T H E U N I V E R S I T Y O F H U L L

SKILL ASSESSMENT AND ITS RELATIONSHIP TO THE TRAINING AND EDUCATION OF NURSES CARING FOR PEOPLE WITH MENTAL HANDICAP

Being a Thesis Submitted for the Degree of

DOCTOR OF PHILOSOPHY

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GLOSSARY

a) Face Validity of Assessment

The test should look as if it is testing what it is intended to test.

b) Criterion Related Validity of Assessment

The relationship between scores on the test and some other related criterion. These could be either (i) Concurrent or (ii) Predictive.

c) Content Validity of Assessment

The extent to which the test covers the syllabus to be tested.

Reliability of Assessment

How far the test will consistently give the same results if it could be repeated by the same group of students under the same conditions.

The Educational Relevance of Assessment

Being satisfied that a particular technique or techniques is/are appropriate to the content and style of the teaching and learning experienced by the student, and also has relevance to the educational objectives and assessment goals, in so far as the content and style relate to the objectives and goals. (Frith and Macintosh 1984)

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)

The Statutory Nursing Body responsible for

(a) maintaining the requirements which govern the assessment of nurses, midwives and health visitors in training for a basic recordable qualification, under Section 19(1)(c) of the Nurses, Midwives and Health Visitors Rules Approval Order No 873 1983 and 12(c) of the Nurses, Midwives and Health Visitors (Training) Amendment Rules No 1456 1989.

(b) setting the 'formulative framework of interpretative principles' applying to the assessment of nurses, midwives and health visitors in training for a basic recordable qualification.

The National Boards for Nursing, Midwifery and Health Visiting

The four National Boards established under the Nurses, Midwives and Health Visitors Act 1979:

English National Board for Nursing, Midwifery and Health Visiting (ENB)
Welsh National Board for Nursing, Midwifery and Health Visiting (WNB)
National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS)
National Board for Nursing, Midwifery and Health Visiting for Northern Ireland (NBNI)

Each National Board is charged with a responsibility for ensuring that the Statutory Rules and the UKCC Interpretive Principles relating to

the assessment of nurses, midwives and health visitors in training for a basic recordable qualification are adhered to.

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The work is dedicated to my wife Mary.

Peter Birchenall

BACKGROUND TO THE STUDY

In recent times, society has experienced enormous changes in the way that people with mental handicap are cared for and supported in the community. Government policy is directed towards a reduction in the number of people who live in long stay hospital accommodation, thus reflecting a need to create a system of care in a more appropriate setting, supported by professional carers who have the necessary skills and knowledge to enhance the quality of life of their client. As with all major change, invariably there will be difficulties, target dates for implementation of policy may fall behind for various reasons, or a change in direction away from the original objectives may occur. Changes in care provision take time to reach fruition, and because nursing is closely linked to these changes through the statutory regulation of its syllabus/curriculum and examinations/assessments, planning for the future is often done in an atmosphere of uncertainty. The Statutory body has to take account of societal changes, and as such may sometimes be ahead, and sometimes following in the wake of social policy. An example can be seen in the change of terminology used to describe people with a mental handicap. It is now more common to hear and read the phrase 'learning difficulties' or 'learning disabilities', yet the nursing guidelines for the United Kingdom Central Council Project 2000 Branch Programme will refer to 'mental handicap' which is the legal term. A prime example of the Statutory body being ahead of social policy was the publication of the 1982 Syllabus in Mental Handicap Nursing. Without doubt this innovation was responsible for a major shift in attitudes towards care practises, and placed mental handicap nursing in a strong position to develop a future role.

This study is concerned with the acquisition and assessment of nursing skills. It is written against a background of nursing education which, apart from the small number of degree courses, expects students to be health authority employees, undergoing a course of study which has its content and examination/assessment controlled from a statutory source (see Figure 1). The main focus of the study concentrates on the organisation and outcomes of practical skill assessment, taking as its theoretical framework the work of Rowntree (1977) and Wong (1978) who show that examination and assessment procedures influence what is learned by the student, and what is taught by the teacher. Even though nursing education has become more complex since the devolvement of practical assessment to clinical staff, (ie trained nurses employed in clinical practice by employers of students) there remains the well documented conflict between idealistic theory in curriculum versus realistic expectancy in practice. (Hunt 1974, Bendall 1975, Birch 1975, Fretwell 1975, Orton 1981). Here again, nursing practice may be ahead or behind the philosophies of care as advocated by the Statutory body.

Changes in government and societal attitudes towards the provision of care for people with learning difficulties has created a need for practitioners to be prepared for a future role which as yet is not truly understood. It becomes essential to analyse existing skills as a means of determining the points of evolution. The study attempts to carry out this analysis through an exploration of practical skills assessment, because it is here at this point where curriculum and work interface. An analysis such as this will show the strengths and weaknesses of devolved assessments, and the influence on skill development from sources other than

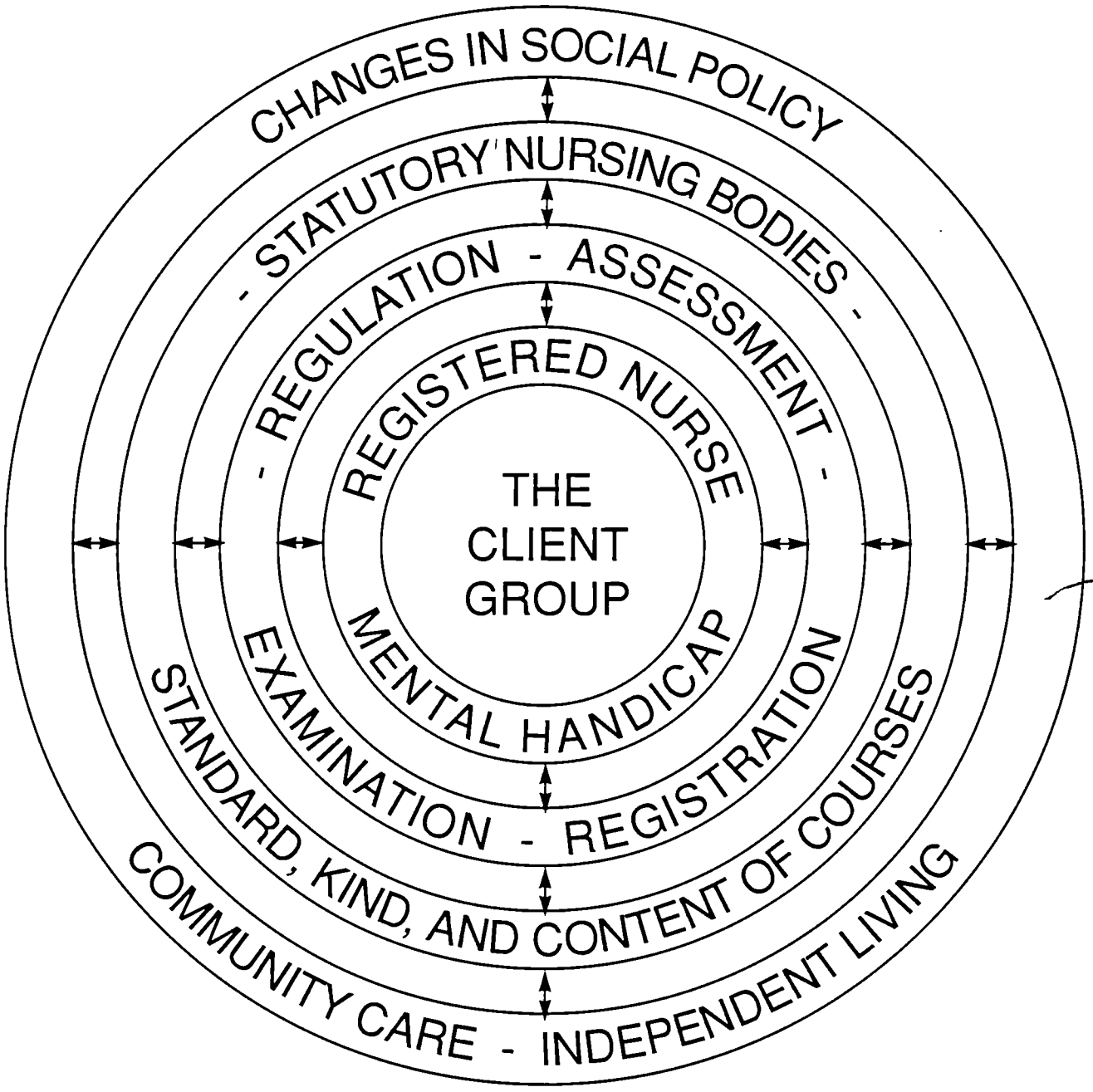


FIGURE 1 The Relationship Between Changes in Social Policy and the Statutory Requirements of the English National Board and the United Kingdom Central Council to provide Relevant Nursing Courses

the Statutory body. These include multi-professional working, societal change and the move towards educational strategies which reflect the theory and practice of adult learning. It will also show points of conflict which still remain, as well as identifying the moves which have occurred towards a more positive relationship between theory and practice.

The process of assessment makes a declaration to the student about what is thought to be important for entry to the profession. This may or may not be at odds with the implicit values gained from a majority of the student's learning which has taken place in the world of work. Also it is necessary for assessment to identify skills required for future practice, rather than inappropriate skills located in the past. Therefore in this thesis there is an analysis of skills thought necessary for present and future use, taken from the student perspective. It is important to obtain this perspective since students are the practitioners of the future, and upon them depends the service that clients will receive in years to come.

CHAPTER 1

INTRODUCTION TO THE THESIS

For the purpose of this study the essential characteristics of assessment are defined and discussed. In particular the work of Deale (1975), Rowntree (1977), and Frith and Macintosh (1984) is applied to the characteristics of validity, reliability and educational relevance of practical skills assessment.

Validity and reliability impose certain requirements on any plan of assessment if it is to adequately fulfil its purpose, and can be described as the quality a test should have if it is to achieve the outcome(s) that is/are intended. (Deale 1975) Various forms of validity exist, these and other related terms are described in the glossary.

The educational relevance of assessment is of direct importance to the study, especially as nursing education is now well established within an andragogical framework, and the mode of assessment employed by respective Schools of Nursing should reflect this.

Collectively the definitions and descriptions of validity, reliability and educational relevance can be applied to nursing education in a particular way. When constructing assessment proforma a number of critical factors require to be considered. The tight relationship between assessment and registration as a nurse is enshrined within the 1983 Nurses, Midwives and Health Visitors Rules Approval Order No 873 (Rule 18) which describes the competencies to be achieved and subsequently tested before a nurse is adjudged to be legally qualified. Therefore assessment and registration are the instruments through which the nursing profession seeks

to ensure that practitioners do the job safely and appropriately. Assessment is primarily the 'gatekeeper' of standards, and should accurately reflect the course of study undertaken by the students, which in turn should reflect the nursing role as expected by society. In recent times society has gained increasing awareness of the difficulties inherent within long stay mental handicap hospitals, and a policy of care in the community is rapidly becoming a reality for many former hospital residents. Nursing has to meet these new and demanding goals through a constant reappraisal of the education and training of future practitioners. Figure II illustrates not only the governing function of the statutory nursing bodies who regulate the standard, kind and content of courses, but how assessment/examination is closely allied to registration as an essential precursor to professional practice, and also the influence of societal changes and pressure groups to the evolution of nursing curricula, and the direction of care.

From the diagram it can be seen that nursing education is strictly regulated by statute. Related terminology conveys specific meaning when applied to this regulation. For a nurse to be deemed competent she/he must display through assessment, an ability to care for patients or clients by demonstrating skills relating to the competencies stated within the Statutory Instrument referred to previously. Clearly the curriculum must be written around these competencies. The competencies are reproduced here because they are central to the practical assessment of nursing skills and therefore highly relevant to this study.

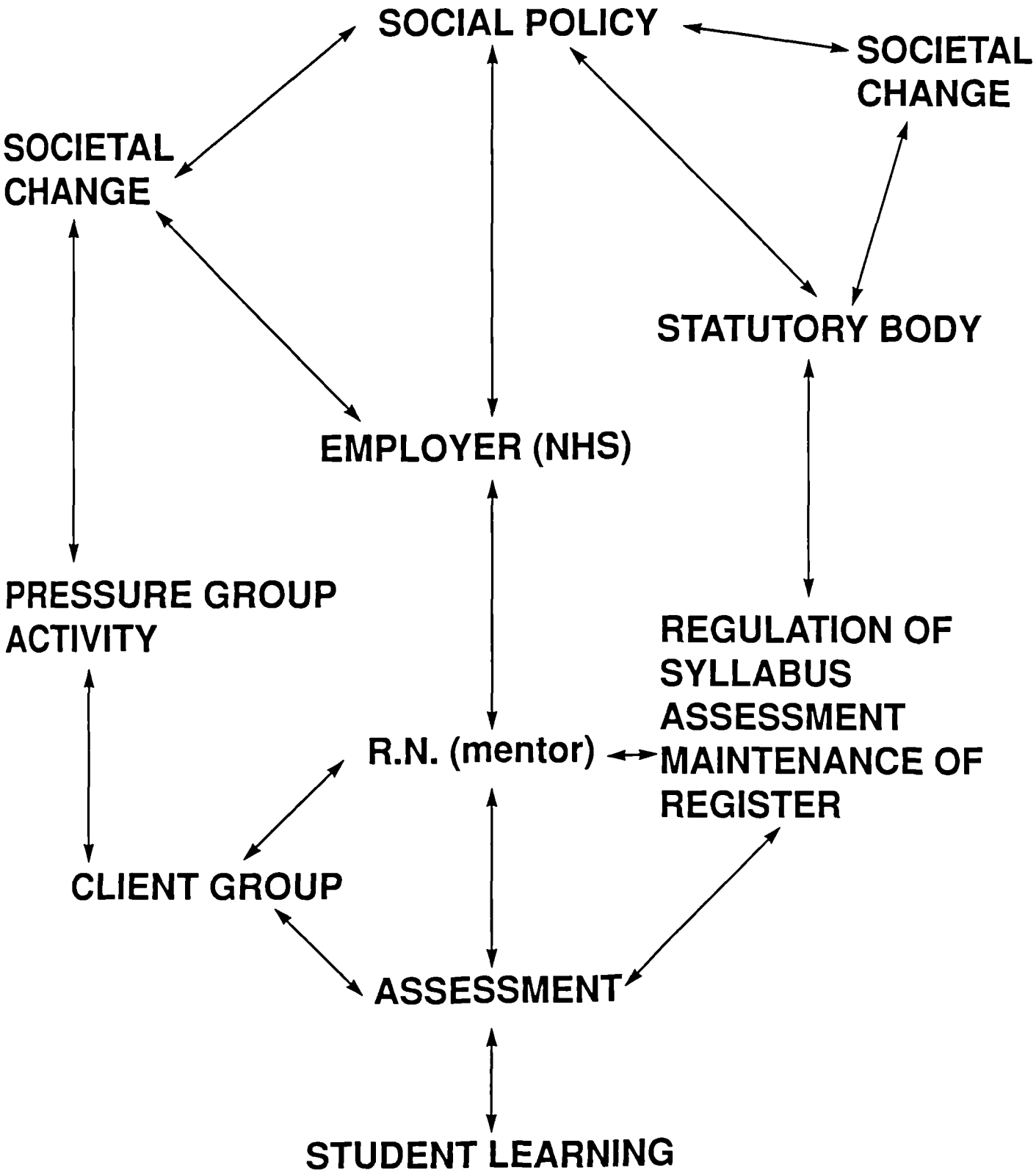


FIGURE II The Influences That Govern the Evolution of Nursing Education

'Courses leading to a qualification . . . enable the student to accept the reponsibility for her personal professional development and to acquire the competencies required to:

a) advise on the promotion of health and the prevention of illness;

b) recognise situations that may be detrimental to the health and well-being of the individual;

c) carry out those activities involved in conducting the comprehensive assessment of a person's nursing requirements;

d) recognise the significance of the observations made and use these to develop an initial nursing assessment;

e) devise a plan of nursing care based on the assessment of the co-operation of the client, to the extent that this is possible taking into account the medical prescription;

f) implement a planned programme of nursing care and where appropriate teach and co-ordinate other members of the caring team who may be responsible for implementing specific aspects of the nursing care;

g) review the effectiveness of the nursing care provided, and where appropriate initiate any action that may be required;

h) work in a team with other nurses, and with medical and paramedical staff and social workers;

i) undertake the management of a group of clients over a period of time and organise the appropriate services.'

These competency statements apply at all stages of initial preparation, and the skill base should be located within them. For example, the 1982 Syllabus of Training in Mental Handicap Nursing is constructed firmly on the basis of the Nursing Process which allows for a staging of skill development through levels of increasing complexity. It can be seen from the competency statements that the problem solving approach depends largely upon the effective teaching of the Nursing Process, and consequently it should be a major component of any curriculum which is approved by the Statutory nursing bodies. It follows that whatever skills are deemed necessary for a nurse to practice successfully either in the community or hospital setting, there has to be a clearly demonstrated relationship between nursing as practiced in reality, and what is practiced by virtue of UKCC regulations. To step outside this boundary for whatever reason could be described as unprofessional conduct and the nurse would be subject to some form of disciplinary action. Following from this it can be seen that assessment of competence to practice is linked with the requirements of legislation, and also with the status of the student nurse as an employee of any particular Health Authority. The criterion for assessment carries not only a description of the skills to be measured, but also an explanation of the consequences of referral and/or failure. Examples are provided in Appendix 1 from one School of Nursing used in the study to show how criterion can be stipulated, and also how it relates to the employment status of the student nurse.

Continuous Assessment of Theory and Practice

Throughout the study reference is made to continuous assessment, largely due to respondents suggesting that this mode of assessment would be preferential to the one in current use. For the purpose of this study, continuous assessment is seen in much the same way as defined by Macintosh and Hale (1976) who say that it is 'a continuous updating of judgements about a student's performance'. Putting this into action is a complex process, and its implementation is still at an early stage within nursing. Therefore the study does not enter into the debate other than to reflect respondents' views, and to make certain recommendations in the light of data from the research instruments.

The Relationship Between Theory and Practice

This important aspect forms an integral part of the study because it is not possible to make judgements concerning the effectiveness of practical skills assessment without a consideration of the theory/practice relationship. During the 1970s and early 1980s a proliferation of research produced evidence to suggest that curriculum development often represents a disorganised attempt at teaching theory and practice as a unified whole.

In a study carried out in 1975 Birch describes some important contributory factors for withdrawal from general nurse training. Factors relating to stresses caused through differences in ward and classroom practices featured highly in the reasons given by Birch's respondents. Later in 1979 Birch found further evidence to suggest that little improvement had taken place. His well known study on Anxiety and Conflict in Nurse Education showed an alarming position in which student nurses were not prepared adequately for their role in relation to the patients'

psychological needs, in particular when called upon to nurse dying patients or those in severe pain. In another study, Gott (1982) found that nursing practice on the wards was different from nursing as taught in the school. Student nurses were sometimes warned that practices were different on the wards, but they were rarely instructed or shown how alternative (acceptable) practices could be performed, and it was frequently emphasised that the school way was 'right'; this was how things should be done. (page 103)

Hunt (1974) discovered the theory/practice gap when she researched the 'Teaching and Practice of Surgical Dressings in Three Hospitals'. Bendall (1975) also questioned the means through which students were taught to meet the realities of nursing. She makes particular reference to practical assessments in the following way:

> 'Criteria may be used which are not present in the everyday situation, so that the assessment can become a "performance" laid on for the occasion, which differs in many instances from the same activity related to the same patients the day before or the day after.' (page 66)

Orton (1981) makes reference to the importance of good communication patterns between ward sisters and nurse teachers as a means of reducing the gap between theory and practice. She writes:

> 'An indication of the extent of the problem is presented with the fact that as many as 43% of students agreed that "even during the introductory course the student nurse is given glamourised ideas of ward work".' (page 65)

The role of the nurse teacher comes into question especially when substantial research evidence suggests that the main influence on student learning comes from the ward sister rather than from the teaching staff. Hunt (1974); Fretwell (1978).

A profession by definition researches into its own practice, and nursing in its many forms represents a practice based activity which infers a need to view research as one of the main supporting structures in the maintenance and development of professional education. Through an appreciation of the ties between nursing practice and research, practitioners will enhance their performance as a result of an extended knowledge base. (Ramos 1989) This study attempts to add further understanding in relation to the assessment of practical nursing skills, and the complex educational issues which affect the students' perception of their professional role, and their ultimate development as qualified practitioners.

Mental Handicap nursing was chosen as being the most appropriate branch for this study because it has a recent history of rapid change following many years of limitation within an institutional focus. The shift in emphasis towards an eclectic practitioner has its origins in the 1982 Syllabus for Part 5 of the Professional Register, which in turn reflects the shift in policy of care. (English and Welsh National Board for Nursing, Midwifery and Health Visiting) This carried in its wake the need for Schools of Nursing to rethink their educational strategy in order to meet the demands of nursing's statutory bodies. Some were able to accomplish this, others fell by the wayside. Where changes occurred it became necessary to introduce greater sophistication into the assessment process, thus reducing the pronounced clinical bias which had become well

established over many years. This move was supported by the introduction of curricular reform more in keeping with modern ideas and philosophies concerning the care required by people with mental handicap.

One of the common difficulties accompanying a change in educational orientation is the transition from an old curriculum to the new. This creates a demand for extensive in-service preparation as a means of providing a learning environment in tune with student need. In so doing it invariably produces a period of time whereby groups of students are following different training patterns in order to achieve the same qualification. Usually, elements which are to form part of a new curriculum are piloted by grafting them onto the existing programme. Often this presents a situation in which qualified members of staff are expected to supervise, teach, and assess students in different ways depending upon the curriculum being followed, and the teaching methods employed. It also serves to add confusion to the 'what', 'why' and 'how' of assessment. Changing assessment criteria, and redirecting the emphasis can easily damage its validity and reliability. Students can become confused and uncertain unless the change is handled sensitively.

Until the phasing process is complete and people have been given opportunities to become familiar with the new requirements, there remains a possibility of misunderstanding, resistance to change, or the inability to adapt to new ways. Such eventualities are well documented, and certainly exert an effect on the viability and stability of a learning environment. It is widely accepted in literature that a relationship should exist between the theory and practice of nursing, which is discernable through the assessment process. (Wong 1978, Rowntree 1977) Therefore, those who assess should be up to date with modern concepts of care, otherwise the

validity of the process is impaired. To recognise this is of particular importance during the present period of extensive change.

The study aims to discover the extent to which this relationship is evident by taking samples of student opinion across nine approved training institutions in England. Each of these institutions was in the throes of curricular change, and because the students surveyed were at least 23 months into their training, many of them had experienced a change in the criteria for practical skills assessment. Data collection for the study involved the use of questionnaires and group interviews which provided a viewpoint from the consumer perspective. In doing this the researcher fully realised the possible shortcomings of an approach reflecting a sectional interest, but as in all research of this type, the participants' viewpoint is the data of interest, and to broaden the study would only serve to dilute the impact of this viewpoint. The research relationship may have been jeopardised if the respondent knew that comparisons were being made with another set of data taken from his/her assessors or teachers. It is also worth remembering that the research participant is on 'home-turf' (Horn 1977) and should therefore possess a personal and often unique outlook on the data being sought, which is sufficient to give substance to this study. There is a likelihood that such an approach will produce enough data and raise many relevant questions to justify a more extensive investigation into practical skills assessment, especially now that continuous assessment is gaining in popularity. It would then be reasonable to involve a variety of role holders as respondents. However, data were collected from a cross section of nurse teachers and nurse managers representing the speciality of mental handicap nursing. This group of respondents were assessors of practical nursing skills and the

data were used to illuminate the style of student assessment criteria used in their respective schools of nursing with a view to giving substance to the main bank of questionnaires. Where appropriate, data were collected from the group in respect of the nature and style of the preparation each had received for the role of practical skills assessor.

The Issues

This study arose from the need to investigate the customs and practices which have accumulated since the former General Nursing Council for England and Wales devolved the practical assessment of student and pupil nurses to training institutions. Prior to this development, examiners were appointed on a national basis, and allocated to approved centres where they conducted their business in practical rooms, never once setting foot in the wards or departments of the hospital. A circular published in 1969 (No 69/43) by the General Nursing Council prepared mental handicap nursing for transition from the old to a new style of practical assessment. The period of transition began in earnest during 1972, and devolved practical assessment became compulsory in January 1974. Since this time, changes in the format and content have occurred, most notably since the introduction of the 1982 Syllabus. The requirements of ENB Circular (84) 21 form the substance to this study, these are summarised below:

The Tests

The practical tests as defined by the English National Board for Nursing, Midwifery and Health Visiting take the form of four principal activities occurring at strategic points within the programme of training.

These activities are designed to demonstrate professional growth and practical ability.

Test (a)

This test will take place at the end of the first year of training, but not before the eighth month. It will consist of the student carrying out the care of one individual following the agreed care plan, but demonstrating an awareness of the total process of care.

This test will take place over a span of duty.

Preparation for Test (a)

The test should be preceded by a discussion between the assessor and the student nurse to ensure that the student:

i) Is aware of the individual's needs and the process by which they were identified.

ii) Recognise the priority areas of the individual's care plan and the nursing care required during the span of duty.

Test (b)

This test will take place between the 19th and 24th month of training but not before successful completion of Test (a). The student, following the care team's assessment of the needs of an individual, will plan and implement nursing care to meet these specified needs and evaluate the effectiveness of the care given with the assessor.

Preparation for Test (b)

The student nurse should choose an individual client in consultation with the assessor. Before commencement of the test the student nurse will be expected to participate in a review of the existing care plan and to identify needs in collaboration with the care team.

From these total needs the assessor should specify the aspects of care that will form the basis of the tests which will take place over a period of one week.

Test (c)

This test will take place after the 24th month of training but not before successful completion of Test (b). The student will assess, plan and implement a care plan for an individual and will evaluate the effectiveness of the care given with the care team and the assessor. The test will take place over a minimum of two weeks.

Preparation for Test (c)

The student nurse should choose an individual client in consultation with the assessor.

Test (d)

This test will take place after the 24th month of training but not before successful completion of Test (c). The student will co-ordinate a team in assessing, planning, implementing and evaluating care for a group of 4-6 individuals.

Preparation for Test (d)

i) The group of 4-6 individuals is to be chosen by the student nurse.

ii) The specific aspects of care of the 4-6 individuals are to be identified by the care team.

Assessment of Teaching Skills

The assessment of competency in teaching must be included in either Test (c) or Test (d). The assessment may utilise any other member(s) of the care team, client(s) or relative(s).

Assessment of Drug Administration

The assessment of competency in the care and administration of drugs must be included in either Test (c) or Test (d). Guidelines have not been included for assessment of teaching skills and competency in drug administration. These skills should be tested throughout the period of the test and be considered as part of the total assessment.

(The summary of tests, and extracts from Circular ENB (84) 21 are reproduced by kind permission of the English National Board for Nursing, Midwifery and Health Visiting.)

These tests are the end result of several years review and evaluation, and they represent a precursor to continuous assessment. Even now there is a tendency for students to confuse them with continuous assessment, especially as three of the tests extend over lengthy periods of time. However, The boundaries are clearly defined which to some extent places them in the realm of extended, rather than continuous assessment. It can be seen that tests 'a', 'b' and 'c' require the student to

implement, plan and assess care for an individual client. Not until test 'd' is the student afforded an opportunity to plan, organise and supervise, as well as implement and evaluate care for a group of individuals. In its entirety the profile of four tests comprehensively covers the training period and reflects progress from being able to implement a straightforward care plan, to managing and organising manpower and other resources over several days.

Preparation of Assessors

Historically, assessors received their preparation through 'Art of Examining' courses, locally held but approved by the statutory nursing body. Training institutions developed their own criteria for practical assessment based on national guidelines, and indeed still do, and assessors complete a check list in respect of each test conducted. The preparation of assessors has become more sophisticated through the introduction in June 1985 of ENB Course 998 'Teaching and Assessing in Clinical Practice', which adopts a more scientific approach to the relationship between teaching and assessing. This course is widely available and should form part of the continuing education programme offered by all approved training institutions.

Summary

Currently, mental handicap nursing reflects a scenario whereby major advances have occurred within a relatively short time scale. Sophistication not previously recognised has created an educational requirement for a clear relationship between knowledge, skills and assessment. Student nurses are expected to develop their skills through reflective practice, and it is the intention of this study to analyse the

place of practical skills assessment in the educational and professional growth of students as they progress through their programme of training.

CHAPTER 2

THE ROLE OF THE NURSE

'If nurses are to continue to function in a professional role, that role must be defined by the profession, and the educational programs must provide opportunities for socialisation into the profession.' King I M (1981) page 2

Nursing as a Profession

This opening quotation was selected for two reasons. Firstly, it emphasises the importance of role definition allied to programmes of training and education; secondly, it overtly describes nursing as a professional activity. These factors are central to any serious discussion concerning the activities of an occupational group which claims to be 'distinct from other occupations in that it has been given the right to control its own work'. (Friedson 1970) Nursing would claim to be a professional occupation especially as it is self governing and protected by statute. The notion of 'professional' and 'professionalism' is now discussed and then directed to the role of the nurse caring for people with mental handicap.

Within the sociological literature 'professional' and 'professionalism' tend to attract writers from either the functionalist or interactionist camps. For example Rueschemeyer (1983) describes a functionalist model as beginning with a knowledge based competence which is developed and held by experts. The competence is then accepted as pragmatically relevant for problems which are of importance to the client

group as well as for others not immediately involved. Rueschemeyer pursues the issue of social control as it applies to the functionalist model by suggesting that the recipients of expert services are not themselves adequately knowledgeable to solve their own problems or to assess the service received.

She writes of the bargain which is struck with society to protect the people from incompetence, carelessness and exploitation. The professions regulate themselves, and the bargain is to exchange competence and integrity against the trust of client and community, relative freedom from 'non expert' supervision and interference, protection against unqualified competition as well as a substantial remuneration and higher social status. A guarantee of regulation and self control is offered through careful recruitment and training, formal organisation and informal relations amongst colleagues, codes of ethics, and professional enforcement of these codes through committees or courts.

The alternative to the functionalist view can be found in the writings of Atkinson (1983) who describes the approach taken by symbolic interactionists of the Chicago school. This school of thought reflects an unease about the very idea of a profession as a goal for study, and that the search for a criterion led definition is quite misconceived. 'Profession' is seen as a lay term with no precise denotation. Occupations claim professional status under certain conditions and at particular times. In this sense it becomes a symbolic label which some occupational groups demand, and which may be granted by others. Atkinson remarks that:

'Despite the wealth of connotations attached to the title, there is nothing inherent in the work, training, values or whatever, which marks out the occupations so designated.' (page 227)

Of further interest is the work of Bucher and Strauss (1961) who say that an assumption of relative homogeneity within any profession is not entirely useful. They remark on the many identities, values and interests which permeate through professional or occupational groups. Bucher and Strauss use the term 'segments' when referring to different interests and outlooks within an occupation, and suggest that occupations strive not only to attain professional status and the maintenance of position, but segments are also engaged in pressing their particular interests.

Friedson (1983) profers the view that some definition of profession is essential if the concept of professionalisation is to be understood. He says that 'one cannot study process without a definition guiding one's focus any more fruitfully than one can study structure without a definition'. Friedson identifies two major distinctions which can be applied to the concept of professionalisation. First there is the broad sector of prestigious but varied occupations whose members have all had some measure of higher education and whose identification is more through educational status than their specific occupational skills. Second there are those occupations which demonstrate commonality of particular ideologies and institutional traits, which according to Johnson (1972) and Parkin (1979) allow us to think of professionalism as a way of organising an occupation. Over and above the consideration of status, it produces distinctive occupational identities designed to meet market requirements. It is of interest to note that the major theoretical writings on

professions have all addressed themselves to professions in this second case. (Friedson 1983)

Nursing represents a complex mixture of functionalism, symbolic interactionism and parochialism. There are those who make the claim for full professional status, Pyne (1981); Clay (1987), and others who align nursing with the minor professional. (Etzioni 1969) It is worthy of note that Clay was the General Secretary of the Royal College of Nursing (RCN) at the time of the Report of the Commission on Nursing Education chaired by Dr Harry Judge (1983). The RCN Council instigated this commission on the grounds of impatience with the pace of gradualism from a system dominated by service led educational policy to one which placed nursing education within the Higher Education sector. Clay defends any possible charge of elitism by maintaining that student nurses would not be removed from their traditional places of clinical experience, namely hospital wards and community settings. The vital difference is that students would be supernumerary to staffing requirements and as such would enjoy full student status. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting has also published a similar intention through its report, Project 2000 - A New Preparation for Practice (1985). To a large extent this represents a crisis of confidence in professional nursing education. The need to conduct a complete review of British nursing education underlines the extreme concern felt at this time by the Statutory Body and the Royal College of Nursing.

Schon (1986) implies that where there is a crisis of confidence in professional education, there is a corresponding crisis in professional knowledge. He writes:

'If professions are blamed for ineffectiveness and impropriety, their schools are blamed for failing to teach the rudiments of effective and ethical practice.' (page 8)

Nursing education has been at this particular crossroads for many years. It is characterised by the unethical use of students as pairs of hands, being taught from a store of knowledge which may have only partial relevance to actual practice. One of the assumptions which underpins the right to be called a profession is that a relevant research base exists which in turn yields professional knowledge applicable to everyday practice. (Schein 1973) Within nursing there is a constantly enlarging fund of research, but Clay remarks that practitioners are becoming frustrated with much of it. He says that for the non-academic nurse research often proves difficult to interpret, yet agrees that academic enquiry is essential for the growth and development of professional knowledge. It is a matter of finding a balance between academic rigour and readable presentation.

