors in each year.

I then analysed the document summary sheets as a whole and used the patterns found in the themes. These were spilt across three groups in cohorts A & B, C & D and E & F to ascertain if mentors were assessing for different aspects as students' progress through the programme and specifically in cohorts C & D and E & F to analyse any impact on assessment with the introduction of the OAR and sign off mentor role in response to the original research question.

Table 4.6 Example of thematic analysis - cohorts C & D year three practice fails taken from individual document analysis summary.

Cohort	ID	Semester failed	Reason(s)	Outcome
C	82	3 & 6	Unauthorised absence and assessment not completed, **lacked confidence**	Confidence improved, mentor reports they made real progress and gained confidence and competence.
D	94	6	Concerns raised re **time management**, safety in **medicine calculations.** Failed 39 outcomes not at required level. Unrealistic about their own level of practice, enthusiastic to learn once opportunities identified.	Tutors supported and visited ward, continual support needed.

Increased confidence and competence, passed 2nd attempt |
| D | 118 | 6 | Issues with **communication skills** – loud voice. Breaching | Support given from tutors and mentors. Passed 2nd attempt at |

			confidentiality Needs to improve on **medications awareness**	required level.
D	120	6	Issues with **medications administration**, **confidence** and knowledge Caring and committed	Support given by mentor and tutors Passed second attempt but mentor identified that support will be required after qualification too.
D	93	4 & 6	Inconsistent with effective practice. Caring and compassionate but **deviates from task**, loss of focus.	Passed 2nd attempt with support.

4.6 Year One Assessment Documents

In the first year of the programme mentors assess students against the full range of NMC (2004) proficiency standards at the level in the Bondy (1983) assessment tool that students can 'practice with assistance' (The University of Nottingham, 2008). During this first year students were experiencing placement, working shift patterns and delivering healthcare to vulnerable patients across a wide range of care settings. In order to prepare for assessment they collate written evidence to meet each proficiency standard alongside mentor assessment through observation in practice. For some students insufficient evidence was seen in year one placements where students struggle to produce written evidence for assessment alongside the demands of the academic assignments of the course and the transition into practice. Where this was the case, mentors were positive in their comments and students achieved early on in the next placement, indicating that all that was needed here was more time to

collate evidence. This was the case in six of the students from eleven who failed first year placements.

Mentors are also assessing students' professional behaviours. This is seen in feedback recorded where there is focus in year one on professional behaviours and characteristics such as 'professional' and 'reliable' (13), 'trustworthy' (40), 'good communication skills' (125) and 'caring' (152). Where students have struggled to achieve the expected level of practice mentors have identified this in their feedback. This was the case with four of the eleven students.

One student was clearly in breach of professional behaviour and was terminated from the programme due to fraudulent use of their assessment documents. It is vital in a vocational programme such as nursing, where students have access to vulnerable patients, that behaviours are maintained at a high standard from the start (NMC, 2015) and when this is not achieved that is it effectively managed. This was seen in this case.

In cohorts E & F, one mentor was seen to give detailed feedback from the notes and records in the student file and copies of the OAR. This feedback in year one was then picked up by the next placement and support was given early on, achieving a pass at the next placement in the second year. This was an effective positive use of the ongoing nature of the assessment records which could not have taken place with cohorts A & B where the assessment records were individual to each placement and not seen by subsequent mentors and practice staff.

4.7 Year Two Assessment Documents

As students progressed into the second year of the programme, they experienced placements in specialised areas, across all fields of nursing,

including emergency care and critical care. At this stage of the programme they were assessed against the NMC proficiencies (2004) as 'practising with decreasing supervision' (Bondy, 1983; The University of Nottingham, 2008). Mentor expectations were rising and the students were expected to contribute towards care delivery as part of the team, still under supervision at all times but demonstrating more awareness of care practice and ability to assess care needs.

Assessment in year two of sixteen students who failed placements showed issues with gaining confidence in practice and care delivery, especially as they stepped up to this higher level of practice. Mentors expected more of them too, especially in clinical skills which can be difficult to achieve in the specialist placements. Nine students failed in cohorts A, B, C, and D due to no opportunity to provide evidence for assessment. None of the four students in cohorts E & F failed for this reason. Mentor comments reflect positively on the students as 'very keen' (67), 'worked hard' (76) and 'enthusiastic' (53). Mentor comments focus more clearly here on professional characteristics too when a student has failed and a link to the 6Cs can be seen here when students are lacking confidence and experiencing issues with communication (Department of Health, 2012). These are key developmental aspects in nursing students who need to be competent across a range of professional behaviours to uphold 'The Code' (NMC, 2015), at the same time as developing expertise in a wider range of clinical skills. In cohorts C & D where three students failed due to not practising at the expected level, the mentors gave clear feedback on the issues, demonstrating why the student did not achieve. 'Struggling to recognise their limitations' (93) and 'failure to identify risk issues' (82) are comments for two of these three students.

In cohorts E & F where the OAR was established as the assessment document four students fail, all due to not working at the expected level. Mentor feedback returns to concerns on safety, competence and confidence in these students, highlighting the characteristics and behaviours expected. For two students a high level of support was evidenced both in the OAR and with the use of additional records of meeting and emails to tutors also seen in assessment records. This reflects the time and work mentors commit to make a clear assessment decision, giving the student formative feedback on their performance prior to a summative assessment decision. This reflects the work by Duffy (2003) and Black, Curzio and Terry (2014) who both identify the time, courage and commitment it takes for a mentor to fail a student.

4.8 Year Three Assessment Documents

In year three the students experience two placements, one in semester five and one in semester six called 'management' placement where cohorts C, D, E & F were assessed by a sign off mentor using the OAR. The level of assessment is that students can 'practise with minimal supervision' (Bondy, 1983, The University of Nottingham, 2008)

This year experienced the highest number of fail decisions with nineteen, which supports the anecdotal assumption stated earlier that more students fail their final placement than at any other time. From nineteen students, six had failed placements earlier on in the programme too. One student had previously failed year one, before progression through year two and then failing both placements in the third year (152). Four students had failed second year, passed the semester five placement before failing the

management placement. All of these students were assessed in management placement by a sign off mentor.

Two of four students who failed in cohorts A & B failed both semesters five and six. This was when assessment documents were single use per placement, so the semester six mentor would not have been aware of the semester five fail unless the student chose to tell them. At that stage, tutors and placement educators were not able to let a mentor know that a student had failed a previous placement, due to breaching the student's confidentiality. Both students failed semester five placements due to lack of opportunity for assessment, but in semester six one failed as not at the expected level and one for unsafe practice. Whilst the cause for both fails appeared to be unrelated, it cannot be ruled out that both of these students were weak during their final year of the programme. Of these one student left the programme prior to completion and one went on to pass at a second attempt and qualify.

In cohorts C & D when the sign off mentor role and OAR was first used for semester six, five students failed, one due to ill health and four were assessed as 'not at the expected level'. For three of these students their first placement fail occurred in this final placement (94, 118, and 120). Mentor comments move away from the characteristics and behaviours identified in year two and instead start to focus on skills, specifically medicines administration and their ability to prioritise care here, as well as a lack of confidence. All five students who failed management placement went on to pass at second attempt.

In cohorts E & F where the sign off mentor role and the OAR have been in use for two years ten students failed, which is the highest number at any stage with any cohort group. For seven of the students their first fail was in management placement. This must have such impact on students who are

expecting to pass the programme at this final placement after successful achievement previously. This would indicate that sign off mentors are using the OAR to review student progress in all years of the programme and are also prepared to make a fail decision when required at this stage of the course.

The decision to fail a student on management placement takes courage as reported by Black, Curzio and Terry (2014) and was identified by Duffy (2003) as having emotional impact on both the student and the mentor. One striking thing in the assessment documents for year three, seen more than in the previous year's records, was the volume of documents and records that went alongside the official OAR university assessment documents. For five students there were extensive records on file showing support for the student from mentors, practice based managers and from university based tutors. Sometimes these were on a daily basis. Action plans for some students were clear, achievable, reviewed and still not met. This indicates the time taken with a failing senior student's assessment.

In year three, fail assessment records recorded different issues for the students than seen in year one and two. In year two, whilst the focus had been on personal characteristics such as lack of communication, in year three there was emphasis on lack of confidence, medication administration and prioritisation of care. It becomes clear that mentors have expectations of students here focused on their future practitioner roles. Assessment of their personal characteristics is less visible, whilst focus on their nursing skills and abilities in managing groups of patients competently, including clear communication to the staff in their team, is a priority.

Table 4.7 Summary Overview of analysis of assessment documents.

Year One. 11 fails in practice across the 6 cohorts. Students struggling in year one with role and lack of portfolio evidence for assessment, only 1 failed due to issues with professional conduct. Feedback from mentors positive – 'Professional, reliable' (13), 'Trustworthy, used initiative' (40), 'caring, good communication' (152) Or negative – 'not at expected level' (2) & (23), 'unsafe practice' (1) Mentor comments generally positive and encouraging. Feedback given where improvements were needed. All but one student passed on 2nd attempt
Year Two. 16 fails in practice across all 6 cohorts. Feedback from mentors;   'very keen, well done' (67), 'reliable & working professionally'(84) as positives or 'lacks confidence & fails to identify risk issues' (82), 'cause for concern' (182), 'lacks confidence in communication' (183), 'grave doubts over ability to become a safe and competent practitioner, lacks fundamental qualities' (186)
Year Three. 19 fails overall, 3 failed both semesters.   4 Cohorts assessed by sign off mentors. <u>Cohorts A & B</u>; 4 failed (2 failed both semesters) not at expected level and unable to step up to management level, mentor comments focus on skills and expectations- 'not confident in leadership and prioritisation' (95), 'not competent in medicines administration & does not communicate and pass information onto others' (95), prioritisation of tasks, takes too long & drug administration' (96) <u>Cohorts C & D</u>; 5 failed – 4 were not at expected level. 'Caring and compassionate but deviates from tasks' (93), 'issues with time management and safety in medicines calculations' (94) <u>Cohorts E & F;</u> 10 students failed, 1 failed both semesters – not at expected level. 7 failed final placement as not at expected level, only one student failed 2nd attempt and was withdrawn from the programme. 7 of the 10 students experienced their 1st ever fail grade in final placement. Feedback focuses on communication and professionalism as well as skills – 'issues with medication administration, observations not recorded correctly'

(152), struggles with prioritisation of workload' (182), 'lacks initiative &
needs to delegate effectively' (159) 'poor communication' (191), not able
to manage a group of patients' (195)

Thematic Analysis.

Year One; Students transition shock – decision to leave, failing due to
inability to perform the role of nursing student as expected, includes
difficulty with shifts, reliability, initiative

Year Two; Existing difficulties lead to decision to leave course, academic
fails impact as level increases. Mentor expectations are rising

Year Three; Inability to manage care and prioritise workload has impact
on practice assessment. Expectations in practice increase significantly –
'Gatekeeper' role seen.

4.9 Summary of Phase One Data

Through this thematic analysis it seems mentors have used the OAR during
the later cohorts to review student progress over the course of the
programme. In the four cohorts where the OAR was available to the
mentor, there were five students who failed at least two placements in this
study. This demonstrates the OAR has impact in the assessment for
mentors, particularly when a mentor may feel they are working alongside a
student who is weaker. It may also show that the sign off mentor, as an
experienced mentor, feels more able to make difficult assessment
decisions at later stage of the programme. Behaviours and tasks expected
to pass placement also changed over the three years of the programme as
the student moves towards qualification. Following this data collection and
analysis, interviews with mentors were then conducted to explore these
themes in more depth.

4.10 Phase Two - Interviews with Mentors

Interviews had taken place for phase two of the study with eight mentors. The nurses interviewed had been mentors for between 2 and 19 years with an average of 8.62 years. Three worked in adult nursing, two in children's nursing, one was a mental health nurse and two worked with clients with intellectual disabilities. Three were sign off mentors.

Table 4.8 – profile of each mentor interviewed.

Ann works in adult surgical nursing, has been qualified eight years and a mentor for three years. Has a practice development role so can protect time for mentoring. Plans to become a sign off mentor soon. Says she is very committed to the mentor role and passionate about doing it right and sometimes will stay after the shift has ended to ensure the student's assessment is given sufficient time. Her placement area takes students in all years of their training. She has experience of failing a student.

Bill works in intellectual disability nursing. He is a qualified mentor of fourteen years but not a sign off mentor as his community team do not host students on their final placement. He has experience of failing one student in his mentoring role. His placement area currently takes 3rd year students prior to their final placement. He shows a clear understanding for his role and the process of assessment in the interview.

Cath works in an adult mental health placement. She has been a mentor for two years. Her placement area takes students in all years of the programme. She has not had any issues with students and has no experience of a failing student. She is the only mentor in her area trained since the introduction of the OAR and her responses indicate some anxiety that she is doing it right and giving the role the time she feels it needs. At the end of the interview we discussed how she would find it beneficial to have a support network of other mentors in her area to reflect with on how they all assess for her ongoing mentor development.