Seen through Friedson's eyes nursing represents an attempt to bring the two major distinctions of prestige and commonality together in providing a practitioner whose preparation for practice stems from a high status educational system whilst retaining specific occupational skills linked by relevant and readable research.

Pyne also nails his colours firmly to the mast by accepting the seven point definition offered by Blanchfield (1978) who says:

'To justify the term "Profession" an occupational group must fulfil not some but all of the following criteria:

1. Its practice is based on a recognised body of learning.

2. It establishes an independent body for the collective pursuit of aims and objectives related to these criteria.

3. Admission to corporate membership is based on strict standards of competence attested by examinations and assessed experience.

4. It recognises that its practice must be for the benefit of the public as well as that of the practitioners.

5. It recognises its responsibility to advance and extend the body of learning on which it is based.

6. It recognises its responsibility to concern itself with facilities, methods and provision for educating and training future entrants and for enhancing the knowledge of present practitioners.

7. It recognises the need for its members to conform to high standards of ethics and professional conduct set out in a published code with appropriate disciplinary procedures.' (pages 5 and 6)

In the main, nursing is structured along these lines and as such there is little doubt that it attracts a functionalist label, but even so there is strong evidence of segmentation within the overall profession. Mental handicap nursing is one of the segments fighting for an identity within a corporate framework. Market forces have pushed this particular segment into a drastic reappraisal of role which calls for a realignment of

its knowledge base to meet the goals imposed by the government community care programme. The demands of practice will change bringing a climate of co-operation with other related occupational groups sharing similar caring values and interests. Intense activity surrounds the nursing contribution, and for the purpose of this study it is essential to place the role in context as a means of guiding the focus of the study which investigates the process and outcomes of practical assessment of nursing competency.

Before a definitive statement can be made regarding the criteria for assessment of the nursing role it is essential that a detailed account of the skills, knowledge and attitudes which form the role of the mental handicap nurse be identified and placed in some kind of taxonomy. This difficult task is made even more arduous through the ever changing environment within which the nurse has to apply her professional skill. In order to qualify this point one needs only to look at past practices, especially in the long stay hospitals to realise the extent to which nursing has moved from its traditional role of custodial care to one of eclectic skilled activity across a wide range of community and hospital provision. This skilled activity encompasses the theory and practice of normalisation, care in the community which includes a detailed understanding of family dynamics and interactive skills, advocacy and the role of national and international advocacy movements, human rights, education, and primary care, each of which must be treated as an integral part of an interlinking and dynamic training curriculum.

The 1982 English and Welsh National Board Syllabus for nurse education in mental handicap care emphasises the main strand of nursing activity as being to ensure that people with mental handicap have the same basic human rights as anyone else living in a free society. The same

principle has also been incorporated into the Project 2000 Branch Programme in Mental Handicap Nursing (1989). This nursing activity is to be achieved by the identification of these rights, and planning the process of normalisation along the lines of basic human civil rights as identified by the United Nations Declaration of Rights for the handicapped person, issued in 1968. The preparation of nurses in the long term must take account of the complex issues resulting from this Declaration and this is made clear within the course philosophy of one particular School of Nursing to which the author contributed, it reads:

> 'The professional and personal growth of the learner nurse should incorporate a move away from custodial practices, towards person centred, community directed activities. Through this the nurse will derive personal and professional maturity from a system of continual development using skills which are essentially humanistic in origin. Professionally the learner will achieve an identity based on those intrinsic standards and values which together develop attitudes conducive to positive care wherever this occurs... In order to maintain a continuum between theory and practice a balance of academic and professional supervision will be required throughout the course. Exposure to different experiences and views will create an inquiring approach thus encouraging political awareness towards changing events in society and how these effect the status of people with mental handicap.' (York School of Nursing 1986, page 1)

In general terms this indicates a role which provides a 'hands on' service based on a substantial theoretical framework. It points towards a

service requiring its professional workers to be expert in the management of resources, facilitating and supporting within the family environment, and engaging in physical caring and community liaison.

In support of this observation let us consider for a moment the population of a moderately sized city in the North East of England, and the numbers of people with mental handicap who live there. The figures quoted were accurate up to March 1989 and take account of people living in the community, and also those resident in two local hospitals for the mentally handicapped person. Within the city itself, 14 areas related to postal codes were surveyed by members of the Community Mental Handicap Team, and a matrix of clientele was produced. The ensuing picture provided a cross sectional representation of the age, gender and geographical location of the clients. In total, there were 581 people with mental handicap living within the city, and an additional 318 were resident in hospital - an overall total of 899 people. By far the largest number within the community were aged between 0-25 years, which accounted for 277 people, and amongst the hospital population, the largest single entity was recorded between the ages of 40-50 years, accounting for 73 people.

From these figures general observations can be made regarding the high probability of many people with mental handicap who live in the community being heavily reliant on relatives to care for them. Conversely, the ageing population resident within hospitals present nursing problems associated with middle and old age, as well as more people being cared for who display challenging behavioural traits. The nursing skills required to meet the needs of clients and their carers are complex and still not fully understood, consequently the role is still developing.

Because of the extensive changes taking place regarding the direction of care and support for people with mental handicap, the role of the nurse has taken on new meanings and new significance. There are pressure groups within society vigorously defending entrenched points of view regarding their perceptions of how people with mental handicap should be supported within the boundaries of normal living. These same groups are often strongly opposed to hospital accommodation on the grounds that it is inappropriate to live out the majority of one's life in an institution just because of a label applied during childhood. There is an equally forceful argument stating the benefits of residential care especially for those who are profoundly handicapped with associated behaviour problems. It is in the main, parents and relatives who wish to retain the services of hospitals and larger residential units because they believe them to be safer and more supportive than small units or houses in the community. The author has attended conferences to which parents have contributed and has never failed to be impressed by the strength of conviction shown by them towards the maintenance of some form of sheltered living staffed by properly trained nurses, physiotherapists, occupational therapists and speech therapists. The accent is not upon normalisation but safety, security and therapy.

There are also those who say that nurses have no part whatsoever to play in the future of mental handicap care. The argument here is that nursing represents the medical model and is seen by the general public in a stereotyped way. It is said that people with mental handicap do not require this kind of service unless of course they are physically ill, and as such would avail themselves of the public medical services which are open to all citizens. Amongst the more radical groups are those who would

abolish the terms 'mental handicap' altogether because of its stigmatising effect which lays a small section of society open to abuse. They prefer to describe their clientele as having special needs requiring some degree of professional intervention. Other terms such as 'intellectual deficiency' are in use but these descriptions vary from place to place, depending upon the strength of feeling expressed by those in positions of influence. More recently, there has emerged a new and less stigmatising description which seems to have gained general acceptance. This description which refers to 'people with learning difficulties' emphasises the person rather than the disability, and avoids using the highly contentious word 'mental', which has always conjured up images of madness in the lay person's mind.

In the face of strong opposition to a continuation of nursing as a viable caring agency within its own right there is little wonder that the profession constantly faces a crisis of identity. Much of the discussion concerning the role of the nurse seems to revolve around a sharing of training with other agencies, especially social work. The following extract from the Chief Nursing Officer's letter to the profession (December 1985) underlines this point:

> 'Government policy... encourages the replacement of services concentrated in large mental handicap hospitals with an integrated network of local domiciliary, residential and day services catering for mentally handicapped people according to their individual needs, and interdisciplinary working in which there will be an important and continued role for mental handicap nurses.' (CNO DHSS December 1985)

This in itself raises many questions about the appropriateness of current schemes of nurse education, many of which are rooted in hospital based Colleges of Nursing. It is argued that nurse education per se would be better sited in colleges of higher or advanced further education. This would have the effect of removing the 'illness' label from nursing and place it firmly in the health orientated model advocated by powerful lobbyists of this method of preparing nurses for their role. This debate which began in earnest following the Royal College of Nursing Report on the Commission on Nurse Education (1985) is likely to continue for a considerable time, but the forecast for mental handicap nursing is that it will be unified within higher education by the end of the century. The English National Board, in its response to recommendations within the Project 2000 report, emphasises the importance for Schools and Colleges of Nursing and Midwifery to forge strong links with centres of higher education. This was a precondition for acceptance as a demonstration or pilot district by the government, through the Statutory nursing body.

As a preliminary to this research the author has attended meetings and engaged in extensive discussion regarding the nursing role. This has provided a wealth of detail from many sources and it is this which forms a basis for the ensuing discussion. By taking into account the complexity of mental handicap and the demands it makes upon the caring agencies it is reasonable to reach the conclusion that nursing is a social service and must identify for itself a place in the safety network of care and support required by many if not all people with mental handicap. This network must be flexible and dynamic otherwise it becomes quickly outdated, and it is only as good as the people who operate within it. Such is the need for sound and relevant practitioner training that nursing with its years of

experience in the field of mental handicap can offer skills and knowledge not generally available amongst other professional workers. The craft of nursing is unique, and is all embracing of the many care practices which contribute to the needs satisfication of the mentally handicapped individual. However these skills have in the main developed from hospital care practice and it therefore becomes essential to facilitate the transferability of this practice to other settings through a system of on-going educational programmes, preferably of a multi-disciplinary nature.

These other settings may be found in places not previously identified as a nursing domain and as such will require tutors and learners to break away from the traditionally established patterns of training which in the main have necessitated following a circuit of institutional experience supported by relevant theory at set intervals. This style of training has evolved from earlier attempts at modular design which have been hidebound by the requirements of hospital manpower levels to which the learners contribute. At the present time all curricula have to meet the extensive demands of the 1982 Syllabus which clearly infers a large component of community, educational and therapeutic content, before it has any chance of success. The eventual direction followed by mental handicap nursing is highy dependent upon the profession itself stating and updating those skills thought essential for good practice, which is why the syllabus of training must be regularly appraised. Indeed the Project 2000 Branch Programme will eventually replace the 1982 Syllabus as the framework around which future training will evolve. The development of nursing competencies and advanced competencies are referred to later. Politicians who control the money supply will look more favourably upon a profession that can prove beyond reasonable doubt that its value to society is worthy of investment,

which in the case of mental handicap nursing means staking a powerful claim to an equal partnership within the 'care in the community' policy advocated by the present government. This requires taking these intrinsic standards and values too long held as sacrosanct, and grafting them to an extended role, founded on a pragmatic field based training. To do so presupposes an interactive role with other professions, yet at the same time retaining a clear professional identity consolidating the essential meanings attached to the term 'nurse'. It becomes important for the nurse to recognise the role of other professions, because failure to do so will only serve to confuse, and a blurring of role boundaries can create conflict and uncertainty, not only for the professional person but for others also, including the client.

Boundaries of the Role

A distinction is made between those professional groups employed in a health context, and those who operate from within social boundaries. This distinction is made to determine responsibilities, lines of accountability, and budgeting. It becomes less clear when attempts are made to define the true roles and boundaries of occupational groups that work across the entire spectrum of mental handicap. The policy of care in the community has caused these groups to question traditional roles, and refocus their activities towards maintaining the client in a setting more akin to normal living.

The relevant care professions are 'on the move' and as a consequence a blurring of roles and boundaries could emerge which at the operational level may cause confusion and friction. For example, Occupational Therapy is on the verge of a major shift of emphasis from specific health

orientation to wider social activities engaging them in key aspects of Individual Programme Planning (IPP) for people with mental handicap. Also, the Social Work profession, because of its community orientation will become increasingly involved within the field of mental handicap, especially as numbers of people relocated from institutional care increase the demand for social services. The medical practitioner and the pharmacist will require to address themselves to meeting extra demands on their services, which in itself will create a need for the enhancement of their knowledge about the the nature of mental handicap. Other important groups which doubtless will have a major role can be found in the professions of psychology, psychiatry, physiotherapy, speech therapy, the ordained ministry, adult education, and others. The common denominator which draws the focus of these specialist groups is the contribution each can make to enhancing the quality of life for people who are designated as having special needs.

Staff training programmes which reflect the essential core attributes of professional intervention are at the centre of multi-disciplinary working. There is a recognition that the knowledge and skills which already exist need to be valued, enhanced and directed in a co-ordinated way towards developing the new service. The literature points specifically towards the maximisation of the person's 'Quality of Life' (QOL), and Whitaker (1989) provides a comprehensive assessment of how the services should collaborate in creating a unified approach to preparing and maintaining people for life in modern society. Whitaker is primarily concerned with people who experience very profound mental handicap, and takes as his starting point research indicators of positive change. The

variables that seem to occur in the research with regularity are as follows:

i) Improvement in an individual's level of skill or abilities.

ii) Increases in adaptive engagement, ie increase in the amount of time people spend doing something purposeful.

iii) Having a greater range of activities.

iv) Increased contact with society.

v) Decreases in various negative or challenging behaviours such as self stimulation, self injury etc.

Using these variables, Whitaker compiled his own list that he claims determines quality of life for people with mental handicap. Within this list are included factors about what people do (i) in terms of behaviour, and (ii) engaging with their environment. These are determined as follows:

Factors about individual's behaviour

a) Level of skills and abilities.

b) Level of adaptive engagement.

c) Level of negative behaviour.

Factors about the environment/regime

d) The conditions of the physical environment in terms of comfort, food, health care.

e) The extent to which the individual is given the opportunity to mix with members of the local community and uses local facilities.

f) The variability and amount of activities made available.

g) The opportunity to make choices.

h) The degree to which people are treated as individuals who are valued members of society. (Whitaker 1989 page 4)

From these factors it can be seen that multi-professional services are an essential prerequisite to improving quality of life for people with mental handicap through the application of specific skills and knowledge. It should be possible therefore to strongly harness the unique activities which give identity to professional groups, and focus them into a unified service. Two way communication and skill sharing will create an allied approach to care with each professional recognising the worth of the other. The enormous change implicit within government policy will continue to guide mental handicap nursing for the foreseeable future, and the direction of change will be influenced by many factors. Keighley (1985) summarises these observations when he writes:

> 'What is required is the development of a rather more specific professional identity for the nurse in mental handicap care, one which would allow other health care professions to identify those elements of care which are specifically within the role and remit of the nurse. It requires a great deal of flexibility, but it must be remembered that when considering the resources made available for the care of these individuals, nurses working in the field represent the largest workforce.

This is a fact which must be worked upon and used for its political worth.' (page 8)

The political worthwhileness of mental handicap nursing depends upon supply and demand for the services on offer. What is on offer must match the needs of the client, and there has been a noticeable shift over time in how communities and politicians under pressure have reappraised what these needs might be. Nurses, however are aware of existing needs which are unpopular amongst reformers, in particular the continuing needs of those residents who live in long stay hospitals. These people must not be forgotten or left behind in the rush to establish a community service. Therefore whatever is defined as nursing must encompass a complex arena of human need and it is to this we must address ourselves when making statements about skills and competencies.

Skills and competencies represent the outcomes of a specifically designed education process containing prescribed information and experiences. From this it is expected that a practitioner develops who must be capable of independent thought, free of the traditional nursing procedure orientated approaches to care. The Chief Nursing Officer (1985) is quite precise about this when she describes mental handicap nursing skills as including:

'...assessment of need, clinical skills and interpersonal communication, observation, recreational, social and domiciliary work with people with mental handicap and of the case load management associated with this work.' (CNO DHSS December 1985)

She goes on to describe specific skills in the areas of behaviour modification, non-verbal communication, teaching and learning, programme planning techniques, all of which are bound up within the nursing process. If this broad description of the nursing role is allied to those skilled activities related to normalisation and human rights then we begin to understand why it is essential to be clear about those skills and competencies which are essentially nursing, a clarity which will only become apparent through research.

Mental handicap nursing has for many years been the poor relation of general nursing. Until recently it was not considered to be a priority area and consequently was unable to attract substantial research funding. This is changing and the profession is now in possession of specific research findings aimed at delineating the role and function of the nurse. (Brown and Walton 1984) The problems associated with such research is that it is relevant only to institutional practice and makes its recommendations based on this element of mental handicap nursing. In accepting the importance attached to this it should be realised that the profession is depleted of broad research extending across the entirety of the nursing role. Keighly (1985) points out that lack of such research may have inhibited the 1982 syllabus working group in their progress towards a community directed pattern of nurse education, and indeed it is to the credit of forward thinking curriculum planners that such an emphasis is now apparent. A report of the working party of the RCN Community Mental Handicap Nurses Forum (1985) gives strength to the view that domiciliary community nursing is representative of where the future lies, and it is interesting to note in the introduction to this report the specific statement that:

'It is not the intention to consider the role and function of nurses working in residential settings although there will be some common elements.'

In reading this report we witness the metamorphosis of mental handicap nursing. Whereas in the recent past it was accepted that domiciliary community nursing was merely an extension of the hospital service, it is now a fact that hospital provision and its related nursing requirement is reducing along with the need for traditional nurse training. The report offers the view that community nurses have the skills and training to work with children, adults and the families of people with mental handicap wherever they reside. Taken to its logical conclusion it is reasonable to pursue the notion that mental handicap nursing has a common core which if properly identified and taught will form the basis for a generic training curriculum fitting the practitioner for work in any setting.

To do this will avoid the two tier system of nurses working in a declining hospital service, and those employed in the community growth area. Interchangeability will greatly reduce the emergence of an elite group of nurses with 'special' skills. By way of example it is worthwhile to draw attention to the needs of children with mental handicap, and focus on the nurse's role in respect of this section of the community. With only a few exceptions long stay hospitals do not admit children into care primarily because there is influential research to show that children who undergo long term hospitalisation are seriously deprived of the normal experiences of childhood. (Oswin 1971, 1978) This adds substantially to their handicap and places them on a cycle of deprivation which permanently affects their lives. However, despite advances in obstetric care and

antenatal screening, babies with mental impairment are still being born, and once they leave the highly supportive environment of the maternity unit it is reasonable to forecast a life of dependence on their parents or others. Admittedly levels of dependence correlate with severity of handicap but research by Wilkin (1976) and more recently by Ayer and Alaszewski (1984) shows that mothers in particular can be virtually imprisoned by the constant demands of their mentally handicapped offspring. This can lead to serious family problems and marital disharmony. In such situations the supportive network previously described is required, with each member of the team being fully trained and experienced in family situations. At the present time training in child care and family dynamics is a weak point in nurse education programmes. The demands of the 1982 syllabus cannot always be met, and even where they are it is more often than not at a minimal standard. If the profession is to move towards preparing its practitioners for an eclectic role then in the case of child care it becomes important for student nurses to gain experience in nurseries, respite centres, hospital wards and even in the person's own home. This is a far cry from what was acceptable prior to the introduction of modern concepts of care. It was unusual for student nurses to gain much in the way of experience with 'normal' children during the training period, but it is now considered right to do so if their all round role is to emerge. In providing learning opportunities and practical experience across the whole spectrum of child care and child development it creates a wider base from which an understanding of mentally handicapped children can grow. However it generates a complex array of competencies which must be an integral feature of the nurse's cognitive, affective and psychomotor skill building process, placing extensive reliance upon the theory and practice of the Nursing Process; the intelligent use of appropriate nursing

models; and the application of interactive curriculum development. The interactive nature of competencies and their transferability to other nursing requirements is probably the most important single factor. Nursing is generally regarded as a problem solving activity involving assessment, planning, intervention and evaluation which points towards the ongoing acquisition of a comprehensive profile of knowledge skills and attitudes capable of extensive transfer. This can be suitably illustrated by reference once again to the nursing role in child care and family support, and how this can extend into other dimensions of care. It is reasonable to expect the nurse to have a good working knowledge of the psychological theories of human development, if she is to be effective in applying the problem solving approach to goal setting in respect of the varying social environments within which mentally handicapped children reside. These social environments do not always equate with the normal family situation, and consideration has to be given to the care necessary for children in non-family environments. Additionally it is important to remember that an increasing number of inner city areas are multi-ethnic which superimposes the need to relate to the customs and traditions of non-western cultures. Almost certainly this will involve the nurse in religious matters; differences in language (dialect); and the interpretation of sensitive issues regarding the process of socialisation, which highlights the real problems to be faced in the area of communication. Most nursing curricula offer the white middle class view of acceptable speech and curriculum theory without taking account of cultural differences and behaviour norms to be found in predominantly non-white, high unemployment urban communities. This will ultimately affect the nurse's perception of situations involving factors outside her own frame of reference with a consequence that things may be seen differently from their true nature. In

discussing this point Mercer (1973) describes 'problem profiles' of persons labelled as mentally handicapped within the Californian city of Riverside. She says:

> 'The "problem profiles" of persons labelled as mentally retarded by various organisations in Riverside were quite varied. These differences undoubtedly reflect differences in the characteristics of participants in various social systems, but they also reflect the varied foci of norms of different types of organisations as staff members select the terms in which they describe the nature of each individual's deviance.' (page 61)

The nature and severity of mental handicap requires care in its diagnosis because as Mercer (ibid) points out there are many analytic statements which may be used to describe various behavioural, academic and physical deficiencies which together point towards a person being labelled as handicapped. The role of the nurse consistently involves interaction with people from all walks of life, with the necessity to adjust in accordance with each situation. Therefore nurse education must emphasise experiences related to the realities of the community as a whole, because it is here that mental handicap nursing will exercise its primary role in partnership with others. It is also important to recognise the special role of the many and varied religions within the community thus keeping us mindful of the nurse's contribution towards the spirituality of those she cares for. (Birchenall and Birchenall 1986)

Summary to Date

It is opportune to remind ourselves of the main factors which influence the nursing role in respect of the discussion so far. In applying the basic principles of human rights and normalisation it has been suggested that a common bond exists between nursing and other professional groups involved in mental handicap care, and as such we should consider a sharing of some elements of training, especially in respect of community care. However nurses must continue to specify those skilled caring activities that fall within their role and remit. Explicit within these skilled activities is the essential framework offered by the nursing process because mental handicap nursing is founded in holism which in turn points towards a specific interpretation of human needs in the physical, social and psychological domains, and it is the specific interpretation of need together with eclectic knowledge which defines the uniqueness of nursing.

The importance of research has been discussed in relation to the broader perspectives of mental handicap care which in turn will provide an underpinning to the nursing contribution. It has also been suggested that dramatic changes in government emphasis away from traditional hospital care towards care in the community will undoubtably witness a metamorphosis of the nursing role, and an example is provided as to how this will affect child care and family support. Special attention has been given to the difficulties which may be experienced when working in urban communities which are multi-ethnic in composition, paying particular attention to the criterion used when defining a 'problem'.

The discussion will now turn towards the important area of education, as it applies to the person with mental handicap, his/her informal carer(s), and to society.

To examine the nursing role within this broad context of education it will be necessary to identify those factors which fall legitimately into the nurse's frame of reference and are not simply seen as an adjunct to the roles of other professionals. As we have seen there is a substantial amount of evidence for the establishment of an educational support system directed at mothers of mentally handicapped children living at home. (Ayer and Alaszewski 1984 and Wilkin 1977) This educational framework would involve the nurse widely in the process of family support, giving numerous opportunities for making a positive contribution towards easing the burdens of many families who at the present time are faced with overwhelming problems which often accompany a severely mentally handicapped child living as a member of a nuclear family. There are specific skills which can be applied to situations involving behavioural difficulties, serious incontinence, dressing, bathing (especially where physical disability accompanies the mental handicap), feeding and eating difficulties, toileting, walking, communication - verbal and non verbal, sex education, and the extensive area of health education. Additionally, the nurse has a definite role in the continuing wider education of the general public because as Ayer and Alaszewski (1984) point out:

> 'Society's attitudes to the severely mentally handicapped are complex and contradictory.' (Page 94)

Nursing accepts that people with mental handicap must be treated as fellow human beings, but also accepts the reality that in many instances

this is not the case. It will be many years before society lives down the ignorance and apathy towards mental handicap which has led to the well documented pattern of institutional care and segregation. In the past, nurses have been the instrument of society in perpetuating this pattern, and part of their emerging role will be to reverse this position and defend the rights of those they care for. To do so will engage nurses in communicating their position through differing aspects of the media, as one aspect of their educational function.

It is fitting to suggest that programmes of nurse education should in some large measure be preparing students for the demands of their future educational role and as such it is not sufficient to concentrate on the process and product of traditional school of nursing curricula. It is more relevant to provide opportunities for educational experience in a wide variety of community and institutional settings. These should be designed to expose the student nurse to many of the areas where ongoing education for people with mental handicap, and perhaps their families is practised. The experience as a whole will enable student nurses to study educational methods and related learning theories as they apply across the age range, which as a consequence, will give them broad access to educational provision. This would support the need to consider the important relationship between the individual, his/her family, the teacher and the nurse in the continuation of essential programmes related to the acquisition of daily living skills so necessary for acceptance within the community.

When considering further the role of the nurse in the socialisation of people with mental handicap it is important to realise that legislation exists to protect the educational rights of children up to the age of 16

years. This is not the case once the individual has achieved adulthood and it is at this stage that nursing can offer a range of supportive skills consistent with the principles of normalisation. These principles underpin the rights of people with mental handicap to enjoy work, leisure, and benefits afforded by social, recreational and occupational training. The normalisation principle indicates that formal and informal educational requirements will vary from person to person depending upon need and personal preferences. (Perrin and Nirje 1982) It is when the formal education stops and the informal education begins that the nurse becomes a teacher. To view it this way gives added strength to the claim that nurses are uniquely placed to give a broad based service, responding to different demands. Nurses must remain eclectic if they are to provide such a service, but should see their concern as being primarily supportive in those instances where the person requires access to agencies or special services.

Additionally, the nursing role should encompass the need for goal planning and the implementation of social, recreational and training programmes aimed at the amelioration of the many problems confronting people with mental handicap in their daily lives. In taking this perspective it indicates a growing and exciting area of work for the nurse.

The Consequences of Multiple Handicap

The person with multiple physical and mental handicap represents a challenging situation for nursing. It would be unrealistic to view it any other way because to be multiply handicapped places the individual in a potentially restrictive situation. The nursing role involves an analysis of factors appertaining to each person with the aim of identifying and

reducing the physical and environmental factors which have an impact on multiple handicap. This brings the nurse into contact with all aspects of therapy and educational techniques used in the treatment of the individual, and the maintenance of those vital influences which affect the quality of a person's life.

It is by careful appraisal of the limiting factors at work within the day to day existence of a person with multiple handicap that one begins to appreciate the need for a broadly based yet highly skilled supportive work force available around the clock. The continuity of care, which is clearly within the remit of nursing, must be a logical follow through of the initial assessment and goal planning activities carried out by members of the multi-disciplinary team, and the nurse thus becomes a vital instrument in providing a sound and appropriate service at the point of delivery. To consider the scope of nursing in this situation encapsulates the skills and the attitudes earlier described as having the qualities of transferability. This consideration highlights the importance of recognising the personal effect of profound handicap on individuals and their families. To do so implies a vast understanding of the stages of human development and the associated factors influencing maturation both physically and psychologically, e.g. the special problems resulting from an increase in sexual awareness which arrives with early adolescence presents the nurse with a situation requiring sensitivity and empathy. Sex education may well be considered an area which lies primarily within the scope of nursing.

Earlier, reference was made to the specific nursing skills necessary to meet the demands of multiply handicapped people. These skills surround the notion of independence, and allow the nurse to be influential in the design of programmes aimed at an increase in mobility, appropriate eating

habits, correct use of the toilet and a reduction in incontinence, dressing and choosing one's own clothing, personal hygiene, and occupation. A large degree of a nurse's work is by necessity allied to the personal and social needs of her client which can in many ways be served by a study of health education practices. Health education encapsulates the entirety of human experience and focuses attention on the many things which are necessary to lead a healthy productive life. We accept as a matter of course that certain environmental influences can have a negative effect on our wellbeing and any steps that are taken to reduce these will facilitate good health. The nursing role should be seen as a facilitating force in both an educational and advisory sense. It seems sensible to suggest that a major aspect of nursing efficiency is dependent upon knowledge of, and access to available resources across the whole spectrum of care. The job demands an extensive profile of competencies which enjoin the psychomotor, humane, interpersonal and helping components of interactive nursing, and it becomes important to recognise that competencies which are generally accepted as being the property of related paramedical groups should also feature amongst the skills of mental handicap nursing. In particular, I refer to an understanding of the theory and practice of relevant therapeutic activities such as physiotherapy, occupational therapy, speech therapy, and recreation and leisure.

This point of view has been strengthened by recent research into advanced competencies relating to those professions which are therapeutic by definition. (Smith et al 1986) Nursing is not included in the research but many of the conclusions drawn could quite easily be applied to mental handicap nurses especially now that greater expectations are required of them as their role increases in complexity. Smith et al (ibid) suggest the

concept of advanced competence necessitates the practitioner to take on a 'wide range of roles'. The research makes the point that 'competent performance in a variety of roles is ***one indicator*** of advanced competence in therapeutic practice'. This can be said of nursing, perhaps even more so than those professions engaged in activities which possibly restrict them to a somewhat narrowly defined skill base.

The Development of Nursing Skills and Competencies

Any analysis of nursing skills should begin with an understanding of the constituent parts of skilled activity. To do so is particularly important when considering the complexities involved in meeting the demands of a client group which can present the nurse with 'out of the ordinary' problems. A skilled individual is in possession of related knowledge and understanding enabling that person to apply facts and principles to an identified role, thus differentiating him/her from a member of the general public who has not undergone specific training with related experience. Tomlinson (1981) describes skilled activity as having three general characteristics:

a) Skills involve a more or less complex organisation and co-ordination of actions and sub-skills.

b) A skilled performance is dependent on feedback.

c) Skills become more accurately and smoothly performed with suitable practice.

A skilled performance involves activities which are complex and rely greatly for their successful application on the co-ordination of action and related sub-skills. King (1981) supports this argument by stating:

'Nursing is perceiving, thinking, relating, judging and acting vis-a-vis the behaviour of individuals who come to a nursing situation.'

She describes the nursing situation as the immediate environment, spatial and temporal reality, wherein the nurse and patient establish the special relationship necessary to cope with problems and situations. The skills of nursing are enshrined in a process of action, reaction and interaction. This process is, of course witnessed in other caring activities, but the nature of nursing infers a particular approach which is designed to situate the interpersonal activity within the domain of nursing. In referring to the special relationships in nursing, King says:

'Through purposeful communication they identify specific goals, problems or concerns. They explore means to achieve a goal and agree on these means.' (1981 page 2)

Mental handicap nursing involves teaching daily living activities involving behaviours which are so much part of everyday existence that to call them skills seems to be overstating the case. Things such as dressing, eating, holding a conversation, shaving, and so on may appear ordinary at first but they require co-ordination and timing which come from internalised automated activity. Such activity is usually only possible through the right kind of stimulation in an environment conducive to learning. Holistic nursing calls for skilled intervention at strategic intervals of a person's development towards social acceptability. This involves the client in developing the skill of rational thought which when applied to everyday life smooths out the rough spots and acts as a substitute for a feedback system. Bartlett (1985) suggested that thinking

should be regarded as 'a complex and high level kind of skill' and refers to thinking generally as the use of information about something present to get somewhere else. In respect of people with mental handicap, especially those with serious multiple handicap it is important to realise that skilled thinking is directed at solving problems through a goal orientated, purposeful process, and people with seriously reduced cognitive ability are not well placed to negotiate daily living problems which would normally be straight forward and uncomplicated. However, this view is not shared by Weller (1983) who writes of Feuerstein's Instrumental Enrichment Programme as a means of liberating the hidden cognitive abilities which for the most part lay dormant in each of us. Feuerstein (1983) sees the problem of retarded performance to be the direct result of inadequate intervention by suitable role models. Weller says:

> 'Instrumental enrichment derives explicitly from a psychological view of learning. Central to the approach is the belief that the vast majority of us can acquire new tools for handling ideas and making decisions at any point in our lives. Feuerstein terms this potential for intellectual growth "cognitive modifiability" and he holds that the necessary conditions are an appropriately rich array of stimuli together with the creative intervention of more experienced human beings. It is this intervention "mediation" in Feuerstein's language, which is crucial if individuals - including performers - are to gain the tools for intellectual autonomy and self esteem.' (Page 11)

From this it can be inferred that even where serious deprivation has prevented maximum cognitive growth the situation can be recovered, and

Feuerstein believes that all age groups can improve if enrichment programmes are individually tailored.

The skills of mental handicap nursing embrace this whole concept and as such it is relevant to look once again at the Chief Nursing Officer's list of skills. (1985) Clearly, the assessment of needs, clinical skills, and interpersonal communication feature high on the list of priorities. When these areas of skill are linked to such things as recreational, social and domiciliary work, plus the associated case load management it becomes obvious that much of the work of a nurse is immersed in intervention. Assessment of the skills and sub-skills related to this major aspect of work would provide a substantial indicator towards competent performance, demanded of the nurse.

Doubtless, mental handicap nursing is directly linked to the general field of psychology with strong overtones of behaviourism which may be observed in behaviour modification, teaching and learning, and programme planning techniques. The future will see a development of community services for people with mental handicap which is certain to change the image and status of nurses working in the field. Allen (1984) underlines the importance of staff education and argues for relevance. He makes the point that people with severe learning difficulties find it hard to express themselves or form relationships, and therefore a need exists for them to be involved in planned and unplanned interactive situations. This opens up the opportunities to be gained from experiential activities. The nursing process offers the flexibility to adopt various methods of care, and the 1982 Syllabus allocates sections of its content to the teaching of interactive skills. These skills are broadly based and form the essential

pathway along which messages are transmitted and from which understanding develops. Douglass (1980) writes:

> '... if there is one characteristic of human beings that is universally valid and important it is that they differ. Individuals are as different as grains of sand in that each is moulded by genetic or inherited characteristics and that all experiences have an impact upon life.' (page 16)

These individual differences must be reflected in the underlying skill base of mental handicap nursing, and the action of listening and responding to the perceived needs of clients is an important element. The interactive process can be substantially helped through the medium offered by drama, music and dance.

The Skilled Practitioner and the Leadership Role

To achieve skilled practitioner status in the professional sense confers a degree of leadership upon the individual concerned. It is interesting to note that texts dealing with the subject of nursing leadership contain descriptions of skilled activities which fit adequately into the role of the mental handicap nurse. When one reads these texts the popular view of a core of knowledge and skills existing throughout nursing is reinforced. The emphasis of interpretation rests with the specialist groups who need to consider how a large body of corporate skills relate to their particular area.

The leadership role assumes a high level of importance when the effectiveness of multi-professional teamwork is under consideration. A successful team will depend upon each of its members taking a leadership

role at some time, and if the notion of mental handicap nursing being eclectic and flexible is accepted then the broad skill base should permit the nurse a freedom to range over the many facets of care. By viewing the assessment of need as an example it is possible to illuminate the professional partnership existing between nurses and psychologists.

When discussing the process of assessment Woods (1983) writes:

> 'There are still many people who think of IQ tests when the word "assessment" is mentioned.' (page 125)

He goes on to explain the sophisticated elements of a psychological assessment in terms of using a behaviour scale in determining the levels of functional skill operating within individuals with varying degrees of physical and mental handicap. In his writing Woods makes reference to several aspects of daily living such as eating habits, personal hygiene, use of money, and conversation. These facets of life are observable and measurable thus lending themselves to modification through careful programme planning, implementation and follow up. Terms such as 'profiling' are much in evidence and form base lines from which an overall assessment can be made of a person's general ability.

A nursing assessment will complement a psychological assessment and vice versa. Indeed, the nursing process begins with an assessment of the person's physical, social and psychological needs which in the case of an individual with mental handicap takes account of the activities of daily living from a somewhat different perspective than that found in general or psychiatric nursing. This can best be illustrated by a care study taken from actual practice.

Care Study

John, a 16 year old boy with a profound mental handicap has lived in long stay residential care since he was 11. His history includes limited speech, severe epileptic episodes, challenging behaviour and a problematic weight depletion due to refusal of food. He is a physically agile young man prone to aggression against his peers and the nursing staff. An arrangement exists with John's parents which enables him to go home each weekend for an overnight stay.

At this stage it would be helpful to consider the full extent of John's problems especially as they are superimposed upon the general difficulties experienced during adolescence. For most people in Western Society adolescence is generally seen as a problematic period involving physical, social and psychological upheaval. There are many adjustments which are required to be made not the least of which includes coping with an identity crisis. The 1982 syllabus for mental handicap nursing previously referred to, identifies the skill base for working in this sensitive area. In so doing the skills are directed towards the development of sensitivity, provision of a facilitative environment, counselling in respect of emotional and sexual difficulties, and directing knowledge of these and other related matters towards an assessment of problems.

In considering the traumas of adolescence it becomes necessary to combine them with a profound mental handicap and create a picture of a teenager with very special needs. John lived with his parents until his admission to residential care which came about through the extreme demands he was making upon both his mother and father. They were almost totally

drained of their physical and emotional resources, and their home was damaged on a regular basis as a result of John's antisocial behaviour. John's mother, in particular had suffered physical abuse from her son almost constantly. He was also adept at manipulating his mother through a rather strange form of self abuse, namely protracted and potentially life threatening starvation. His refusal of food was almost certainly aimed at attention seeking and in a perverse way had set him upon a path leading ultimately towards self destruction.

During his period in residential care his eating problems were modified and the subsequent weight gain enhanced his appearance. However he still attempted to use eating as a means of manipulation and the nursing staff had to be on their guard against this. John's general behaviour became more aggressive, physically striking, kicking, headbutting anyone who frustrated him. This included nurses, fellow residents and parents. During his weekends at home he continued exhibiting disturbed behaviour, remained destructive to property, and stayed awake all night, he became aggressive if the word 'no' was used. This type of behaviour was more noticeable upon his return from home. If his mother visited mid-week he became destructive and aggressive once again. Paradoxically John slept very well at night whilst in care.

Nursing assessment in combination with other components of the nursing process is a cyclical activity repeated as and when the situation demands. Regarding John there were three core problems requiring frequent evaluation and reassessment, these being:

i) Eating/weight.

ii) Severe constipation resulting in faecal overflow.

iii) Aggressive/destructive outbursts.

The action agreed by the case conference is now described:

The dietician arranged for a special diet to be prepared. This was achieved through individual members of the nursing staff identifying separately those foods which John liked and these being used to create attractive dishes for him. General aims were agreed beforehand to encourage the habit of eating at regular and social intervals. These measures were intended to increase his weight and stimulate growth. The provision of attractive and agreeable meals was also aimed at removing a source of frustration, as mealtimes could be very difficult, resulting in aggressive behaviour unless his demands were constantly met. Specific nursing behaviour to support this strategy was designed to avoid eating between meals other than with fellow residents. It was anticipated that to do this would precipitate the experience of hunger which would then be satisfied by John eating regular meals. At the same time a means by which John could manipulate others was removed.

At mealtimes an air of quiet and calm was encouraged and John was verbally rewarded for sitting and eating in a socially acceptable way. Nursing staff paid particular attention to how much he ate, and requests for more were met with an immediate and appropriate response. A detailed record of all food eaten was kept for the purpose of monitoring his fibre intake, the intention being to tackle John's problem of constipation. Wholemeal bread, bananas, tinned tomatoes and beans were all liked by him and therefore began to feature regularly in his diet. He also had a liking for tea and this ultimately formed a significant part of his fluid intake.

The matter of his constipation was taken very seriously because faecal smearing had become a feature of his antisocial behaviour at home. John's mother initially had difficulty understanding that faecal overflow was not in fact diarrhoea, but once this had been clarified action could be planned and a programme designed. In the past John had been given regular enemas, but this practice was discontinued and suppositories were given as and when necessary. As the balanced diet began to pay dividends the need for suppositories lessened, oral medication in the form of Duphalac syrup was given on a regular daily basis. In the past John must have experienced some pain when attempting a bowel movement and was visibly afraid to visit the toilet. Reassurance, encouragement and praise became a constant element in his life which in this context was designed to defuse the issue of bowel movements thereby extinguishing the unpleasantness associated with this natural activity. Thirdly, and probably the most serious aspect of John's behaviour was his prediliction for aggression and violence. To have a person with his potential for extreme violence residing with 14 other people, many of whom had some form of behaviour problem presented the nurses with a highly charged environment within which to work. John was prescribed tranquillisers as a short term measure primarily to enable the staff to approach him. During the tranquil periods he was continuously cuddled and spoken to. The need for tranquillisers lessened and his aggressive outbursts reduced in frequency. Intelligible speech was encouraged and the nurses insisted upon being asked properly when he required something. The importance of listening and responding appropriately was paramount. Two further factors existed which had a direct bearing on his aggressiveness. John suffered from epilepsy and it was noticed, through skilled observation, that there occurred a repetitive bizarre behaviour pattern which on closer examination was found to be

linked to a form of petit mal seizure. The nursing and medical staff agreed a regime of anticonvulsants aimed at reducing this problem.

The second factor was psychological and related to a form of behaviour modification. John had a particular attachment to his jumper in much the same way that a small child has for a 'comforter'. Any aggressive outburst was met with a standard response. His jumper was removed which immediately enabled the nurses to break into the cycle of aggression. He was asked to sit down and request to have his jumper back. This usually took about a minute but the effect was good inasmuch that a violent episode could be avoided, or reduced to manageable proportions. The nursing staff were aware that such action could lead to attention seeking behaviour, and when conditions permitted John's aggressiveness was sometimes ignored. Such action on the part of the nursing staff was taken in line with the Skinnerian Principles of Reinforcement which says that when behaviour is ignored there is less likelihood of it being repeated.

Over a period of six months these efforts abolished the aggression. His weight also increased resulting in a growth spurt and the onset of puberty. Furthermore John's language competence increased and his vocabulary extended. His general behaviour at home improved, and both he and his mother are supported by regular visits from the Community Mental Handicap Nurse.

The Skill Base in Relation to this Care Study

This care study demonstrates nursing skills under nine general headings:

a) An understanding of the special sensitivity necessary when working with adolescents who are mentally handicapped. This could be said to encompass a knowledge of the physical, social and psychological pressures which form part of the growth towards puberty.

b) Working as a full professional member of a multi-disciplinary team. This involves an understanding of the role and function of professional colleagues.

c) Recognising and using the available resources to create a caring, supportive and age appropriate environment within which individuals will feel secure.

d) Being in possession of good counselling and communication skills. In particular those associated with listening and responding.

e) Developing a helping relationship with clients' relatives.

f) Knowing some of the basic skills of speech therapy.

g) A sound knowledge of medications and their effects.

h) The technique of behaviour modification.

i) Management of constipation.

It is acknowledged that each of these general sections can be easily broken down into more specific skills. The aim of the care study is to illustrate the complex nature of mental handicap nursing through day to day activities. In using this method it becomes possible to show how easy it is for nurses to underestimate their highly developed battery of skills, and accept what they do as being 'all in a day's work'.

Conclusion

The arguments contained within this chapter are intended to describe nursing as an eclectic profession which over the years has developed the flexibility to respond to a wide variety of health and illness situations, thus building up an impressive array of theoretical and practical skills and knowledge. Smith et al (1986) refer to people with mental handicap as representing a client group for professional carers to move forward in the development of 'personal' resources. This statement is highly relevant in the nursing sense especially as the move towards community care brings a responsibility to share many generic facets of care with families and other professional agencies. It also clarifies the need for co-operation and a sharing of insights regarding residential care for a section of the population whose human condition creates special demands incapable of fulfilment outside of a structured environment.

The current and long term role in the care of people with mental handicap will remain under close scrutiny. It will have to withstand critical appraisal from within and without nursing if consolidation and professional maturity is to be fully achieved. There are several positive indications in different parts of the country which show that nursing is becoming innovative and taking the lead in worthwhile schemes of residential care and domiciliary practice. The English and Welsh National Boards for Nursing, Midwifery and Health Visiting have approved a variety of new courses based on the 1982 syllabus of training which is now producing qualified nurses with modern ideas and attitudes. Project 2000 will continue this process. There is also some evidence of the interprofessional rivalries becoming reduced which points towards the

eventual inevitability of shared training between health and social services becoming a reality.

CHAPTER 3

PRACTICAL ASSESSMENT IN NURSING EDUCATION - A LITERATURE SEARCH

The majority of literature in this area of nursing education seems to hold a general view that the process of assessment is a mine field of subjectivity, conflict and misunderstanding. In particular the educational value of assessment, which is emphasised as being essential to the personal and professional growth of the individual, seems to be greatly overlooked, Wong et al (1978) say:

> '... few educators who really take evaluation (assessment) seriously can be in any serious doubt about how relative their teaching is.'

However there is a great deal of evidence to show that people rarely take evaluation seriously. The problems associated with practical assessment are well documented and include reference to the preparation of assessors as well as to the content of the assessment itself. It is the intention of this literature review to critically analyse current thinking, and later on to apply the main strands of the analysis to mental handicap nursing.

It comes as no surprise to serious students of the educational process that any system of education can be judged by the methods used to assess its students. Rowntree (1977) makes this point when he writes:

> 'If we wish to discover the truth about an educational system we must look at its assessment procedures. What student qualities and achievements are actively rewarded by the system? To what extent are the hopes and ideals, aims and objectives

professed by the system ever truly perceived, valued and striven for by those who make their way within it?' (page 1)

The aims of any nursing curriculum are primarily to produce a well educated work force, and the achievements and qualities which are valued by the profession revolve around those which are necessary for providing the general public with a safe practitioner in whom they can place great trust. This position of trust is carefully guarded and any person who wishes to practice as a qualified nurse must first of all surmount the hurdle of scrutiny through assessment.

There are various styles of practical assessment each of which have varying degrees of usefulness. In psychological terms the main function of any test or assessment is to establish a baseline for future development, as well as measuring current performance. In this respect assessment is said to be either formative or summative. (Scriven 1967) This terminology arose from the methods employed to evaluate courses, but Rowntree (1977) holds the view that a similar approach is possible when describing assessment. Formative evaluation of a course, for example, aims to improve and develop the content and teaching until its effectiveness is maximised. By the same token formative assessment seeks to maximise the intellectual and professional growth of the student through ongoing diagnostic appraisal. On the other hand, summative evaluation is aimed at discovering the effectiveness of a course once it is fully established, and generally comes at the end. Again, by the same token, summative assessment is designed as a terminal, end of course appraisal during which an overall judgement of the students ability is made.

Formative assessment may be described as an educational exercise, and summative assessment as a means of grading and classification, or as Rowntree (ibid) puts it, one is intended to reflect potential, whilst the other measures actual achievement. This leads to the conclusion that either form of assessment may be valuable in its way, and may figure together in reaching a decision about an individual. Indeed it is perhaps false to interpret them as distinct forms of assessment but more accurately to say that the description of formative and summative depends upon the assessors' interpretation of whatever means of assessment he is using. (Sheahan 1979)

This interpretation can be taken a stage further into the area of criterion referenced, versus norm based measurement. Criterion referenced assessment is usually employed to judge the student's performance against a set of criteria or specified level of achievement. (Satterly 1981) Criterion reference specifies an absolute standard of quality which relates individually to each student, and is not reliant for its validity upon the assessment grades of others who have completed the same course and taken the same test. This style of assessment can usefully be applied to nursing inasmuch that it can be helpful in diagnosing particular learning difficulties because it concentrates solely on measuring ability and skill in one area of professional practice. In this sense it can be used for estimating whether a student nurse is competent at a certain level of expected attainment. However, as seems the case with all types of assessment this method is open to criticism, and a careful analysis will reveal that many of these criticisms may be justified. Criterion referenced measurement requires clear and well written behavioural objectives to give it a reasonable chance of success, and the more complex

the behaviour to be assessed the more unlikely it becomes that practical assessors will be consistent in their measurement. This criticism is linked with the view that knowledge and understanding cannot always be clearly defined, and the criterion referenced measurement can be misused by concentrating on the lower levels of the Taxonomy of Objectives (Bloom et al 1952) and therefore does not give a clear test of higher abilities.

Kenworthy and Nicklin (1989) refer to the 'whole student' perspective of assessment offered by the experiential taxonomy of Steinaker and Bell (1979). They suggest that through this approach it is possible to avoid domination of the curriculum by assessment. Student participation, including self assessment, is said to be an explicit requirement of this taxonomy, and therefore subscribes to the adult or andragogical model of education which is becoming the norm in nurse education.

In a series of detailed studies of the reliability and validity of rating scales in assessing the clinical progress of psychiatric nursing students, Squier (1981) found difficulty in obtaining inter-rater agreement on the assessment of nursing skills. He considered several reasons for this including the possibility of a lack of stability in nursing behaviours, or the differences in attitudes, expectations and perceptions of the assessors, or a combination of both. Squier (op cit) argues that it would be unreasonable to expect consistency in any practical nursing assessment because nursing skill varies with the requirements of the patients being cared for and the nature of the student's relationship with other staff members. This argument is seen as being somewhat naive in the literature and indeed may be used as an excuse for poor techniques employed by the assessor. It is equally valid to argue that as a student nurse gains in experience and knowledge especially in her final year of training

she will have developed some stability in her levels of performance and will be better able to overcome the variables within any working environment. However, in response to this Squier says:

> 'Unfortunately, none of the studies carried out demonstrated a significant amount of consistency in the ratings made by different senior nursing staff in the same or in another ward situation. Furthermore, the pattern of ratings, taken together with collateral evidence from discussions with senior nursing staff making the ratings, suggest that the primary source of difficulty lies in what can be termed rater error.' (Squier 1981 page 165)

Squier (op cit) supports the view that assessors will often concentrate on the lower levels of objectives as these are safer and give some degree of inter rater agreement. He refers to behaviour such as tidiness, promptness and personal appearance as falling into this category but admits that these traits do not figure as being amongst the most significant skills requiring assessment in a future psychiatric nurse. This view is supported by Wood (1982) who agrees that we must recognise that practical assessment of student nurses is performance based, and this is carried out in a clinical setting, or as in the case of mental handicap nursing, a wide variation of practical settings ranging from a hospital ward to a community home. Wood (1982) makes the point that clinical or practical assessment relies on an individual making direct observations. She says that such observation is prone to inherent bias and subjectivity, and is therefore a subjective process. Ashworth and Saxton (1990) say that it is

> 'the objectivity issue that gives some reason for concern. In our view, the fact that comparatively clear statements of outcome are laid down as assessment criteria (and we set aside for the moment the issue of the intrinsic quality of such statements) has beguiled some into thinking that they are now in possession of a thoroughly reliable and valid assessment scheme. This is a serious misunderstanding.' (Page 23)

When one interprets grading standards they usually vary from assessor to assessor, thus making it very difficult to achieve any real degree of uniformity. In support of criterion referenced measurement Sommerfield and Accola (1978) say:

> 'Criterion methods of evaluation clearly depict how well the student's performance measures up to what is expected and helps the student direct her energies for her own growth by describing the expectations at subsequent levels.' (Page 443)

It seems from literature that despite its problems criterion referenced measurement is the most favoured method of assessing practical nursing skills, presumably because it represents the most effective way of ensuring that the entrant to the profession is safe. However, norm referenced measurement does have certain things to offer and it is worthwhile considering these, especially as to concentrate on one method of assessment only can be unwise. Norm referenced measurement, as its name implies, compares one student with others in the same peer group. The overall usefulness of this in practical assessment is debatable but it should not be overlooked that it may be carried out covertly especially as practical areas usually receive students at a similar level of training on

a regular basis. Training programmes follow a 'circuit of experience' and those areas chosen to provide this experience are designated in respect of the learning outcomes of the students at a particular stage of training. It would not be at all surprising if assessors based their decisions on a comparative performance of other students previously assessed. If norm referenced measurement develops through constructing a scale or framework against which individual scores can be measured then it follows that such a framework can be cognitively constructed and used without any reference to agreed criteria. Meisenhelder (1982) accepts this as a serious consideration, and makes the point that assessors can often be in cognitive dissonance when a student appears to meet the criteria of a test, yet it is well known that her performance generally is poor. She says of this:

> 'Despite the multiple forces that tear at a teacher's (assessor's) conscience, the final decision lies in the behaviourally based appraisal... the evaluative role is like that of an umpire: one must call it as one sees it.' (page 348)

Critics of assessment often refer to the grading of students as a ritual, (Hiner 1980) but accept that it will always be with us because of societal demands, and the challenge therefore is not to seek ways of reducing its status within the curriculum, but to make it work more efficiently. Wood and Wladyka (1980) say that such efficiency can only be brought about through clearly stated objectives which are reached through a curriculum which integrates course design, teaching methods and learner assessment. They recognise the difficulties in providing each learner with the same educational experience but say that by using all the tools available for teaching success, the assessment problem can be minimised. A

nursing curriculum operates at several levels and therefore it is important to recognise that assessment must reflect the amount of change expected in a learner at certain stages along the way towards qualification. For example Reese, Swanson and Cunning (1979) talk about 'different level-different evaluation'. They say that assessment (or evaluation) must measure the direction as well as the amount of change, and this can only be achieved through conducting assessment at different levels, each having a different purpose and requiring different data on which to judge the progress of each student.

They argue for the specification of learning experiences at various levels of training and make a plea for educational goals to be clearly stated in behavioural terms. This, they say, will enable the learning environment to be structured so that desired responses will have the opportunity to occur. This clearly defined behaviourist approach relies greatly upon the measurability of the objectives used to describe the desired behaviour. These authors continue by making a case for task analysis linked to the identification of the stimulus-response requirements of a specific skill, the logic and arrangement of the skills acquisition, and the teaching strategies required by its different components. An extension of this is to break down the skill into its psychomotor, perceptual and cognitive domains.

Kehoe and Harker (1979) describe such an approach being used in the preparation of assessors where it is considered important for them to be wholly familiar with the criteria for each assessment. Each area of skill is clearly defined into its component parts and various weightings allocated to each area. Using criterion referenced measurement the assessor expects the student to reach a satisfactory standard overall. An

interesting extension of this style of assessment is that certain key criteria carry compulsory elements. Such a rigid stance is defended on the grounds of 'professionalism' whereby the prime purpose is to filter out the unsatisfactory nurses and allow only the best to go through. An approach such as this has been described as educationally unsound and invalid as a means of assessment, and despite appearing to confuse behaviourism with behavioural objectives, Satterly (1981) makes a point when he says:

> 'In behaviourism, learning is studied only at its observable level and all other terminology or interpretations in terms of hidden entities or mental process is denied. Early behaviourism was influenced by a philosophical movement known as positivism which dismissed as meaningless all statements which were not empirically verifiable. Accordingly the cardinal educational principles derived from this set of beliefs was that the only meaningful goals of learning and teaching were those which are objectively measurable as observable outcomes. Other aims are dismissed as little more than pious hopes.' (page 52)

To see assessment purely as a filter applied at strategic points along the way infers that a student nurse is facing a selection procedure at each of these points. She is being selected to proceed to the next part of her programme. Failure at any one of these hurdles can lead to rejection which carries with it the label of 'unsafe practitioner'. This seems to be a typical outcome of any assessment movement which primarily concerns itself with judging a student's performance in relation to a particular job of work. Indeed it is often the case that in many professional or technical courses the teacher is often faced with the task

of assessing the student's current performance and future potential as a lawyer, doctor, nurse, manager, engineer etc.

Mostly it is the teacher who carries out the task of practical assessment, but in nursing this is often not the case. Ward managers are usually the ones responsible for undertaking this important and mandatory task, and in doing so are accountable to the profession for maintaining standards. It is this accountability which militates against assessment being used for anything other than judging professional competence, especially when carried out in a climate of industrial legislation. Students can appeal against any decision that goes against them and this must affect the attitude and approach of the assessor when s/he is fully aware that as a consequence of stating that a student is not competent s/he could be involved in a protracted procedure of appeal. The paperwork involved in such a procedure takes priority over student learning, and Wood and Wladyka (1980) writing of the Canadian scene comment that future trends will probably bring more pressure onto the clinical practitioner, simply because student appeals are here to stay. This observation is equally valid in the United Kingdom, and Squier (1981) points out that careful selection and training of raters (assessors) is essential if practical assessments are not to lose their educational value completely. This is dealt with in greater detail at the end of the chapter.

What to Assess

It has been said that for an assessment to be valid it must measure what the educational institution has set as the objectives for the course. Satterly (1981) describes this as content validity and says that under this heading, tests should aim to ascertain the extent of learning achieved by

the students. This may be because the tutor or College of Nursing intend to evaluate the curriculum, or to provide an order of merit in respect of achievement. He carries on to say:

> '... In each case there is a need to know how well the items or problems which make up the test match the objectives of the curriculum and the actual content of the teaching and learning experiences. Content validity is an especially important concept for achievement tests and requires that the teacher or test constructor builds into the test not only the topics which were covered but also items which demand the application of the skills and concepts in the manner in which they are presented and exercised during learning.' (page 27)

In support of this Rowntree (1977) points out that when planning an assessment strategy there are several important factors which require consideration. He says that in deciding what to assess we are:

> '... deciding, realising, or otherwise coming to an awareness of what one is looking for, or remarking upon, in the people one is assessing.' (page 81)

There can be little doubt that when practical skills are being assessed it is essential for assessors to have a detailed working knowledge of the competencies under scrutiny. To enter an assessment unprepared is not acceptable because to be aimless is denying the student clarity and purpose in respect of the skills and knowledge to be judged. Thus these previously agreed competencies must be presented for all to see in the form of a list. Such a list will constitute a criterion sheet or assessment report form upon which the assessor will base his decision.

In arriving at this list of competencies individual Colleges of Nursing should make public their criteria, having first decided upon such things as rating scales, levels of difficulty and suitable environments in which assessment may take place. Devising a system for assessment has received attention in British and American literature, in particular Litwack (1976), Young (1982), Sommerfield and Accola (1978) write in critical terms of the difficulties faced by nurse educators when attempting to reach agreement concerning assessment criteria. Litwack (1976) is clearly disturbed about the uses of behavioural objectives as a basis for practical assessment, and describes the search for a suitable overall statement of competencies which would serve generally. He particularly dislikes objectives which encompass areas which are 'impossible to measure' such as, commitment to nursing. Similarly, Young (1982), Sommerfield and Accola (1978) avoid such criteria also.

Litwack (1976) describes how one American Faculty of Nursing reviewed and renewed its clinical evaluation methods in the light of current dissatisfaction with the ones already in existence. He says that a lengthy list of objectives was replaced with two new programme objectives which the Faculty expected students to achieve at the end of the course. It is worthwhile reproducing these objectives as they have a direct bearing on all elements of the profession including mental handicap nursing. They are:

> 'Each student must acquire the attitudes, scientific knowledge, and skills necessary to give safe and comprehensive patient centred nursing care. Each student must demonstrate the ability to formulate, implement, and evaluate individual patient care as a member of the health team.' (page 46)

These programme objectives were used to form a foundation upon which the curriculum could be revised, and from this revision there evolved an assessment check list. This check list reflected two main elements relative to each component of the course as a whole. The first was the element of uniqueness which accompanied each course component, the second was the common core which ran throughout the course. An example of each element is given in the literature, ie the unique element of a clinical speciality with its types of illness and specialist nursing, and the common core subject of communication studies. Litwack (1976) makes special reference to the importance of sharing each stage of development with the students. This observation is made by others, for example Young (1982) writes of including student representation on a working party whose terms of reference involved them in devising a schedule of continuous assessment, plus the additional responsibilities of monitoring its implementation and advising all members of staff concerning its progress. Likewise, Sommerfield and Accola (1978) voice strong approval of student involvement at all stages of development.

Litwack (1976) continues by describing the grouping of student behaviours relative to the original programme objectives, and then proposes a rating scale which he feels adequately covers all eventualities. It is interesting to compare the list of categories selected by Litwack's group with those devised by another group working independently.

Litwack (1976)	Sommerfield and Accola (1978)	
Provision of a safe environment	i	Use of the Nursing Process
Assistance with nutritional needs		A. Problem-solving approach
Safe administration of medications		B. Assessment of patient need
Provision for circulatory and elimination needs		C. Nursing goals
Organisation/integration of nursing care		D. Nursing interventions
Communication skills		E. Evaluation of nursing goal achievement
Provision of personal comfort	ii	Use of helping relationships
	iii	Use of adaptation theory
	iv	Use of nursing tools
	v	Synthesising
	vi	Progress towards professional functioning
		A. Risk taking and accountability
		B. Self-evaluation
		C. Professional discussion
	vii	Learning goals

There are similarities and differences between these two sets of categories. For instance, Litwack does not overtly mention the nursing process, yet by using a humane approach to care it is implied as such, whereas Sommerfield and Accola (1978) do use the process and specify the four stages as being important when assessing student progress. They also extend student assessment into the realm of self-evaluation and professional growth which increases the complexity of assessment. To do this adds an essential dimension to the measurement of a student's overall performance in respect of those skills which have been assimilated, as well as identifying those which require extra work.

Litwack (1976), on the other hand, describes a more conventional hard line approach in the behaviourist mode. There is no real evidence of self evaluation in his writing leaving the reader to infer that if a behaviour

cannot be clearly identified and rated it is not included as a criterion to be achieved.

This viewpoint is contrary to those expressed by other writers. For example, a guide to assessment published by King Edward's Hospital Fund for London (1972) contains the following information:

> 'The trainee should also be encouraged to examine herself and judge her own abilities. In this she will be helped by familiarity with the type of questions her assessors will be expected to answer. (This means being familiar with the current report form.)' (page 13)

Such familiarity with the criteria for assessment is highly advisable as this will enable the student to plan her own self evaluation pro-forma which should reflect the overall training programme as well as the 'official' assessment requirements.

In support of this Harden (1979), says of self assessment in the undergraduate medical programme:

> '... it follows that self assessment has to be encouraged in the undergraduate course. New approaches to self assessment in continuing medical education have been developed over the past few years and many of these are equally appropriate in the undergraduate context.' (page 69)

Corcoran (1985) carried out a pilot study to examine a student self assessment system. He used an established method called the Sequential Criterion-Referenced Education Evaluation System (SCREE) which is a self administered, repeated measurement pro-forma. It was used originally to

help students overcome the anxiety often associated with taking social work research and statistics courses. This system enables each student to assess individual progress and provides aggregate information on the growth of an entire class, and allows students an opportunity to compare their learning rates with peers.

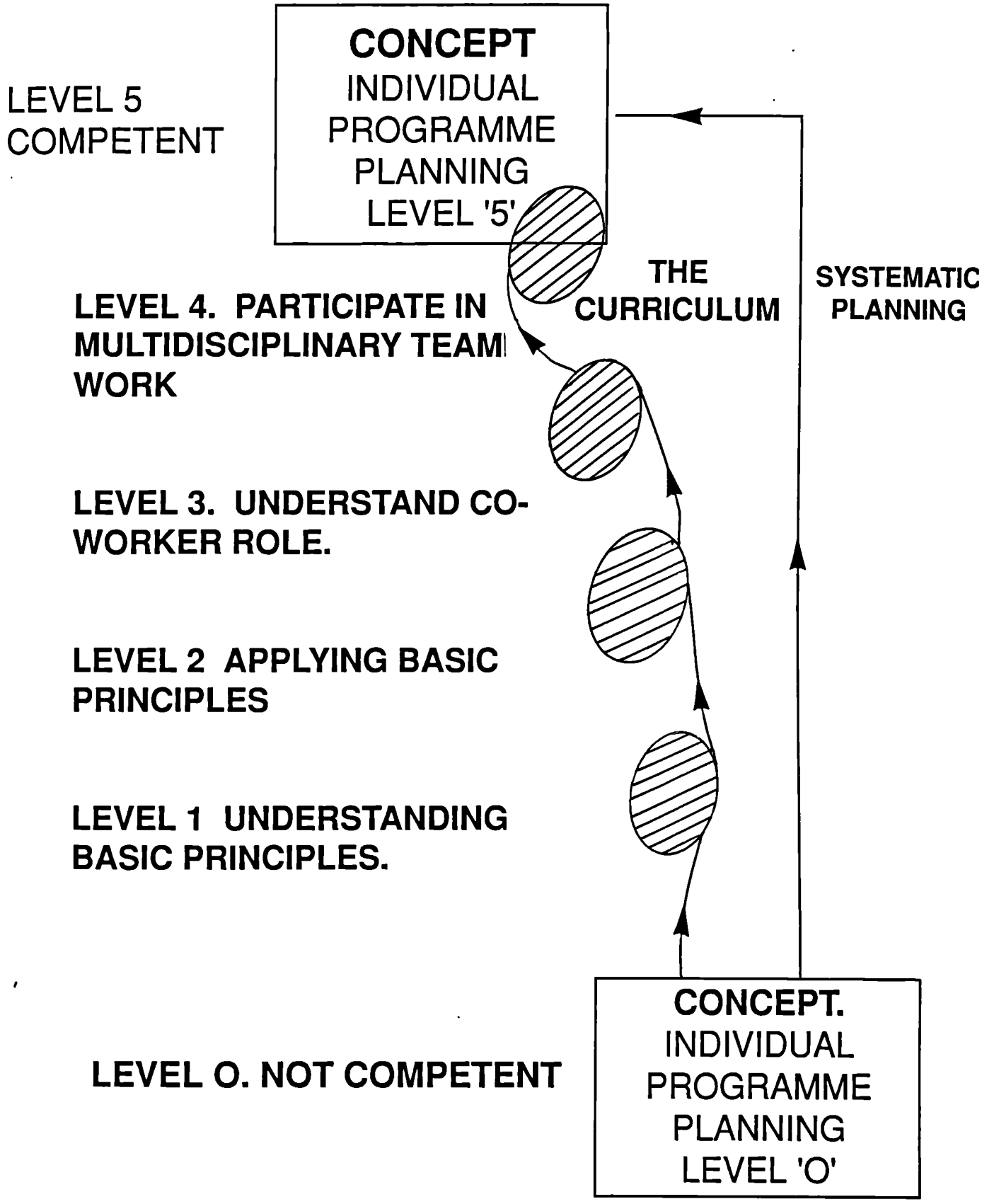
The data from this study supported the use of the SCREE system in social work education. Its main value was in the continuous feedback it provided for each student, but because of its formative nature, course grades were not derived from its use, and it was particularly time consuming. The study suggests that self assessment based on a system of criterion referencing may be less effective when attempts are made to self assess professional qualities such as empathy, attitudes, and values. This method is likely to be successful when applied to predetermined outcomes associated with hard skill development.

Throughout the American literature there is evidence of self evaluation being greatly favoured. Writers such as Palmer (1969), Chuan (1972), Bauman and Benoit (1976), Moritz and Sexton (1970), as well as Sommerfield and Accola (1978) extol its virtues each having developed various strategies for enabling students to benefit from assessing their own progress.

As previously shown, the use of the nursing process in developing criteria for assessment is becoming popular. Its logical progression through the stages of nursing care has enabled educators to develop curriculum planning using a spiral model which integrates the knowledge and skills required when teaching the planning and delivery of care. The term 'spiral curriculum' has been coined by Bruner (1960) to demonstrate a

particular type of task analysis using the same material reintroduced at different levels with increasing conceptual difficulty. (Childs 1981) The following diagram (Figure III) offers a simplified version of this approach using the concept of Individual Programme Planning as an example. It illustrates Bruner's notion of 'Spiral' Curriculum which is based on the view that difficult concepts need to be introduced not once and then assumed to be understood, but several times in carefully placed contexts. (Lawton D 1983 page 89) Learning will occur in increasing complexity as the student proceeds through her course, and practical assessment can be linked to the expected level of ability at various, previously identified points. The English National Board for Nursing, Midwifery and Health Visiting (1983) used this approach when designing the four practical tests which complement the 1982 syllabus for mental handicap nursing. For example, we have seen that test (a) is designed to take place at the end of the first year of training and asks the student to implement an agreed care plan relating to the needs of ONE individual. In contrast, test (d) takes place following the 24th month of training and involves the total care for a group of four to six individuals over a period of one week, based on the four stages of the nursing process. The test criteria for part (a) are straightforward and in keeping with the anticipated level of knowledge. Test (d) on the other hand is complex and demanding as one would expect it to be, considering the amount of time the student would have been in training.