Diana is a sister in a busy adult medical acute unit. She has been a mentor for four years and is also a sign off mentor. She has experience with a failing student and supporting other mentors on her ward. Her placement area takes students from all years of the programme. She appeared confident in her mentor role. She was also able to relate how the quality of assessment during the programme impacts onto the newly qualified nurses' confidence and competence at the start of their role as a registered nurse

Erica is a children's nurse working in a critical care placement. She has been a mentor for eight years and has worked elsewhere before her role here as a practice development nurse. She was able to offer a comparison on the two assessment documents from her last trust and this one. She is not a sign off mentor as her placement area does not host final placement students. She can create diary time for her mentor role when she has non clinical days

Flora is a ward sister on a children's surgical ward. She has been a mentor for nineteen years and a sign off mentor for eight years. The placement hosts students from all levels of the programme but as ward sister, Helen mainly takes final placement students as their sign off mentor. She has also been involved in supporting more junior staff to mentor a failing student. Her experience in the mentor role was evident during the interview. She is clinically based and mentioned the links between the levels of experience as a mentor and the sign off mentor role requiring experienced mentors who fully understood the responsibility of this role.

George mentors in a community setting with clients with intellectual disability. He has been a mentor for eight years but has taken more students in the last three years. He is not a sign off mentor. He manages his own diary and at interview was clearly confident in his mentor role although struggled with some of the terminology differences such as the change between the assessment records from APR to OAR. He appeared very committed to mentoring and has experienced mentoring a failing student.

Helen is a staff nurse working in adult critical care. She has been a mentor for twelve years and a sign off mentor for eight years. She has also had a previous secondment to a dedicated mentor support role. She is a very confident mentor, committed to this role and has experience of failing a student. Her placement area takes students from all years of the programme. She works clinically on all shifts.

Transcripts of these interviews were then analysed alongside audio files to establish patterns in the transcripts and generate initial themes. Interviews

were read and re-read, and audio files were listened to on a few occasions, in order to identify key themes emerging from the mentor responses. These were mapped across interviews and cross checked for consistency and definition as per the thematic analysis framework (Braun and Clark, 2006, Standing, 2009). This is an inductive back and forth approach where the data produces repeated patterns that I have interpreted into themes (Braun and Clark, 2006).

Figure 4.1 Example of transcript analysis to identify themes – Bill

Figure 4.2 Example of transcript analysis to identify themes – Flora

At this stage I needed to be open to exploring all possible emerging themes and be aware that I minimised any assumptions to ensure all findings were uncovered and included. Depth of interpretation was sought, to ensure perspectives were correctly represented and my reading of their dialogue was contextual and situated in this shared understanding of the role of the mentor held by myself and the respondents. In this process a diagram was created to capture the themes and during the rereading of the interviews to ensure all were identified.

Figure 4.3 Diagram to capture themes across all mentor interviews
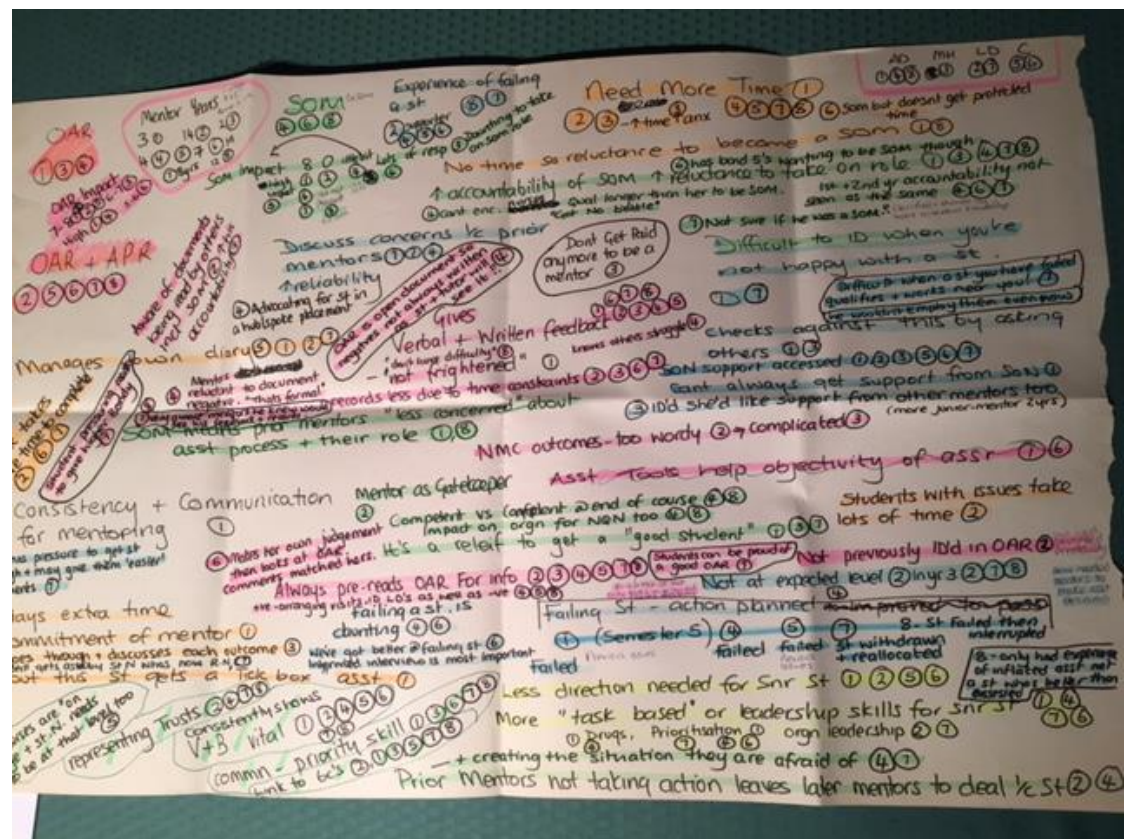
These were then clustered into common themes as similar issues were identified. Throughout data collection and analysis it was vital I was reflexive and took account of my own influences and 'taken for granted' assumptions (Engward and Davis, 2015). It was heartening to see this occur within the interview with Diana and to reflect on how this altered my assumptions regarding recruitment of sign off mentors, as discussed on page 141.

Phase two of the data collection took six weeks, however transcription and analysis took eight months and reflexivity during this timeframe naturally occurred. This represents the hermeneutic phenomenological approach identified earlier, through uncovering meaning in the data generated and then moving onto interpretation of these coded themes.

From this analysis, four themes were identified:

1. Using the assessment documents

2. Failing a student

3. Accountability and the sign off mentor

4. Mentor assessment of behaviours and levels of progress

Table 4.9 Themes identified from interview transcripts for analysis.

Using the assessment documents
Have used OAR and APR (B, E, F, G, H), OAR only (A, C, D)
OAR Impact: 5-6 (F), 6-7 (C), 7-8 (B, E, G, H), High (A, D)
NMC outcomes too wordy (B), complicated (C)
Not previously identified in OAR but student had struggled before
Always pre reads OAR for information (B, C, D, E, G, H)
Can be positive for arranging visits as well as negative (D, E, H)
Makes her own judgement, then look at OAR, comments matched hers (F)
Mentors reluctant to document negative feedback, formal, open document - negatives not always written as student and tutor will see it (D)
Very aware mentors would see his feedback and records, increases his accountability (G)
Records less written feedback due to time constraints (B, C, F, G)
Gives verbal and written feedback (All), knows others struggle with verbal feedback (D)
I don't have difficulty with feedback (H), not frightened (A)
Goes through and discusses each outcomes (C)
OAR takes more time to complete (B, F, G)

Failing a student

Experience of failing a student (G, H)

Have supported mentors to fail a student (B, D, E, F)

They discuss concerns with prior mentors (A, D, G)

Difficult to pin down why you are not happy with a student (A, G)

Checks with this by asking others (A, C)

Difficult when a student you have failed qualified and works near you (G) – and he would not even employ them now

Access support from School of Nursing (A, B, C, E, F, G)

Identified she would like support from other mentors too (C)

Not at expected level (B, D), in year three (B, G, H)

Failing student action planned (A, D, E, G, H)

We've got better at failing students, intermediate interview is most important (F)

Failing a student is daunting (D, F)

Accountability and the Sign off Mentor

Is a sign off mentor (D, F, H)

Impact of sign off mentor role; none (B, H), little bit (D), 8/10 (A, F, G), high (E)

Students with issues take lots of time (B)

No time so there is a reluctance to become a sign off mentor (A, H)

Lots of responsibility to be a sign off mentor (F)

Daunting to take on role (C)

Increased accountability of sign off mentor, reluctance to take on role ((A, C, D, G, H)

Need more time (A, B, C, D, E, G, H)

Sign off mentor but doesn't get any protected time (F)

Time it takes makes her anxious (C)

Manages own diary (A, B, E, G)

Stays extra time, mentors need to be committed to this or students get a tick box effort (A)

Prior mentors not taking action (B, D, H), leaves later mentors to deal with student (D), creates situation they are afraid of (D, G)

Behaviours and Values

Vital they consistently show right behaviours (A, B, D, E, F, G, H)

Communication as a priority skill (A, C, F, G, H)

Links to 6Cs (A, B, C, E, G, H)

All nurses are on stage and student nurse needs to be at that level too (E)

Representing the Trusts (B, D, G, H)

Less direction given to senior student (A, B, E, F)

More task based or leadership skills for senior student (A, D, G, H),

medications (A, D), prioritisation (A, D, F, G), organisation leadership (B,

G)

Themes will now be presented. Quotes are used in the text to demonstrate the voices of the participants through the interviews and shared experiences. Exploration of links between analysis of the assessment documents and themes identified from the interviews follows this, enabling the multi methods approach to return to the research question and meld the results into a whole, thereby answering the research question posed. This reflects the interpretive phenomenology approach used in this study. By capturing the mentors' feedback on assessment documents and then capturing their lived experiences of assessment in the interviews I was able to interpret this whole data set alongside my knowledge of the context of the mentoring situation and develop the themes identified as discussed below.

4.11 Theme One - Using the Assessment Documents

Five of the eight mentors had used both the individual assessment records prior to 2007 and the ongoing achievement record (OAR) subsequently. The three mentors who had less than 5 years' experience in mentoring had only used the OAR, as would be expected.

Time taken in completing the assessment document was consistently mentioned with three mentors reporting that the OAR takes more time. Four of the mentors managed their own diaries and described how they created time for their mentor role and assessment to take place, but others who were clinically based and did not have this level of control over their time did not state how they managed the time for assessment, except for Ann stating that she would stay late past the end of her working shift to complete the documents for students.

Two of the mentors commented on the complexity of the NMC outcomes for assessment; Bill was an experienced mentor who was familiar with the language used in outcomes and Cath was inexperienced and specifically stated she discussed each outcome with her students at the final assessment,

> "It's not just writing. It's discussing and reflecting and talking
> as well, so I go through them all, every one of them separately
> and talk about it and that's why it takes so long and you know
> then you just keep going back to your Bondy level and checking
> they are at that level". (Cath, Q18)

When asked about the impact of the OAR on their mentoring all identified it as having an impact, scoring it 6/10 and above. Four mentors responded that the impact was 7-8 and two responded to the question by saying the impact was high. Flora felt the impact of the OAR would be higher when

dealing with a student who was struggling and you could use the assessment record to check their past placement assessments, but that was not a situation she had been in yet.

Five mentors stated they always read the OAR for all students, Helen would read it for her final placement students and for junior students would only read it if anyone was struggling. Flora, as an experienced mentor clearly stated she made her own judgement, then read the OAR to confirm her judgement was right and so far this had been consistent with her assessment. Mentors used past assessments to inform their plans for placement assessment for students in a positive as well as a negative way, through planning opportunities and visits to expand learning, as well as to highlight if a student was struggling. George stated, "It's just nice to have a read through I think, especially when the student's quite proud of what they've done". (Q9)

All eight mentors stated they felt able to give verbal as well as written feedback. Two mentors expressed their commitment to the mentor role. Ann stated, "I've never actually been frightened, when I have had to give feedback I have done so. (Q11) Helen referred to students that had struggled to meet the expected level stating, "I don't have difficulty in assessing them". (Q10)

Two factors impacted on the written feedback given. One was time, which was mentioned by four mentors and as illustrated by Ann when referring to other mentors,

> "…because they haven't got the time to do so, I wonder if they
> are quite succinct in what they write? Because they think, well
> it's not up to me anyway, I won't be the sign off, so just put
> anything". (Q13)

The second factor was that mentors are aware that others will read their assessment records. George stated that he knows many of the subsequent mentors and this makes him aware of his documentation, feeling an increased responsibility to record it correctly, "knowing that not just someone else would be reading it but people that know me, that really did have an influence". (Q13) A response by Helen concurs with this,

"(The OAR) has had more impact as I think people now are more aware of everybody else seeing their assessment as well, so if there are certain things that there are concerns about or they do particularly well I think people tend to be documenting it a little bit more aware of what they're writing and other people will read that in the future". (Q14)

Diana stated that she felt mentors are so aware of others seeing their assessments they will not record the negative feedback,

"Because it's an open document isn't it and I sometimes wonder if they are a little bit nervous about anything? There's nothing negative that I've ever ever seen. So it's an open document isn't it? So are you a little bit nervous about documenting that they've failed on something or that they weren't so good at something, because then the students going to read that, the tutors are going to read that and it's an open document, it's not very private between mentor to mentor". (Q9)

Struggling students were mentioned and with two of these, the mentors identified that students were struggling to meet the expected level in practice but nothing had previously been recorded in the OAR. Bill gave an example of this with a 3rd year student,

"We have had one in particular who we were flabbergasted had

got to this point in his training [pause]. We'd had a look yeah,

and we didn't pick up anything that we thought, there was

nothing in there, which questioned the placements themselves

and how this guy had got through". (Q10)

In summary, the introduction of the ongoing achievement record was seen as having a positive impact on mentor practice, with most mentors using it to guide them during the assessment process and learning what the student had achieved in prior placements. The complexity of the NMC outcomes and time required to complete assessment documents were negative factors. All mentors interviewed were able to give verbal and written feedback but it was identified that lack of time did affect some mentors' ability to write detailed feedback and when students struggled to work at the expected level the assessment record did not always reflect this.