Wood (1982) describes the major changes in emphasis which have evolved through the use of the nursing process, she says:



Adapted from Davies, I. K. (1976)

Objectives in Curricular Design 5
McGraw Hill

FIGURE III A Spiral Curriculum

'A major movement has been the development of clinical evaluation forms based on various adaptations to the concept of the nursing process.'

Of the seven forms described, six were based on the nursing process, and Wood explains that certain modifications were considered necessary in some cases. She cites an example from the work of Murton et al (1976) who used the basic process categories of data collection, communication, identifying patients' needs, developing a plan of action, evaluating and revising the nursing plan, plus the additional categories of attitude to learning, accepting nursing responsibilities, adapting to new and stressful situations, integrity and self appraisal. Within these 10 categories, 74 behavioural objectives were devised, and it is interesting to compare this approach to that described earlier by Litwack (1976) who adopted a more formal, well defined system.

In considering 'what to assess' it is clearly relevant to a focus on objectives, as these represent what has to be attained. It is suggested that the use of objectives in education should determine the direction of student change thought to be desirable by those who design the programmes. Objectives describe to some extent how students can develop existing qualities and abilities, whilst at the same time acquiring new ones. They should guide students into new ways of thought, action and feeling. It is assumed that successful attainment of objectives produces a more knowledgeable, skilful, confident, rational, sympathetic, insightful and autonomous individual. (Rowntree 1977) The construction of objectives has been explored in many textbooks and articles, not least of which is the seminal work of Bloom et al (1956), Stenhouse (1975) and Steinaker and Bell (1979), each of whom describe the uses of objectives in interesting ways.

For example, Bloom (op cit) differentiates three domains of human activity namely cognitive, affective, and psychomotor, under which they list a taxonomy of objectives relating to each category. Stenhouse (1975) talks about objectives arranged in a linear fashion along a continuum between a 'hard line' behaviourist standpoint, and what he calls a process or open approach. It is the Taxonomy of Educational Objectives which has caught the imagination of many nurse educators especially in the cognitive domain. (Tomlinson and Birchenall 1981) This taxonomy can be linked to the nursing process in a way that makes objective writing more precise. The cognitive domain is arranged in six levels and the behaviours attained in the higher levels are assumed to depend upon prior acquisition of the behaviours at the lower levels. (Blood and Budd 1972) These levels are as follows:

1. Knowledge
2. Comprehension
3. Application
4. Analysis
5. Synthesis
6. Evaluation

It will aid clarity to expand these levels in a way which shows the categories of each. From this it can be seen why educators find such an arrangement appealing when constructing assessment criteria.

A Summary of Bloom's Taxonomy of Educational Objectives - Cognitive Domain

A. Knowledge

Knowledge of Specifics
Knowledge of Specific Facts
Knowledge of Terminology
Knowledge of the Ways and Means of Dealing with Specifics
Knowledge of Conventions
Knowledge of Trends and Sequences
Knowledge of Classification and Categories
Knowledge of Criteria
Knowledge of Methodology
Knowledge of the Universals and Abstractions in a Field
Knowledge of Principles and Generalisations
Knowledge of Theories and Structures

B. Intellectual Abilities and Skills

COMPREHENSION
Translation
Interpretation
Extrapolation
APPLICATION
ANALYSIS
of Elements
Relationships
Organisational Principles
SYNTHESIS
Production of a Unique Communication
Production of a Plan, or Proposed Set of Operations
Derivation of a Set of Abstract Relations
EVALUATION
Judgements in Terms of Internal Evidence
judgements in Terms of Internal Criteria

(Bloom, B S et al (eds) 1956 page 62)

(See also Bloom, B S (Ed) 1979 page 62)

It may be inferred from the literature that a general agreement exists which says that nurses should be educated in the skills of flexible problem solving, and their practical assessment must reflect this. The nursing process, when allied to the Taxonomy of Educational Objectives will provide a framework for developing modular courses within the spiral curriculum. It can be seen for example that the 'synthesis' category has

much in common with the nursing process wherein it describes the expected outcome of patient assessment leading ultimately to the nurse operating at various levels of cognitive activity. This in turn will provide substance to the practical activities of nursing. Some writers view this as a band wagon, and suggest that in the main, examiners will opt for the lower level of objectives because these are easier to quantify. (Kenworthy and Nicklin 1989).

Myco (1981) writes of the importance of realising that assessment of practical skills based on the nursing process cannot be effective unless the environment within which these skills are acquired is wholly committed to the nursing model. For example, she suggests that assessment of practical nursing skills can be partly achieved through the use of care studies. Myco says:

> 'The introduction of the nursing process into practice presupposes certain skills are inherent in the nurse. This is not so. Skills which are present in the inexperienced nurse are not always allowed the opportunity to develop within a medically dominated philosophy. The patient care study is a means of stimulating and assessing these skills.' (Myco 1981 page 1305).

In considering this statement it becomes clear that the practical assessment of student nurses is a complex affair. The use of care studies is but one of a number of strategies open to assessors and yet the areas which may be explored through this method alone are numerous. Myco (1981) describes how biological and social sciences become a necessary feature of nursing care studies. Additionally she says that a patient care study can

demonstrate the level of observational skills and degree of insight shown by the inexperienced nurse. Spencer (1985) supports this by giving prominence to the skills implicit within observation. In quoting Eggert (1975) she agrees that nurses should be trained towards making therapeutic use of themselves by, amongst other things, acquiring the skills of observation, and that continuous assessment of these skills should be a natural part of the student nurses' development. Because of the direction being followed by nurse educators towards an overall system of continuous practical assessment it seems that future policy will be wholly inclined towards this method. Indeed the English National Board for Nursing, Midwifery and Health Visiting say that ALL students entering training on or after January 1 1988 must be assessed in this manner. However, Sellek (1982) warns that constructing a new test is as likely to be as difficult for the Faculty as taking the examination is for the student. The notion of continuous assessment will now be discussed.

Continuous Assessment - A Way Forward?

There is an increasing interest in continuous assessment, which means evaluating learner performance through a series of units of achievement extending across the entire course of study. This interest stems from the foundation work of the 1960s. In particular, there is substantial American literature describing the many and varied schemes already operating in that country. The contribution of the early pioneers of assessment provided the invaluable legacy of objectives. (Bloom 1956; Mager 1962; Scriven 1967; Harrow 1972; Anderson and Faust 1973) There can be no escape from the value of properly constructed learner centred objectives in determining the means by which practical assessment criteria are determined.

In reviewing the literature, Spencer (1985) says that continuous assessment is a major way of evaluating nurse learners' clinical competence and can be thought of as composed of units of achievement. These are related fully to a nursing model of care and add up to the desired level of competencies. It should be an integral part of the total curriculum and based on the use of behavioural objectives. The importance of objectives in continuous assessment is supported by McBride (1983) who emphasised the flexibility which must be built into the scheme if it is to be fair. He describes the objectives as being related to four main groups of nursing activity, ie

1. Identifying the needs of patients.
2. Supplying these needs.
3. Communication.
4. Work organisation.

Some of the objectives in the scheme are applicable to second and third year nurses and some are applicable to all three years. If a nurse satisfies the assessor in an area not under immediate scrutiny then credit is given even though there is no requirement to do so. McBride (1983) highlights the problems which must be faced when writing objectives for continuous assessment, and Kratz (1981) emphasises the importance of preparing objectives for individual areas of study which collectively integrate with the curriculum. Integration of the curriculum calls for a multi-faceted view to be taken of the whole course of study and the means by which it can be continuously assessed. (Tomlinson and Birchenall 1981) To do this makes the assessment more natural and realistic and more accurate. (Spencer 1985)

Continuous assessment can also be arranged so as to avoid both the unfair and untypical notion of final examination and the anxiety provoked by every piece of practice work being assessed. (Rowntree 1977) Such schemes count for grading purposes only the best pieces of work produced by the student. It is unlikely however that such a liberated approach will be fully adopted by the nursing profession, but through a system of sensitive grading criteria it is possible to enable a student nurse to progress through the course without being totally skilled in every facet of nursing practice providing they achieve a minimum level of safety. (McBride 1983)

Selecting and Preparing Assessors

The selection and preparation of practical nursing assessors has received scant attention in the literature, and yet remains an area which attracts controversy and criticism from within the profession. Earlier in this chapter it was pointed out that the majority of practical assessments are conducted by ward managers who have at some stage of their career undergone an 'art of assessment course'. Such courses have been mandatory for a number of years and only those nurses who successfully complete the requirements are permitted to assess. Where a course of this nature is described it is seen that emphasis is placed upon the acquisition of certain skills, in particular asking questions which demand varying levels of response, and the development of social skills aimed at reducing learner anxiety and promoting a supportive atmosphere. (Jefferson and Birchenall 1979) The same authors describe situations which respond to role play and the transfer of assessment skills from an unrelated activity, (ie motor skills assessment in the catering department of a College of Technology to psychomotor skills measurement in a nursing environment) which seems to indicate a common core of criteria relevant to practical assessment in any

situation. For example, in their guidance for assessors the Health Education Council (1984) describe the personal qualities required of an assessor as, tact, diplomacy, adaptability, reliability and impartiality. MacGuire (1984) takes a similar but more detailed view of nursing assessors, and places emphasis on the interpersonal qualities necessary for building mutual trust between the candidate and her examiner. She describes the 'good' assessor as one who:

> '... manages to make the successful candidate feel that she has really made an important step forward in her training and that the effort has been worthwhile.' (MacGuire J 1984 page 13).

More recently the English National Board has developed a post-basic course 'Teaching and Learning in Clinical Practice' (ENB 998) which has a stated objective of giving participants the opportunity to acquire skills in the principles of teaching, supervising and assessing in clinical/practice areas.

Of the unsuccessful candidates, MacGuire (1984) says they require help in order for them to feel that the hurdle is not insurmountable and that they did not do 'everything' wrong. Assessment failure is particularly traumatic for both parties, and the American literature in particular refers to such an event as a life tragedy for the student. (Meisenhelder 1982) It has a similar meaning in the United Kingdom especially when failure at the third attempt in any of the four assessments can invoke the disciplinary procedure thus putting the student's job in jeopardy. (MacGuire 1984) The disciplinary procedure can also create inconvenience for the assessor, especially if an appeal is lodged. This procedure can be extensive and exhausting in its pursuit of "truth" and is

never a pleasant experience. For this reason many assessors are reluctant to refer or fail a candidate unless no other choice is available to them. (Kehoe and Harker 1979) There is a body of opinion seeking to introduce external independent assessors, (Brown and Walton 1984) which is seen as one way of reducing the anxiety felt by internally appointed assessors. The notion of external examiners being involved in practice areas has been the subject of conferences and study days organised by the English National Board. Involvement in the whole process of assessing was seen by one speaker as possibly the best way towards achieving some validity in any vocational training course which seeks to apply theory to practice. (Jarvis 1987).

Jarvis (op cit) took the view that if the external examiner has been involved in the entirety of the assessment process then the whole curriculum will be the subject of her/his report. Jarvis said of this:

> 'In looking at the course work the external examiner will have gathered something about the level of knowledge being learned, which is acceptable or otherwise. In the practical assessments, the external examiner will have some knowledge of the ongoing teaching and learning on the ward, how the students are assessed and taught and the standards of practice that are regarded as acceptable to those who act as assessors on behalf of the profession and the school of nursing.' (page 6).

There remains much controversy regarding the role and function of external examiners. In the main it is the possibility of an increased workload which debars a number of people from taking up the role to its fullest extent. For others it carries political implications in respect of

the use made of reports which evaluate the clinical/practice aspects of assessment. Whatever the objections, it will be a considerable time before external examiners fulfil their obligations as evaluators of the whole spectrum of assessment.

Conclusion

This literature review reinforces the educational premise which links assessment with the learning process. It places current methods of practical skills assessment into their historical context, and shows clearly the difficulties when faced with constructing a valid and reliable assessment tool. Continuous assessment of theory and practice is gaining in popularity, but as this review makes clear, the problems associated with providing good assessments in appropriate environments are many. The thesis will address many of these problems from the point of view of student nurses in the mental handicap speciality, and the literature review will positively inform the direction taken by the research.

CHAPTER 4

PURPOSE OF THE STUDY AND METHODOLOGY

Defining the Problem

The purpose of the study is to determine student views on the relationship which may exist between nursing skills as they are officially taught, and:

1. the realism of practical skills assessment in determining whether the skills have been adequately taught, assimilated and appropriately directed, and

2. the secondary consideration of the practical relevance of these skills to the day to day work of the trainee mental handicap nurse.

The rationale which underpins the need for this investigation stems from insights and experience gained by the researcher in a variety of key activities related to the training and education of mental handicap nurses. These activities include:

a) Experience in the practice of mental handicap nursing.

b) Membership of the 1982 Mental Handicap Nursing Syllabus Development Group.

c) Executive Chairman of the Royal College of Nursing Society of Mental Handicap Nursing.

d) Involvement in the initial and in-service training of teachers of nurses within the speciality of mental handicap.

These activities have enabled the researcher to become critically aware of the increasing number of references made to the 'skills' of mental handicap nursing. There is a belief that in order to gain and sustain credibility as a profession it is vitally important to legitimise one's existence through the identification of a substantial and highly defendable skill base. Additionally, to add to the credibility, these skills must be supported by a related body of knowledge, which is the mark of a true profession.

Within a relatively short space of time there has been a noticeable shift in direction away from a largely physiologically orientated curriculum to one which is strongly biased towards holism. This has brought with it a reassessment by educationalists of the forms of knowledge and associated skills which should now be a major influence in the preparation of practitioners. Resulting from this reassessment there has grown a body of opinion that to survive as a specialist entity mental handicap nursing should give serious consideration to a sharing of professional training with the social services.

Should this eventually come to fruition, then the practice of nursing will consolidate within a social context, and the direction of residential and family support for people with mental handicap will be towards a community model. Herein lies the problem. Mental handicap nurses are still taught predominantly within Schools/Colleges of Nursing. These Schools often include long stay institutions and the students usually gain a substantial measure of their experience within hospital wards and departments. Their role models could be nurses or other professional workers with long experience in hospital-style care practices, and as such

may not always be completely in tune with the modern concept of care in the community.

The English National Board for Nursing, Midwifery and Health Visiting requires that assessment of practical skills be carried out by approved assessors who possess the appropriate nursing qualification. In the main, these assessors are ward managers, their primary role is to provide a caring environment, and therefore it is unlikely that they will be in a position to update themselves on a regular basis as far as educational issues are concerned. In support of this Lewin and Jacka (1987) refer to the haphazard nature of the individual student's practical learning on the wards, Additionally, they are critical of the lack of effective monitoring. This led them to write:

> 'However skilful and watchful a sister may be she is heavily committed to other tasks; she is an intermittent overseer of a given student's development, and that only for eight to ten weeks.'

Admittedly, the research from which this quotation is taken was carried out within the general field of nurse education, but Brown and Walton (1984) have recorded similar observations from within mental handicap nursing. Indeed, the whole area of educational support within the wards is a long standing, widespread deficiency in nurse training. In order to summarise the meaning of this deficiency it is relevant to consider the work of Marson (1981) who explored the teaching and learning of nursing in the practical area and investigated the characteristics of perceived effective Ward Sisters. Hawker (1986) encapsulates Marson's research when she writes:

'She found that although most sisters were aware of the conditions under which learning takes place on the ward, most equated ward teaching with didactic instruction. There was little systematic approach to ward training programmes, and most teaching centred on nursing procedures and medical tests and diagnoses: "Important issues such as values in nursing and communication and management skills appeared to be low priority or not considered at all... It may be that the assumption was that these skills are 'caught not taught'". Few sisters in Marson's sample had attended a course to develop their training role. The majority of learners in the study had a similar passive view of teaching and learning but appreciated ward learning experiences "when asked to recount an incident when they were aware of learning something important, or that had caused them to think or behave in a different way, few incidents involved didactic instruction". She concluded that "on the job" teaching of nurse learners was a "complex global activity" in which the role model is a powerful influence. Those perceived as effective teachers were caring, competent, sensitive to learners' needs and committed to nurse training.' (Hawker 1986 page 67).

The present study, therefore, recognises the importance of understanding the complex relationship between theory, practice and assessment of practical skills. It had been possible through a review of the literature, and a detailed analysis of the mental handicap nurses' role, to generate a research question. This question is based on four characteristics as outlined by Best (1959), ie (i) that it be a reasonable

question to ask, (ii) that it be consistent with known facts, (iii) that it be stated in such a way that it can be tested as true or false, (iv) that it be stated in as simple a terms as possible.

The Research Question

The question which forms the basis for this study was arrived at through a process of becoming familiar with established facts, existing principles and previous research relating to the phenomena of assessing nursing skills. Most of the previously described work is derived from the general nursing field, and therefore it is reasonable to suggest that any question generated from this body of knowledge may or may not have any real significance from the point of view of mental handicap nursing. This aspect forms the basis of originality from which the study is developed and takes account of the following aspects (as yet unproved):

a) Mental handicap nursing is underpinned by a SPECIFIC body of knowledge and skill. This relationship between knowledge and skill can be more readily observed in this branch of nursing than in others.

b) That through the current system of mental handicap nurse education it is possible for the student to organise and co-ordinate the complex process of learning.

c) Continuous assessment of practical nursing skills is more likely to be favoured by students than the ones currently in use.

The research question takes the following form:

In the view of students nurses is the assessment of practical skills in mental handicap nursing:

i) Competently performed, taking account of the professed skill base?

ii) Does it take cogniscence of those factors affecting the assimilation of related knowledge e.g. time and the allocated exposure to the learning environment?

iii) Does it reflect the expected relationship between knowledge and practice?

Overall Plan of the Study

The data were generated primarily through a survey approach.

Following a detailed review of the literature surrounding practical skills assessment in nursing and other occupations, and a careful analysis of the mental handicap nurse's role, a series of questionnaires and follow-up interviews were employed to collect data from two main sources.

(i) Qualified (RNMH) nurses who were assessors of practical nursing skills. Each person was given a self-administered questionnaire with the aim of gaining some baseline attitudes and feelings towards practical assessment and the relevance of preparation they had each received to carry out this aspect of their role.

(ii) Student nurses who had reached a point in their course where they had each undergone at least two of the four practical assessments. The students were each 23 months or more into their training, and each one received a series of three self-administered questionnaires. Data from the questionnaires were enriched by the data gleaned from

group interviews. The questionnaires reflect a logical progression through an analysis of the following aspects:

(a) The skill base underpinning nursing competence.

(b) The development of nursing skills.

(c) The assessment of practical nursing skills.

Each questionnaire relies heavily on the material contained in Chapters 2 and 3 of the thesis. The main issues identified in these chapters formed the substance of the questionnaire.

It is considered important when assessing practical nursing skills to take cognisance of the conditions under which they have been acquired.

Student Questionnaire One investigates the nature of the skill base used in practice as perceived by students and how this relates to theory. It also seeks responses to several items relating to specific components of mental handicap nursing, with a view to compiling a profile of views regarding how these components fit into the curricula of each of the Schools of Nursing surveyed. The importance of defining the relationship between this profile of views, and practical skills assessment, is fundamental to making some judgement regarding the breadth and depth necessary for effective assessment.

Student Questionnaire Two is focused on student learning relative to the organisation and coordination of the complexities of mental handicap nursing. It investigates the nature of feedback experienced by the respondents, and questions the type of supervision available whilst on practical placement. The relationship of the main elements of

questionnaire two, to practical assessment, can be found in the notion that for assessment to be effective it must reflect the whole curriculum. This takes account of how students learn, the development of attitudes to their work, and the diversity of emphasis placed on important issues such as models of nursing, and the use of research in the curriculum. For an educational programme to be truly effective it should ensure that each student experiences similar learning environments (Ausubel, 1968). It follows that each student should be assessed on this premise also. Questionnaire two is designed to measure degrees of difference within individual respondents as far as the development of skills is concerned, and consequently how assessment differs in individual cases.

Student Questionnaire Three is concerned directly with gaining views and opinions regarding the process of practical skills assessment. It is designed to probe individual reactions and identify inconsistencies in the way assessment is carried out.

Initially, it was considered relevant to observe a number of practical assessments in a non-participative capacity, but this was rejected as unacceptable on moral grounds. It would have been wrong to add further pressure to the already stressful situation of an assessment.

Fieldwork for the research was carried out in ten locations, nine of which were Schools of Nursing administered by the National Health Service. The other location was a College of Higher Education which had a particular interest in providing post experience courses for mental handicap nurses. The use of this College was primarily to obtain data from a relatively large sample of qualified (RNMH) nurses who were from a service or educational background.

The nine Schools of Nursing selected for the research were systematically chosen from five English counties - Yorkshire, Surrey, Nottinghamshire, Humberside and Derbyshire. Of the nine Schools, four were situated in urban locations and five rurally placed. It was considered that this grouping of Schools was representative of the national scene because:

(a) each offered a curriculum based on the same statutory syllabus.

(b) the sample population would be at or around the same stage of professional development as their counterparts in Schools not involved in the research.

(c) the sample population were derived from urban and rural localities as would be the case if a national survey was undertaken. This also assists in reducing bias.

Access to the field was achieved by writing formally to the heads of each institution informing them of the nature of the research. Permission was requested to visit their Schools and apply the questionnaires to an appropriate sample of students. The letter also contained a request for copies of the educational philosophies underpinning the curriculum. These philosophies would show similarities and differences in the educational approaches taken by each School.

The Sample

(i) Assessors

Data were collected in the Summer of 1986 from a group of qualified RNMH nurses. (n = 43). 27 were teachers of nurses and 15 were from

nursing service/management positions. At this time these nurses were attending a National conference specifically to do with the education and training of student nurses. Because of the nature of this conference and the national spread of the delegates, it provided an ideal opportunity to survey a sample of nurses who were also experienced assessors. Data collection was largely opportunistic using an instrument which had not been piloted. A return of 71% of the questionnaires circulated was achieved. (See Appendix II for the questionnaire and Appendix III for the table of results). These data were used to give an assessors' view of the spectrum of student assessment criteria used within their respective nursing schools. Where applicable, opportunities were provided for each to comment on the nature and style of their individual preparation for the role of assessor.

2. Student Nurses

Data were collected from a sample of student nurses (n = 80) who were at least 23 months into their training. This sample came from a total of nine training institutions, and each student was following an approved course leading to the RNMH qualification. The choice of students for this research was negotiated between the researcher and respective senior nurse teachers. In order for the method of questionnaire distribution to be effective the students chosen would have to be together at any one time. Therefore part of the negotiation was for senior teaching staff to arrange in advance for the data collection to occur when relevant groups of students were in their study blocks. The administration of the questionnaires took place in an environment familiar to the respondents. In this case it was either a classroom or seminar room in a School of

Nursing. Students chosen to take part in the research were individually contacted by letter containing the following points:

1. Strong emphasis was given to the 'opting out' choice offered to potential respondents.

2. The overall nature of the research was explained.

3. The right to confidentiality was guaranteed.

The spread of students varied across the Schools of Nursing, the minimum number in a group being four and the maximum 14. The mean was 8.98, median 11, mode 11. Data were collected between Spring 1987 and Summer 1988, with a response rate of 100% to the questionnaires. This response was achieved through the questionnaires being administered personally to respondents in their respective Schools of Nursing. The sample is located within a wider sample of Schools nationally which offered the RNMH course during the period 1987-1988. During this time 43 Schools of Nursing offered the RNMH course, therefore the research sample represents 21% of this total.

Of the 80 people in the student sample 75.5% were female and 25.5% male, with a majority age range between 18 years and 29 years (n = 69). (See Tables A, B and C for a comparison with the national and regional profile). The statistics comprising these tables were kindly provided by the English National Board for Nursing, Midwifery and Health Visiting.

TABLE A

NATIONAL ENTRANTS TO RNMH TRAINING - GENDER 1985-1989
(Reproduced by kind permission of the ENB)

Time Period	Male	Female	Total	% Male	% Female
1985-1986	201	585	786	25.6	74.4
1986-1987	241	683	924	26.1	73.9
1987-1988	208	592	800	26	74
1988-1989	260	595	855	30.40	69.60
Mean	227.5	613.75	841.25	27.04	72.96

RESEARCH SAMPLE

Time Period	Male	Female	Total	% Male	% Female
1987-1989	18	62	80	22.5	77.5

TABLE B

NATIONAL ENTRANTS TO RNMH TRAINING - AGE RANGE

Time Period	18 - 21	22 - 29	30 - 39	Over 39	Total
1987-1988	280	394	94	45	813
1988-1989	349	361	101	44	855
Total for 1987-89	629	755	195	89	1668
% of Total	37.7	45.26	11.7	5.34	100

RESEARCH SAMPLE

Time Period	18 - 21	22 - 29	30 - 39	Over 39	Total
1987-1989	27	42	10	1	80
% of Total	37.75	52.5	12.5	1.25	100

TABLE C

REGIONAL ENTRANTS TO RNMH TRAINING - AGE RANGE

Time Period 1987 - 1988	18 - 21	22 - 29	30 - 39	Over 39	Total
Yorkshire	26 (36.1%)	35 (48.65)	7 (9.70%)	4 (5.6%)	72
Trent	45 (40.5%)	46 (41.4%)	15 (13.5%)	5 (4.5%)	111
S.W. Thames	23 (31.1%)	42 (56.8%)	8 (10.8%)	1 (1.35%)	74

RESEARCH SAMPLE

Time Period	18 - 21	22 - 29	30 - 39	Over 39	Total
1987-1989	27 (33.75%)	42 (52.5%)	10 (12.5%)	1 (1.25%)	80

(This Table includes the three health regions from which the research sample was taken)

Developing the Instruments

Under this heading it is proposed to attend to those issues governing the choice of questions, and the rationale employed for the questionnaire design. The interview schedule will also be discussed.

Developing the Main Questionnaire Bank

Guidelines for developing the main instruments were constructed and adhered to. Because the questionnaire method of collecting and measuring data demands clarity of thought when formulating its desired goals, it was considered prudent to concentrate on the development of a narrowly defined data set. Prior to the respondents being presented with their questionnaires, they had been told of the nature of the research. This makes it imperative for each questionnaire to reflect accurately the data to be collected, and that particular specifications regarding the process

through which responses will be measured, are clearly evident. In an effort to compile a series of questionnaires appropriate to the research, a staged approach was adopted beginning with a detailed literature review of the area of practical assessment. This was followed by a detailed analysis of the mental handicap nurse's role. From this it was possible to make an accurate judgement of those factors which together would create a fund of knowledge from which questions could be formulated. This in-depth study of the professional role enabled a first hand exploration of the concepts and vocabulary related to mental handicap nursing, much of which would be familiar to the respondents. It was anticipated that such an approach would go some considerable way towards avoiding the use of inappropriate vocabulary or knowledge. At face value it may seem that some words in the questionnaire are indicative of complex issues, e.g. competence, but the use of such words can be defended on the basis that they form part of the register of everyday professional language. Nursing education is framed around a list of competency statements which are discussed with students on a regular basis. The aims and objectives inherent within a nurse education programme are directly linked in some way to these statutory competencies. It seems reasonable to suggest that student nurses who are at least two-thirds of the way into their course should have at least a working knowledge of the meaning of competency in the context of its relationship to their course of study. In constructing a questionnaire one needs to ensure that trivial and irritating questions are avoided. A balance needs to be struck between over complexity and triviality, and the questionnaires used in this study attempt to strike this balance.

Developing the Assessors' Questionnaire

The assessors' questionnaire was developed using knowledge gained from the literature review. In particular, issues concerned with the style and organisation of practical assessments, and the preparation of assessors were addressed by the questionnaire. Analysis of the data from this questionnaire was achieved through direct quantitative description.

Reliability and Validity of the Instruments

Throughout the literature there seems to be a lack of clarity concerning validity and reliability of research instruments pertaining to social/educational research. Hammersley (1987) writes:

> "When one looks at discussions of reliability and validity one finds not a clear set of definitions but a confusing diversity of ideas. This results in a lack of clarity when reliability and validity claims are made." p 73.

Hammersley (op cit) gives several definitions from various sources which seem to support his argument. For example,

> "The validity of a measuring instrument is defined as the property of a measure that allows the researcher to say that the instrument measures what he says it measures. The reliability of a measuring instrument is defined as the ability of the instrument to measure consistently the phenomenon it is designed to measure." Black and Champion (1976) pp 222 and 234.

> "Reliability refers to the reproducibility of measurements - would it result in the same data and conclusions?" Goode and Hart (1952) p 153.

> "Reliability refers to the capacity of the instrument to yield the same measurement value when brought into repeated contact with the same state of nature." Johnson and Pennypacker (1980) p 191.

Hammersley (op. cit) takes the view that the primary concern in measurement must be whether the set of scores produced by the data accurately reflects the

> "presence/magnitude of the target property in the objects we have measured. This is what most writers seem to mean by validity." p. 77.

He says in this case we need to use some adjective like 'measurement' or 'descriptive' validity. He goes on to say that in the case of the term 'validity' there is the problem of the relationship between two typologies. Criterion, predictive, concurrent, content, face and construct validity on one hand and internal, external, population, and ecological validity on the other. He suggests that the former refers to measurement, the latter to the whole process of assessing the truth of explanatory claims. In Hammersley's view most definitions of validity are realist, that is the extent to which an instrument measures the property it is intended to measure. He also says that most definitions of reliability are normalist - referring to the scores produced by repeated efforts to measure the same property by means of the same instrument.

When the notion of validity is considered, the researcher is confronted with three important questions especially when a multi-method approach to data collection is being contemplated. These questions are:

1. Which methods should be used?
2. How are they to be combined?
3. How are the data to be used?

This present study takes a triangular or multi-method approach to data collection by employing three distinct methods.

1. The questionnaire administered to qualified RNMH nurses.
2. The bank of three questionnaires administered to the student nurses.
3. Follow-up semi-structured group interviews with the student respondents.

This approach is well supported in literature, for example, Boring (1953) writes:

> "As long as a new construct has one single operational definition that it received at birth it is just a construct. When it gets two alternative operational definitions it is beginning to be validated. When the defining operations because of proven correlation are many then it becomes reified." p 169.

The methods selected for use in this study were designed to collect data concerning skill assessment and its relationship to the training and education of nurses caring for people with mental handicap. The instruments themselves were constructed against a background of literary

evidence concerning professional nursing skills and practical skills assessment. The data were intended to be integrated as a means of providing information from which a critical analysis could be made of the current situation in respect of practical nursing skills assessment. From this analysis it would be possible to make recommendations which could apply to a wider population. Prior to the main study a pilot study was carried out.

The Pilot Study

The primary objective of the pilot study was to try out the main bank of questions for clarity of communication, relevance of the data being sought, and any general difficulties experienced whilst completing the questionnaires. Initially, the instruments were administered to groups of third year student nurses in Schools of Nursing at Leeds (West Yorkshire), Balderton (Nottinghamshire), Epsom (Surrey), Chesterfield (North Derbyshire). Each questionnaire was administered by the researcher, and upon completion the respondents were asked to comment verbally on the following:

a) What was it like filling out these questionnaires?
b) Were there any questions with which you had difficulty?
c) Were there any questions you did not understand?
d) Were they either interesting or boring, too long or short?

Derived from Bunker, B B, Pearlson, H B, Schulz, J W (1975)

The questionnaires were also read by academic colleagues who made useful suggestions for improvement.

Following this exercise, adjustments were made to a small number of items mostly in relation to the wording of question stems, which in some cases were too involved and difficult to differentiate. The required number of alterations and adjustments were surprisingly few, and it was relevant to include the data taken from the pilot in the main study. Included as part of the pilot study was a computer programming exercise aimed at testing the compatibility of the questionnaires to the SPSS-X system. This system was to be employed to analyse the data numerically, to compute correlation coefficients as a means of establishing the internal consistency of the instrument, and carry out the chi-square test of association in relation to the urban/rural data previously referred to. As a consequence it became necessary to alter the questionnaires in order to realign the variable identification and column numbering. Upon completion of this exercise the data could then easily be transferred to the computer. In addition to the locations used for the pilot study, the main study involved Schools of Nursing sited at York (North Yorkshire), Wakefield (West Yorkshire), Bradford (West Yorkshire), Hull (North Humberside) and Halifax (West Yorkshire).

Group Interviews

Semi-structured group interviews were adopted as probably the most effective means of acquiring data complementary to the questionnaire survey. This method would appear to have the advantage of being reasonably objective whilst permitting a deeper understanding of the respondent's opinions and reasons behind them. Borg and Gall (1979) say that a semi-structured interview is generally the most appropriate for interview studies in education. It provides a desirable combination of objectivity and depth and often permits gathering valuable data that could not be

successfully obtained by any other approach. The participants were groups of students from three of the locations used in the questionnaire survey. These groups were from two of the health regions represented in the study (Yorkshire and Trent). This was done to give some balance to the responses. The South-West Thames region was not used because of the expense of travelling. The researcher introduced himself to the groups as a postgraduate research student.

Recording the Interview

For the purpose of this study the use of a tape recorder was seen as the most preferable way of recording data. Despite the disadvantage which accompanies the presence of a tape recorder, namely the intrusive effect it can have on the interview situation, the advantages make it worthwhile. The main one is that it reduces considerably the possibility of interviewer bias which can easily occur if one relies solely on note taking. A further advantage is the facility for repeated play backs to ensure greater understanding of what has been said.

Maintaining Effective Communication During the Interview

Throughout their course of training individual respondents should have experienced similar learning environments, but the effect of these will be unique to each person. The design or structure of the questions will mean different things to different people, and it becomes essential to establish a common mode of communication. In this case it was necessary to phrase the questions in language universal to mental handicap nursing rather than that which forms the language of education.

The Choice of Questions

Entwistle and Nisbet (1972) advise:

> "The main principle governing the choice of questions to be asked in the interview was that the information obtained should be factual, objective and as free from interviewer bias and prejudice as possible." (p 90).

The interview schedule was designed to tap into personal understanding of matters directly appertaining to assessment. Peer group differences and disagreements were also sought in relation to the positive and negative effects of assessment. However, Powney and Watts (1987) urge caution against the tendency to ask more questions than are actually necessary to meet the specified line of inquiry. Because of the well documented difficulties which accompany the transcribing of lengthy taped interviews a short list of highly relevant questions was arrived at. The interviews were to be directed by the researcher who would control the order of questions. In doing this it was anticipated that each interview would last no longer than 35 minutes. A copy of the interview schedule is included as Appendix V.

Data Analysis

The entire data set from the main questionnaire bank were converted to tables of results from which conclusions could be drawn, and for this purpose some categories of response were collapsed. Data were summarised through descriptive analysis and presented in an interpretative style which enabled discussion of the issues. Some opportunities were provided for respondents to expand on their answers. These opportunities took the form

of open questions which occurred principally in questionnaire two of the main bank of instruments. Data from these open questions were post coded for ease of computing, and rank ordered in relation to their frequency of response. Tables were constructed and presented in the text. Data from the assessors' questionnaire were converted to a table of results from which conclusions could be drawn. These conclusions were discussed. Results from the assessors' questionnaire plus data from the group interviews were used to support the data from the main student questionnaire bank.

Statistical tests were carried out on data taken from the main bank of questionnaires. These tests were performed in order to make a judgement about the validity and reliability of the questionnaires as research instruments, and to test for the possibility of significant differences in data collected from urban sources when compared with those taken from rural sources. N.B. In these statistical tests the full range of Likert responses were utilised.

Internal Consistency of Response to the Main Questionnaire Bank

In developing the questionnaires on an a priori basis there seems to be a case for suggesting that relationships should exist between variables when paired and tested for a positive correlation. Checking for correlation helps to establish reliability of the instrument. The data from the questionnaires were ordinal and as such not appropriate for parametric testing. However, some data were considered suitable for statistical analysis, and a non-parametric test of correlation coefficient was chosen and applied to 21 variables suitably paired. This accounted for 25.6% of the total number of variables available for testing. Of the 21

variables 8 were related to different models of nursing, and for convenience these were located under one heading namely 'nursing models'.

The paired variables were subjected to the Spearman Rho test, and the results for each pairing are shown below. It can be seen that internal consistency across a range of variables was identified. A significant result was achieved in 5 cases involving 17 variables. Non-significant results were shown in 2 cases involving 4 variables.

The paired variables chosen for this test were:

V14 The essential framework of care offered by the Nursing Process was a feature of your course.

paired with

V15 Individual care planning based on an appropriate model of nursing is encouraged within the School of Nursing.

Rho = 0.44 Significance = 0.001

V24 My course has not equipped me with the counselling skills of listening and responding.

paired with

V21 My course has not equipped me with interviewing skills.

Rho = 0.41 Significance = 0.001

V45 Have you been taught the skills of listening and responding to individuals perceived needs?

paired with

V24 My course has not equipped me with the counselling skills of listening and responding.

Rho = 0.10 Significance = 0.18 (NS)

V32 Mental handicap nursing involves teaching self help skills to residents. Do you feel that you have the teaching ability to adequately meet the requirements of individually designed programmes for your residents?

paired with

V27 Have your tutors taught you the theory of skill development?

Rho = 0.06 Not significant

V30 During your community practical placements from whom did you usually receive positive/helpful feedback regarding your skill development?

paired with

V29 During your hospital practical placements from whom did you most frequently receive positive/helpful feedback regarding your skill development.

Rho = 0.31 Significance = 0.01

V56 to V63 Models of Nursing in use within respondents' Schools of Nursing.

paired with

V55 Is nurse education in your particular School of Nursing based on a specific model of nursing.

Rho = 0.89 Significance = 0.000

V78 In the main, I was adequately prepared to undertake practical assessments.

paired with

V82 Prior to an assessment, I was aware of the actual skills to be assessed.

Rho = 0.42 Significance = 0.000

Reliability Analysis of the Main Questionnaire Bank

The Spearman-Brown split half correlation test for reliability was carried out on a sub-scale of variables from questionnaire one, and the entire range of variables from questionnaire three. Data from questionnaire two were not considered suitable for this form of analysis. The sub-scale from questionnaire one consisted of the following variables:

V10 The theoretical aspects of my course were <u>not</u> always relevant to the practical situation.

V21 My course has <u>not</u> equipped me with the skills of interviewing.

V22 My course has not equipped me with the skills of setting aims and objectives for care.

V23 My course has not equipped me with the skills of planning and determining priorities for care.

V24 My course has not equipped me with the skills of counselling - listening and responding.

V25 My course has not equipped me with the skills necessary for reviewing outcomes of nursing action.

V26 My course has not equipped me with the skills necessary for forming an understanding of family dynamics.

The split correlation score for this sub-scale was

0.84 on the Spearman-Brown test

This score suggests that the total sum of the sub-scale can be taken as a reliable reflection of consistent response by the students. In this case the variables were attempting to measure individual opinions regarding the relevance of theory to the practical situation in general and the success of the course in teaching basic skills associated with case load management in particular. The data seem to indicate that whilst respondents could not always appreciate the relevance of some theory to practice they had fewer problems in identifying particular base line skills necessary for day to day case management. (With the notable exception of interviewing skills). It seems that respondents were more able to pinpoint actual skills than the relevant theoretical concepts which support them.

The split-half correlation value for questionnaire three was 0.6495 on the Spearman-Brown test. This score is not exceptionally high but may be taken as sufficient to indicate that the scale V64 - V82 is 'reliable' in the sense that the sum of items is a reasonable estimate of the consistency of response about the value and conduct of ward based practical assessments.

In addition to this analysis an association between data taken from the assessors' questionnaire and that taken from the main bank of student questionnaires was sought. There was congruence or direct agreement on a number of responses, and appropriate references to these occurrences have been made in the body of the thesis.

CHAPTER 5

(i) INTRODUCTION TO THE SURVEY

(ii) A SKILL BASE FOR THE DEVELOPMENT OF NURSING COMPETENCE

Introduction to the Survey

The previous chapter illustrated that data were generated through a variety of means, primarily a questionnaire survey supported by an assessors' questionnaire and a series of semi-structured group interviews. Initially, the main student questionnaire bank contained response sets designed on a Likert Scale offering a four point continuum ranging from 'strong agreement' to 'strong disagreement'. Other continuums employed gave respondents a four point choice between 'always' and 'never', and a five point choice between 'strong agreement' to 'strong disagreement' inclusive of a 'not sure' category. When the data were computed it became clear that it would be advantageous to collapse the responses into opposite poles, namely 'agree-disagree' and 'frequently-infrequently'. This was done to concentrate the responses under distinct headings rather than have them spread somewhat thinly over a wider area, especially as the two extreme categories of the scales offered only minimal attraction to the respondents.

The assessors' questionnaire is designed to probe aspects of student nurse training and practical skills assessment which have a direct or indirect bearing on the assessor's role. The table of results (Figure IV) illustrates a number of interesting factors. In particular it can be seen that 48.8% of respondents felt that practical skills assessment by ward staff is the most effective way of measuring learner competence, whereas

41.9% said the opposite. (9.3% of the sample declined to offer an opinion). There is also an important observation with regards to the question concerned with practical assessments fitting naturally and realistically into the daily ward activities. It can be seen that 48.8% of respondents agree this to be the case, with an equal number saying the opposite.

A large majority (86%) say that continuous practical assessment is a viable alternative to the four ward based assessments. There is also a majority view that student nurses are adequately prepared to undertake their practical skills assessments (74.4%). A question concerned with the use of specific models of nursing as providing a base to programmes of nurse education elicited a range of responses. 34.9% agreed with the statement that their school of nursing based its course on a specific model of nursing, whereas 44.2% said the opposite, and 18.6% did not know.

Further discussion is not attempted, but where appropriate the data from this questionnaire is used to give substance to data from the main student questionnaires, and this is indicated in the text.

In the interests of clarity the results are presented and discussed taking each of the main questionnaires in turn and the relevant tables are presented as Appendix X. Cross referencing between the main bank of questionnaires, and interview responses is carried out as a means of giving breadth and depth to the discussion. A transcript of each group interview can be seen in the Appendices.

FIGURE IV

MENTAL HANDICAP NURSING : STUDENT ASSESSMENT

A REVIEW OF THE OPINIONS OF 43 EXPERIENCED QUALIFIED NURSES

		YES	NO	NO OPINION	NO ANSWER
Q1.	Do you feel that student nurse training is primarily concerned with passing examinations?	34.9% 15	65.1% 28	0	0
Q2.	Do you feel that practical assessment by ward staff is the most effective way of measuring learner competence?	48.8% 21	41.9% 18	7% 3	2.3% 1
Q3.	Should learners be encouraged to plan and carry out their own self assessment?	81.4% 35	16.3% 7	2.3% 1	0
Q4.	Do you believe that continuous practical assessment is a viable alternative to the method currently in use?	86% 37	9.3% 4	2.3% 1	2.3% 1
Q5.	In the main are learners adequately prepared to undertake their practical assessments?	74.4% 32	23.3% 10	2.3% 1	0

		YES	NO	DON'T KNOW	NO ANSWER
Q6.	Is nurse training in your particular school based on a specific model of nursing?	34.9% 15	44.2% 19	18.6% 8	2.3% 1
Q7.	Are care studies used as a means of practical assessment in your particular school?	55.8% 24	39.5% 17	2.3% 1	2.3% 1
Q8.	Are particular skills associated with observation taught in your particular school?	41.9% 18	21% 9	32.5% 14	4.6% 2

		YES	NO	NO OPINION	NO ANSWER
Q9.	Do prestated behavioural objectives influence your personal teaching style?	51.2% 22	39.5% 17	4.7% 2	4.7% 2
Q10.	Do you find that practical assessments fit naturally and realistically into the daily ward activities?	48.8% 21	48.8% 21	0	2.3% 1
Q11.	Have you attended an 'Art in Examining' course?	90.7% 39	9.3% 4	0	0

		YES (N = 39)	NO	NO OPINION	INELIGIBLE
Q12.	If the answer to Question 11 is YES do you feel adequately prepared to carry out the task of practical assessment?	82.1% 32	17.9% 7	0	4
Q13.	Have you ever referred a learner in a practical assessment?	61.5% 24	38.5% 15	0	4

Biographical Information

Historically, mental handicap nursing has attracted recruits from both sexes across a fairly wide age range and of differing marital status. This has meant that some applicants for training, especially women, have taken this step once their children had achieved maturity. A biographical profile of the respondents' status in respect of age, sex, previous job experience, other nursing qualifications, marriage and children was compiled.

The age range was categorised in four distinct sets, ie 18-21, 22-29, 30-39, over 39. Overall the responses covered each of the category sets, but the majority (51.5%) fell into category two, ie 22-29 years old. Category one attracted 34% response, with categories three and four sharing the remainder. Of the nine groups sampled, only one contained members representative of the complete age range (see Table 1). The historical perspective in respect of the age of entry was not upheld by the cohort surveyed. A similar conclusion can also be drawn from an analysis of gender, 77.5% of the cohort were female, which is an interesting observation, especially when considering the high proportion of men attracted to this branch of nursing in the past (see Table 2).

Previous job experience attracted a broad spectrum of response which indicates that many of the students surveyed had worked in other areas prior to entering nurse training, 38% had previous job experience in either commerce, industry or sales. A total of 42% came from a caring, nursing or voluntary work background, with only 9% entering training directly from full-time education (see Table 3). Of those who originated from a nursing background only one of the entire sample was an enrolled nurse from the

field of mental handicap. By way of a side issue, considering the spread of schools from which the respondents came, there does not appear to be a demand from enrolled nurses in the speciality to convert to registration through the medium of a three year course.

A review of the respondents' marital/family status revealed that 27.5% were married and that 87.2% of the total cohort did not have children. At the outset of the study it was considered relevant to establish whether child rearing skills obtained from personal experience of bringing up a family had any relevance in determining an individual's approach to people with a mental handicap. It is difficult to gain any real evidence from the data that skills of this nature are transferable. The maturing process derived from life experience in general will be mirrored in a person's response to situations, but evidence to support this is not overtly apparent.

It can be derived from the biographical profile that maturity gained through age and past experience does exist amongst the respondents. This will have played its part in their overall personal and professional development, and may have influenced their responses to some of the questions either in the questionnaires or through issues raised during the group interviews.

Questionnaire One

Providing a Skill Base for the Development of Nursing Competence

The cultural environment within which students prepare for a professional role can exert an influence on their perception of what counts as a skill base for the development of competency. Questionnaire One

contains 13 statements relating to this, and each statement requires respondents to agree or disagree with the content.

Special Nursing Skills

Statement 1 suggested that Special nursing skills are an essential feature of mental handicap nursing.

89% of the sample agreed with the statement (see Table 4). Respondents were requested to indicate some of the more explicit skills which could be described as 'special'. They identified a wide spectrum of activities which seem to fall within this category, but a strong bias exists in favour of six primary skills. These seem to form a framework from which all other skills can grow, and show a definite move towards a humanely inclined skill base. These primary skills are:

a) Counselling (including bereavement counselling)

b) Communication skills (understanding the person)

c) Teaching skills/skills teaching (this to include creating a positive therapeutic environment)

d) Community care skills which involves caseload management and family care

e) Research

f) Physical nursing skills

g) Management of self, others and the environment

Underpining these primary skills is a broad diversity of related activities which in themselves contribute to the uniqueness of the role of the mental handicap nurse. This uniqueness arises from the emphasis placed on the skill and its applicability to the specific role. One interviewee sums it up in the following way:

> 'Understanding of and being able to act upon such understanding for the client's benefit; of patterns of behaviour - verbal, gestural, facial, tone of voice, mannerisms etc, which the nurse learns through experience and relevant knowledge. By understanding I mean being able to assess client's needs, both met and unmet and give a facilitative nursing intervention to meet the unmet needs.'

Another interviewee said:

> 'I don't feel "nursing" is the right word for our skills.'

It is relatively easy to see how divergent views can be formed. Depending upon the philosophies of care followed by trained nurse role models, and perhaps even more significantly the views and opinions of teaching staff, there will emerge different avenues towards fulfilling the syllabus requirements. Important differences emerged which reflect extreme ideas of the nature of mental handicap nursing. For example, the clinical aspects which represent a traditional feature were evident. Such activities include, understanding clinical syndromes/medical problems, giving injections, understanding medication, performing clinical procedures, and making effective use of equipment, e.g. hoists and ripple mattresses. At the other extreme there is the social model with its

emphasis on relationship formation and the nurture of life skills and independence necessary for full integration into the community.

Occupying the centre ground is a set of activities which attract the generic title of 'management'. That is to say, management of the client, of the environment, and of self. In this category there can be found such skills as, organising constructive play sessions, dealing with aggression, and agitated behaviour, (challenging behaviour) positioning and feeding, behaviour modification, and understanding the nursing process and normalisation. From an environmental point of view emphasis is placed on the skills implicit within multi-professional team work, and also organising and managing long term care. Management of self through the development of observation skills, self awareness and role modelling is also said to be essential. One interviewee said:

> 'I would say that our strength is that our skills are generalised, that we have skills that can be adapted to any situation and environment, they are not purely based on say, ward work or whatever, I think that makes us look at things more holistically; we can sort of help out in all kinds of situations or refer to other professionals.'

Another interviewee was of a different opinion:

> 'The dangers are that people are getting very protective about what their job description is. An occupational therapist will say this is my role. If we're not careful because we do little things, little bits of what other people's jobs are as specialisation, we are in danger of having our skills just taken away. I think we should specialise and say "I have a

specialist skill in . . . as my role as a mental handicap nurse". I think the job definition is going to get smaller and smaller and smaller.'

The process through which skills are identified and learned is of great significance to this study. It has a direct bearing on the validity of practical skills assessment and will offer vital pointers when considering continuous assessment, the preparation of assessors, and updating those who have been assessing for some considerable time.

Theory and Practice - The Relationship

Statement 2 suggests that theoretical aspects of the course are not always relevant to practical situations.

Almost 80% agreed with this statement, although the balance between agreement and disagreement varied from School to School. Of the nine Schools only two reflected total agreement with the statement, and one School had a majority which disagreed (see Table 5). From these results there emerges two issues worthy of consideration:

a) Does the practice of mental handicap nursing reflect a 'hidden agenda' of theory?

b) How valid and reliable are practical assessments? This becomes a serious question because it is a fact that many assessors are ward sisters or charge nurses involved in the day to day practical nursing environment. Because of the potential mismatch between assessor expectation and student expectation it would be unrealistic for assessors to be wholly in tune with the students' theory base. It is important to recognise that through the activity of assessment,

students are also in a learning capacity and as such it would seem highly desirable for assessors to be up to date.

For example, the assessors' study, which reviewed the opinions of 43 experienced qualified nurses regarding student assessment, showed a division of opinion regarding the effectiveness of practical assessment by ward staff. A similar division was apparent when assessor respondents were asked whether nurse training in their particular School was based on a model of nursing. One of the students interviewed said of the theory/practice dichotomy:

> 'Its very hard to say anybody is to blame, but its very hard to have standardised expectancies of how students should perform - the assessors have very different opinions and there is often quite a difference between how the School expect us to perform and what the assessor is expecting.'

Similar sentiments were recorded in other locations. When asked about the relevance of theory to practice there seemed to be a general consensus regarding the inapplicability of some theory. This is not to say that theoretical concepts should not be taught in depth, but the interviews revealed a perceived lack of realism amongst tutorial staff. Comments from students indicate that often the ideal is taught in the classroom, but it is highly unlikely for situations in practice to reflect idealism.

> '... some of the things we are taught in here just don't occur on the wards, whether or not they should is another matter, but they don't.'

'...teachers teach you about dealing with potentially violent residents . . . they show you films, and there's hundreds of staff running from everywhere. You get on the ward and there's three of you, so how can you apply the things they've taught when you haven't got half the things to deal with it?'

Criticism was levelled at tutorial staff and their fitness to teach:

'... some of these people haven't been on the ward for quite a long time, and it is different to how they imagine it, or how it was when they were working on the wards.'

It would appear that a strong case could be made for the development of the tutorial role. It is difficult for teaching staff to escape criticism levelled in the previous quotation unless they maintain credibility as practitioners. A hidden curriculum is evident which can create a learning environment continually at odds with itself regarding the skills and knowledge necessary to do the job. A situation such as this has the potential of producing a vicious circle from which even the newly qualified would have difficulty in breaking out, the continuation of well established practices whether theoretically sound or not is a likely corollary of this.

Statement 3 probes further by suggesting that during practical placements there have been times when the students were expected to carry out skilled activities not underpined by the theoretical content of their course.

At first there may appear to be some contradiction with responses to the previous statement, but it is important to recognise the emphasis on

relevance. This statement concentrates on the theoretical content of the course irrespective of its direct relevance, and because there is a requirement for up to one third of the course to be ascribed to theory, it comes as no surprise to find that 70% of respondents disagreed with the statement. However, it is illuminating to discover that 30% agreed with the statement, and even more interesting is the spread of this agreement. The responses show marked differences of opinion within groups. For instance, of the 11 students questioned in one School, nine agreed with the statement. In another group of 11 students, nine disagreed with the statement. Of the nine groups questioned, six reflected split opinions (see Table 6).

Amongst those who agree with the statement there exists a wide spectrum of opinion regarding the nature of skilled activities carried out without having been taught theory in the School of Nursing. Collectively it is possible to group these activities under four headings:

a) Care planning - Nursing Process

b) Working within a therapeutic environment

c) Teaching - staff and residents

d) Physical nursing

Within the parameters of these headings a substantial amount of information was gleaned regarding activities which in themselves represent complex nursing behaviour. This becomes clear when consideration is given to the many inter-related situations which typify a therapeutic environment. Respondents provided evidence of having to deal with behavioural problems including spontaneous aggression. The notion of

restraint in cases of violent outbursts cause concern especially when some training institutions are said to be unclear about procedures and actions which are acceptable in certain situations and incidents. One interviewee describes such an incident:

> 'I was expected to fetch someone back who had left the hospital of her own accord. I had to persuade her to come back, although I felt rather alone in this situation and didn't know how to handle it.'

Another said:

> 'I was left to cope in difficult situations - behavioural problems.'

Other important issues were raised, particularly within the area of physical nursing and counselling. It is now widely accepted that interpersonal relationships between client and nurse are to be given high priority in the curriculum, and a growing body of theory gained from research and other literary sources has found a place in nursing knowledge. Highlighted in the data are a number of instances regarding a lack of theoretical preparation when students were called upon to deal with serious physical illness and bereavement. One School was criticised for expecting students to perform certain physical nursing routines whilst undergoing experience in a general hospital, without having first been provided with the necessary theory related to care planning, or practical procedures such as sterile dressing techniques. Similar observations were made about teaching and the range of situations requiring the nurse to take on this role. From the data it would seem that this range can vary from teaching across the client group, to instructing peers and staff from other

disciplines. The difficulty is not that theory is never taught, but when it is taught, and as one interviewee said:

> 'Skills have sometimes been taught in theory after being acquired in practice.'

If skills learning is one of the main aims of nursing education, then progression from the initial learner stage through to autonomous, knowledgeable practitioner depends upon sound course planning. The analogy of skills growing onion like, layer by layer, has been used by several authors, and requires the course content to exhibit considerable regularities. (Knight, P. 1985) Because of the nature of mental handicap nursing it becomes difficult to reach a conclusion regarding the regularity of content when courses in different Schools are compared:

> 'Our course of study has been quite all embracing of a lot of different areas as well as the ones laid down in the syllabus... it has provided areas where we can branch out and explore issues not covered in the syllabus.' (Interviewee)

There are many layers of knowledge and related skill but priorities accorded to each are dependent on the philosophy adopted by the course planners and teachers, this can vary even within individual Schools. An added complication arises when consideration is given to integration of theory and practice. The relevance and relationship of theory to practice has been discussed, and it seemed logical to investigate the extent to which integration occurs.

Statement 4 says:

'During your course sufficient emphasis has been given to the integration of theory and practice.'

The responses indicate a 65% agreement with the statement. In a similar fashion to the previous statement there are marked differences of opinion within groups. Three groups are virtually divided equally as to whether they agree or disagree with the statement, others are more inclined to agreement (see Table 7). This raises fundamental questions about the fairness of assessment. Especially of concern is the possibility of students from the same group being assessed on the premise that each has undertaken similar learning experiences. In the case of at least three groups questioned it is clearly not the case, and this could place an assessor in some degree of dissonance. Should students be assessed on what they can actually do or what the assessor thinks they should be capable of at a certain stage in their training programme?

The question of integration of theory and practice gave rise to certain views being expressed during the interviews regarding the perceived role of the School of Nursing in the overall preparation of students. A question concerning the role of the School was asked and elicited a varied response. The responses can be interpreted in a number of ways, and reflected the relationships between student and teacher, teacher and practice area, and the balance between content as it is taught and put into practice. One student said:

'To me, the School of Nursing is a base, I go out to various placements, but I go from the School of Nursing and always come back to it... It is also a place where there is somebody to talk to, where we are taught things - its a bit of a lifeline really.'

Others describe it as a resource centre, a place for ongoing education following qualification, and a safe environment of a kind that does not exist in the 'areas of work'.

The separateness of the School from the practice areas was sharply emphasised by each of the groups interviewed, but when asked whether this applied to the course itself, opinions differed. Generally the course was seen as the whole three years, and the practical areas offered opportunities for study which are unavailable in the school building. An observation was made about the need to modify theory to make it fit in practice.

'If the wards are so understaffed then you are not able to do what you have learnt in theory; so you modify what you have learnt to be acceptable in practice.'

'It depends very much which area you are on, you know. Quite often the theory and the actual hands on practice can be two entirely different things and then it is a shock.'

In situations where practical approaches can be influenced by so many variables, some of which are unpredictable, then it seems that modification of theory to fit practice may be the norm for most students. Should this

be the case then assessment of practical skills must take account of this phenomenon.

Respondents talked of consistency in the learning environment. They had been told a lot about consistency, things happening time after time to enable them to learn. This hasn't happened in many cases, and projects started in good faith lacked the reinforcement and commitment necessary for successful completion. A certain amount of cynicism towards students still exists, especially within the hospital environment. New theory and new ways of doing things are met with the attitude that despite it all, change will not happen quickly.

Despite this, it does seem that government policy in respect of the developments appertaining to community care has already begun to exert an influence on the direction of skill development for the future.

Educational Demands of Modern Nursing Practice

Statement 5 of the questionnaire sought the views of respondents regarding the modern approach to mental handicap nursing:

> 'Modern care practices demand that RNMH qualified nurses have a substantial profile of skill in community, educational and therapeutic aspects of care.'

From the entire sample only two respondents disagreed with the statement (see Table 8). This clearly indicates an overwhelming acknowledgement of the changing emphasis towards a community model of care, which has created a demand for an eclectic practitioner. The skill base is widening and embraces factors hitherto thought inappropriate, even though a majority of students still follow schemes of training which have their

origins in the hospital environment. Future trends are clearly indicated within Project 2000, and the branch programme will give rise to dynamic curricula which place the notion of mental handicap nursing as a social service, into a new dimension. The concept of facilitation was explored during the interviews, and it was surprising to find an overall lack of understanding regarding the meaning of the term. Despite there being such a large response in agreement with statement 5, the discrete skills which form the matrix of the social, educational and therapeutic care profile are probably misinterpreted. Institutional influences could be at the root of this dichotomy whereby nurses spend much of their time working in understaffed wards caring for relatively large numbers of residents. Undoubtedly, hospitals are closing, some on a more accelerated scale than others, but the fact remains that two well demarcated training grounds are in existence - namely the hospital and the community.

To illustrate the potential difficulties which can arise from this situation a group of students were questioned about the facilitation aspects of their work. When asked whether they had met the term 'facilitator' at any time during their training, the unanimous answer was no they hadn't. In explaining the term to them the researcher referred to discussion recorded earlier in the interview where the group had identified with some of the difficulties experienced when working in small community homes. When asked whether different skills are needed to work in these homes the response from one student seemed to sum up the feelings of her colleagues:

> 'I think you might, because I found it difficult when I went to my community place to actually sit back and let everybody do everything themselves... I find it hard not to get involved

> because you come here (the hospital) and there is a ward of 20, and you go into a group home where there is about eight... I find it hard just to be laid back and to actually encourage them to do it all... I get worried about silly things like crossing roads and things like that. I was thinking, oh dear, because I'm not used to doing it up here (the hospital) you see.'

This particular group of students felt disadvantaged when considering their mode of training and the future expectations placed upon them. There was a feeling that hospital training wards are plagued with staff shortages, too much to do and not enough time to do it.

> 'There does seem to have been quite a lot of qualified staff leave, and out of all the staff nurses who have recently qualified there is only one left, and he's leaving in four weeks. The newly qualified staff aren't staying, even the older ones are leaving.'

Another group of interviewees were pessimistic regarding the outcomes of Project 2000 and the effect it would have on their future. They agreed that modern approaches were moving in the right direction but the opinion seemed to exist that Project 2000 would be primarily rooted in general nursing, and that the mental handicap component would be in danger of becoming lost. The concern was centred around the larger more powerful general nursing lobby which would become predominant. It was felt necessary to defend the skills of mental handicap nursing and in doing so identify specific areas of difference from general nursing. The notion of

being valued by the client group is an important element in the survival issue, and this was stressed as follows:

> 'If its going to the community the emphasis is on keeping people at home and helping that family cope. We can't do our job without others - that's the difference. As long as we are valued by the carers, by people who need our skills in the community then we are in employment, we are seen as being valued.'

Unlike the previous group there was an understanding of the facilitating function implicit within mental handicap nursing. The group were asked to analyse the meaning of 'being valued' in association with the professional service offered by the nurse. The value appears to lie in the possession of all round experience in caring and supporting people with a mental handicap. An enhancement of this value is having knowledge of an access to other helping agencies as and when they are required. Being able to gauge the felt and perceived needs of clients, and to provide a positive response is a commodity which is of high value. For example, one group member gave the instance of parents and family who often say that meeting other people facing similar difficulties can be of immense help. Through a facilitating function the nurse can arrange for this to happen in several ways which calls for an array of skilled activities. One student said:

> '... community nurses seem so skilled, they seem to be the culmination of all our skills... because they work on their own, they've got their own case load and they are the access point to so many other services.'

The Nursing Process

The process of nursing has been greatly influential in determining the content and style of curricula since the inception of the 1982 Syllabus in Mental Handicap Nursing (English and Welsh National Boards for Nursing, Midwifery and Health Visiting) and before this in the Scottish General Syllabus. This influence and its applicability to current and future services was tested. ***Statement 6*** reads:

> 'The essential framework of care offered by the Nursing Process was a feature of your course.'

In a similar fashion to the previous statement, there was virtually unanimous agreement that the Nursing Process had been a feature of the course. This result demonstrates an overall application of the Nursing Process within the Schools of Nursing from which the sample came, and raises the question regarding its usefulness in developing future training programmes (see Table 9).

Two of the groups interviewed were reasonably forthcoming about the value of the Nursing Process, but as one student said:

> 'It's all we've ever known... it's the way that I organise things now.'

From this it can be deduced that other approaches related to care have not been given the same prominence, and therefore it must be expected that the Nursing Process represents the principal framework surrounding courses based on the 1982 Syllabus. However, its relevance was supported generally by the two groups. The response to a question aimed at determining relevance elicited comments such as:

'More so than ever before, because it is the main way of informing everybody related with that particular client and getting information across. As things become more multi-disciplinary out in the community you are going to need the central data information.'

The interviewees placed value on the Nursing Process as a basis to their studies. It was not seen as restrictive in the way it prescribes the four main elements of care, on the contrary it was said to have the quality of flexibility. This is gratifying since the Nursing Process was originally intended to encourage flexibility and individually planned care. One group indicated the usefulness of the approach when caring for residents who by definition are highly dependent. the relationship of the Nursing Process to this particular client group makes for a system of care which as one student puts it:

'...you are looking at them all the time and trying to involve them.'

It is evident from the data that a major contribution to nurse education and training can be found in the framework offered by the Nursing Process. It follows that practical skills assessment should be linked to this framework if it is to be considered relevant.

Statement 7 probes further into care practices and invites responses to the following:

'Individual care planning based on an appropriate model of nursing is encouraged within the School of Nursing.'

(See Table 10 for results).

Statement 7 can be linked with ***Statement 11*** which says a similar thing but in relation to the practical areas including the community (see Table 14). It is also relevant to compare the data with that taken from ***Statement 24*** in Questionnaire 2 which attempts to determine the models most frequently used (see Tables 39-43).

There are several issues here requiring clarification. It is necessary to differentiate the essentials of individual care planning, models of nursing, and the Nursing Process.

Individual Care Planning

Evidence of systematic care planning is required before the statutory nursing bodies will approve courses within any given training institution, so it is relevant to consider the means by which care plans are integrated into the curriculum. For the purpose of the study, Individual Care Planning has been closely allied to the Individual Programme Planning Intervention Model which is used as a way of planning services on an individual basis. This model represents a cyclical arrangement of planning, action, follow up and review which is not unlike the elements of the Nursing Process, but with essential differences. The Royal College of Nursing (1988) describes the role and skill requirements of a nurse in respect of Individual Programme Planning (IPP). The skills said to be of importance are reproduced below:

1. Advocacy and representation of consumer needs.

2. Co-ordination of service delivery both in terms of human and of local resources.

3. Assessment skills to identify individual consumer needs.

4. Goal planning strategies.

5. Use of behavioural intervention techniques.

6. Communication skills both with clients and with significant others.

7. Recording skills to ensure that a regular account is kept of all assessed needs and intervention strategies.

8. Interpersonal skills to work as an equal member of a multi-disciplinary team in which the consumer plays a vital role.

9. Skills to research and obtain local community resources to enhance opportunities for individual service users.

Analysis of these skills highlights the influence of IPP over a long term, perhaps years, whereas the Nursing Process creates in the individual nurse a logical approach to problem solving which is one of the support structures of successful programme planning. The inter-relationship between the two strategies provides a positive feature of mental handicap nursing especially when linked to a relevant model of nursing.

Reference to the responses shows a virtually unanimous agreement that individual care planning based on a model of nursing is encouraged within the Schools of Nursing. Therefore it would be reasonable to assume that in theory at least, attention is paid to this element of nursing education. There is a variance within the questionnaires which belies this assumption, for example Question 24 in Questionnaire 2 asks:

> 'Is nurse education in your particular School based on a specific model of nursing?'