4.12 Theme Two – Failing a student

Four mentors had supported other mentors to deal with students failing to meet the expected level and two of the experienced mentors had failed a student themselves. In responses, the process of assessing a struggling student was always linked to the time required to deal with this. Bill details how he supported two mentors to feed back to a failing student with the tutor from the School of Nursing present too,

"I think he'd got through at a basic level of hands on care and

he was pretty good at that, was OK at that, but the step up to

what was required with us at a 3, he was a mile off and that

then created a whole dialogue then with the School of Nursing

and obviously the lecturers, we'd never kind of failed a student, we had always kind of said, well look perhaps you have not reached these levels but you could go on and reach them elsewhere, but this guy created, was real difficult time for us because he wasn't expecting to be, he had been signed off at previous placements and was automatically [pause] there was an acceptance from him that he would go into a placement and be automatically signed off and this was the first time he'd been challenged really or been questioned, not challenged – wrong word, had been questioned about what he was asked to do and what he wasn't doing and the shortfalls and they were massive. I was actually acting team leader at the time and I was overseeing really the mentors from our team and asked two mentors to share him because it was such a kind of challenging situation, but yeah it felt right to sit him down and to go through it and explain what was happening or what wasn't happening and where we felt we were. But again the student really, I have to say didn't get it, was just an expectation that we would just sign off and we'd all move on". (Q10a)

This quote demonstrates the intensity of a situation of giving negative feedback when the student is unaware of their weakness, alongside the time and commitment in managing the feedback situation and supporting both the student and the mentors involved.

When faced with a student who is struggling, Ann and Cath mentioned they would check their decision by asking others. Three other mentors also stated they would go and discuss with other mentors involved in this student's assessment, using the OAR to contact prior mentors, as Ann explains here,

"so sometimes before I start progressing down that route of look, we need to pick that up first, I'd go the informal route first; I'd talk and have a chat with the prior mentors because sometimes it will be that they say 'yeah they were struggling with that, but what we did was this and that's how that brought that out of them', so you know it would be about supporting the student and sometimes it might be about something you have not thought of, have you offered them that insight visit, they really shone there, but just to get that second, I suppose it's a second opinion as well because like I say, it goes back to this subjectivity.   When there has ever been issues where I've, y'know, I really don't think I could assess them as competent, I would talk to the associate mentors within the working area and then we'd go from there and see what we can do, let's set some time frames, let's see what we can get going". (Q9)

When dealing with a student who was not at the expected level, six mentors said they accessed School of Nursing support with the assessment. This support was requested at the midpoint of the student's placement so that feedback and action plans could be given in time for the student to improve and pass the placement as seen in Bill's quote earlier for Q10a. Flora gives detail on this too in response to question 10,

Interviewer "have you ever had difficulty in assessing when a student has not been at the right level?"

Flora "Erm no I don't think so [pause], if I was concerned I would always speak to our link person from the School of Nursing, because I think their view is very very important for us in practice that we work together. So we have had failing students before and we would fail them if we weren't happy,

but only with the School of Nursing being involved… I think

people have real big concerns about failing any student. They

find it really hard to do and I would definitely say it's easier

early on in the process to say right, you are not quite getting

this or this part of what you are doing is not correct - how do

we work through it? And I think, I think maybe the documents

have helped us with that because I know we are much better

than we used to be at doing our beginning interview, our

intermediate interview and the end one. The intermediate one

is almost more important than the other two because you have

seen the progression or if they've got a problem, then at that

one you can say well, how do you think you're doing? and then

you can bring up, well you've got so far but this is what you

need to be working towards to get to your level". (Q18)

This quote demonstrates how an experienced mentor feels the introduction
of the OAR has helped identify students who may be struggling and
support them earlier on. It was clear, from mentor descriptions of support
given, that the system relies on the commitment of all mentors to deal
with this and document it accordingly. When students are identified as
weak in practice but there are no prior records in the OAR this creates
more difficulty for the subsequent mentors as described by Ann,

"but sometimes it feels that because of this lack of time that

we're given to complete this role, unless you're personally

motivated to stay that extra time and assess the staff

thoroughly and they haven't, it has become a bit of a tick box

exercise and maybe it's personal, so I look at it and think well,

they've not elaborated there and it's not clear". (Q10a)

This was also expressed clearly by Bill,

> "I don't know how he'd got onto the nurse training, but surely
> someone somewhere should have recognised before his 3rd year
> that this guy is not really cut out for this, because this can't be
> something new, this is not this guy turning up and all of a
> sudden not being able to do certain things, but I think, you
> know, a culture of sometimes a student just coming into other
> placements and them just signing off". (Q11)

Ann gives an indication though of her views when mentors she has
supported have failed a student on how difficult it is to do,

> "From what I gather it dragged on that long for them, I think
> one of them did follow it through, but it was such a nightmare
> she vowed never to do it again and then I think the other one
> did go through, but they both acknowledged it was a bit of a
> nightmare. I mean it's never going to be an easy thing to do. I
> think some of this we need to acknowledge, it's never going to
> be comfortable for us to be that person making that judgement
> call". (Q11)

This theme summarises the issues for mentors in practice, reliant on time
and the commitment of the individual mentor and on the confidence and
courage of individual mentors who deal with a student who may be failing,
as shown in prior literature. This demonstrates the issues are still apparent
despite the introduction of the ongoing achievement record but also that
mentors are starting to use this to inform their own decisions.

4.13 Theme Three – Accountability and the Sign Off Mentor

Three of the eight mentors interviewed were sign off mentors and two
indicated it was something they would work towards in the near future.

When questioned about the impact of the sign off mentor, five said it had a high impact. Diana (sign off mentor) responded that it had only had a little impact and Helen (sign off mentor) stated it had had no impact. I believe this is because they were already experienced mentors prior to the introduction of the role and therefore had continued to mentor in the same way. For Erica the introduction of the sign off mentor had no impact as the placement area did not have students on final placement. This however indicates no insight into how her assessment feeds into assessment by subsequent mentors and the sign off mentor at final placement.

Five respondents mentioned that increased accountability of the sign off mentor meant that mentors were reluctant to take on this role. Being a sign off mentor meant lots of responsibility in signing a student as fit to practice and some of the responses to this question were emotive. Bill stated,

> "I've not really had much dialogue with other sign off mentors
> but I think the general feeling is yeah, it probably is a positive
> thing for both the student and a bit perhaps daunting perhaps
> for the nurse to think, [pause] because I think the perception is
> that you're signing off this student as kind of 100%
> capable."(Q14)

Ann describes how the accountability had made her wait to become a sign off mentor,

> "No one likes to think about it, but in 5-10 years' time and this
> nurse cocks up and you were the nurse that signed them off, I
> think the accountability of it all, for me that's what's made me
> wait a little bit longer". (Q13)

Diana responds clearly that sign off mentor is daunting to many mentors,

Interviewer; "Do you think that the introduction of the sign off mentor has had any wider impact on the assessment of students?" (Q14)

Diana; "Yes and they don't want to do it. I'm the only sign off mentor on ward XX and it's encouraging them to do that with me and the thing is they've got a fear of responsibility now, are they actually going to be accountable for what they're signing off? I don't know. I think it's because they believe that it's more official if they are signing this student off, they are saying that they are competent and for all these enquiries, for all the failings at different Trusts, that actually they might be putting a less competent nurse out there and that can come back and bite them a couple of years down the line [pause] so I've got a little bit of a barrier at the moment. I can't encourage nurses that have been qualified longer than me to become a sign off mentor."

Interviewer: "But they're not worried about that if they are assessing a first year student or a second year student?"

Diana; "No no, because it's a first year and second year, because they are actually passing that on to somebody else to deal with aren't they? They are passing it on to another person. 'Cos actually you're saying that you know, maybe they aren't so good but somebody else can pick that up"

Interviewer; "It sounds as though you are saying that there are instances where people pass the buck and so they've passed the buck onto the subsequent mentor and they're not happy to be that sign off final mentor themselves, so it may well be that

they are actually creating the situation that they are frightened of?"

Diana; "Yes but they're not signing it at the end are they? And that's what [pause] that's their ultimate, that they are signing at the end and that it's official and you've signed that they are going to go on the NMC Register as a nurse and you've said that they are competent to be a nurse but actually in the first year you said they weren't, and they don't want to do it, got no bottle". (Q14)

This demonstrates that the introduction of the sign off mentor has created two tiers of mentor in practice and the level of accountability in the assessment decision is incorrectly seen by mentors to lie solely with the sign off mentor. This was confirmed in the interviews with Flora and George who also made similar comments about the mentor perceptions of a different level of accountability with the sign off mentor. This behaviour then causes the issue that mentors are afraid of in becoming sign off mentors and links back to work by Duffy (2003) on failing to fail. If mentors in earlier placements do not see themselves as equally accountable for their assessment decision, or fail to take action with assessing a student who is struggling, this situation then passes along the student's course for a later mentor to deal with. Since the introduction of the sign off mentor, it would seem that prior mentors are abdicating their accountability and hoping that sign off mentors take the difficult decisions for them. This gatekeeper role now seems to firmly sit with the sign off mentors.

Two mentors discussed the impact on the NHS of employing newly registered nurses who are weak in their practice and the difficulties this causes in their preceptorship period of supervision. Whilst this is outside

the scope of the study it shows that failing to deal with a struggling student during their course means that weak students are qualifying and then requiring ongoing support from their employers. In one case in this study this has required a significant level of input and action from the employing trust, with a past student now removed from the NMC register for poor practice and causing harm to patient safety. They had failed 2 placements during the programme, including management placement, but had passed on reassessment.

Mentors conversely expressed a sense of relief at having 'good students' to assess and not having to make difficult assessment decisions. Ann discusses feedback to a failing student then goes onto say "I was quite lucky after that, I got excellent students" whilst laughing (Q12) and this appears to demonstrate a sense of relief when students were not presenting challenges for the mentor in their assessment role.

In summary this theme identifies the longer term impact of failing to fail a weak student when mentors do not see themselves as having accountability for their decision and leave it to the sign off mentor to deal with. Introduction of the sign off mentor has, albeit unwittingly, meant the two tier mentor role identified with Diana's interview and seen in practice, brings an incorrect understanding of different accountability levels too and may perpetuate mentors' reluctance to act when they have doubts.

4.14 Theme Four – Mentor Assessment of Behaviours and Levels of Progress

During the interviews mentors were asked directly about the level of assessment they expected for junior and senior students. This emerged from analysis of the assessment records where it became clear mentors

assessed against behaviours and different levels of the student, many of whom failed placement as 'not at the expected level'. Whilst you would expect a student to progress during their programme and require less direct supervision in their final year than earlier, the assessment records of student who failed identified this as a theme where students who struggled were given feedback on not meeting the required level. The interviews presented opportunity to explore this in more depth.

Mentors at interview stated they clearly expected a senior student would require less direct supervision, but their answers also revealed what behaviours and tasks they assessed them against too. For junior students it was apparent they were assessed on their communication and behaviours but for senior students, their weak areas were identified as task based skills around the competency required to be a newly qualified nurse, such as managing a group of patients or medication administration. There was consistency across the mentors, despite the different practice areas they worked in, about their assessment practice. This is reassuring and demonstrates inter-mentor reliability.

When responding to the question on what they assess a student against, 5 of the mentors responded with communication as their first answer. This demonstrates awareness of the pivotal nature of good communication in nursing, both with patients and carers and with the healthcare team.

> "I think there's certain areas where you are looking for good skills as in communication". (Bill; Q16)

> "Yeah well that's one part of it, communication, well obviously lots of things we look at, their level of commitment, their compassion and caring nature". (Cath; Q16)

Mentors also went on to discuss other behaviours and values the nurses should display from an early stage of the programme,

> "So communication is the biggest for me. That is my biggest
> thing. I feel you can have an amazingly competent nurse that
> could do cannulation, ECGs you know she could walk out of the
> School of Nursing proficient in everything, but if she couldn't
> communicate with a patient and express empathy and concern
> for them, if she couldn't [pause] I always say she's pretty bad
> her, but if she couldn't show them the same regard that she
> could show for her parent, you know, what can we do with
> that? Where can we go from there?" (Ann; Q17)

The behaviours mentors expected to see from an early stage of the programme link to the 6Cs; characteristics for healthcare workers identified by the Department of Health (2012). There has been criticism in the press that nurses are not demonstrating compassion and good communication (The Patients Association, 2011) so it is heartening to see that mentors consistently value this as part of their assessment from the start of the programme. In Cath's quote above she mentions communication, compassion and commitment – all values expressed in the 6Cs.

As students progress through the programme they work with less supervision and by their final year should be working with minimal supervision, prior to qualification. The assessment records showed that the level of supervision was identified clearly when students were not meeting the required level and went on to fail the placement. This is demonstrated through interview too where mentors identify that students who struggled were not working at the expected level,

"the student to me was not anywhere near the level of a 3rd

year student so throughout the placement we discussed it all

the way throughout and I'd said to them right from the

beginning I would expect you at your level to know these kind

of things and nothing seemed to get any better". (Helen; Q12)

As students moved into the 3rd year and became more senior the

assessment records showed tasks changed too and mentors were

questioned on this. Tasks mentioned were medication administration,

management of care for a group of patients or prioritisation of care. These

key tasks indicate the advanced level of the senior student and their

readiness to pass onto the NMC register. The behaviours and

characteristics were also mentioned as part of this around the student

representing the placement area even as a student nurse.

"I think very much for us as a team how we present to people,

how we present to families, how we present to people at day

centres, to all kinds of environments where people live and

where we work. It's very important that you're not just having

the ability and the understanding of learning disabilities and the

crisis and the situation, it's how you are as a person and how

well you know [pause] and that is about being on time, about

looking relatively smart you know and presenting yourself and

representing our team and the Trust as a whole". (Bill; Q17)

"It makes a difference to professionalism and reliability I would

say. Obviously we've all got to be on stage at all times and so

they need to be doing that now, whilst they are a student".

(Erica; Q17)

> "Although they're not employed by the Trust we would still
>
> expect them to be aware of the Trust values and behaviours, so
>
> we would expect them to kind of, conduct themselves in the
>
> same way that we would be expected to conduct ourselves and
>
> certainly yeah you would bring that up if that wasn't the case".
>
> (Helen; Q16)

Seven of the mentors mentioned that students should show these behaviours consistently in practice. This links into assessment records where a lack of consistent behaviours, or behaviours not consistent with good quality care were identified on the assessment records of failing students. This demonstrates that mentors are assessing these behaviours throughout the course.

4.15 Chapter Summary

Analysing the assessment documents of the forty students who failed placement enabled themes to be identified across the breadth of records analysed. This led onto thematic analysis of mentor comments at interview completed for each year and across all six cohorts. This showed the reasons for the fail were likely to differ between a junior and a senior student. Junior students were assessed by mentors against their behaviours and induction into the role of the nurse whereas senior students were assessed more on the skills and tasks expected as they moved toward entry to the register. Where students failed their final year there was considerable documentation in the files reflecting the time spent on the assessment decision.

Interviews with eight mentors and subsequent thematic analysis identified four themes. These were around assessment documents, the difficulties in

failing a student, the accountability of the mentor and finally the confirmation that mentors assess behaviours of students and have prior expectations of their level of performance based on their year of study. When the student does not meet this expectation this was a key trigger for doubt and concern in the assessment. There was evidence that sign off mentors review the OAR for prior assessment decisions but where issues were identified with a student, the OAR was not always reliable in holding comments from prior mentors about issues with the students and there was a sense that time and commitment to the mentor role impacted on how well the OAR was completed.

Having analysed the data and found these themes the next chapter will discuss the results and link to the literature and the original research question.

Chapter Five - Discussion of the Findings

This chapter will interpret the data further and present interpretation and discussion linked into existing literature on each theme, in line with the methodology of the study. This will demonstrate that the introduction of the ongoing achievement record has had impact on mentors and the robustness of the associated assessment practices, thereby returning to the research question. Each of the four themes will be discussed in turn, with collation of results from both phases of data considered, alongside the contemporary literature.

5.1 Using the Assessment Documents

Both phases of data collection showed assessment documents were used variably by the mentors. Some mentors wrote minimal feedback in the records, whereas others wrote detailed feedback that was helpful and constructive to the student and to future mentors. Mentors interviewed also reported that previous feedback and comments in the OAR were variable when they reviewed them. Time to complete the documentation affected the detail in assessment feedback, which was consistently mentioned by the respondents when interviewed. This is a key theme in the literature (O'Connor, Fealy and Kelly, 2009; Gainsbury, 2010; Huybrecht et al, 2011). Mentors in a study by Myall, Levett-Jones and Lathlean (2008) reported taking assessment documents home to complete and this was referred to in the report by Robinson et al (2012) and Veeramah (2012a) and is my experience too. It was unsurprising therefore to hear this during the interviews. Where the mentors interviewed had more control of their diary time, like Bill and Erica, mentoring was allocated some time, however more time was still required.

All mentors interviewed identified that introduction of the OAR had a high impact on mentoring. Mentors stated they used it to inform their assessment decisions, however in analysis of the assessment documents no feedback in the documents linked into past placements or carried forward any development needs. This indicates that not all mentors use the OAR at the start of the placement to review and plan a student's progress, or that if the OAR is used in this way it is not recorded. This again may link to the time element mentioned above, or there may be less emphasis on using past placement assessments to inform planning for new placements and mentors are not making these links. George and Helen stated that the OAR can also be a positive tool for students to be proud of, as well as a tool to identify weaker students earlier, indicating that they use it at the start of placements. Neither of them referred though to making any record of this in the OAR.

Bill and Cath reported issues with the complex language used in NMC outcomes. This has also been reported in other literature (Duffy, 2003; Myall, Levett-Jones and Lathlean, 2008; Butler et al, 2011; Casey and Clark, 2011) and is also a factor for time required to complete the assessment when mentors are explaining and translating the standards.

The assessment documents used for mentoring have changed. Moving away from a single use document where the mentor received the student into their placement with no prior knowledge of their progress towards a continuous assessment document for the whole programme. Mentors appear to use the OAR at the start of the student's placement to assist in planning learning opportunities as well as for identifying any issues the student may have. This is a positive result of the introduction of the ongoing achievement record. Whilst most mentors seem to use the OAR in this way, from the interview data it is apparent that the system is reliant

on the quality of the prior mentor comments and assessment decisions. This remains variable in quality. This study has found that locally mentors cannot yet trust the OAR to give the full information required or be wholly reliable and this indicates quality issues with the consistency of the mentoring system.

Mentors take on the assessment role as an extension of their NMC Code (2015) following preparation for the role (NMC, 2008). The mentor requires confidence in giving feedback and some studies have identified this as an issue (Duffy, 2003; Gainsbury 2010; Jervis and Tilki, 2011). All mentors in this study stated they felt confident to give written as well as verbal feedback, although time was a limiting factor. Fitzgerald, Gibson and Gunn (2010) reported that their study of assessment documents showed a difference in feedback the mentor had documented versus what they reported about the student verbally. Duffy (2003) and Duffy and Hardicre (2007a) advise mentors to record specific examples for feedback in the documents for planning and assessment purposes. For some of the assessment records seen in this study there were detailed action plans for learning, but feedback on the achievement of these was less detailed. I expect this is supplemented by verbal feedback to students which cannot be captured in the same way and therefore there is no evidence of this, however the lack of written feedback results in weak records that may not always reflect the level of support given to a student in practice. Cooper (2014) writes specifically about community settings and the role of the sign off mentor, however one point she raises is that sign off mentors have not had clear documents to work with. In her experience, mentor comments were vague and there was no audit trail of the students' progress with no evidence of development plans. If mentors do not provide clear assessment documentation, it makes the assessment decision harder

for sign off mentors. This was seen in this study too and commented on by the mentors interviewed.

Duffy and Hardicre (2007a) refer to principles of good record keeping, detailed in The Code (NMC, 2015), stating that assessment documents should be clear and factual. For some mentors this requirement to be objective in recording their assessment decision may mean that detail is lost, or examples are not recorded. George stated that using the OAR made him aware that others would see his assessment decisions and comments recorded. This may reduce what mentors write in the assessment documents as Ann and Diana commented. George stated however that he personally found it a motivator to completing the documents correctly, suggesting this raises the quality of the feedback recorded for the student when working in smaller fields and sharing mentors across local teams. In the larger fields where more placements are used, the mentors would not be known to each other due to numbers of placements used across a wide geography of NHS trusts and therefore this motivator is not apparent. The system relies on all mentors sharing a commitment to find the time to record clear specific feedback in the OAR.

Mentors interviewed inferred that other mentors did not always share this commitment, either through the time they gave to the role or the detail recorded in the assessment records. There is currently a shift away from an expectation that all nurses undertake mentor preparation towards a view that only those committed to a mentor role and eager to support student nurses should be prepared as mentors. This is in line with current reports asking for a review on who should become a mentor (National Nursing Research unit, 2015; HEE / NMC, 2015). This change would mean a radical shift in the model of 1-1 mentoring towards mentors taking on responsibility for more students but having a more defined role. A recent

publication from the Royal College of Nursing in response to Lord Willis'
Shape of Caring review (HEE/NMC, 2015) discusses these issues around
mentoring and whether all nurses should be mentors (RCN 2016). This
RCN Mentorship report calls for a radical review of mentorship and for
protected time for all mentors. This should help to reduce the key barrier
of time impacting throughout the mentoring role including completion of
the assessment documents (RCN, 2016).

It would seem overall that the introduction of the OAR has had a high
impact on mentor assessment, with a positive change in mentoring
practice to one where mentors review the students' OAR at the start of a
placement to plan progress. This practice however was not documented in
the OARs reviewed although all but one of the mentors interviewed stated
they did this. Time seems to be a significant barrier to thorough
completion of the assessment documents, in line with the literature,
although commitment to the mentor role was felt by some mentors to also
determine the amount of feedback in the OAR. A review of mentor models
as proposed by the RCN (2016) alongside their call for protected time for
all mentors may start to address some of these issues.

5.2 Failing a Student

Use of the assessment documents by mentors has rarely been researched
in the past, therefore this theme is useful in that it brings new information
into the literature on failing a student directly from the documents. By
choosing to analyse the assessment documents for phase one of this
study, the findings emerge from a strong evidence base of what was
recorded during assessments in practice when students fail.

The assessment records show the fail decision with feedback to the student. This is variable in detail as previously discussed, but does give indication of the reasons for the fail. Comments from mentors were non-specific at times and more detail would have been useful to the student and the university assessment processes, especially where issues also arose in the second attempt. In this study thirty three students were successful on their second attempt in practice and only two students were withdrawn from the programme due to failing practice on two attempts. Five students commenced a second attempt but then chose to leave the programme due to continued difficulty in meeting the required level in practice.

Analysis of the assessment documents and interviews with mentors demonstrate that for many mentors the decision to fail starts with a concern about the level of the student's work. This has been identified in earlier studies (Duffy, 2003; Black, Curzio and Terry, 2014). Mentors in this study clearly identified deficits in knowledge, skill and attitudes demonstrating the use of holistic assessment in practice (Hager et al, 1994) and consistency was seen in the documents of what should be expected of a student nurse in each year of the programme. Cath, with least experience, expressed concern about making assessment decisions and this supports work by Ilott and Murphy (1999) and Hunt et al (2016), who identify that inexperienced mentors require support and guidance to assist them with fail decisions. It may be that the impact of the support available and the changes to mentor preparation following the SLAiP standards (NMC, 2008) are producing more concerns about students earlier in their programme, as proposed by Andrews et al (2010). This is not however supported by the evidence in this study as the number of students failing placement earlier in the programme was not increased following the introduction of the OAR (NMC, 2008). In the interviews

mentors indicated support was available when required and was accessed by six of the eight mentors interviewed.

Black, Curzio and Terry (2014) discuss the emotions surrounding a fail decision as a key point in their study. However interviewing mentors for this study, I did not hear feelings of guilt or concern that the mentors had failed in their role by failing students, as discussed by Black, Curzio and Terry (2014). I found that mentors appeared confident about the decisions to fail students, although they describe it as daunting. All the fail situations discussed had involved the support of other mentors or link tutors from the university and no mentor discussed being left alone to make a fail decision. This is in line with the study by Hunt et al (2016), where support for mentors may help them to feel secure in their fail decision and this is the interpretation I have from these interviews.

One key point for indicating a failing student identified by George and Diana was the question of whether they would employ this nurse. If their answer was no this would indicate the student was not at the expected level. Ann asks herself if the student is good enough to care for her family members. These points agree with findings from previous studies where mentors have used this as a measure of students' readiness for practice (Black, 2011; Earle-Foley, Myrick, Luhanga and Yonge, 2012; Bennett and McGowan, 2014; Hunt et al, 2016).