Seventy nine people responded from which 47% replied 'Yes', 38% replied 'No' and 15% didn't know. When compared with the assessors' study which asked the same question of 43 experienced qualified nurses the responses indicate the following pattern: 36% replied 'Yes'; 45% replied 'No' and 19% didn't know. This shows a wide variation in uses and understanding when applied to models in mental handicap nursing. Of the student respondents who answered' Yes' the following rank order of models in use was derived:

Roper, Logan and Tierney	33 respondents
Henderson	24 respondents
Roy Adaptation	9 respondents
Orem	9 respondents
Peplau	Nil
Rheil	Nil
King Interaction	Nil
Others (mainly Johnson's Model and Nursing Process - not a model)	9 respondents

(Rank ordering was carried out through frequency of response)

In some instances more than one model is in use within the same School of Nursing, but it is clear from the responses that there exists two clear preferences. The RCN Society of Mental Handicap Nursing has identified a problem when attempting to apply theoretical models of nursing to practice. This problem is exemplified in the responses described above which show an overwhelming use of models which according to the Society are 'considered by some to be too clinically orientated to be appropriate to mental handicap nursing'. It is claimed that such an orientation may have contributed to the current view that nursing does not provide a suitable framework for the care of people with mental handicap. The Society in

response to this criticism proposes the Peplau Model as being the most relevant. None of the nine Schools of Nursing used in the research use this model, and it must be assumed that for them it has little to offer, or it has not been explored.

The discrepancies identified have serious consequences for practice based student assessment, which relies heavily upon a stable relationship between theory and practice. If as the RCN state, the Roper et al, and Henderson models allied to Roy and Orem models are unsuitable because of their clinical bias, and if assessors subscribe to differing models it becomes highly likely that values and opinions held by them will not coincide with those held by the students. One or the other will need to compromise, which subsequently injects some instability into the relationship. Inconsistency of approach was an issue identified by the groups interviewed. This inconsistency which seems to extend across the learning environment reflects the anxieties which exist when students are trying to find stability upon which to build professional understanding. These anxieties are captured in the following quote:

> '... in the way we are taught there has to be a consistent approach... we've had changes in tutors, it would be much more consistent to have a tutor solely responsible for our three year course... consistency in the way that assessors assess all the way through.'

The relationship of theory to practice is tested by ***Statement 11*** which asks whether Individual Care Planning based on an appropriate model of nursing is encouraged within the service area, including the community. Although 79% of respondents say that it is encouraged there is evidence of

inconsistency across certain groups, which once again brings into focus the possibility of misunderstanding in what counts as a model of nursing and/or individual care planning. This reflects on the quality of experience gained by individual students during their course which has a knock-on effect for the validity and consistency of practical assessment.

Normalisation and Independent Community Living

A major component of modern care practice is implicit within the theory and practice of normalisation and independent community living. ***Statement 8*** asks whether this component featured strongly in the nurse training courses undertaken by the respondents. The overwhelming majority agreed that it did, with only one group showing any marked disagreement amongst themselves (see Table 11). It is worthwhile relating this response to previous comments regarding the relevance of certain theory to practice. How much was taught in the classroom as opposed to the knowledge gained through practice?

Health/Sex Education

Statement 9 asks whether health education and sex education for people with mental handicap featured strongly in the course. 66% of the respondents said that it did, but there is evidence of marked inter-group disagreement. Of the nine groups questioned, five displayed a serious lack of consistency in their overall response, which once again identifies the difficulties which face course designers when attempting to provide a balanced curriculum (see Table 12). There is virtually no guarantee that each student will be exposed to similar learning experiences, and this problem is often compounded by constant changes in placements, supervisors and teachers. Inconsistent responses to questions about course content may

well reflect inconsistent teaching and role modelling in the theoretical and practical domains. Once again the implications for student assessment are clearly evident.

Community, Educational and Therapeutic Aspects of Care

Statement 10 related to ***Statement 5*** and checks out whether community, educational and therapeutic aspects of care featured largely in the course. Responses indicate an overwhelming measure of agreement with the statement, but other data shows varying discrepancies in the means by which the discrete skills relating to the three major components of community, education and therapy are acquired (see Table 13). Earlier it was shown that theory is not always related to practice, and students have, in some cases, been expected to carry out skilled activities unsupported by relevant theory. Later the notion of counselling, teaching and skill acquisition will be discussed which again raises questions about the true relationship between subject theory and nursing practice. This is especially important because the essential or primary skill bases from which professional competence grows depend greatly upon the many associated discrete skills being soundly taught, with clear points of integration identified.

Nursing and Social Work

It is now recognised that caring for people with a mental handicap is not the privilege of one professional group, and that a sharing of expertise between nursing and social work would be advantageous. ***Statement 12*** addresses this issue and responses indicate an 89% agreement with this point of view (see Table 15). An open question was presented to those who were in agreement which requested them to identify common areas of

knowledge and skill. Several important statements were made in response to this question which reflect a positive outlook, but status and position is kept to the fore. Some of these statements are reproduced below:

> 'Social work and nursing are two different occupations, nurses are not trained in aspects of social work. Mental handicap nurses and social workers do often work together, however the rift between the NHS and the Social Services requires to be healed through greater integration.'

> 'I believe in an integrated service, but if the RNMH nurses don't retain distinctiveness they will disappear. If nurses train partly with social workers it should be at Qualified Social Worker level. Nurses should have equal status.'

Several respondents identified weaknesses in the preparation of social service staff in the aspect of ***caring*** for people with mental handicap.

> 'Social Services need a more in-depth training to deal with caring for mentally handicapped people in residential settings in the community.'

> 'As there is at present no specialised course for the social worker in mental handicap, and the care of the mentally handicapped is becoming community based, I believe a joint basic training would benefit both carers and clients and help bridge the large gap between the two services.'

It is the notion of ***care*** which is seen as the main stumbling block to sharing. Traditionally, nurses have cared within an environment which has clinical connotations, whereas social workers approach their clients from a

different perspective. Project 2000 with its health orientation could herald a common language encompassing the essential ingredients of nursing and social care. The respondents recognised that common principles do exist between health and social services and that these could form a general framework for mutual co-operation. These principles include, human rights, values, goal setting through Individual Programme Planning, understanding family dynamics, and developing therapeutic skills in a variety of settings.

The respondents not only describe a spectrum of activities reflecting their nursing bias, they also provide insight into a broader dimension of thought. They identify common knowledge such as:

- Advanced sociology and its usefulness in practice.
- Knowledge of available social services - welfare rights, benefits
- Holistic care, e.g. sex education; communication; relating to the mentally handicapped person's situation and general problems; advocacy.
- Networking.
- Counselling in all its forms.
- Teamwork in a multi-disciplinary setting.
- Basic nursing practice - common approaches to caring (e.g. feeding, positioning, challenging behaviour).
- The role of the person with a mental handicap in the community.
- Mental health legislation.

- Human biology as it relates to syndromes and associated medical conditions.
- Epilepsy, drug therapy.
- Teaching and training for daily living skills.
- Relevant models of nursing and social work.
- Organising case loads.
- Using leisure time effectively.
- First aid.

By way of a summary to this part of the discussion, the following response is offered

> 'Nursing and social work should integrate in providing care for people with a mental handicap in community and hospitals - hopefully for the benefit of clients, unlike now where it is a case of them and us.'

Case Load Management

The concluding part of Questionnaire One concentrates on the basic skills associated with case load management. These skills are of a generic nature but have implications for the developing role of the mental handicap nurse, and also for certain competency statements and the direction of practical skills assessment. This profile of skills was derived from the Cumberlege Report which reviewed community nursing services in England and Wales. Each activity was presented individually and respondents were asked

to say whether their course had equipped them with the required skill. The skill profile is as follows:

(a) Interviewing.

(b) Setting aims and objectives for care.

(c) Planning and determining priorities for care.

(d) Counselling - listening and responding.

(e) Reviewing outcomes of nursing action.

(f) An understanding of family dynamics.

Interviewing - 61% of respondents stated that interviewing skills had not featured in their training course (see Table 16).

Setting aims and objectives for care - 95% of respondents stated they had been taught this skill (see Table 17).

Planning and determining priorities for care - 92% of respondents stated they had been taught this skill (see Table 18).

Counselling - listening and responding - 85% of respondents stated they felt equipped to perform this activity (see Table 19).

Reviewing outcomes of care - 85% of respondents stated they had been taught this skill (see Table 20).

An understanding of family dynamics - 72% of respondents stated they had this understanding (see Table 21).

The overall returns are encouraging in so much that activities relating to setting aims and objectives, planning for priorities and reviewing outcomes of care, attracted a high positive response. This corresponds with ***Statement 6*** which asked about the extent to which the

Nursing Process was taught. A point of interest arises when relating the skill of interviewing to other components of the profile. In order to obtain information upon which to base an individual programme for the clients, it is often necessary to interview different people. Yet the response to this was low compared with other components. As in previous responses, there exists a wide difference of opinion across groups regarding this particular skill. In some cases there is almost an equal division of opinion within separate groupings, which again raises questions about the curriculum and the way it is perceived. A similar observation can be made about the component relating to an understanding of family dynamics. This produced major disagreement within three groupings, and minor disagreement in three others.

Counselling is a key skill area which has emerged as an essential aspect of mental handicap nursing. Listening and responding forms part of the case load management profile, and the high percentage of students who stated that they felt equipped to use these sub-skills provides evidence of the importance attached to them. This observation is supported by the responses to Question 14 in Questionnaire 2 which is more specific about the client's perceived needs. 89% of those who answered the question stated they had been taught how to operationalise the skills of listening and responding.

The subject of counselling was explored in the group interviews and the practical implications became apparent. Despite the importance placed on this skill and the high positive response to the related questions, there appears to be some inconsistency in the way that counselling is taught and practised. The group interviews disclosed problems of relationships with certain clients and family members, which resulted from

policy decisions at local level regarding the parameters within which student nurses could work. The teaching of counselling skills to students is also described as problematic. It is a subject which has grown in popularity over a short time scale, and teaching strategies are well documented in nursing texts, but these relate primarily to classroom activities where techniques are practised within an artificial environment. Experiential methods are said to be the main vehicle through which the skills are acquired, but this approach is controlled by tutorial staff, thus providing a safe, structured learning experience. The face to face contact with people in the care setting gives many formal and informal opportunities for practice but these can be restricted. One interviewee said:

> 'I think the wards are very unwilling to let you loose on counselling until you are qualified... we were allowed to observe but not encouraged to counsel because it was for the qualified staff... you are seeing it done, knowing how you would do it but not being given the chance.'

The transferability of the discrete skills of counselling to the wider dimension of care is apparent from the interviews, being non-judgemental, avoiding bias, having an open mind, featured strongly. Several interviewees were of the opinion that much of what they do in a counselling sense is carried out unconsciously during their day to day work. The following responses from different sources seem to reflect this view:

> 'Sometimes you may do it without actually realising.'

'I counsel every single day. It may not be a conscious counselling session but just conversation with a man I am working with, or I am explaining something.' 'It's a kind of counselling.' 'It's not a set up, you use it every day.'

'I think that you do counsel without knowing it or without realising it.'

The importance of counselling across the curriculum is a major outcome of this research study. When taken from the students' viewpoint it seems that counselling is practised under differing guises. Whenever a helping relationship is forged then some aspect of counselling, therapeutic communication, or other interpersonal activity becomes an essential part of the nursing role. It is generic to whatever care setting the nurse finds her/himself in. In this context it becomes necessary to clearly identify valid strategies for assessing the competence of students to skilfully apply this aspect of their job. This will be addressed in Chapter 6.

Summary of Chapter 5

The identification of a skill base is fundamental to valid and reliable assessment. Skill and knowledge together form the essential ingredients of professional nursing, and it is vital that both elements are complementary and integrated. This chapter has analysed the students' response to an overall question concerned with the existence of a well defined framework of skilled activities which are at the centre of mental handicap nursing. Through this analysis there emerged a profile of what may be termed 'Primary Skills', each of which is comprised of many related activities.

These skills are reproduced below:

(a) Counselling (including bereavement counselling).

(b) Communication skills (understanding the person).

(c) Teaching skills/skills teaching (involving case load management and family care).

(d) Community care skills (involving case load management and family care).

(e) Physical nursing skills.

(f) Management of self, others, and the care environment.

The questionnaire requested responses to 13 statements related to skill and knowledge, and how the curriculum is designed to accommodate effective learning. One outstanding issue is the extent to which individuals in the same group perceive highly important things in different ways. This says much about the fluidity of the learning environment and the variety of experience to which the student is exposed. Attitudes and opinions are formed often by virtue of individual experience, both professional and personal, which seems to indicate that knowledge gained through theoretical pursuits will be uniquely interpreted by individual students. This will lead to individual application in practice and creates a dilemma from an assessment point of view.

It is relevant to look at Parts II and III of the research question in the light of this analysis. Does the assessment of practical nursing skills take cognisance of time, and the allocated exposure to the learning environment? Also, does it reflect the expected relationship between

knowledge and practice? Much of what has been discovered in Chapter 5 would indicate that practical skills assessment, particularly in mental handicap nursing is fraught with difficulty. It highlights the need to ensure that assessors are aware of the vagaries inherent within the practical training of nurses, and to make allowances for the ever changing characteristics of the environment where students are expected to learn.

CHAPTER 6

THE DEVELOPMENT OF NURSING SKILLS

Analysis and discussion of the data collected from Questionnaire Two forms the substance of this chapter. The relationship between skill development, learning environments and the whole curriculum will determine the degree of validity ascribed to practical skills assessment. Questionnaire Two uses as its basic premise the following statements:

i) Skilled mental handicap nursing involves a complex organisation and co-ordination of many differing activities.

ii) A skilled nursing performance is dependent on feedback from a variety of sources.

iii) Nursing skills become more accurately and smoothly performed with suitable practice, ideally under supervision.

The primary skill bases already described in the previous chapter clearly demonstrate the importance of understanding how people learn. It is particularly relevant for mental handicap nurses to be familiar with the process of skill development, especially as the substance of their work is with a client group comprised of people with learning difficulties. The first question attends to this process by asking respondents to consider whether they had been taught the theoretical perspectives of skill development during their course of study. 57% stated that these perspectives had either not been taught or they were unsure of their inclusion in the curriculum (see Table 22).

This is an important response especially when one of the primary skill bases is teaching and skill development. The results illustrate a diversification of opinion within groups which is particularly marked in four cases. Reflected in this response is a strong indication of the difficulties which must exist when attempting to provide reliable and valid assessment of nursing competency. It illustrates the problems which face those who strive to provide learning experiences common to each student group. Highlighted within the response is a clear message that variables and approaches within a given learning environment will constantly affect the student's perception of what is being taught. Examples of integrated skill activities were sought from those who responded positively to the question. From these responses there emerges evidence of complex activities which support the notion that skilled nursing is fundamentally concerned with the organisation and co-ordination of many related aspects. In some cases where personal and client directed skill development had featured in the course, the difficulties of putting theory into practice are described. When collated these difficulties fall into four categories:

(a) Insufficient time.

(b) Staff attitudes towards students.

(c) Staff ignorance of what is expected of them.

(d) Apathy towards the job.

One respondent wrote:

'Some theory was done on skills but it was very shallow.'

In the main those who volunteered information regarding skill development gave instances of activity levels requiring a broad knowledge base. For example, devising an individual goal plan could include the use

of the Nursing Process, behaviour modification, organising other professionals, and may require the nurse to teach some essential aspects of daily living, ie cooking. Insightful written comments regarding client assessment, care planning, teaching and rehabilitation were received. (N = 32). A selection of these are provided:

> 'The teaching of new skills to individuals with a mental handicap requires assessment with nursing staff and other professionals, with feedback and re-assessment at regular intervals. It also involves other areas of activity to help strengthen the skills to be learned.'

> 'Assessment of the individual would involve observation, communication, recording, interviewing, looking at the environment, looking at the individual holistically, prioritising and evaluation.'

Several respondents displayed their understanding of skill development. One example illustrates the use of task analysis by applying it to an every day activity, namely teaching a person with mental handicap, living in the community, how to use a local video library. The respondent described it thus:

> 'Finding the way to the video library;
> Identifying the video library among other shops;
> Understanding the content of films;
> Paying for film and using membership card;
> Returning home safely with film;
> Returning film the following day.'

Other examples describe the complexity of skills required to promote teamwork amongst people from various professional groups:

'Multi-team assessment - care review.
Teamwork - pooling of professional insights.
Delegation to key workers.
Liaison and observation.
Monitoring progress - re-assessment.
Evaluation skills.'

These examples of skilled mental handicap nursing involving related activities are supportive of the fact that the theory and practice of skill development does feature in nurse training programmes. It is worrying however, that only a minority of respondents recognised this.

Question 2 focuses on the need to practise developing skills under appropriately qualified supervision. Respondents were asked to comment on whether or not their tutors had emphasised the importance of supervision when carrying out skilled nursing activities. 82.5% said 'Yes' their tutors had emphasised this as being important, yet once again there is a spread of opinion across groups (see Table 23).

Linked with this is ***Question 5***, which asks respondents to comment on whether or not they had been placed in care situations which enabled them to practise their skills under qualified supervision for most of the time. 82% said they had, which is encouraging (see Table 26). Those who said 'No' were invited to give details. (N = 18). A large proportion of the comments was received from one group in particular who indicated their disappointment at the lack of supervision in the practice area. Similar observations were also obtained from others in four of the groups

questioned. Much of what is said reflects staff shortages, high work load, personal attitudes, and lack of teaching support. Disturbing features exist which infer a general lack of care towards students, and comments such as the following are not uncommon:

> 'I've mostly been placed in situations where my nursing skills have been supervised by enrolled nurses or freshly qualified staff nurses who are very unsure themselves. Even during my general placement I was left to take care of patients and assist doctors with their assessments when I knew nothing of the procedure or illness incurred, then made to feel inadequate when mistakes were made.'

In other instances supervision was variable from placement to placement, teaching staff were not with the students for long enough to be effective, and staff shortages often meant that support staff were moved to depleted areas thereby leaving students in a vulnerable position.

> 'Most ward work meant that we were the predominant staff. The nursing assistants were moved so we weren't supernumerary. So I didn't have the time to practice under qualified supervision.'

This quotation seems to encapsulate the feelings of those students who wrote that they were not adequately supervised, which despite their minority standing, reflects a real problem deserving of further investigation.

Skill development is enhanced when positive, helpful feedback is available. ***Question 3*** explored this availability and discovered that in

the hospital practical placements respondents claimed that 70% of the feedback most frequently came from qualified nursing staff based in the wards. Whilst this is encouraging, it transpired from the data that the reported frequency of feedback from teaching staff was exceptionally low. Only 9% of the respondents said that teaching staff from the School of Nursing frequently provided feedback on skill development (see Table 24). This observation adds further to understanding why there are difficulties in the integration of theory and practice. It also illustrates one of the major concerns associated with continuous assessment. The format governing this process will be chiefly designed by educationalists with input from trained nurses engaged in giving care. It seems relevant to suggest that from these data there emerges an important need for these two groups to work closely together in respect of student development. This would go some considerable way towards ensuring that assessment of practical skills was valid.

Question 4 explored the availability of positive, helpful feedback during the community placement. The predominant providers were the community mental handicap nurses. 60% of the respondents said they received the most frequent feedback from this grade of staff, but the general spread of response indicates the complexities facing those people responsible for planning and conducting assessment, especially that which is continuous. A relevant observation can once again be made regarding the reported low level of teacher involvement during community placements. Only 4% of the respondents said that teaching staff from the School of Nursing provided the most frequent feedback regarding skill development (see Table 25).

Pathways for effective feedback to students should be reflected in the quality and appropriateness of support and supervision available in the practice areas. It can be inferred from the data that a majority of students do receive help and guidance from a qualified source. A main concern exists in respect of the support and guidance available for those whose task it is to ensure the satisfactory development of students. The main educational input should by definition come from the teaching staff who provide most of the theoretical underpinning. Overwhelmingly, the evidence suggests that teaching staff are not generally available in the wards or community placement areas. This leads to the conclusion that supervision and training are carried out by people who themselves are in need of consistent educational support which may only be available in a piece meal fashion.

Question 6 investigates the extent to which respondents felt they were in possession of teaching skills, in particular those necessary to provide the client group with a measure of independence (see Table 27). 80% answered positively, and provided a comprehensive profile of those elements of skilled teaching activity which they considered to be relevant. These are reproduced overleaf in order of ascribed importance:

Elements of Teaching a Skill : Perceived Relevance

Respondents were requested to identify:

Rank Order (By frequency of response)	Teaching Skills	Responses
1	Theory and practice of behaviour modification	28
2	Patience and consistency of approach	23
3	Communication and counselling	22
4	Understanding the person/recognising potential	20
5	Effective use of the Nursing Process	8
6	Techniques of instruction/use of different teaching methods	7
7	Planning and creating a learning environment	6
	Promoting appearance and presentation in society (client)	
8	Recognise the appropriate skill to fit the situation	5
9	Methods of evaluation	4
10	Goal setting and progress review	3
11	Possessing appropriate knowledge/ knowledge of available resources	2
12	Advocacy	1
	Total	**129**

Respondents were requested to identify more than one teaching skill which they considered to be most important. The results indicate four ***main*** areas of skilled teaching activity, and when placed in rank order they far outstrip the remainder in terms of importance. These stated activities provide evidence of a move towards a person centred orientation in mental handicap nursing. This move reflects the influence of the 1982 Mental Handicap Nursing Syllabus which placed great emphasis on the need to

provide a service aimed at promoting self help skills in the person with a mental handicap.

Despite the largely positive response to this question it is still worthwhile considering the 20% who answered 'No', or were unsure as to whether they had the teaching ability to adequately meet the requirements of individually designed programmes for the residents. The main difficulties seem to arise from being unable to practise the skills in the training areas. This inability is largely due to lack of role modelling, or insufficient time to develop the skills. A small number of respondents (N = 6) volunteered additional information which highlighted these difficulties. For instance, one wrote:

> 'It very much depends on the individual, I feel that I can teach certain things but I cannot say that I feel confident about teaching. While on my educational and children's block I felt very confident as I always had a lot of support, but on the villas there is not the support, and sadly there is not a lot of teaching (in any areas) going on.'

Another wrote:

> 'I haven't had enough time to practice... lack of staff made practice impossible... time was spent doing other jobs around the ward.'

These situations reflect a minority view but they illustrate how situations can reduce opportunities for learning and as such must be taken seriously.

Questions 8 and 9 continue to probe the issues surrounding independent living and the need for people with a mental handicap to have

some measure of problem solving ability. The questions sought opinion regarding the need for such people to possess logical thinking and problem solving abilities as a necessary precursor to successful community living. It is evident from the response to the question that a wide range of views exists, especially when discussing these abilities in relation to profoundly mentally handicapped people.

The response to Question 8 yielded a 64% agreement, and 20% strong agreement that logical thinking and problem solving abilities are essential ingredients for independent living (see Table 28). The main issue in relation to people with mental handicap seems to be the levels of independence necessary for either partial or total integration into the general community. In practical terms it is important to define the criteria for the assessment of nursing skills based on the contribution the nurse makes to the provision of an environment within which thinking and problem solving abilities can be nurtured. Question 9 in particular, produced a diverse set of comments which provide insight into the respondent's individual attitudes towards people with profound mental handicap. This question asked respondents to state whether they believed that profoundly mentally handicapped people could develop skills required for logical thought and problem solving. 62% said 'No' and 38% said 'Yes' to the question. Out of the total number of respondents, four declined to comment (see Table 29). Respondents who answered 'Yes' were requested to describe how the development of these skills could be achieved. Those who answered 'No' were requested to describe why they felt that way.

Each response was coded and placed into a category. The responses are reproduced below showing the response rate given to each category.

	'YES'	RESPONSES
1.	Intensive training over a period of time	11
2.	Focus resident's attention on appropriate activities (making use of role modelling)	9
3.	Developing relevant problem solving activities (regular practice of daily living skills)	6
4.	Play activities including role play	4
5.	Providing a positive learning environment	4
6.	Enable risk taking	2

	'NO'	RESPONSES
7.	Insufficient cognitive development	31
8.	Lacking life experience	3
9.	Physical needs take priority	2
10.	Constraints of time/lack of continuity between staff	2
11.	Risk taking not usually acceptable	2
12.	Handicapping condition too great - physical or psychological	2
13.	Logical thought and problem solving are not always necessary conditions of a fulfilled life	2
14.	Respondents who stated they were not prepared to answer	3

As in previous results there exists a spread of opinion across groups which becomes a major consideration where student assessment is concerned. Of particular interest are the extensive comments recorded concerning those people who are profoundly mentally handicapped. A major component of nurse education is related to goal planning over a life continuum, and the Royal College of Nursing Society of Mental Handicap Nursing is particularly keen to promote the nursing role in meeting the progressive needs of people with a mental handicap through an analysis of life styles and cycles. This

activity takes account of all people with a mental handicap irrespective of the severity or extent of the handicapping condition. The skills required of nurses are complex and sophisticated, therefore the same can be said of the skills necessary for the measurement of nursing competence, as it is applied to all the stages of life planning. Of direct relevance to the research question are the attitudes and opinions projected by the respondents as they enter the final stage of their training. Much of what is reflected in their written comments exposes the inadequacy of certain care environments, staff attitudes, personal experiences, institutional versus community care, and some degree of frustration at situations which militate against the integration of theory and practice.

It would be impractical to include each and every comment, but for the sake of accuracy and the necessity to provide a representative cross section of opinion, examples have been chosen to illustrate the main areas of concern. The strengths and weaknesses of care environments received a large amount of attention. One respondent who did not think that profoundly mentally handicapped people could develop logical thinking and problem solving skills wrote:

> 'Through my experience I am obliged to say "no", as we are in a state of "doing things" for the mildly handicapped, the profoundly handicapped are physically nursed. Although I do believe some logical thought can be developed, problem solving cannot be, owing to the denial of allowing mentally handicapped people to make mistakes - we guard radiators, lock doors - we feed, clothe and do everything (in hospital), and a great deal in the community.'

The views expressed in this quotation seem to place a clear emphasis on physical care as the primary function of the nurse in circumstances which involve people with profound mental handicap. From the data there appears to be an assumption that to be profoundly mentally handicapped infers an additional physical handicap. However, the major reason for the inability to develop logical thinking and problem solving skills is said by the respondents to be insufficient cognitive development. The notion of profound mental handicap could differ depending upon professional standpoints. Traditionally, mental handicap nursing has relied on the physical or medical model as a base from which to operate, which in recent times has given way to a wider, holistic approach. Physical care remains an influential factor when the nursing perspective is applied to a section of the population which attracts the label of profound mental handicap. The following quotations support this view:

> 'When I have worked with profoundly mentally handicapped people, I have been working along very basic lines, mainly physical. It takes a very long time and I cannot envisage how one could teach profoundly mentally handicapped people problem solving skills.'

Another respondent wrote:

> 'Brain damage and physical disability may mean the child is so severely handicapped that there is no possible way of learning these skills.'

Institutional practices received criticism, and are blamed by some respondents for providing care environments which stultify human potential. Denial of normal living activities is seen as a contributory factor towards

maintaining rather than reducing the person's handicap. Instances quoted include residents being put into night clothes in mid afternoon; not having much idea where they are because round the clock care removes any responsibility and even the most minor decision making possibility from the individual.

The self-fulfilling prophecy was evident in many of the responses, for example:

> 'The skills required for logical thought and problem solving are not present in profound handicap. To say they can develop is a contradiction.'

Also:

> 'People with profound mental handicap may be able to think logically and solve one particular problem, but due to their handicap would not be able to cope with all day to day events - if they could they would not be labelled with mental handicap.'

Several respondents were positive towards providing a facilitative learning environment within which profoundly mentally handicapped people could develop whatever potential they had. It was thought that in certain situations a profoundly handicapped person may learn every day things such as tying a shoe lace, making a cup of tea or dressing himself. Major obstacles to more complex activity learning are also described, the main ones being, shortness of concentration span, lack of self motivation, and once again the inherent need for carers to absorb the person's problems.

Conditions under which logical thinking and problem solving may be nurtured were specified by some respondents. (N = 13). They wrote that a basic

level of logical thinking and problem solving is possible through an environment which is relaxed, supportive and informal. The value of play received emphasis, as did the need for residents to have choice, to make mistakes, to practise basic activities, and to experience achievement. Concentrated efforts towards regular assessment of the individual's progress should be aimed for, and the need to bring about a change in parental and staff attitudes was also stated. The skills of counselling and communication were given attention, which coupled with intensive behavioural therapy could help people with severe learning difficulties to overcome basic problems.

As a means of following through the views and opinions on logical thought and problem solving, a question was asked seeking views on whether ***ALL*** profoundly mentally handicapped people could achieve some measure of independence. 80% answered 'yes' to the question, and then qualified their response by saying how this could be made possible (see Table 30). The universal opinion centred around minimal rather than maximal independence. It was suggested that it is possible to be independent in one small aspect of life whilst remaining dependent in all others. Therefore the need to promote logical thinking and problem solving in most cases is virtually removed, and is replaced by specifically targeted behavioural training. The comments promote this view, and examples are provided below:

> 'There are many self help skills which carry a measure of independence which profoundly mentally handicapped people can master, e.g. ability to use the toilet appropriately, to feed oneself, simple dressing skills.'

'I feel that anything a person learns, however small this may appear, ie recognising the difference between tea and coffee gives that person something to build on in the future and gives them independence. A person who recognises the difference between tea and coffee can make a choice, and making choices is part of being independent.'

Throughout the responses there emerges a strong emphasis towards mastery of those activities which are attainable, which in most cases does not rise above the very basic elements of life maintenance. Feeding, dressing, use of the toilet, and personal hygiene featured strongly, and in some cases even single movements such as putting an arm into a jumper, or the movement of the eyes in response to a voice were said to be indicators of independence. As a means of summarising the positive responses a composite of several statements is produced:

'There are many, many skills required to live independently, some of these are quite complex but others are quite attainable for the most profoundly handicapped' 'even if that individual only learns how to grasp something or show a longer attention span' 'I have never met a person who I consider was beyond help or who could not improve on the present level of skill' 'a profoundly handicapped person is above all an individual, and even if it is just refusing a particular type of food it shows that he/she has a will of his/her own and therefore some measure of capability in achieving independence' 'the smallest thing that any person can do for himself shows some degree of independence. This can provide a basis to build on, a positive aspect of their lives to overcome a negative.'

The 20% of respondents who answered 'No' to the question provided a stark and occasionally blunt contrast. Some felt that ideally, people with a profound mental handicap should be given opportunities for independence but because of extensive physical and mental disability it would be largely a futile exercise. One respondent said that someone with an IQ of 10-20 would need a miracle, another said that she had seen and nursed some people whose level of physical handicap was such that they showed no response to any event, nor did they have any real muscular control, which inferred they were physically incapable of attending to any of their own needs. An additional factor was said to be the inability of profoundly mentally handicapped people to adapt to differing circumstances. The example given was in relation to the use of domestic appliances:

> '... one of the biggest problems for the mentally handicapped is adaptability, ie you can teach someone to use a gas cooker effectively then have to teach them to use an electric one - adaptability does not seem to follow.'

Perhaps the starkest and most negative comment was that:

> 'Some profoundly mentally handicapped people do not wish to learn and will refuse to do so in spite of the best staff efforts.'

Clearly, the data illustrate a spectrum of opinion which polarises from positive optimism to negative pessimism. The spread is not confined to specific groupings but can be found extending across the entire range of respondents. It can be deduced that a proportion of the sample would choose to work in a care environment which consists of people with mild to moderate mental handicap rather than those with a profound handicap.

The style of care differs in these situations, and nursing skills would be prioritised with regard to the main demands of the client group. Nurse education exposes students to experience with people whose mental handicap varies from mild to profound, and the assessment of practical nursing skills is performed in different settings depending upon where the student is allocated. The assessment should take full account of the eclectic nature of mental handicap nursing, and attempt to judge the student's performance competently with this in mind. Assessment of attitudes and approaches to the person assumes direct relevance when dealing with people whose long term potential is seriously impeded by virtue of physical/mental handicap. Assessors have personal beliefs about certain groups of people with mental handicap, and the question is how do these beliefs affect the final outcome of student assessment, especially if there is a difference of opinion? The next chapter will address this issue.

Questions 11-18 are focused on specific nursing activities which relate to the provision of a supportive care environment within which people can develop. The first of these skilled activities is role modelling, and the sample were asked to respond to the question: 'Have you been taught the skills of role modelling?' The results are consistent with previous responses, as 80% said 'Yes' and 20% said 'No' (see Table 31). Yet again the responses are spread throughout the groups, with two in particular showing marked inter-group disagreement. A relevant cross reference can be made to ***Question 9*** where role modelling was given some degree of priority by respondents who felt that people with profound mental handicap could be taught thinking and problem solving skills. It was seen

as the means through which residents/clients could be focused on appropriate activities related to skill development.

The holistic nature of mental handicap nursing has placed emphasis on personal interaction between the nurse and those who are cared for. People who are mentally or intellectually handicapped may experience difficulties in forming relationships with others, and it becomes an important part of the nurse's role to involve them in a variety of planned and unplanned interactive situations. This attracts even greater significance when people are being prepared for life in the general community. These activities take various forms and occur in many different settings. Respondents were requested to say whether their course had made them aware of this, and if so how was this awareness achieved?