A recurring factor raised during interviews was the time taken to fail a student. This has been discussed in previous studies (Ilott and Murphy, 1999; Duffy, 2003; Hunt et al, 2016) and links to the demand for protected time for mentors seen in the recent RCN mentor report (RCN, 2016). It is clear from analysis of assessment records and the volume of records created and stored, that for many mentors failing a student takes hours of their time in identifying the issue, tracking the progress, recording

feedback and making the assessment decision. Earle-Foley et al (2012) identify the stress involved in being a mentor especially when busy and support is insufficient.

Where the OAR comments from previous mentors do not confirm a mentor's assessment of a student, they question their own assessment, then go on to express concern about the quality of the past mentor decisions as expressed in the interview with George. They state during interview that they are aware that not all mentors are committed to the mentor role and may not fail weaker students, but it does not appear to alter their final assessment judgement.

Where prior mentors have not documented weaknesses in their assessment of the student, no mentor in these interviews stated this would alter their assessment decision. Helen and George reported confidence in maintaining their own assessment decision and failing the student. This is seen when OAR comments do not tie in with the performance and knowledge currently demonstrated by the student. Mentors interviewed, including Ann, Helen and George, demonstrated how they improved the reliability of their assessment decisions by discussing their concerns with others, alongside the reciprocal support they give to other mentors in their team who may be faced with a student who is struggling. This demonstrates a commitment to improving the reliability between mentors, but that they do not always feel they can rely on mentors in prior placements, whom they do not know, for the same reliable quality of mentorship to be documented in the OAR.

As part of the interpretive methods used in this study I must reflect on the interviews with some caution. In coming forward and agreeing to be interviewed, mentors are likely to want to show themselves in good light offering high quality, reliable mentorship. Through the interviews they

refer to others as not performing the role as well, but none of them say there were events that they could have managed better or occasions where they failed to take action and fail a student. This leads me to be cautious and understand that all mentors interviewed want to show themselves in a positive way and would not share events in their mentoring that they feel would show them in a negative light. I need to be reflexive and recognise this.

I know from the analysis of assessment documents that the quality of mentor records of assessments varies and therefore can assume, even for the mentors who are interviewed, that the quality of recording their mentor assessments may vary in the OAR. There may be times in practice with a struggling student when they are not as responsive and pro-active in managing this situation as they would like to portray. As I chose not to track assessment documents for the mentors interviewed I cannot analyse this directly, but can only make an assumption that with limited time for the role, and heavy clinical workloads, the mentors interviewed may not always give the quality to the mentor role that they intend, due to the limitations on them.

When a student is failing to meet the expected level, the action of the mentor is pivotal in identifying issues, developing action plans and supporting the student to achieve. If this action is not seen or recorded, then it may be that some students are being left to fail through lack of time and opportunity to receive this support from their mentor, or due to a lack of commitment from individual mentors who do not seek to give feedback on the students' work during their placement but go on to make a fail assessment decision.

5.3 Accountability and the Sign Off Mentor

Mentors interviewed were asked their opinion on the impact on assessment of the introduction of sign off mentors. The majority felt that the introduction of sign off mentors has had a positive impact on the assessment process. As sign off mentors are only used at the final practice assessment point and are experienced mentors (NMC, 2008), the assessment decision should be a confident one. However, when mentors are receiving students into the final placement and identifying quickly that this student is struggling they are concerned about the prior assessment process as George and Diana stated. The interviews uncovered a sense of bitterness toward prior mentors from the experienced sign off mentors here, as demonstrated in the quotes from Diana (pages 141-142), especially where the sign off mentor may feel that the student is struggling but the OAR does not have any evidence of this previously. This is seen in the quote from Bill where reviewing the OAR showed no prior issues had been highlighted (page 135). Black's (2011) study discusses this in detail.

The three sign off mentors, Diana, Flora and Helen, seemed to have a raised awareness of their role as gatekeeper to the profession (Macdonald, 1998; Andrews et al, 2010; Wilson, 2014a; RCN, 2016) alongside the issue of their own professional accountability. This is highlighted in the NMC Mentor standards (2008) and is seen to be increased in the sign off mentor role (Casey and Clark, 2011; Rooke, 2014; RCN, 2016). Sign off mentors are also experienced mentors so it may be they use that past mentoring experience to make a decision on the student passing placement or not and know what they would expect from a student who should be working under minimal supervision (Bondy, 1983; The University of Nottingham, 2008) at this final stage of the programme from their preunderstanding of the level of the student at this stage of the programme.

Where there are no issues with a student, the sign off decision is not expressed as any different from other stages of the programme as evidenced by Flora who does not use the OAR to guide her assessment decision until the end, but then went on to state she had not had a weak student to assess since the introduction of the OAR and therefore had not had reason to look through it for past mentor decisions.

However, when sign off mentors do have doubts about a student's ability and the OAR contains no prior issues, they feel that they are left to make the difficult decision that others have left to them. The interviews showed a strong sense that prior mentors were not always acting on their concerns when a student was not performing well, but instead left this difficult decision with the sign off mentor. Bill expressed this well (page 135). This was seen to be due to the belief that the sign off mentor is accountable for the assessment decision and whether or not the student enters the NMC register as seen in Diana's interview (Pages 141-142). This attitude is incorrect though, as it does not recognise that each mentor carries equal professional accountability to assess the student fairly and take action on any concern (NMC, 2008; Earle-Foley et al, 2012; NMC, 2015).

The resulting situation is that of a two tier mentoring system where the prior mentors who are not sign off mentors are abdicating their responsibility for action when faced with a struggling student. Robinson et al (2012) predicted this may be the issue emerging as sign off mentors were established and in this study it has proven to be the case. Sign off mentors recognise this abdication of accountability when the OAR contains no past concerns and then feel that the difficult decision has been left to them to action at the final stage of the programme. In Diana's interview it became apparent that this sense of increased accountability as a sign off mentor was a key challenge in encouraging mentors to progress and

become a sign off mentor (pages 141-142). Mentors stated how concerned they were that the sign off mentor is accountable to the NMC and that is whom the NMC would return to in order to challenge when a qualifying student went on to have fitness for practice issues. However, in discussion with Anne Trotter, Education and Quality Assurance director at the NMC (2016) there are no known cases of any sign off mentor being called to account for their assessment decisions at fitness to practice investigations with the NMC.

In my prior experience however and my informal conversations with mentors (Murphy and Dingwall, 2003), I had never heard this strong feeling expressed about the challenge of recruiting sign off mentors. The interview with Diana specifically challenged my understandings about recruiting sign off mentors and made me reflect on the difficulties within this process in the system. As I am mainly involved in mentor preparation and sign off mentors are recruited at a later point by NHS Trust staff through their education support networks, I have previously naively understood that many mentors came forward willingly to be sign off mentors. I was unaware that in some areas there was reluctance and that existing sign off mentors were being asked to carry the role alone within their team.

Following interpretation of this theme in the transcripts I discussed this with two colleagues who were clinical educators who confirmed that this is the case. I also returned to the literature but only found this concurs with one point raised by Bennett and McGowan (2014) as part of their study findings. This is in contrast to findings in a study by Rooke (2014), where the sign off mentor role was seen to be an opportunity for increased recognition and value for the mentor role. There were no negative expressions for the role in Rooke's (2014) study and sign off mentors

expressed less anxiety about the role than the mentorship students and lecturers she also questioned. Locally it seems that recruitment of new sign off mentors is a challenge as many of them do not see a value in the role but instead are concerned about the increased accountability that they perceive the role to hold as Diana stated.

Ilott and Murphy (1999) identified assessors in their study of occupational therapists felt that failing a student in the final year was worse and affected both the student and the assessor more deeply, causing a great deal of concern for the mentor left to make the decision. Black, Curzio and Terry (2014) studied the issue of failing nursing students in their final placement and this qualitative study focused on the mentors' feelings. Black, Curzio and Terry (2014) found that mentors needed moral courage to make the difficult decision to fail and carry it through. Inexperienced mentors may not always have the courage or be able to access the support they would need to fail a student at earlier stages of the programme. However sign off mentors in this current study feel they are being asked to make the difficult decision to fail a student and prior mentors are passing responsibility for this decision onto them, reinforcing the perceptions of two levels of mentors and not recognising each mentor's accountability in the assessment process. Inexperienced or less committed mentors are not taking action, as they do not see themselves as accountable in the same way as the sign off mentor who is the gatekeeper to the profession (RCN, 2016) as demonstrated by Ann in her quote about mentors not completing the OAR in detail (page 133).

Whilst some of this issue may be linked to time available for the role and learning how to create time for mentoring a student through experience as a mentor, sign off mentors are also expressing concern that the difficult decisions are being left to them to make at the end of the programme. This

is seen most starkly in the final cohorts in the analysis of assessment documents for this study. In cohorts E & F, ten students failed their final placement and for seven students it was their first experience of a placement fail. The impact on the students' emotions is great and progress to the end of the programme is interrupted until a reassessment is successful. The decision to fail a student at this stage of the course is not taken lightly (Ilott and Murphy, 1999; Jervis and Tilki, 2011; Black, Curzio and Terry, 2014), however this does demonstrate that sign off mentors as experienced mentors are prepared and confident enough to make the final assessment decision as required and fail students who are not yet ready to enter the register.

This discussion seems to bring into focus that the decision to fail a student is not based on which stage of the programme the student is at, but more on the level of experience and confidence a mentor has in their assessment decision as Flora and Diana show in their assessment practice. As there is no evidence base for the implementation of the sign off mentor there is nothing to look back to for consideration of the intended aims of introducing this role. My interpretation of this issue is not concerned with when a sign off mentor is used, but about the experience and confidence that any mentor has in making difficult assessment decisions. Sign off mentors do not exclusively support final placement students. If they have the experience as a mentor to fail a student in final placement I believe they would equally use that and fail a junior student.

In order to improve the reliability of an assessment decision it would seem to be more appropriate to offer further support to junior mentors with less experience as they complete their mentor preparation and to enable anyone who feels confident and experienced in the mentor role to take on a final placement student, alongside their assessment of students in other

years too. The distinction in these mentor roles between mentor and sign off mentor is not about the stage of student, but more on the experience of the mentor and their development in supporting a range of students (NMC, 2008), including those who struggle to meet the expected level. If junior mentors were given more time for their role in practice and could access support for the assessment process when they required it, in turn their confidence and experience would equip them for assessment of a student at any stage of the programme, including final placement and the underpinning quality of the assessment process would be improved (Hunt, 2014).

Instead of the current process asking mentors to become sign off mentors, and go through the additional specific assessment process required to be entered onto the local register of mentors as a sign off, could we instead ask mentors to ask for support when needed and give them the opportunity to decide when they are ready to assess a wider range of students with less support? The issue of support for mentors is identified in the study by Hunt et al (2016), where findings indicate that providing support to mentors enables them to fail students securely and gain confidence in their role. Rooke (2014) also indicates in her study that support from academic staff was vital, especially when mentors were experiencing issues with assessing students. This may lead towards a model of team mentoring which some placement areas already use. This was demonstrated by four of the eight mentors interviewed who had offered support to colleagues with struggling students. This model could be formalised as proposed by the Royal College of Nursing in their mentor report (2016) and is already being considered by many stakeholders in order to improve the quality of mentoring, increase the sustainability of a reliable model for assessment and offer support from senior mentors to

junior mentors as they come out of mentor preparation and start to take on the role themselves.

Black, Curzio and Terry (2014) make the point that if mentors are not failing weak students in the programme they in turn are failing in their professional duty as an NMC Registrant. Macdonald (1998) refers to failure to fail as professional cowardice and Black, Curzio and Terry (2014) also make this point. As NMC Registrants, mentors should recognise their own level of accountability in the role and specifically in the assessment process. This is clearly outlined as outcome 3.4 in the NMC (2008) Mentor standards (Appendix 1) and all mentors who have completed mentor preparation since 2008 have been made aware of this. Since Duffy's work on failing to fail was published in 2003, there has also been an increased emphasis in preparation, mentor updates and through the mentor literature on failing students and the mentors accountability (Duffy, 2003; Duffy and Hardicre, 2007b; Gainsbury, 2010). The introduction of the sign off mentor however seems to have led mentors who are not sign off mentors to believe the majority of the accountability in the assessment process sits with the sign off mentor and not with themselves. Rooke (2014, p.45) states that respondents in her study felt the role was 'daunting' and this was also expressed by mentors in this study. Therefore mentors appear to be leaving the difficult assessment decisions to the sign off mentor to make in the final placements. This abdicates their own accountability in the assessment process and it would seem that the introduction of the sign off mentor by the NMC (2008) has backfired and not improved the quality of mentorship overall as intended (Rooke, 2014).

If all mentors were assessing to a good standard with regard to their accountability as a mentor (NMC, 2008) and their duty of care (NMC, 2015) then the sign off mentor role would not be required as the quality of

the assessment process would be supported and consistent throughout the nurse student's programme (Andrews et al, 2010). For the nursing profession this delegation of accountability for assessment to the sign off mentor is morally wrong (Black, Curzio and Terry, 2014) professional cowardice (Macdonald, 1998) and does not maintain their own code of practice and offer protection for the public (NMC, 2015), suggesting mentors who do not take action on failing students are not meeting their professional duty of care (Black, Curzio and Terry, 2014; NMC, 2015)

If the mentor system was changed in light of current proposals and literature around mentor preparation (National Nursing Research Unit, 2015; RCN, 2016) with a shift away from all nurses being prepared as mentors, it should result in a team of mentors working together and individually committed to student support. With the high number of students moving through nursing programmes and requiring placements, these members of the mentoring team would require protected time for the role, however this would improve the quality of the mentoring process including the assessments and result in improvement to the standard of the placement assessment and provision of the future nursing workforce. Novice mentors should receive support from experienced mentors in the team following completion of mentor preparation (Hunt, 2014) and these experienced mentor roles may have further protected time and transition into wider educational roles to include preceptorship. This links into development of the student nurses through transition to staff nurse and creating a career pathway for mentors to develop into educators (RCN, 2016). Whilst this is a route for some mentors already, there are no clear career pathways established nationally. Increasing the time and support system for mentoring would increase the value given to the role too.

Casey and Clark (2011) refer to the support that should be available to mentors outlined in the NMC SLAiP standards (2008). Veeramah (2012b) also identified that support for mentors is required as they transition into their new mentor role after preparation. Whilst locally this support is available through mentors' links with practice learning teams, it is reliant on the individual mentor to seek support and ask for help, especially when dealing with a failing student. In the mentor interviews six of the eight mentors had accessed this support when required.

If this support system were reversed and practice learning teams were notified when new mentors completed preparation, then support could be proactive to reassure novice mentors as they transition into their role and empower them to challenge students earlier if required, rather than reactive and only apparent to the mentor who asks for help and knows where to access it.

Elcock and Soohoo (2008) evaluated a support role for mentors in practice in their study and concluded that access to support from a dedicated educator in practice positively influences the quality of assessment and supports mentors who had concerns about a student. With a variety of these roles now working in practice with some employed by the NHS trusts offering the placements and others employed by the local university where the students are studying, there is clearly a need to recognise and formalise these roles. Further work to develop a national role descriptor with designated support for mentors would improve the quality of the assessments in practice and provide a level of support and moderation to the practice assessment system and improve reliability between mentor assessments. In turn this would meet the aim of protecting the public by ensuring a quality assessment system in practice that was valued and less reliant on goodwill and the individual commitment of each mentor.

5.4 Mentor Assessment of Behaviours and Levels of Progress

This fourth theme does not link to the research question but needs discussion as it arose from both phases of data collected in the study and has positive results for the nursing profession, at a time of some negative publicity. For this reason it is included here.

At a time when reports identify that nurses lack the compassion and caring characteristics the public expect of them (The Patients Association, 2011) it is clearly seen here that assessment in the earlier stages of the programme does focus on these attributes for nursing students and continues throughout. Assessment documents repeatedly showed assessment of the student's personal and professional behaviours and this was used as a reason for failure when they were absent or weak.

However, in the final year the focus in assessment appears from the records to move towards a student's abilities to practise effectively using management and leadership skills required for the registered nursing role. These skills are not often recognised by the public who cling to a notion of nurses without power being directed by doctors (Hart, 2004; Gough and Walsh, 2000). It is good to see that when mentors are assessing nurses towards the end of their programme they are looking for those attributes and characteristics, but are also looking for the management and leadership skills that are required for nurses on graduation (NMC, 2004).

One key aspect of mentoring is acting as a role model for the nursing student (NMC, 2008; Walsh, 2014; RCN, 2016). Students spend so much time in practice, in order to learn the professional behaviours and skills alongside the technical skills and knowledge base required (NMC, 2004) and it is vital that development of this whole is seen as the student

progresses through the programme. Dall'Alba (2009) discusses that professional practice programmes should cover actions and reactions required as changes are seen, the underpinning knowledge required to inform the decisions made and knowing who they are as professionals. This should be seen through the role modelling in practice and the holistic assessment used by mentors who expect students to demonstrate this knowledge, skill and attitudes in response to meeting the NMC competencies and achieving their progression through the programme (NMC, 2004) regardless of the academic level of the programme (Ali and Watson, 2011). It is clear that this can be seen in the assessment strategies used and that mentors are failing students when knowledge, skills or professional behaviours and attitudes are not up to the expected standard. It is heartening to see this in practice and through the data.

As a registered nurse myself I am protective of my registration. I worked hard to become a nurse and have been proud to be a nurse in my career. When I am faced with a failing student I always consider this pride and whether I would be happy for a student to gain access to the same register through the assessment of their mentor. Whilst I cannot change the mentor's assessment decision, I do go into situations to support mentors and students through assessment fails in placements. It is traumatic for all involved and yet it has to be done when a student is not meeting the required NMC outcomes. During this study I have found it enlightening to see that mentor assessments are reflecting that they are making judgements on the student's values and professional behaviours as part of this assessment, as it is known these affective behaviours are difficult to assess (Fitzgerald, Gibson and Gunn, 2010; Jervis and Tilki, 2011; Walsh, 2014). Equally it is good to see that as the student progresses mentors are testing the student's knowledge and skills in the wider complexities of the nursing role and failing them if they cannot meet the expected levels

(Black, Curzio, Terry, 2014; RCN, 2016). Key areas where students struggled later in the programme link into research by others suggesting this is not a local finding from this data but instead supporting the work done elsewhere (Black, Curzio, Terry, 2014, Hunt et al, 2016). Morrell and Ridgeway (2014) conducted a phenomenological research study exploring student nurses' perceptions of their own preparedness for their final practice placement. Interestingly students identified that they needed more preparation in university for some skills which included medicines management and leadership. These are both skill based activities lacking in the senior students who failed in this research too and it is interesting to compare these two studies as they contain common themes, but from different perspectives of the students and the mentors.

There is also a link seen here with sign off mentors failing final placement students who are not at the expected level to qualify. The final year of a student nurse programme is demanding with an increased standard of both academic and practice based work expected. This progression cannot be achieved by all students and anecdotally it has been felt that more students fail in the final placement than at other times in the course. With the introduction of the sign off mentor another factor is introduced in that the sign off mentor will always be an experienced mentor. This should mean they have the confidence in their role to make a difficult fail decision and this was seen in the assessment records studied in cohorts E & F where more students failed than at other times in other cohorts. This can be linked to confident sign off mentors assessing students who are struggling with that progression and making the difficult decision to fail them. As previously stated for seven of these students this was their first placement fail. It does raise the question that if students have had confident experienced mentors throughout the course, would any weak students have been identified earlier on and dealt with? If a team

mentoring model was adopted where novice mentors are supported by experienced mentors when a student is seen to be weaker in their progress, would these students have progressed to their final placement without concerns being raised and recorded earlier?

There has been a lot of development work around the concept of the 6Cs since their publication by the Department of Health in 2012. This was a response to the public perception that nurses were failing to care and show compassion to their patients (The Patients Association, 2011; Hayter, 2013; Francis, 2013). Training packages, development conferences and contemporary literature has been developed to ensure that all registrants were aware of the 6Cs and are embedding them into their practice (Department of Health, 2012; Duffy, 2015).

Figure 5.1. The 6Cs logo.

Taken from: Compassion in Practice (Department of Health, 2012)

As this research study considered assessment records which were all completed prior to 2013, it was very heartening to discover the core themes from the 6Cs are embedded in the assessment documents showing mentors are considering them for students right from the start of the programme and have been doing so prior to publication and dissemination of the 6Cs. This provides evidence that can be used to argue that nursing is not losing the capacity to care, communicate and show compassion and courage, in contrast to the headlines news. This data shows that mentors expect student nurses to show these behaviours early on and throughout their programme. When questioning mentors about this during interviews, they consistently referred back to their own expectations of values and behaviours, linking these into both their employer organisations policies and also their professional code (NMC, 2015). It was very clear that all mentors are confident that students should demonstrate these skills throughout their programme as they will be expected to demonstrate them throughout their career. This is of value to the profession, their employers and most importantly to the public they care for.

5.5 Chapter Summary

The four themes identified from the mentor interviews have been discussed in this chapter. Interpretive phenomenology of the data obtained from phase one of the assessment records and phase two of the mentor interviews have been linked with integration into contemporary literature and suggestions for changes in future mentor models.

Returning to the research question it seems that mentors interviewed in this study view the introduction of the Ongoing Achievement Record as positive and impacting on the robustness of the assessment process for

mentors. Mentors have welcomed the use of this document and adopted it to guide their mentor role especially with regard to the assessment element. It is not always a reliable record of past placement assessments though. Mentors interviewed felt this was due to two issues; lack of time for the mentor role as supported by the literature, alongside a lack of commitment to the mentor role. This seems to create an issue in the quality of the mentoring linked to the current pattern of all nurses becoming mentors. The quality of mentors might be improved if recruitment of mentors identified those who wanted to be mentors and they were given time and value for the role and supported by experienced mentors as they transition into the team (Hunt, 2014; RCN, 2016).

Regarding the second element of this study on the introduction of sign off mentors, during interview mentors identified this has not had a positive impact on the robustness of assessment practices. Whilst they felt that sign off mentors have had an impact on mentoring, further evaluation of the interviews showed they felt that this was not always positive impact. Prior mentors seem to be delegating their accountability in assessment and failing to fail weaker students. There is an incorrect perception stated during the interviews that the sign off mentor carries the accountability for the assessment decision in signing the students as fit to enter the register. Existing sign off mentors see this happening in their assessment experiences and show bitterness towards this phenomenon which has created a two tier system of mentoring. This risks dividing mentor colleagues when mentors are reluctant to take on the sign off mentor role due to the challenge of the perceived accountability. If mentors cannot be persuaded to become sign off mentors as Diana states and yet are shown to be failing to fail students earlier in the programme as the assessment records show, then the problem is not with the final placement assessment. It is with mentorship earlier in the programme as data from

the assessment documents shows that experienced sign off mentors are prepared to make the fail decision at the end of the programme if needed despite the challenge to themselves and the impact on the student affected.

Finally, the data shows that mentors are assessing students' behaviours and values throughout the programme and failing them when these are seen to be lacking. As student's progress, if they cannot show competency in the complex nature of the nursing role and take on leadership and skill based roles they are failing in their final year as the assessment records show. This is a heartening result of this data when nursing has been recently criticised for failing to be a compassionate and caring vocation. This will be reassuring to individual mentors, employers and the public who receive nursing care.

I recognise that by adopting thematic analysis of this data (Braun and Clark, 2006) and applying my interpretation here, my findings and discussion are my thoughts and others may not see the data in the same way. Equally this data comes from one locality and one university where nursing is studied. However, in early discussions with colleagues at national level I am reassured that these findings do provide evidence based results for the anecdotal thoughts we have previously shared. Early conference presentations (Royal, 2016a; 2016b) received favourable audience response and indicate others in this context nationally recognise these findings which resonate with their experiences. Further dissemination of this research once the study is complete will also demonstrate if others agree with my findings too, but I recognise that in writing this thesis the interpretation is mine alone.

Chapter Six - Conclusion and Implications for Practice

This doctoral study arose from my working role where an investment of time and partnership work was required to introduce the ongoing achievement record and the sign off mentor. In establishing this study, consideration was given to which methodology to use and my own epistemology on assessment in mentoring. One aspect that drew me towards a qualitative study was my prior research experience on mentors' achievement of their standards (Royal, 2007) and my frustration with the quantitative methods employed there which resulted in a lack of depth of the results obtained. In concluding this study I feel that I have explored the depth of data I wished to and uncovered a series of issues and challenges in mentorship. I have used my understanding of mentorship to inform my interpretations within this study from the data collected. I have also generated evidence based data that explores and explains some of the anecdotal beliefs I had prior to the study, and shared by many colleagues involved in mentorship. I hope that the findings of this study can provide a useful foundation for work to improve the quality of mentorship in the future as we continue to develop the role and the mentorship support systems. These will be intended to improve the quality of the assessment process, for student nurses and their future employers and ultimately for the public they will care for.

Discussion of the role of the mentor, the development and difficulties with the role were outlined in Chapter One. This led to the rationale for the study and why at the start of this thesis I felt that this research was required. Following this, Chapter Two contained a literature review, underpinned by a systematic approach. The literature then drew the themes for mentorship together and analysis of these followed. Discussion of the elements of the mentor role described the tensions and complexities

of being both teacher and assessor, in a role where no time or value was attached. The lack of clarity and a common definition meant that other healthcare systems outside of the UK use different terms for this same role. Issues in assessing competence and the use of continuous assessment were discussed. Finally, policy changes following work by Duffy (2003) on failing to fail result in the introduction of the ongoing achievement record and with no visible evidence base, the introduction of the sign off mentor (NMC, 2008). The literature review concluded with the research question used in this study;

What impact has the introduction of the ongoing achievement record and sign off mentor had on the robustness of mentors' assessment practices?