76% said 'Yes' and 24% said 'No' to the question (see Table 32). There exists what has now become a familiar pattern of inter-group disagreement with three groups in particular disagreeing. Those who answered 'yes' provided 10 activity sets which they said had created an awareness of the need to be involved in interactive situations. A rank order of these activities was calculated and is presented overleaf:

Interactive Skills Development : Learning Experiences

Rank Order (By frequency of response)	Activity Sets	Responses
1	Social skills training in the School of Nursing including role playing, video exercises and discussion	28
2.	Planned outings, parties, Gateway Clubs, and other social activities	9
3.	Actual contact with mentally handicapped people	7
4.	Discussion groups involving staff and residents	6
5.	Experience in special schools and occupational therapy departments	4
6a.	Working with psychologists and through an understanding of psychology	2
6b.	Through unplanned occurrences	2
8.	Through an understanding of human sexuality	1
	TOTAL	**61**

From this table it can be seen that effective use is made of a variety of teaching methods to provide a theoretical and practical framework. Several respondents volunteered additional information in support of this, which gives a positive profile of activities experienced by those who answered 'Yes' to the question. A composite of the comments is produced below:

> 'It was pointed out that not all mentally handicapped people naturally have the impetus to form relationships and that it was the role of the nurse to plan and execute any policies to increase this' 'This awareness mainly came about through working on wards and in community houses' 'We were involved in a play therapy workshop which emphasised the importance of this; we were taught dancing and parachute dancing.' 'By

direct and indirect learning to involve the residents in activities' 'Through learning experiences on the ward, and a study day with the Disabled Living Foundation aimed at promoting trust and relationships' 'By placement at special schools particularly. Play is used constructively to encourage peer group formation' 'Work on institutionalisation made me aware of homosexuality and inappropriate sexual responses' 'We have studied sociology, psychology, human development and Maslow's hierarchy of needs' 'Theories relating to the subtlety of normal socialisation experience. Aspects of this were taught in school plus emphasis on social activities to develop social skills in service areas.'

It would be difficult to imagine the 24% who answered 'no' to the question, not being involved in many of these activities. There is an underlying concern that their course failed to create an awareness of the need for people with learning difficulties to experience interactive situations. From this, it can be inferred that aspects of skilled nursing practice were acquired through trial and error learning without the benefit of their awareness being sensitised through learning aims and objectives or reflection and feedback. This assumption can be made because the majority of respondents had already been assessed in a wide spectrum of nursing theory and practice prior to this study being carried out. An assumption such as this raises important questions concerning the validity of the assessment process.

Question 14 asks respondents to say whether or not they had been taught the skills of listening and responding to individual's perceived needs. The data received from this question have been integrated with a

previous set of responses (Question 13 in Chapter 5), but in the light of the data obtained concerning planned and unplanned interactive situations it can also be discussed again here. Listening and responding forms a substantial part of counselling, and by definition involves the nurse in interactive situations with residents/clients. Through this involvement it is possible to discern needs, and respond in the appropriate way. Under circumstances where the client can benefit from such an interaction by deciding their own course of action, the counsellor would take a facilitator role. In circumstances where the client experiences difficulty reaching a stage of total independence by virtue of a mental handicap/learning difficulty, the nurse would act in the role of advocate.

This would in many cases require the planning of interactive situations specifically directed towards a goal, or non-specific, situations, e.g. leisure activities. 89% of the respondents said they had been taught the skills of listening and responding (see Table 33), and when asked to say how this had been achieved they answered in the following way:

Listening and Responding: Learning Experiences

Rank Order (By frequency or response)	**Activities**	**Responses**
1	Through role play, video and other learning activities in the School of Nursing (counselling skills training)	60
2	Practice whilst on placement	22
3	Through observation	4
4	Using the Nursing Process	3
5a	Psychologist's lecture	1
5b	Trial and error	1
	TOTAL	**91**

From the data it is clear that a substantial majority of responses fall into 'counselling skills training' occurring within the School of Nursing. Considerably fewer respondents attribute their skills to actual practice whilst on placement. This adds reinforcement to previously documented findings regarding the over emphasis on school work and the relative lack of 'real life' practice opportunities. It also demonstrates the ease with which students can focus on specific techniques and yet experience some difficulty when asked to describe awareness of the need to create more diverse activities. Only one respondent said that listening and responding skills had been acquired through trial and error, yet it can be assumed that 24% of the sample discovered this method. This leads to a conclusion that assessment of practice may contain a bias towards those things which are highly specific, and neglect areas of complexity and diversity, due to ease of measurement and therefore greater reliability.

Question 16 attends to the complex activity of leadership. It asks the respondents to consider the statement that 'Working with others in a multi-professional team calls for skills of leadership - were you taught these skills during your course?' 54.5% answered 'yes' and 45.5% said 'no'. Three respondents elected not to answer the question (see Table 34).

With two exceptions, each group exhibited disagreement amongst the membership regarding the teaching of leadership skills. Of the two exceptional groups, one unanimously said 'yes', and the other unanimously said 'no' to the question. Overall, the responses seem to indicate a difference of opinion or understanding as to how certain activities contribute towards leadership preparation. Considering the responses to ***Question 17*** which asks for an explanation from those who answered 'yes' to Question 16, as to how they acquired leadership skills, it would appear

that theory and practice provided within the School of Nursing featured highly. The following table illustrates the rank ordering of the responses:

Leadership Skills Development: Learning Experiences

Rank Order (By frequency or response)	Activities	Responses
1	School of Nursing activities including: a) Theoretical perspectives b) Role play, video, discussion c) Preparation for management	31
2	Practical experience in the wards	18
3	Practical experience in the community	5
4a	Assertion training	3
4b	Attending meetings	3
6	Self directed learning	2
	TOTAL	**62**

As in previous open ended questions respondents were free to indicate more than one activity. This occurred here, and the evidence points towards a good integration of theory with practice. Despite this, there remains a matter of concern that whilst theoretical perspectives and experiential learning opportunities featured in the school curriculum, a significant number of respondents did not associate these with preparation for leadership. The process of nurse education and training is directed towards producing a qualified practitioner capable of providing good quality care, plus leadership and guidance to others in the nursing team.

For the purpose of this study it is relevant to consider these observations in the light of practical skills assessment. It would appear that in the case of leadership skills assessment there is a serious

difficulty to be addressed. The origin of this difficulty appears to lie in the transference of a particular body of knowledge and related practice across more than one component of the curriculum. Unless an activity is specifically related to defined theory it may be difficult for some people to make the cognitive leap between those activities which share the same theoretical framework.

Question 18 attracted a set of responses which to some extent support the previous observation. Respondents were requested to say whether or not they had been taught the skills of profiling. In the context of the Nursing Process, profiling can be likened to the assessment phase which generates a comprehensive picture of relevant information concerned with the person and his/her problems or needs. Profiling is a commonly used activity associated with individual care planning and is designed as a flexible information gathering instrument which embraces the person's life experiences. In this respect it forms an important part of the nurse's practical skill base, yet 81% of the respondents said that they had not been taught this particular skill. Five of the nine groups exhibited differences of opinion, but the remaining four groups gave a unanimous 'no' to the question (see Table 35). Those who answered 'yes' were requested to say how they had acquired the skills. The following table illustrates a rank ordering of the responses:

Development of Profiling Skills: Learning Experiences

Rank Order (By frequency of response)	Activity Sets	Responses
1	Writing care plans	7
2	School of Nursing activities	5
	TOTAL	**12**

This minority view is important because it illustrates the presence of School of Nursing activities which were actually available to all those groups where a difference of opinion exists. The data also show the presence of profile writing skills obtained through working on care plans. Further investigation would be necessary to discover whether it was unfamiliarity with the term 'profiling' which resulted in respondents saying they had not been taught the relevant skills, or the inability to transfer learning between related activities, or forgetting they had covered the topic.

Questions 20 and 21 focus on how respondents perceive case conferences in terms of furthering their understanding of the nursing role in the overall care and support of people with mental handicap. Firstly, respondents were requested to say whether they had been involved as a member of a case conference. 80% answered 'yes' and 20% said 'no' to the question (see Table 36). Yet again, the responses indicate inter and intra group differences, which in the case of this question, suggests either a variation in opportunity, or the respondents may have forgotten. Attendance at a case conference seems to coincide with the availability of the student, and it becomes a hit and miss situation in some instances. Those who did attend were asked to describe what the experience gave them in terms of understanding the nursing role. The responses created a continuum which extended from 'nothing' to 'a great deal'. The question gave an opportunity for respondents to be critical as well as supportive of the means through which case conferences contribute towards multi-professional care. A rank ordering of the response continuum is presented overleaf:

Case Conferences: Understanding the Nursing Role

Rank Order (By frequency of response)	Nature of Response	Number of Responses
1	The nursing role in relation to: (i) other care staff (ii) leadership (iii) communication	33
2	The nursing role in relation to holistic care (client and family)	19
3	Re-evaluation and assessment of the client	17
4a	Very little/not sure	5
4b	The nurse as an inferior being/subordinate to the medical staff	5
6	Nothing	4
	TOTAL	**73**

In support of these responses a number of individuals volunteered additional information, a synopsis of which is provided:

> 'Case conferences make you really analyse the residents in all aspects of their development. It's important to remember that you represent the residents in some way; speaking out for their needs and desires as well as voicing your own opinions.'

For some, the nurse's role within the multi-disciplinary team was emphasised in ways that implied criticism of other members, for example:

> 'The case conference portrayed the strength of the multi-disciplinary team together, but highlighted the incompetence of senior management and medical staff. The nursing role can be seen as ***critical*** and the ***backbone***, as others' knowledge is often superficial.'

'It gave me an idea of how the nurse should work with other professionals. However, to be honest, at many case conferences very few people outside the nursing staff would bother to turn up. In hospital the nurse represents the hands on worker, she is the most knowledgeable person about a specific individual, specific plans, and goals achieved.'

The majority of people who provided additional information saw the multi-disciplinary team approach as being essential to the total care of the individual and his/her family, for example:

'How important it is for all professionals/workers involved with the client to interact and give different views - how the nurse is not alone but part of a team. It helped me appreciate the need for co-ordinating the efforts of all involved in the care of an individual. Learning how to identify problems, how to liaise, communication and co-ordinate with others in the individual's interest. - Understanding the influence we have on people's lives and how important it is to make the right decision.'

Other respondents who had unfortunate experiences also recorded their opinions, and these are summarised:

'I am not sure what I gained from the experience. - A cynical view of how little concern was really shown for the individual, but rather how each section became detached, and protected their own contributions. - The nurse presents a report, although it isn't taken very seriously, if at all noticed. - Subservient to the medical profession, being at the

consultant's whims. - We are thought of as inferior to other professionals on the team.'

It is clear that this section of the questionnaire provoked a varied response. This illustrates the importance of understanding why each student on a course of nurse training experiences a sequence of activities which are individually unique. It is evident that even when 80% of quite a large sample of students attend a case conference, the learning outcomes for each one will vary. Variance of this nature occurs regardless of educational planning, and may give rise to an element of chance when these learning outcomes are subjected to practical skills assessment. It is relatively easy to plan an allocation programme of related experiences, yet it is virtually impossible to predict accurately the degree to which individual students will assimilate what is on offer. The use of self assessment is a valuable step towards validity because students can voice an opinion of their own ability, and the value or otherwise of their learning experiences. This particular aspect is addressed more fully in Chapter 7.

Question 22 explores the extent to which valid research was used throughout the training period to underpin practical skills development. 68.4% answered 'yes', and 31.6% answered 'no' to the question (see Table 37). The important aspects of this data set are to be seen in differing opinions which exist across each group of respondents. With only one exception, each group varies in its overall response. In most cases this variation is quite marked and reflects the extent to which individuals perceive research based teaching. It is possible that where valid research is used as an underpinning to practice, teaching staff will be more likely to introduce it as a classroom activity, it is unlikely for it to be

overtly taught as part of day to day practice. Further work is required to discover the main source of research based teaching within Schools of Nursing, but these results are of concern because there is a general expectation by the statutory nursing bodies, for research to be taught across the curriculum.

The obvious differences of opinion concerning research based teaching, leads to the possibility of questions being asked about the organisation of the curriculum within the Schools of Nursing from which the groups came. This observation is also highly relevant to the research question which asks whether the assessment of practical skills reflects the expected relationship between knowledge and practice? The research question also asks whether assessment takes account of those factors affecting the assimilation of related knowledge? Research based teaching is one of the main factors in modern nursing education which has a direct bearing on the type of knowledge assimilated by students. Therefore, the collective response to Question 22 does provide serious cause for concern regarding the differences of opinion about the nature of research and its place in practical skills development. Ultimately this will influence the student's practice, and affect his/her approach to practical skills assessment. This raises the possibility of a mismatch between the expectations of an assessor and the capability of the student being assessed. Usually it is the student who bears the brunt when such a mismatch occurs.

Question 23 refers to the inter-relationship between skills, knowledge and values, and asks the respondents to say whether this approach had been taken in their professional development. An overwhelming 94% said 'Yes' to the question which is a highly pleasing result (see Table 38). It

indicates that values are an essential part of the curriculum, and respondents were able to recognise the inter-relationship existing therein. The indications are that values are personally derived and do not always coincide with those held by others. A clear example of this is seen in the responses to Question 9 and 10 which refer to the profoundly mentally handicapped and their ability to develop some measure of independence. It is evident from these responses that different values exist which are genuinely and firmly held, but may be in direct opposition to those held by an assessor. This potential area of conflict is addressed in Chapter 7.

The remaining question in this section refers to models of nursing and their uses. Data from this question are used to enhance part of Chapter 5, and will therefore not be discussed at this juncture.

Summary

At the centre of any educational programme which seeks to prepare people for a lifetime of professional practice there exists the means through which skills are defined and developed. Professional nursing skill development which, to a large extent, is controlled by a statutory body, requires a system of practical skills assessment aimed at determining individual competence in relation to pre-determined criteria. This part of the research has attempted to determine what relationship exists between skill development in mental handicap nursing, and the many factors which comprise the whole curriculum. The educational relevance of a curriculum which is validated against a legal framework of requirements is mirrored through the interpretation of content, and methods of assessment adopted by individual schools and colleges of nursing.

In attempting to illuminate some of the major considerations in respect of the integration between theory and relevant practice, there has emerged a number of issues which could be said to represent the so called 'hidden curriculum'. By taking account of the fact that each student nurse is a unique being who is likely to respond in a personal way to any learning environment, there exists the possibility of conflict between the student, his/her teacher, and those responsible for assessing the student's fitness to practise as a qualified nurse. Learning environments are composed of constructs devised by people who form the permanent staff of the ward, department or community care facility. Student nurses are transient, and the extent to which they relate as individuals to the learning climate varies from person to person. A similar observation can be made about the assimilation of theoretical material, and the extent to which it informs practice.

From the outset of this chapter it became clear that individual differences played a significant part in deciding modes of learning, attitude development, the diversity of emphasis placed on important issues, and the degree of importance attached to theoretical perspectives. Throughout the entire data set there is evidence of inter-group disagreement on such things as the process of skill development as it applies to people with mental handicap, the issues surrounding independent living and problem solving abilities, attitudes towards people with profound mental handicap/learning difficulties, the provision of a supportive care environment, and the acquisition of leadership skills. A pleasing feature of this chapter can be seen in a number of instances where respondents overwhelmingly agreed on important issues regarding the need for practising skills under qualified supervision, the amount of feedback

which came from appropriately qualified people, the possession of teaching skills, the need for profoundly mentally handicapped people to achieve some measure of independence, and the importance of effective role modelling. Perhaps the issue which causes most concern is the almost total perceived lack of contact and feedback in the practice area by teaching staff. This single factor must play a significant part in determining the ways and means through which students relate theory to practice. It is reasonable to suggest that many of the qualified staff working in the practice areas are not as theoretically inclined as the teaching staff. The place of research based theory is becoming more significant in nursing education, but it requires to be translated into practice through a recognition of relevant opportunities. Appreciating these opportunities should not always be left to the student alone, but is a joint activity including tutorial guidance, and practice insights. The modern forms of practical skills assessment may not succeed unless this is universally recognised.

Chapter 7 deals with the process of practical skills assessment through individual reactions, and the identification of inconsistencies.

CHAPTER 7

ASSESSMENT OF PRACTICAL NURSING SKILLS

Analysis and discussion of the data collected from Questionnaire Three form the substance of this chapter. The process of assessment provides the framework for analysis and takes account of individual reactions to practical skills assessment as well as identifying inconsistencies in the methods respondents reported to be in use. Respondents were requested to consider 19 statements and respond to each of them using a Likert scale measurement pro-forma.

Statement One - Nurse education is **PRIMARILY** concerned with passing examinations.

The results indicate a considerable difference of opinion across the sample range. Overall there was a 61% disagreement with the statement and a 39% agreement (see Table 44). (Data from the assessors' questionnaire shows similar results, with 35% agreement and 65% disagreement (n = 43). See Appendix III). With the exception of one group which unanimously disagreed, there is clear evidence of intra-group differences of opinion. The reason for this can only be surmised, but it could be argued that individual views are reflective of different approaches adopted by tutors and assessors. Follow up interviews with one of the groups appears to substantiate this. When they were asked to qualify their collective response to Statement One there was general agreement that, in their view, passing examinations and assessments was the primary purpose of the School of Nursing. One interviewee seemed to capture the feelings of the group when he said:

'... that's what they are doing with us, they are teaching us to get through exams. While at the same time they might be teaching us theories we can use when we qualify, but I think the main idea of the school is to get you through the exam.'

In an attempt to balance this view with a more altruistic approach, the group was asked during the interview to look at the situation from a teaching point of view. It was suggested by the researcher that tutors are dedicated towards their students qualifying at the end of the training period, but at the same time they pay great attention to them becoming skilled, competent practitioners. This infers that gaining competence requires more of a person than just an ability to pass examinations. In response it was pointed out that if the first priority was producing a good all round nurse, then why is there such an insistence on high academic entrance requirements for gaining access to nurse training? An observation such as this carries the assumption that in order to practise mental handicap nursing successfully, personal attributes and academic prowess should be considered as carrying equal weighting. Once again, this raises the much debated issue relating to the theoretical underpinning of nursing, and highlights the problems often faced by students who are following study programmes of a practical and academic nature. The notion of scholarship in mental handicap nursing means different things to different people, and by inference could vary the approaches taken by individual assessors when making judgements about student performance.

Statement Two attempts to attract opinions regarding the effectiveness of practical skills assessment when carried out by ward staff in hospitals. 60% of the respondents agreed that practical assessment by ward staff is not the most effective way of measuring learner competence.

40% disagreed with the statement (see Table 45). During the follow up interviews, data were recorded which supported both points of view. However, there is general agreement that situations are contrived to provide the optimum environment within which assessment can occur. The ever-changing patterns of daily ward activities create a certain instability within which students are expected to be assessed. Uniformity and consistency are accepted as being essential prerequisites to fair and valid assessment, but in order to provide some form of stability it is often necessary to create situations through 'falsifying' the environment.

In his studies, Squier (1981) describes the possible reasons for rater error when assessing student nurses. These reasons are discussed earlier in the thesis, but instability within the learning environment appears to play its part.

The increasing popularity of continuous assessment of theory and practice in nursing education seems to reflect an opinion amongst the student sample that this is a more reliable method than the traditional 'staged' event. ***Statement Three*** asks for opinions regarding the use of continuous assessment as a viable alternative to the ward based tests. 91% of respondents said they were in favour of continuous assessment (see Table 46). (This result concurs with the data from the assessors' questionnaire which recorded 86% agreement that continuous assessment is a viable alternative to the method in current use (n = 43). See Appendix III). Although none of the respondents had actually experienced continuous assessment, there was a feeling that stress levels would be reduced below those which are currently experienced by both assessor and student, which may have the effect of improving performance. One interviewee describes a

situation in which the ward staff were so anxious about her assessment that she became affected by it:

> 'The other ward staff were more on edge than I was. They seemed to see that if I failed it would be a mark down on their side, so they made me more on edge because they were sort of panicking the day beforehand and panicking on the morning, and that just made me worse.'

During the follow up interviews respondents described themselves as being on edge because of the possibility of passing or failing on the strength of a one-off assessment. This was highlighted by one student whose assessment was to be conducted by an assessor from a different ward. The assessor was 20 minutes late arriving, and the student kept herself occupied by making beds. She describes herself as feeling fine until the acting ward sister began pacing up and down outside the office. The student then began to experience stress, and describes below how she felt:

> 'I said to her, for God's sake go and sit down, and she said "I've smoked about 20 fags", and she was saying "he's late, he's late", as if it were her assessment. It wasn't, and then when he did actually come I was sort of on edge, and I had been fine up until then, I'd been fairly calm.'

The perceived stress reduction that would occur following the introduction of continuous assessment is described by interviewees. They express an opinion that the longitudinal nature of this form of assessment reduces the build up period which accompanies the standard method. The opportunity to experience an integrated approach towards measuring overall competence enables areas of weakness to be pin-pointed and strengthened

without the fear of falling at a particular hurdle, and possibly failing the entire assessment. It was described in the follow up interviews as a means of measuring progress, but with a safety net to enable people to have a bad day without it drastically affecting the final outcome. One interviewee said:

> '... you could have a really bad day and everything could go totally wrong, and they could get a really false impression of you, whereas if it is sort of continuous they might think, oh well, she's not as bad as we first thought.'

The response to ***Statement Four***, which sought opinions regarding the extent to which practical skills assessment fit naturally and realistically in the daily work activities, illustrates a particular strength of feeling. 65% of the interviewees disagreed that particular skills assessment fitted naturally into the ward activities (see Table 47). During the follow up interviews, interviewees were asked to enlarge on this particular aspect. There were mixed feelings about the realism or otherwise of practical assessment, and the responses indicated human failings as well as resource deficiencies. Once again, the expectations of both assessor and student seemed to differ on occasions, seemingly more so when the assessment was being conducted by a member of the teaching staff. A good example of this came from an interviewee whose assessment involved taking charge of a residents' living area for a period of time. She reported that her assessor during this time was a member of school staff rather than someone who worked in the area. The student inferred that three differing sets of expectations existed as to the substance of the assessment, which led to a feeling of bewilderment sensed by the student. The tutor appeared to have gained inaccurate expectations regarding the nature of care provided in the

area and the nature of the assessment to be carried out. The person who was supervising the student's practical placement seemed to have assumed the assessment would involve managing the whole ward and therefore remained aloof from the situation for much of the time, and the student expected to be nominally in charge of one section of the ward, not its entirety. This led to a breakdown in communication between the student and her assessor in respect of the skills to be assessed. The assessor seemed to expect nursing skills to be displayed, whereas the student was expecting to be assessed on management skills. Another instance involved an assessment of nursing care which had been carried out by a member of the teaching staff. The following extract illustrates the difficulties experienced:

> 'I can remember being assessed at one place by a member of staff from the School of Nursing who expected very different things - it tends to be the ideal - you go into a place that has no care plans or anything for this assessment, and you will sit down and write a care plan. It doesn't reflect what is happening on the ward, you shouldn't have to set a false situation.'

The same respondent had experienced other assessments which had fitted naturally into the ward activities. One assessment was particularly noteworthy because it demonstrated realism and flexibility on the part of the assessor who was a member of the ward team. The assessment was designed to fit into the ward setting and took account of what actually happened. Appropriateness, rather than immovable criteria, was employed to make the assessment a natural activity.

Problems with staffing were said to affect some assessments, and this added a sense of realism to the situation. Examples were given of staffing and resource levels being low. Despite efforts by senior ward staff to maintain a responsible level of cover, it became necessary for the student and assessor to modify the assessment as a means of taking account of a less than suitable environment. Evidence of ward managers maintaining staffing levels for the benefit of students undertaking assessment was forthcoming. For a student to have the optimum chance of being successful at an assessment, support staff are necessary to act as resources, as well as providing stability to the living environment. Interviewees spoke of the difficulties when support staff are moved during the assessment period, and the evidence would suggest that this is realised and prevented by some ward managers. It remains that for those interviewed, maintenance of staffing levels is a bonus, and reflects a situation out of keeping with usual practice. One student provided clear evidence of this when she described each of her four assessments. On each occasion staffing levels had been maintained, and she found this made all the difference to her confidence and competence. Her reaction was:

> 'If they could do that every week it would be brilliant, because everybody makes an effort - more of an effort than perhaps usually.'

The process of practical skills assessment is dependent on the many variables affecting the day to day physical and social environment of a ward or other living area. Respondents spoke of the stress when attempting to practise in an ideal way for their assessments. It becomes a compromise in many cases, because the evidence suggests that despite routines and predetermined criteria for care, actual practice can vary from day to day.

It is impossible to predict what is going to happen on the day of an assessment. Interviewees expected their assessors to be mindful of this and make the necessary adjustments. The evidence indicates that for many interviewees this was the case.

Statement Five required respondents to say whether in their opinion, assessors appeared to be well prepared to carry out the role. The data provide evidence of intra-group disagreement on whether the preparation received by assessors was adequate. Without exception each group of respondents projected mixed opinions, but overall 64.6% agreed that assessors were well prepared, and 35.4% said they were not (see Table 48). (Data from the assessors' questionnaire showed that of the 39 replies received 82% said they felt adequately prepared to carry out the role of practical skills assessor (n = 39) See Appendix III).

These opinions were distilled from personal experience derived from interacting with assessors over a lengthy period of time. The expectations regarding the quality of their assessors clearly varies from respondent to respondent, and this was addressed during the follow-up interviews, and the diversity of opinion remained apparent. Comments were made about the style and approach of assessors as well as their competence in judging performance. Typical responses are reproduced below:

> 'I enjoyed my assessors, I have found them very easy to talk to... I haven't felt under a microscope... I have had a very good relationship with them, no complaints whatsoever.'

> 'I have had the same assessor every time, and before each assessment I have felt that what the person wanted from me wasn't real, wasn't what would be expected from the area itself

and was partly based upon this person's own personal interest on specific subjects.'

Not all interviewees had the same assessor for each of their practical assessments, indeed it is rare for this to happen because each area used for student training should have its own assessor. One respondent told of the differences she noted in her assessors. She said that some will insist on staying five paces behind the student at all times during the assessment, yet others try and keep it as normal as possible, and through being discreet will reduce the pressure.

Length of service was seen by one interview group as having an effect on the style and approach of assessors. It was felt that whereas one assessor may have been in the job 30 years and be very institutional in his/her approach, another who was more recently qualified would take a wider and more dynamic approach. These comments and observations lead into ***Statement Six*** which suggests that practical skills assessment usually reflects the attitudes and approaches to care held by the assessor, rather than enabling learners to demonstrate their individual skills. The data provide evidence of wide variation within the groups surveyed. Overall 57.5% agreed with the statement, and 42.5% disagreed (see Table 49). This result reflects a disturbing picture, which if repeated on a wider basis would require a re-appraisal of the preparatory courses currently employed for new assessors, and some remedial work for those already practising.

The follow up interviews provided evidence of assessor attitudes and approaches which found disfavour with the students. There is also evidence of good practice whereby students received encouragement to display skills and knowledge in a manner that reinforced their professional development.

It is evident from the data that many respondents had to deal with problems associated with perceived assessor bias, which was not confined solely to being assessed by senior ward staff. One respondent recalled having an argument with a tutor who was to conduct his second assessment. The assessment required the student to display teaching skills as part of the overall activity, and his assessor began by stating his own preference towards behavioural objectives. This preference was at odds not only with the student's view of teaching, but also the approaches encouraged within the placement area. The following quotation describes what happened:

> '... In the end I told him to go because strict behavioural objectives just weren't relevant to what that person needed at that time. In fact the charge nurse backed me up and said that he was very pleased that I had written more expressive objectives rather than behavioural ones. But it was very distressing undergoing an assessment, getting ready, preparing for the assessment when you are getting that sort of conflict...'

Of particular interest here, is the professed knowledge of expressive objectives attributed to the charge nurse. The question arises as to why it was necessary for a tutor to be involved at all, when it seemed more relevant for the charge nurse to conduct the assessment.

Direct hostility and confrontation between assessor and student were rare, but there is sufficient evidence to suggest a more subtle form of manipulation being applied to bring the assessment into line with the assessors' personal frame of reference. On one occasion the assessor had, according to the student, displayed all the traits of fairness and

objectivity. The assessment concluded with good advice being offered yet the student still felt uneasy and distressed about the experience. She referred to the 'wind up' before the assessment began, and described a process of 'fitting the frame' to what the assessor wanted to see, rather than what the student perceived as reflecting the reality of practical assessment. Each of the student's three assessments was carried out by this same assessor, and on each occasion she had altered her plans to fit a perceived set of values and opinions held by the assessor.

Another respondent describes a situation which reflects a more understanding attitude by a ward sister who had conducted the lengthy and involved management assessment. This assessor apparently allowed the student to 'manage' in her own style, and at the conclusion discussed the assessment in a helpful way. The assessor stated that she

> '... liked to sit and talk to the people I've assessed so they don't think that I'm just an assessor.'

She probed what the student had learned, and how the ward could be changed for the better, based on the student's observations.

The identification of strengths rather than weaknesses during assessment forms the basis of ***Statement Seven.*** Respondents were asked to consider each of their practical assessments in terms of strengths as well as weaknesses being identified in respect of nursing skills. A large majority (86%) agreed that strengths had been identified, as well as weaknesses during their practical assessments (see Table 50). This aspect of assessment was briefly followed up during a group interview. Interviewees were asked to reflect on the positive nature of their assessments and say what had been learned from the experience. The

researcher asked about feedback from the assessor which supported strengths, and enabled the student to gain professionally from having to put his/her nursing skills to the test. A set of mixed views resulted from this, and there appears to be a possibility of some confusion regarding strategies used by assessors to praise or criticise students' performance. For one respondent the entire series of practical assessment had produced positive outcomes, she had received praise and advice throughout, and summed it up in the following way:

> 'All through I've had, "Perhaps you should do this, perhaps you should do that, and I like the way you did this, how did you feel about this, that and the other?" I got asked questions afterwards about the actual assessment itself.'

Another interviewee reflected a more cynical view when he suggested that a major factor responsible for producing positive and helpful comments from assessors was related to whether they (the assessors) enjoyed their job. When asked to describe some of his experiences at the hands of assessors, he simply said:

> 'It just shows whether they enjoy assessing or not, whether its a bind to them, or whether they enjoy what they are doing.'

For other interviewees the strategies employed by assessors for prompting, probing and supporting were not always appreciated. For example, questioning can be intrusive if carried out during the assessment, and any kind of intervention by the assessor is viewed as unnecessary (unless it is to protect the client from harm). The best kind of assessor is described as one who stays on the periphery and lets the student get on

with the job. Comments relating to ongoing questioning during an assessment took the form of,

'I think it puts you out of your swing a bit',

and

'... if people are on at you all the time you feel more uneasy'.

An additional factor affecting the learning aspects of assessment seems to be the degree of professional familiarity which exists between the assessor and the student. Generally, interviewees within the group felt that to know the assessor is often advantageous, this allows for greater understanding and has the potential for a better educational relationship during an assessment.

Statement Eight is focused on the measurement of personal values or attitudes through practical assessment. Respondents were asked to say whether, in their opinion, personal values could be adequately measured during the course of a practical assessment. The responses indicate a certain degree of variation of opinion across the groups, but overall, there was a 73.4% response agreeing that personal values cannot be adequately measured through practical assessment. Of the 26.6% who disagreed, the majority can be found in five out of the nine groupings, in particular only two of these displayed marked differences of opinion (see Table 51).

This response seems to underline the nature of mental handicap nursing in its holistic form. It takes the discussion back to earlier issues concerned with theory and practice, which illuminated the inhibiting

forces at work within a dynamic yet unpredictable work environment. Throughout the group interviews, oblique references were made to the human interface which typifies nursing practice. Individual differences amongst the carers and those being cared for will produce an endless variety of interactions. People respond uniquely to situations depending upon personal values and characteristics. When questioned about this, one interviewee said:

> 'It's people, it's individuals out on the ward, you can't apply direct theory to individuals... Well it's down to personality, you may be taught how to do things and how things should be done, but you go out on the ward and the residents and staff are so totally different from each other that you can't approach one person how you would approach somebody else, so you can't be taught all the situations.'

Another respondent in a different group highlighted the skill of relationship building, and questioned the direction which should be taken when assessing personal qualities. She argued that assessment should be focused on the student and the client as an interactive unit, with emphasis being given to the benefits accrued by the client, resulting from the assessed nursing practice. Her view encapsulates not only practical nursing skills but also the improvement in the quality of life for her client. The same respondent provided insight into the selfish aspects of assessment whereas everything has to be organised for the student's benefit. She and others in the group condemned the 'pass at all costs' mentality but accepted the need to prime individuals to make complimentary statements to the assessor. However, the client-centred approach prevailed

within the group and reflected the important value of working with like minded people in a supportive environment.

Others in this group talked of compromising their values to ensure a successful assessment outcome. They made reference to the damage that can result to clients from the 'hit and run' nature of some assessments. They questioned the fairness in this and debated the moral issues involved. One group member said:

> '... is it fair to the person you are working with? I have done this week of intensive activity, and then thank you very much that was lovely, I'm only here another three weeks - morally, it's not right.'

Another discussed the pressure to be always active during an assessment. She spoke of having to 'keep that extra eye on what's going on', and how clients have to be kept constantly occupied. Seeing a person sat down doing nothing evokes the response, 'Oh God I'm doing the assessment, he shouldn't be sitting here - we'll go for a walk or something'. The compromise of values seems to be inevitable as long as practical assessment involves working in a situation which can entail a temporary shift of personal standards. Discussion within the group centred on the imbalance of care that can ensue when all the effort is directed to one or two people, to the obvious detriment of others. The very fact of having to make the extra effort seemed to indicate that at other times effort of similar magnitude was not always possible. Consequently, a false picture is created from which inaccurate inferences may be drawn.