There is limited literature reporting on research into the impact of both the sign off mentor or ongoing assessment records. Whilst Rooke (2014) and Hutchinson and Cochrane (2014) looked at perceptions of the sign off mentor role these studies did not correlate findings with assessments records in the way this current study has done. Research by Fitzgerald, Gibson and Gunn (2010) whilst examining assessment records did not focus on the changes with the OAR as much as on the tension between verbal and written feedback. In considering both changes and using a Two Phase study to interpret data from both assessment records and mentor interviews this study has added to what is already known about mentorship, with a specific focus on the introduction of the ongoing assessment record and the sign off mentor.

The thesis continued by outlining the methodology used in Chapter Three and gave consideration to the philosophical approach to the research and methods used to collect data. Through the use of an interpretive phenomenological approach I was able to integrate and acknowledge my

experiences from my working role with mentors into this study. Whilst these results emerge from my own interpretations, I believe that they uncover themes that are familiar to the educators like myself who are involved in the context of mentorship, supporting students and their mentors.

By choosing to examine assessment records generated by mentors in their assessment of student nurses I have used an unusual method to collect the data for phase one of the study. No literature was found that focused on using existing assessment records for this purpose. Through interviews with mentors as phase two of the research I was able to further interpret the themes from assessment records and generate data from mentors currently assessing student nurses to ensure my interpretation of phase one was congruent with their assessment experiences. This formalised the prior informal conversations (Murphy and Dingwall, 2003) I had with mentors in my daily work and enabled the content and mentors' lived experiences to be recorded and interpreted.

Inclusion of the detail of the data aims to present these findings as trustworthy (Graneheim and Lundman, 2004). Use of reflexive thinking whilst collating the data and through the phases of thematic analysis (Braun and Clark, 2006) has ensured I am open to alternative themes found in the data from the perspective of the participant (Pratt, 2012). This is evidenced through the inclusion of theme four on the mentor assessment of behaviours and levels of progress which was not originally sought as part of this study.

Identification of the themes is followed by presentation of the results and some interpretation in Chapter Four and continues in more detail and with further interpretation and analysis in Chapter Five. In response to the research question the introduction of the ongoing achievement record has

had a high impact on the robustness of assessment processes locally, as identified by mentors interviewed. This is new knowledge as no prior published work has researched this nor established this impact. Mentors interviewed clearly showed they do not rely only on the assessment records to inform their judgement, but use this as one source alongside their own judgement of the student's progress and level of work as they start to work alongside them. Where the student is not at the expected level mentors know they cannot rely on the OAR to confirm there are issues, as this may not be recorded or later in the programme it may be that the student is only just experiencing difficulty as they progress.

As the student moves towards the end of the programme and the final placement, a sign off mentor role has been introduced as the final assessment point, judging the student as fit to enter the NMC register. This sign off mentor is required to be an experienced mentor (NMC, 2008) and for the mentors interviewed confidence in mentorship was seen to be as important as experience. Once the role of the sign off mentor was established it was seen that students were failing at a higher number at the final assessment point locally. For some students it was evidenced in their inability to progress into the leadership and prioritisation skills required of them at this stage of the course, but it was also seen in the assessment documents and confirmed by mentors interviewed, that students had been allowed to pass prior placements when they were not at the required level.

Where sign off mentors received weak students into their final placements but the OARs showed no prior issues, there was bitterness expressed that prior mentors had left that decision to them. The main reason given for this during interviews was that prior mentors did not see themselves as having the same accountability to the assessment decision as the sign off

mentor and therefore failed to fail the student, not demonstrating the moral courage discussed by Black, Curzio and Terry (2014).

This study shows that the introduction of the sign off mentor has not improved the quality of assessment from mentors over the whole of the students' programme within the local context, but instead has promoted a system it was trying to solve. It has had a negative impact locally as the data shows mentors now pass the responsibility to make the difficult assessment decisions onto the sign off mentors in the belief that they are the assessors accountable for this. In this way the introduction of the sign off mentor has backfired and could allow weak students to progress through the programme unchallenged, only to be failed in the final placement by an experienced mentor, who as a sign off mentor will not pass the weak student. Introducing the sign off mentor role has not increased the quality or robustness of assessment practices as intended. This research is the first time the impact of the sign off mentor has been researched to examine impact through investigation of the assessment documents and mentor perspectives gathered via interview. This brings new knowledge into the forum of mentor assessment regarding the sign off mentor within the scale of this study.

It was also found that mentors are reluctant to become sign off mentors and describe the role as daunting. Mentors interviewed stated many do not want this increased accountability to make these decisions as part of their role. This perpetuates a system where there is a lack of sign off mentors and yet prior mentors rely on them to have the confidence to make the difficult assessment decisions, delegating this gatekeeper role whilst being unwilling to do it themselves.

Figure 6.1 Summary of Recommendations

1	Abolish the sign off mentor role as this study has shown it has not improved the quality of assessment as intended and has created two tiers of mentor roles.
2	Develop the use of team mentoring, with experienced mentors supporting novice mentors as they start their mentoring role
3	Highlight the accountability of all mentor assessment decisions in mentor preparation and mentor update activities
4	As NMC standards for pre-registration nursing are revised, ensure assessment of values and behaviours is explicit in the ongoing assessment records
5	Continue to use the ongoing achievement record for mentor records of their assessment decisions and include a record to show it is reviewed by the mentor at the start of a student's placement.

I propose the sign off mentor role should be abolished nationally as there is no evidence base for establishing the role, literature has not shown the role to have value and this study shows it has not improved the quality of the assessment process, which appear to be the intended aim. Instead a support system using teams of mentors should be established to ensure new mentors are supported by experienced mentors as they build up their experience and confidence in the role. This support can come from other mentors in their team, or from educators in post employed by either the placement organisation or by the university. Where these roles are in use and support is available it is already proved that mentors make these difficult decisions (Hunt et al, 2016). Within my university different models of mentoring are being explored with two local large NHS Trusts, with a view to teaming novice and experienced mentors to maximise the quality of the assessment process.

A positive finding from the data that was not sought but could not be ignored was the evidence that mentors are assessing students for behaviours and values required for effective nursing practice right from the beginning of the programme and commenting on these when they are not present. It is heartening for the future of nursing education to see that nurses who do not demonstrate the required behaviours and values from an early stage should not progress on the programme and nurses who complete the programme are competent in the range of skills required and identified by their professional body (NMC, 2004). Whilst this was a local study this finding was reinforced by feedback and audience comments when the study was presented at national events (Royal 2016a; 2016b). As the newer graduate exit standards (NMC, 2010) are revised and new outcome based standards are due in 2017 it will be good to know that mentors have shown the ability to assess competence using an outcomes based framework already.

This study has used assessment documents to capture and interpret mentor assessments and trends in assessment practice. It is a strength of this study that phase one has been conducted on naturally occurring data available to the researcher. By moving onto phase two and interviewing mentors, this has further strengthened this study by confirming the trends seen in the assessment documents and capturing this as a whole. The research question has been answered and further trends on the assessment of behaviours and values has also been found.

6.1 Implications for Policy and Practice

The findings from this research study on the positive impact of the OAR and the negative impact of the introduction of the sign off mentor will have

implications for policy and practice both locally and nationally. Dissemination of these findings will take place through conference presentations, publications and local and national clinical education networks. The NMC have also requested a summary of this work in order that it may inform their future policy on mentorship, which is currently under review.

Figure 6.2: Summary of Dissemination

Context	Action
Policy	Provide summary of this study to the NMC. Input to NMC review of Standards to Support Learning and Assessment in Practice where requested.
Dissemination Publications & Conferences Nationally	May 2016 – Presented at CNE NET Cheltenham September 2016 – Presented at NET2016 Conference, Cambridge March 2017 – accepted to present two papers from this study at RCN International Education Conference, Cardiff Paper on the impact of sign off mentors in progress for submission for publication. Paper on the impact of the ongoing achievement record in progress for submission for publication. Paper on mentor assessment of behaviours in progress for submission for publication.
Dissemination Locally	Presentation at Conferences and meetings at local NHS Trust partners Review models of mentorship within 2 local NHS Trusts and develop evaluation of changed support systems Presentation to mentors at mentor updates. Introduction of assessment workshops linking the findings of this study in to mentor preparation modules. Presentation within the School at strategic practice learning partnership meetings. Involvement in development of the new electronic OAR to ensure mentors review prior assessment decisions at the

	start of subsequent placement.
	Continue practice support for mentors and students in placement through the local practice learning team structure
Further research	Introduction and evaluation of team mentoring locally at 2 NHS Trusts
	Widen data collection from assessment records to other universities to explore if findings are seen within wider context.

Early findings were presented in May 2016 at a national clinical educator conference (Royal, 2016a) attended by seventy clinical educators. The presentation was very well received with encouraging feedback which has informed the writing up of this study. A second presentation in September at an international healthcare educator conference (Royal 2016b) also received positive feedback, indicating audience members were familiar with the themes and findings discussed within their own context too. Further presentations at international nurse education conferences are planned. Additionally dissemination activities locally include presentations to clinical educators and practice development matrons in our partnership Trusts. This will initiate discussion on future models for mentorship and opportunities and limitations for student nurse assessment through mentoring.

I will also submit three articles for publication to international nurse education journals in conjunction with my supervisors. One on the impact of the ongoing assessment record, one on the issues and negative impact of sign off mentor roles and a final paper on the assessment of values and behaviours which is topical in nursing at the moment and this study has provided evidence demonstrating how mentors assess these throughout the programmes. This will ensure findings from this study reach a wider

audience and may influence assessment practices both nationally and internationally.

On a local perspective I will work with academic and Trust staff who support practice learning to ensure the study impacts on practices at my School of Nursing and within our partner Trusts. We need to ensure that the accountability of all mentor assessment decisions should be highlighted at mentor preparation, updates and during individual support activities. It is vital that all mentors recognise their individual accountability for taking the assessment decision, however difficult that may be.

We also need to ensure that ongoing achievement records will continue to be used, but more time should be given for their completion so that variability is reduced and detail is maximised for the benefit of the student and future mentors. Records in the OAR should also show the OAR is reviewed at the start of each placement, when the initial interview is documented. As part of this a podcast on completion of the OAR has been developed by a colleague and peer reviewed by myself for use locally with mentors as an online learning tool. An assessment workshop has been integrated into the content of mentor preparation modules using some of the findings from this research, alongside examples of OAR completion from mentors in practice. This work is led by myself and was used for the first time in October 2016 with the aim of giving a research background to worked examples from practice highlighting the importance of completion of the assessment documents accurately alongside their accountability as a future mentor.

Recruitment of future mentors should consider their professional and individual commitment to the role. Everyone progressing through mentor preparation modules should want to be there and motivated to offer help and support to students. Those who do not want to be a mentor should not

be expected to take on the role as the quality and commitment of their mentoring may affect the students' progress.

Work will be done to offer experienced mentor support to all mentors when required and especially when novice mentors transition into the role. This could be done by educators based in universities or placement organisations as well as existing mentors who have this experience already. Models of mentorship locally may be changed to ensure this occurs and where changes are made evaluation of the success of the changes will be completed.

6.2 Reflection on Limitations of This Study

At the conclusion of this study I must reflect on the limitations. I recognise that this study cannot answer all mentorship questions and indeed it has not set out to do so. The limitations here are primarily that data has been taken from one university in one area of England. Through an interpretive phenomenological methodology I have stated my interpretation of this data. However, this cannot be generalised to a wider community of mentorship without further work, as local contexts for mentorship and mentor use of the assessment documents may show other issues, not found here. During early dissemination of this work my interpretations have resonated with other educators in practice who support mentors and this gives me confidence that these findings can be of wider use than the locality of study. It may also be that detail of how this study was conducted will enable others to explore their own assessment documents to look for patterns too. This evidence based study should give answers to support others' anecdotal thoughts and findings on the quality of mentorship. I am open that my interpretations may not however be shared by everyone and there may be themes they expect that I have not found.

Qualitative studies have been criticised for their lack of generalisability (Avis, 2003), however I chose a qualitative study in order to have depth of data and interpretation beyond that of my previous research. In choosing to include six cohorts of students in phase one I hope to have captured a wider timeframe of assessment documents to show the changes I have studied regarding the OAR. I cannot however say that these changes would be seen in all nursing programmes across the UK where the OAR has been introduced, but am confident they represent the change in practice I have witnessed locally. Interviews with mentors have confirmed my interpretations of the mentor assessment records but others may not hold those same interpretations. It may be that if a different set of individual mentors had been interviewed, data and interpretation may have altered. I have reflected on this over the course of the study to ensure I am representing what I see in the data obtained and not what I expect or wish to see. I do acknowledge that others may have a different view as interpretation is a subjective element by its very nature.

6.3 Changing Perceptions through the Study

This study has been completed over four years. As is human nature, experience changes thoughts and understanding. There have been challenges in completing this research study and I have needed to remain open to changes in mentorship that have taken place whilst the study is in progress, to ensure all elements are considered. I have grown as a researcher through the completion of this study but my primary motivation has always been aligned to my working role and how the changes in mentorship impact on my work and on the quality of mentorship and the students who graduate from the programme.

During this time I have been involved professionally in four key situations where students have failed placements. For two of these students it was a final placement fail by their sign off mentors. In witnessing the decisions and feedback given to the students, and the experience and courage of the mentors involved I have seen that the mentor system works effectively when mentors stand by their judgement and are supported to do so. They have all sought support for the student and themselves in the assessment process and both the university and the NHS organisations value them and the role they are performing here for the future nurses in training. Whilst the impact on the student nurses has been emotional and affected their progress on the course, making that fail decision has protected the public, which is the primary function of the Nursing and Midwifery Council.

As a registered nurse myself I have been satisfied the right assessment decision was made by those mentors at that point in time. I have felt privileged to be present to support both mentors and student at this time and to follow up on the student's progress and to return and debrief the mentor when possible. Two of the students passed on second attempt after progress and improvements were clearly seen. Two students however did not meet the required standard and were terminated from the programme. However, this process took a considerable time for all concerned; students, mentors, tutors, and practice educators alongside the emotional impact of the situation.

Mentorship is a complex task that is in addition to the nurses' clinical role. As discussed in this study it needs to be valued and given time. Mentors all need to understand the importance of mentoring and be committed to the role, and they need support to do the role effectively. Students need to understand the demands placed on mentors and be proactive in their

placements. Where a student is struggling, support should be readily available to both the student and the mentors.

It was vital in these situations that support was available to all, decisions were transparent, assessment documents were correctly completed and action plans for improvement were clear and objective. Record keeping for the assessment decisions was a priority. I felt through my involvement in these situations in my working role, I was taking my learning from this research into the situations and using it to inform my advice and support and to give unbiased support to all concerned. This was not an easy task and I found it emotionally draining. My professional registration and therefore my accountability meant I needed to be clear in my role and involvement here. I was pleased to be able to offer help and support in these situations and I work alongside other educators who feel the same.

6.4 The Contribution to Knowledge

This study has researched the impact of two national policy decisions from the Nursing and Midwifery Council which took place in 2007. It is the first qualitative study to explore the impact of the ongoing assessment record on assessment practice locally. It has evaluated the impact of these changes within the local context. Whilst findings from this study cannot be generalised, the results of this study are recognised by other educators nationally for application to their areas of work.

The contribution to knowledge from this study is that ongoing assessment decisions were felt by mentors locally to have a positive impact on the quality and reliability of mentor assessment when the records are completed accurately. This is enhanced when mentors are given time for completion of the assessment documents.

This study has also explored the impact of the introduction of the sign off mentor role. Whilst this has been researched by Rooke (2014) the introduction of sign off mentors locally has had a negative impact on mentoring. When prior mentors did not take action with weak students the sign off mentor had to make the difficult decision to fail the student at the end of the programme. This caused a two tier system of mentorship to emerge and mentors interviewed expressed bitterness about the incorrect belief that accountability of the assessment decisions sits with the sign off mentor and not with all mentors. Within the context of this small study sign off mentors have not improved assessment quality and future work will explore using team mentoring to enable novice mentors to be supported in practice by experienced mentors as they commence the role after preparation.

It is important to have this finding through research as there is no evidence base found to support the introduction of the sign off mentor role and this current study shows it has not led to the expected improvement in quality of assessment locally that was assumed when the role was introduced by the NMC in 2007.

6.5 Chapter Summary

Whilst this situation of support is improving, and mentors interviewed for this study confirmed that support was available when requested, we need to ensure the mentor role is valued. New mentors need to be supported by experienced mentors as they transition into the role, as literature is showing not all nurses need to be mentors (National Nursing Research Unit, 2015; RCN, 2016). Further support systems locally need to be developed as outlined here and be consistent to ensure the mentor role is

valued and assessment is given the commitment and time required by the individuals and the organisations involved. Support should improve the robustness of assessment practices. Without this weak students may still qualify and the future implications to the patients they care for cannot be underestimated.

As policy changes are made it is vital that research evaluates the impact and success of the changes. Within this study on changes to mentors' assessments, policy changes have been examined and the quality of assessment has been challenged in regard to the introduction of the sign off mentor. Moving forward these findings will inform local work on mentorship quality and systems and be disseminated more widely aiming to impact on future national policy on mentorship. It is the key principle for this work that patient care is delivered by safe and competent practitioners who have been robustly assessed in their programmes of nursing study prior to entry to the NMC Register.

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Appendices

Appendix 1 - NMC Mentor Standards

Domains and Outcomes for Mentors

(Stage 2 of Standards to Support Learning and Assessment in Practice – NMC 2008).

Domain 1: Establishing effective working relationships - Demonstrate effective relationship building skills sufficient to support learning, as part of a wider interprofessional team, for a range of students in both practice and academic learning environments;
1.1 Demonstrate an understanding of factors that influence how students integrate into practice settings 1.2 Provide ongoing and constructive support to facilitate transition from one learning environment to another 1.3 Have effective professional and interprofessional working relationships to support learning for entry to the register
Domain 2: Facilitation of Learning - Facilitate learning for a range of students, within a particular area of practice where appropriate, encouraging self-management of learning opportunities and providing support to maximise individual potential
2.1 Use knowledge of the student's stage of learning to select appropriate learning opportunities to meet their individual needs 2.2 Facilitate selection of appropriate learning strategies to integrate learning from practice and academic experiences 2.3 Support students in critically reflecting upon their learning experiences in order to enhance future learning
Domain 3: Assessment and accountability - Assess learning in order to make judgements related to the NMC standards of proficiency for entry to the register or for recording a qualification at a level above initial registration
3.1 Foster professional growth, personal development and accountability through support of students in practice 3.2 Demonstrate a breadth of understanding of assessment strategies and the ability to contribute to the total assessment process as part of the teaching team 3.3 Provide constructive feedback to students and assist them in identifying future learning needs and actions. Manage failing students so they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future 3.4 Be accountable for confirming that students have met or not met, the NMC competencies in practice. And as a sign-off mentor confirm that students have met or not met the NMC standards of proficiency in practice and are capable of safe and effective practice

Domain 4: Evaluation of learning - Determine strategies for evaluating learning in practice and academic settings to ensure that the NMC standards of proficiency for registration or recording a qualification at a level above initial registration have been met

4.1 Contribute to evaluation of student learning and assessment experiences – proposing

aspects for change resulting from such evaluation

4.2 Participate in self and peer evaluation to facilitate personal development, and

contribute to the development of others

Domain 5: Create an environment for learning - Create an environment for learning, where practice is valued and developed, that provides appropriate professional and interprofessional learning opportunities and support for learning to maximise achievement for individuals

5.1 Support students to identify both learning needs and experiences that are

appropriate to their level of learning

5.2 Use a range of learning experiences, involving patients, clients, carers and the

professional team, to meet defined learning needs

5.3 Identify aspects of the learning environment, which could be enhanced negotiating

with others to make appropriate changes

5.4 Act as a resource to facilitate personal and professional developments of others

Domain 6: Context of practice - Support learning within a context of practice that reflects health care and educational policies, managing change to ensure that particular professional needs are met within a learning environment that also supports practice development

6.1 Contribute to the development of an environment in which effective practice is

fostered, implemented, evaluated and disseminated

6.2 Set and maintain professional boundaries that are sufficiently flexible for providing

Interprofessional care

6.3 Initiate and respond to practice developments to ensure safe and effective care is

achieved and an effective learning environment is maintained

Domain 7: Evidence-based practice - Apply evidence based practice to their own work and contribute to the further development of such a knowledge and practice evidence base

7.1 Identify and apply research and evidence based practice to their area of practice

7.2 Contribute to strategies to increase or review the evidence base used to support

practice

7.3 Support students in applying an evidence base to their own practice

Domain 8: Leadership - Demonstrate leadership skills for education within practice and academic settings.

8.1 Plan a series of learning experiences that will meet students defined learning needs

8.2 Be an advocate for students to support them accessing learning opportunities that

   meet their individual's needs, involving a range of other professionals, patients,

   clients and carers

8.3 Prioritise work to accommodate support of students within their practice roles

8.4 Provide feedback about the effectiveness of learning and assessment in practice

**Appendix 2 - School of Education Ethics Approval
2011/16/AK**

School of Education – Research Ethics Approval Form

Name   Jan Royal

Main Supervisor   Roger Murphy

Course of Study   PhD

Title of Research Project:
            Practice Based assessment in nurse education

Is this a resubmission?   Yes

Date statement of research ethics received by PGR Office: 25.05.11

Research Ethics Coordinator Comments:

I am satisfied that the issues I raised after the initial submission have been addressed.

Good luck with the research!

Form Updated November 2012

original   Research has remained the same as the submission in 2011

Appendix 3 – School of Nursing Ethics Approval

School of Nursing, Midwifery and Physiotherapy
University of Nottingham
Queen's Medical Centre
Nottingham
NG7 2UH

22/11/2012

Dear Jan

Ethics Reference No: NA
Study Title: Practice-based assessment in nurse education
Lead Investigator: Jan Royal
**Co Investigators:** Professor Roger Murphy, School of Education.

Further to the ethical approval of your project by the School of Education, I am happy to confirm that it also has R&D approval from the School of Nursing, Midwifery and Physiotherapy.

Yours sincerely

Stephen T.

Dr. Stephen Timmons, Associate Professor, SNMP & School Ethics Officer

stephen.timmons@nottingham.ac.uk

Appendix 4 - Nottingham University Hospitals Ethics Approval
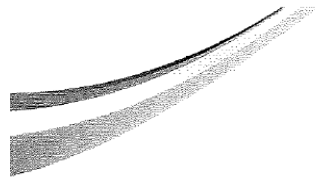
Nottingham University Hospitals **NHS**
NHS Trust

Research & Innovation
Nottingham Integrated Clinical Research Centre
C Floor, South Block
Queen's Medical Centre Campus
Derby Road, Nottingham NG7 2UH

Tel: 0115 9249924 ext 70659
www.nuhrise.org

Professor Roger Murphy
School of Education
The Dearing Building
Jubilee Campus
The University of Nottingham
Nottingham
NG8 1BB

2 3 JAN 2013

Dear   Professor Roger Murphy

  Re: 13RS001

Introducing an ongoing assessment record for mentors in practice

The R&I Department have reviewed the following documents and NUH is in agreement to act as a patient identification site (PIC) for the above research. The agreement has been granted on the basis described in the application form, protocol, and supporting documentation. The documents reviewed were:

Protocol, version 1.0, dated 18/12/12.

PIS, version 1.0, dated 18/12/12.

CF, version 1.1, dated 18/12/12.

Please note that the R&I department maintains a database containing study related information, and personal information about individual investigators e.g. name, address, contact details etc. This information will be managed according to the principles established in the Data Protection Act.

Yours sincerely,

We are here for you

220
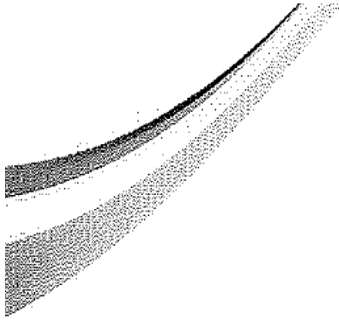
Nottingham University Hospitals **NHS**

NHS Trust

Dr Brian Thomson / Dr Maria Koufali

Director of Research and Innovation / Deputy Director Research and Innovation

Appendix 5 - Nottinghamshire Healthcare NHS Trust Ethics Approval

222

positive

Nottinghamshire Healthcare **NHS**
NHS Trust

Positive about integrated healthcare

Research Management and Development Department
Institute of Mental Health
University of Nottingham Innovation Park
Triumph Road
Nottingham
NG7 2TU

E-mail: emma.pearson@nottshc.nhs.uk
Direct Line: 0115 748 4320

Our ref: AMH/30/01/13

Date of letter: 30th January 2013

Ms Jan Royal

Dear Ms Royal

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Trust's R&D Department. The project has now been given NHS permission for research on behalf of:

Dr Peter Miller: R & D Lead, on behalf of Nottinghamshire Healthcare NHS Trust

Study Title: Introducing an on-going assessment record for mentors in practice

PI: Jan Royal CI: Prof Rodger Murphy

Summary:

The researcher is hoping to recruit Nurse Mentors to undertake a hour long interview to establish mentors perceive the introduction of the on-going assessment record strengthens the assessment process. She will display a poster that asks them to contact her should they be interested, she will then arrange a suitable time and university location for the interview.

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation.

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the

Stonewall DIVERSITY CHAMPION   POSITIVE ABOUT DISABLED PEOPLE   INVESTORS IN PEOPLE UK   2010 EMPLOYER   cpaa Award Winner 2011   MINDFUL EMPLOYER

REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

Shirley Mitchell
Head of Research Management and Governance

CC:

Chief Investigator: Prof Rodger Murphy

Sponsor: Angela Shone

Appendix 6 - Document Summary Record Sheet

Document Analysis Summary   Vs. 1

Cohort: _____   **Student Code** _____

Grading   Above required level

                At required level

                Below required level

                Not achieved

Notes on grading and why not achieved if applicable

Conduct and Professional Behaviour – mentor comments

Mentor Feedback Comments – keywords / phrases

Student Comments – keywords / phrases

J Royal Ed D research study Dec 2012