From the data so far, respondents have been outspoken and clear in their views and opinions regarding practical assessment. ***Statement Nine***

invites them to say whether they are always encouraged to voice their opinions within the School of Nursing. 57.5% disagreed with the statement that they are always encouraged to voice their opinions. 42.5% said they were encouraged to have an opinion (see Table 52). As with many other response sets there emerged a cross-group disagreement, but only one set disagreed with the statement unanimously. The nature of the response makes it difficult to draw any specific conclusions. It is evident that some respondents have seen fit to articulate an opinion, and others have not. Within the data obtained from the group interviews there are several instances cited whereby individual assessors either encouraged or discouraged opinion appertaining to the assessment. These references are somewhat oblique, but once again it appears that whilst no official directive exists which discourages open discussion, it is left to individual assessors to decide whether students should be encouraged to voice an opinion. It is relevant at this stage to return to the literature review and consider the work of Derek Rowntree (1977) who wrote, 'If we wish to discover the truth about an educational system we must look at its assessment procedures'. Rowntree suggested that these procedures embraced the qualities and achievements which are actively rewarded by the system. It is emerging from the data that individual assessors are to be given freedom to reach decisions using personal bench marks. This freedom is indicative of the adult approach to nurse education, but to deny open opinion regarding any aspect of the curriculum, including assessment, is contrary to this approach. Where denial of open opinion occurs it may indicate a situation which is hierarchical and rigid.

Statement 10 provides a further data set which is puzzling. This statement addresses one particular method by which practical assessment may

be achieved. It asks respondents to consider whether care studies are used as one of the means by which practical assessment is achieved. The data show that 55% disagreed with the statement that care studies are used, and 45% agreed they were (see Table 53). This diversity of opinion is mirrored within the groups, and initially it would appear that care studies used for assessment purposes become a matter of choice depending upon circumstances. Further reflection would suggest the possibility of confusion in the minds of respondents. It is likely that care studies and care planning have become interchangeable concepts, yet in reality they are not the same because the planning of care based on the Nursing Process is a mandatory requirement for all nurses in training within the speciality of mental handicap. Care studies may be used as part of an assessment profile, as they are a valuable means of enabling students to reflect on practice, thus creating opportunities to make conceptual relationships with nursing theory. From the data available it is not possible to reach a specific conclusion regarding the place of care studies in individual cases, but the response pattern would suggest the need for further investigation. This becomes especially relevant when considering the move towards continuous assessment of theory and practice, and the need for training institutions to identify more than one piece of evidence when identifying measurement criteria.

The notion of practical skills assessment as a learning experience is central to this research report. Respondents were asked to relate the activity of learning to their personal experience of practical assessment. ***Statement 11*** addresses this issue, and 74.7% agreed that practical assessment was a worthwhile learning experience. The 25.3% who disagreed were spread across seven of the nine groups surveyed, therefore only two

groups provided a unanimous agreement with the statement (see Table 54). Whilst the response in agreement is pleasing, there is enough evidence to suggest that some examiners are more insightful and responsive to learning opportunities than others. The literature suggests that anyone involved in assessment of student competence is by inference involved in teaching, as it is important for students to exit from an assessment in a positive frame of mind, irrespective of whether they have passed or not. Post-assessment counselling is an important aspect of the assessor's role and this has been alluded to previously. The relationship between assessment and learning is illustrated within one of the group interviews. This illustration links several issues which led the respondent to a conclusion about herself as a communicator. Following a community based assessment which involved creating and applying a care plan to meet a particular set of client needs she realised the omission of several important factors. The following extract explains the situation:

> 'Sometimes... the people you are working with don't always appreciate what the assessment is about, you try to plan it so that when you have left the area it will hopefully carry on, so you have to be realistic what is set up on the first place. For example, if you set up a care plan from scratch, keep it so that you will carry on when you have gone, people that you are working with who haven't had any form of training do not understand. I did this for an assessment, and a fortnight later they rang up and said that I had left all my notes behind, I'd forgotten them. I hadn't done my job properly, because if I had they would have understood that it (the care plan) was to carry on when I had left - it was a fault.'

The student, upon realising her mistake returned to the area and discussed the nature of the exercise with the care assistants. She discovered her initial plan was too complex, and following simplification the plan was resumed successfully. It is reasonable to suggest that reflection of this kind represents an acceptable spin off from assessment.

The subsequent learning did not arise from the assessment itself but from the effect it had on others, in particular the care staff who were assumed to have the competency levels necessary for activating a complicated care plan. From this experience, the respondent developed a greater understanding of 'people centred' skills, and as a result became less orientated towards her own needs.

It should not be forgotten that over a quarter of those questioned said that practical assessment was not a worthwhile learning experience. From this it may be inferred that learning opportunities are being missed for a variety of reasons including the inability or reluctance to be reflective. The process of student empowerment towards becoming skilled in the art of reflection is invested in part within those who teach and assess. This responsibility carries a requirement for the assessor to be competent and credible as facilitators of learning, and their preparation and subsequent professional update should reinforce this.

Statement 12 addressed the potential bias which may exist in the direction taken by assessment of practice. Recent changes in patterns of care for people with mental handicap have resulted in community located provision being used on a much wider basis for student placement. Practical skills assessment will remain valid only if it takes into account the nature of change and the competencies required for successful practice

in non-institutional settings. The assumption underlying Statement 12 is that a majority of assessors are more in tune with hospital practice than with community care skills. Statement 12 therefore says 'Practical assessment is heavily biased towards hospital rather than community care'.

A substantial majority (82.3%) agreed with the statement (see Table 55). This result highlights an important concern for the future student who will be undertaking a scheme of training located primarily in a non-institutional environment. One of the groups interviewed had spent time recently in the community, and this concern was put to them. Their response centred around the course and its requirements, and there was some doubt as to whether the curriculum was understood by community staff who were supporting the students. When asked whether the community staff were familiar with the demands of his course one interviewee said:

> 'No I really don't, it depends who they are, what sort of background they have, where they have come from. I would say my community placements have been a laugh a minute, they really have.'

This group of interviewees met together with their tutor each Friday to discuss problems, and from this it became necessary for the tutor to visit the placement area more frequently than previously. It also transpired that one of the clinical teachers had extensive community experience, and she conducted some of the practical assessments. This was appreciated by one student who remarked how she was motivated into maintaining certain standards of care during her assessment because she knew the clinical teacher would not accept anything less. An impression was gained from the discussion that interviewees did not hold their

community placement in high esteem. Working in this environment seems to militate against the values already held, and it was inferred that standards of care could be compromised because of a more 'laid back' approach.

Statement 13 addresses the type of skills which should predominate in practical assessment. Specifically, respondents were asked to indicate whether practical assessment should concentrate only on psychomotor skills. 89.6% stated they disagreed with the statement, which entirely supports earlier findings in relation to the preferred direction taken by mental handicap nursing (see Table 56). The seven primary skill bases described in Chapter 5 place mental handicap nursing firmly in the humane, holistic category of caring. Within this category psychomotor skills are relatively unimportant and relate mainly to physical nursing procedures which do not require lengthy periods of training.

As Project 2000 style preparation becomes the norm, many of the physical caring activities will fall into the support worker remit, under the supervision of qualified staff. The practical skills required of nurses take on a wider dimension, and the competency statements contained within the Mental Handicap Branch Programme of Project 2000 offer a breadth of skill which reflects the modern approach. Applying the findings of this study to the future professional preparation of mental handicap nurses will form part of Chapter 10.

The remaining six statements ask respondents to state a preference under two main headings:

(i) Frequently

(ii) Infrequently

Statement 14 asks respondents to say whether ward reports constantly gave an accurate reflection of their abilities. 85% replied that ward reports frequently gave an accurate reflection of nursing abilities (see Table 57). From the data it may be inferred that the level of satisfaction is related to a decrease in subjectivity often associated with certain types of report formats. The actual methods adopted within the nine Schools of Nursing from which the sample came were not scrutinised in any detail as part of this study, but increased involvement of students in the compilation of their reports is possibly one of the main reasons for this satisfaction.

Ward reports afford assessors an opportunity to give feedback gleaned from the entirety of an allocation, and as such represent a crude form of continual assessment. Throughout, respondents made reference to this type of assessment, and as the trend is towards greater sophistication in the measurement of competence, it can be expected that traditional ward reports will rapidly give way to instruments objectively designed to give an accurate reflection of professional and personal growth.

Statement 15 is concerned with the adequacy of preparation for assessment, and asks, 'In the main, were you adequately prepared to undertake your practical assessment?' 84% replied in the affirmative which indicates care and understanding on the part of those responsible for enabling the students to undertake their assessments fully aware of the requirements (see Table 58). (Data from the assessors' questionnaire shows that in the opinion of 74.5% of respondents (n = 43) students are adequately prepared to undertake practical assessments. See Appendix III).

This agrees with Statement 19 which asks respondents whether prior to an assessment were they aware of the actual skills to be assessed? In this case 89% answered in the affirmative (see Table 62). An interesting side issue resulting from the data can be found amongst the minority who were dissatisfied with the arrangements made on their behalf in respect of preparation and awareness of the requirements for assessment. In each case a large proportion of the dissent came from the same two groups which may indicate some local difficulties.

This was followed up during the group interviews, and when questioned about preparation for assessment one respondent described a system which appeared to display a surprising lack of understanding on behalf of the training institution. The system involved a somewhat impersonal and bureaucratic method of communicating with students. Details of the assessment and who is to conduct it were sent to the student through an internal mailing arrangement. From this, the onus rests with the student to make all the necessary arrangements in respect of the assessment. The group was asked whether the assessor ever contacted them prior to the event. There was a universal 'no' to this question. Apparently the assessor just turns up on the day, conducts the assessment, and then leaves. Feedback from the assessor may or may not happen, according to the respondents. This particular training institution is depleted of qualified assessors, resulting in those who are available acting in a peripatetic role. The extent to which this represents the norm is worthy of further study, especially now that hospital care is being phased out. Once again it raises the issues surrounding selection and preparation of effective practice assessors, which becomes more important if continuous assessment is to succeed.

Accompanying the trend towards continuous assessment is self and/or peer assessment. Respondents were requested to comment on this from their own perspective, and ***Statement 16*** asks, 'Were you encouraged to plan and carry out your own self assessment?' The data reflect an equal split in opinion across the sample range. From the nine groups, only one unanimously said they frequently were encouraged to engage in self assessment (see Table 59). Amongst the remainder there exists a significant disagreement within groups, and the activity of self assessment was addressed during the follow up interviews. It transpired from the interviews that self and peer assessment occurred almost accidentally. The reference came during a discussion about assessor attitudes, and the interviewee describes a forward looking approach taken by one of her assessors:

> 'For my last assessment the assessor spent time with me, but at the end of the day I passed or failed myself. It is much more valuable to assess yourself, and I pointed out how I thought I had met the criteria ... it was valuable and I preferred to do that - it suited me.'

Peer assessment was addressed by another group in relation to the teaching and counselling aspects of their training. Peer assessment and peer teaching became interrelated, and it occurred mainly in role play situations organised within the School of Nursing. The group described the feedback they gave each other during experiential activities, but the evidence seems to suggest that self and peer assessment are relatively rare at ward level, except in cases where there is evidence of an enlightened approach being advocated. (Data from the assessors' questionnaire shows

that 81.4% of respondents agreed that students should be encouraged to plan and carry out self assessment (n = 43).

Statements 17 and 18 addressed the range of skills and relevance of knowledge explored during assessments. Respondents were asked to say whether their practical assessments provided ample opportunities for them to express a wide range of skills. They were also asked to say whether their practical assessments attended to relevant nursing knowledge. The former attracted a 68.4% response agreeing that ample opportunities had been frequently provided for the expression of a wide range of skills. Three of the nine groups surveyed were unanimous in this view. Two of the groups were biased towards non agreement, one group was equally divided, two groups marginally biased towards agreement, and one group strongly biased towards agreement. With regard to the latter statement, 85% stated that assessments frequently assessed relevant nursing knowledge, but only three groups were unanimous in this view. Whilst the remainder portrayed a strong bias towards the assessment of relevant knowledge, there are intra-group differences of opinion. However, in all but one case these are not particularly marked. (see Tables 60 and 61).

The English National Board for Nursing, Midwifery and Health Visiting expect the assessment of practice to encompass the statutory requirements contained within legislation. The competencies listed therein must be tested to ensure that a nurse can be legally qualified by registration. These competencies provide for the teaching and assessment of a wide range of nursing activities and any institution approved for the purpose of providing statutory training should ensure that practical assessment covers the entire range of requirements for registration. It is of interest that 31.6% of respondents identified a lack of opportunity within their

practical assessments for them to express a wide range of skills. It would be inaccurate to suggest that the full competency range was not being assessed in these cases, but the data raise questions concerning the autonomy of assessors to interpret the agreed criteria according to their own expectations. There may be a link with data appertaining to Chapter 6 which suggested in some cases assessment of practice may contain a bias away from complicated issues, and concentrate predominantly on the straight forward elements. There appears to be a case for a system of supervision which is aimed at:

a) Maintaining a high level of student assessment which is valid and reliable;

b) Provides opportunities for students to display a wide range of skills;

c) Enables them to benefit educationally from the experience of being assessed.

Further work is necessary to ascertain the extent to which assessors are updated and supervised.

Summary

The literature is unanimous in the view that for assessment to be of use it should reflect a process that is valid and reliable. It should measure what it is supposed to measure, and do so consistently and accurately. By taking a student perspective of assessment it is evident that anomalies appear to exist in each of the Schools of Nursing from which the sample was selected. Through gaining individual student reactions to many important aspects of practical skills assessment, it is possible to

obtain views relating to the research question. This question which is in three parts, probes: whether in the view of students,

a) Assessment of practical skills in mental handicap nursing is competently performed, taking account of the professed skill base?

b) Does the process of assessment take cognisance of the time and exposure to the practice of nursing which is necessary for skill development?

c) Does it reflect the expected relationship between theory and practice?

The data show perceived variations in levels of competency, not only on the part of individual assessors, but also in relation to the social environment within which assessments occur. Almost 40% of the sample agreed that nurse education is primarily concerned with passing examinations. The data provide evidence of environmental inconsistencies in respect of the requirement for practical assessment to fit naturally and realistically into daily work activities. Because of the ever-changing activity levels which characterise the areas where care is provided, it often becomes necessary to provide some measure of stability in order for students to be assessed. Special setting up of the environment was commonly experienced by many respondents, which creates doubt as to the fairness of a proportion of assessments carried out under existing criteria. This common difficulty appears to be linked with the dissatisfaction expressed by respondents in relation to the effectiveness of a well defined, criteria related series of practical assessments conducted by ward staff. The possibility of continuous assessment becoming the norm attracted an enthusiastic, positive response even though for most

respondents it was still an unknown process. It would seem that a system which is believed to enable students to display knowledge and skills to a greater effect than at present, is preferred. There is a view expressed concerning the stress and anxiety levels which are inevitably increased prior to, and during assessment. The opinion is that these could be reduced if students had a greater length of time within which to be assessed. Through a more economical use of time allocated for practical experience, the assessment of skills could be linked firmly to the learning process, thus giving emphasis to the predominating reason why students are placed within practice areas, namely to learn their trade.

The preparation of assessors to meet the demands of their role requires further consideration. From the data, there is evidence which suggests that assessors require a higher standard of preparation and on-going support than is currently available. Variations in standards will lead to a reduction in the validity of assessment, and the picture which emerged from the questionnaire survey suggests that assessors do conduct assessments basing their final judgement upon personally held standards, rather than agreed criteria. This criticism is levelled not just at ward staff, but at teaching staff also. Undoubtedly, there are many good assessors, and it is in their best interests to improve the environment within which they work, thus giving students a better all round deal.

A number of encouraging issues emerged from the data, in particular the large majority who felt that strengths as well as weaknesses were considered during the assessments. Inevitably, some assessors were seen as being more expert in this than others, but generally most respondents had experienced some degree of praise regarding their strengths. When this aspect of assessment is compared with the data, which indicates the

majority consider that personal values cannot be measured adequately through practical assessment, issues are raised regarding the underlying structures which support practice. Respondents have reiterated the need to recognise the change in emphasis towards a more person centred care philosophy which relies heavily on the development of values and positive attitudes. It is of interest to find that apparently practical assessment does not attend to these factors in a way that emphasises the modern approach to care. Personal values and attitudes determine the relationship between carer and client, and the practice of nursing is highly dependent on this relationship being positive and facilitative.

There is a possibility that students do not appreciate the entire nature of practical assessment, but it should be of some concern that many of those who responded to the questionnaire did not feel as if the holistic approach to care had been assessed. Assessment should be a two way process involving the student and assessor in a dialogue about the care strategies employed, which can often give opportunities for the expression of personal feelings and attitudes which would benefit from greater exploration. An excellent example would be the approaches to care required by people whose lives are impaired by serious physical and mental handicap. Previous data have illustrated the differing views which exist concerning the type of care and support required by this section of the population. The direction taken by individual nurses in their professional practice is determined by personal values derived from experience gained through a life time of interaction with other human beings. A three year training will offer an educational process which directs these personal values and attributes into a more precisely defined area of interaction, therefore assessment should

be concerned with the identification of personal as well as professional characteristics.

Central to the education of adults is the notion of reflection, which in the case of nursing and other caring activities can be facilitated through practical skills assessment which employs a system of triangulation. This will enable a student to display nursing competence through different yet related role activities, and has been referred to as a 'comprehensive role map'. (Tuxworth 1989) The data show a particular role activity (care studies) which is either being neglected or confused with something else. Care studies and care plans seem to produce confusion, and this is highlighted by the interchangeable use which some respondents attach to these separate entities. The use of care studies has been shown to encourage reflection on practice, (Myco 1981) as they focus students into a consideration of care in its entirety. It seems reasonable to pronounce a view that wider credence be given to usage of care studies as a major component of practical skills assessment. This would promote learning, encourage innovation, enable the projection of practical insights, and develop positive attitudes through in depth exploration of human need.

Practical skills assessment should be located within the area where practice occurs, and in this sense it can be separated from the assessment of theory which takes place in another setting. There is undoubted evidence from the data that practical assessment in mental handicap nursing carries a strong bias in favour of institutional practice. This flies in the face of modern trends, and indicates a serious difficulty with predictive validity. It represents an area of conflict for students who possibly see their future outwith the institutional setting, and require to

be prepared for this eventuality. The data suggest that a revision of criteria be undertaken as a means of increasing the validity, and reducing the subjectivity of practical skills assessment. Relevance of knowledge to the skills under assessment was said to be present by a large majority of respondents. A conclusion which may be drawn, is in relation to the source of this knowledge and its application. Many respondents would have experienced most, and possibly all, their training based on a syllabus prior to the one introduced in 1982. Most of the early syllabus was institutional in its direction, but Schools of Nursing began to introduce new concepts into existing courses. Herein lies a source of confusion in deciding the relevance of certain knowledge. Many existing assessors will be hybrid, and it will be some time in the future before assessment with a strong bias away from institutional practice becomes a reality. Respondents identified that in some cases their range of abilities did not appear to be fully assessed, and there is a strong indication for assessors to be regularly appraised, and also provided with regular opportunities for updating their own practice. The introduction of continuous assessment of theory and practice will create a requirement for this to be essential.

CHAPTER 8

ANALYSIS OF ASSOCIATION - AN INTERPRETATION OF THE DATA WHEN APPLIED TO URBAN AND RURAL LOCATIONS

The main data were collected from a total of nine departments of nurse education located within National Health Service hospital premises. Group interviews were conducted with students nurses from three of the hospitals, two of which were located in rural settings. Each of the nine hospitals were exclusive to mental handicap care and occupied either a rural or urban setting. In defining these settings it was considered relevant to make reference to the classical study carried out by Jones et al (1975) which surveyed the location of mental handicap hospitals within a particular regional health authority (Gateshire Survey, 1974) and the consequence for residents and relatives as a result of their relative isolation from surrounding communities. This chapter will explore whether location of a centre for nurse education has any effect on educational outcomes, and approaches to practical skills assessment.

Jones writes:

> 'One of the major points of criticism of hospitals for the mentally handicapped has been their physical and social isolation from the surrounding community.' (p 131).

The same author also notes that:

> 'Urban hospitals have a much greater potential for community contacts than rural hospitals'. (p 140).

In arriving at suitable criteria for determining rural/urban locations Jones et al use similar guidelines to the following:

1. The area within a five mile radius of the hospital should include a large town or city if the location is to be classed as urban.

2. The degree of accessibility to the hospital by road and rail networks will be greater in an urban location.

3. The general attitude of the nearest community is said to be important. For a location to be rural the nearest community would be a village or small market town within which there may be entrenched attitudes against the hospital and its residents.

It is considered reasonable to analyse a proportion of the data from a rural/urban perspective because as Jones et al observe:

> 'A hospital for the mentally handicapped is a "society within a society"'. (p 152).

Historically, hospitals were built in the face of local opposition and for them to operate successfully there needed to be a large amount of team spirit and loyalty amongst the staff. Often this loyalty could be misplaced, and Jones et al suggest that organisations which were closed to the local community could operate almost without reference to, and sometimes in spite of, its immediate environment.

> 'Tradition and expediency have therefore combined to create centripetal or inward looking systems'. (p 152)

Because of this, student nurses who train primarily within the hospital environment are exposed to practice partly or wholly reliant on home grown 'philosophies of care' handed down from generation to generation of nurses. It follows that practical nursing skills and their assessment may be

influenced by this handing down process especially as many assessment are carried out by experienced hospital based nursing staff, and this is more likely to happen where the extent of the centripetal or inward looking is greatest - namely in rural locations. Jones et al are of the opinion that despite the general negatives of hospital life it would seem that urban situations are far preferable to rural locations for many and varied reasons. However, data from this study contradicts the view of Jones in one important area, that is the practical assessment of student nurses. The findings are discussed later in this chapter.

The general criterion offered by Jones et al for determining urban and rural locations were applied to the nine locations used in this study. Tables were constructed in which data were classified as being from an urban or rural source. The resulting data were collated and analysed by comparison using SPSSx through the Pearson Chi Square test of association. Each of the locations was categorised as follows:

URBAN	RURAL
Location 1 Epsom (Surrey)	Location 3 Balderton (Notts)
Location 2 Leeds (W Yorks)	Location 4 Chesterfield (N Derby)
Location 7 Bradford (W Yorks)	Location 5 Calderdale (W Yorks)
Location 8 Wakefield (W Yorks)	Location 6 Easingwold (N Yorks)
	Location 9 Brandesburton (N Humb)

The number of respondents from the urban and rural locations are 41 and 39 respectively.

Grouping of Variables

Where appropriate, variables from the main bank of student questionnaires were grouped together to form new variables. The grouping was done on the basis of logic and the identification of apparent similarities which made them suitable for analysis. For ease of analysis the scores of the negatively worded statements were transposed into the positive mode. These new variables were prefixed with the label 'X' and in total it was possibly to identify 10 groupings. Therefore the new variables X1 - X10 were analysed with reference to the urban/rural criterion previously specified. The relationship of these results to the urban/rural criterion is discussed following the tables X1 - X10. The groups and their unifying factors, chi square values, and level of significance are as follows:

Variable 'X'1 = V10, V11, V12

V10 The theoretical aspect of my course were not always relevant to the practical situation.

V11 During my practical placements there were times when I was expected to carry out skilled activities not underpinned by theory.

V12 During my course sufficient emphasis has been given to the integration of theory and practice.

The unifying factor is the relationship of theory to practice.

X^2 value = 4.84 DF6 p = 0.565 (NS)

Variable 'X'2 = V17, V43

V17 Health education and sex education for people with mental handicap featured strongly in my course.

V43 People with learning difficulties may find it hard to form relationships, and therefore express a need to be involved in planned and unplanned interactive situations.

The unifying factor is the value of positive health and sex education to the formation of sound interpersonal relationships amongst the hospital residents.

X^2 value = 1.55 DF3 p = 0.670 (NS)

Variable 'X'3 = V21, V24, V45

V21 My course has not equipped me with interviewing skills.

V24 My course has not equipped me with the skills of counselling - listening and responding.

V45 Have you been taught the skills of listening and responding to individual's perceived needs.

The unifying factor is client counselling.

X^2 value = 6.74 DF5 Significance p = 0.241 (NS)

Variable 'X'4 = V27, V29, V30, V31

V27 Have your tutors taught you the theory of skill development?

V29 During your hospital practical placements from whom did you most frequently receive positive/helpful feedback regarding your skill development. (5 options were provided).

V30 As V29 but referring to community practical placements.

V31 During your practical placements have you for most of your time been placed in care situations which enabled you to practice your nursing skills under qualified supervision?

The unifying factor is the development of practical nursing skills.

X^2 value = 16.68 DF13 p = 0.215 (NS)

Variable 'X'5 = V32, V35, V36, V39

V32 In terms of teaching self help skills to your residents - Do you feel that you have the teaching ability to adequately meet the requirements of individually designed programmes for your residents?

V35 Logical thinking and problem solving abilities are essential ingredients for independent living.

V36 Do you believe that profoundly mentally handicapped people can develop the skills required for logical thought and problem solving?

V39 Do you feel that <u>ALL</u> profoundly mentally handicapped people are capable of achieving some measure of independence?

The unifying factor is the respondents' role and attitude towards independent living for their clients.

X^2 value = 4.023 DF5 p = 0.546 (NS)

Variable 'X'6 = V47, V49, V51

V47 Working with others in a multiprofessional team calls for the skills of leadership.

V49 Have you been taught the skills of profiling?*

V51 Have you been involved as a member of a case conference?

The unifying factor is the skills and involvement with respect to multiprofessional team work.

X^2 value = 15.96 DF3 p = <0.001

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* Profiling calls for a spectrum of skill involving the professional carer in identifying client needs across a wide range, thereby involving the nurse in multiprofessional approaches to care.

Variable 'X'7 = V53, V55, V56 - V63

V53 Were valid research findings used in our course to underpin practical skills development?

V55 Is nurse education in your particular school based on a specific model of nursing?

V56-V63 If the answer to V55 was yes, respondents were invited to identify the model(s) in use from a list of suggestions.

The unifying factor is the theory base to mental handicap nursing education.

X^2 value = 6.809 DF = 2 p = <0.05

Variable 'X'8 = V64 - V82

Variable X8 consists of the entire question set from questionnaire 3. The unifying factor is the value and conduct of ward based practical assessments.

Overall, variable X8 gave a X^2 value of 30.707 DF22 p = 0.102 (Not significant).

From the data which formed variable X8 there emerged 6 components giving results which could possibly be analysed further. These were given the label of variable X9 which gave a X^2 value of 19.14 DF = 10 p = <0.05

Variable 'X'9 = V64, V68, V70, V73, V76, V79

V64 Nurse education is primarily concerned with passing examinations.
(X^2 value = 9.25 DF3 p = <0.05)

V68 Assessors appear to be well prepared for their role.
(X^2 value = 11.44 DF3 p = <0.001)

V70 Each of your practical assessments have identified strengths as well as weaknesses in your nursing skills
(X^2 value = 6.21 DF3 p = 0.101)

V73 Care studies are used in your school of nursing as one of the means by which practical assessment is achieved.
(X^2 value = 6.27 DF3 p = <0.01)

V76 Practical assessments should concentrate only on psychomotor skills.
(X^2 value = 4.44 DF2 p = 0.109)

V79 I was encouraged to plan and carry out self assessment.
(X^2 value = 6.11 DF3 p = 0.106)

Overall p = <0.005

Chi square testing of the Rural versus Urban responses for each individual variable is reproduced here together with the significance level. These data were examined in this form to guide the development of X10.

Collectively, the components of variable X9 did not represent an identifiable unifying focus but from these it was possible to identify 4 components which could be tied together to form variable X10. The unifying focus of variable X10 is the positive and flexible approach to practical skills assessment taken by the school of nursing.

Variable 'X'10 = V68, V70, V73, V79

V68 Assessors appear to be well prepared for their role.

V70 Each of your practical assessments have identified strengths as well as weaknesses in your nursing skills.

V73 Care studies are used in your school of nursing as one of the means by which practical assessment is achieved.

V79 I was encouraged to plan and carry out self assessment.

X^2 value = 12.62 DF2 p = 0.000

Interpretation of the Significant Results

From the 10 'X' variables, 4 gave significant results. Each individual table (excluding Variable X9 is reproduced in turn and interpreted from the urban/rural focus previously described.

Location	Very Low	Low	High	Very High	Row Total
Urban	2	8	23	5	38
	5.3	21.1	60.5	13.2	53.5%
Rural	5	19	6	3	33
	15.2	57.6	18.2	9.1	46.5%
Column Total	7	27	29	8	71
	9.9	70.4	40.8	11.3	100%

Number of missing observations = 9

Variable X6 The level of respondents' involvement with different activities related to multiprofessional teamwork.
X^2 value = 15.96 DF = 3 p = <0.001

This table of results clearly indicates that respondents from the urban location experienced a higher level of involvement in multidisciplinary activities than those from the rural location. Of the three component variables of variable X6 two are particularly significant. Variable 47 (p = 0.018) and variable 51 (p = 0.019) deal with leadership skills in a multidisciplinary team, and general involvement as a member of a case conference respectively. The data show that 67.5% (n = 40) of respondents from the urban location said that leadership skills are a necessary condition of working in a multidisciplinary team. 59.5% (n = 37) of respondents from the rural location said the opposite. The data also show that 90.2% (n = 41) of respondents from the urban location had been involved in case conferences whereas 31% (n = 39) from the rural location had not. Therefore when taken as a composite it can be seen that the level of involvement with activities related to multiprofessional teamwork is greater amongst respondents from the urban location. 73% (n = 38) of those from the urban location reported a high or very high level of activity. When compared with the 72.8% (n = 33) of those from the rural location who reported a low or very low involvement, the result is very significant.

In attempting to interpret this result it is helpful to make reference to the work of Jones et al (1975). There seems little doubt that access to services and facilities outwith the hospital is more likely to happen in an urban setting. For example, child development centres, play groups and educational/training facilities are within easier reach for clients who reside in or close to a large town or a city. As a consequence multiprofessional team work becomes more likely, which means that student nurses training in an urban setting are probably at an advantage as far as being involved is concerned. The interview data contains some evidence in support of this observation. Interviewees from an urban location suggested that the Nursing Process was a suitable vehicle for promoting multiprofessional working. When asked to justify this claim one person said:

> "... it is the main way of informing everybody related with that particular client and getting information across. As things become more multidisciplinary out in the community you are going to need the central data information."

Interviewees from rural locations were unspecific about multidisciplinary working and its relationship to their role. This observation underlines the importance of courses leading to the mental handicap nursing qualification being sited near to community and residential services, otherwise the essential skills, knowledge and personal attributes related to multiprofessional working may not always be given the prominence demanded for a modern service.

Location	Low	Medium	High	Row Total
Urban	20	6	14	40
	40	15	35	51.3%
Rural	20	13	5	38
	34.2	13.2	48.7	48.7%
Column Total	40	19	19	78
	51.28	24.36	24.36	100%

Missing observations = 2

X^2 value = 6.796 Df = 2 p = <0.05

Variable X7 The relationship of theoretical perspectives to nurse education in urban and rural locations.

This table of results indicate that theoretical perspectives within the nurse education programme are more likely to receive prominence in schools of nursing in urban locations than rurally situated schools. The table shows corresponding figures of 35% (n = 40) of respondents from the urban location and 13.2% (n = 38) of respondents from the rural location who reported a high relationship of theoretical perspectives to their professional education. It can also be seen that consistency occurs under the medium and low relationship columns in as much that the rural location offers a lower possibility of theoretical perspectives being given high prominence. The reasons for this are not immediately apparent, and the interview data were unable to show why the difference exists, but it could be argued that because the rural locations are often housed some considerable distance away from the main school/college site, there is a problem of accessing wide library resources. It is therefore possible for students in rural locations to be disadvantaged in this respect, and again a case can be made on this basis to support the central location of educational activities as a means of making the best use of available resources.

Location	Low	Medium	High	Row Total
Urban	9 22.5	26 65	5 12.5	40 51.9%
Rural	3 8.1	16 43.2	18 48.7	37 48.1%
Column Total	12 15.5	42 54.6	23 29.9	77 100%

Missing observations = 3

X^2 value = 12.64 DF = 2 p = <0.001

Variable X10 The extent to which schools of nursing located in urban and rural settings reflect a positive and flexible approach to practical skills assessment.

This table shows a marked difference in data orientation to that seen in the two previous tables. An analysis of the data under variable X10 provides evidence to suggest that positive and flexible approaches to practical skills assessment are more likely to occur in the rural location. 48.7% (n = 37) of respondents from the rural location reported a higher incidence of occurrence than respondents from the urban location (12.5% (n = 40). This tendency is reflected across the table as a whole. Once again it is not possible to identify a clear reason for these results, and the interview data were unhelpful, but suggestions can be offered which may throw some light on why the differences exist.

There is a long standing tradition of "ownership" within long stay hospitals which in many cases promote a strong feeling of pride in the School of Nursing and its training programme.

This notion of pride is strongly allied to the family spirit which contributes to the ethos of a hospital. Earlier, the work of Jones et al (1975) was seen to criticise the mental handicap hospital for its inward looking culture. Paradoxically, the loyalty and team spirit to which Jones

and her colleagues refer engenders the sort of pride which could promote educational innovation. If as Jones suggests, tradition, loyalty and team spirit is more likely to occur in rural locations then it should follow that nurse education in these settings will reflect this ethos to the point where preparation of assessors, the use of self assessment, and more flexible approaches to assessment in general are given priority as a means of improving the outcomes of training. Other factors which may play a part in producing figures as seen in Table X10 include the employment situation, tutor/student ratio, skill mix in the practical areas, and the level at which in-service training and education occurs, all of which contribute to the overall quality of the learning environment. It is not known whether one or more of these factors influenced the results.

Eventually the total closure of hospitals for people with mental handicap, and the universal adoption of Project 2000 will alter the conditions under which nurses are prepared for their role. Future research could investigate the effect that large complex colleges of nursing and midwifery may have on the dual notion of pride and belonging. In this respect it is possible that history may carry important messages for teachers of nurses concerning the need for students to identify positively with the school or college where they trained, and how this is associated with morale and attrition rates.

Conclusion

This secondary analysis of the main questionnaire data has extended the scope of the thesis by applying the findings to urban and rural locations. Precedents for taking this approach can be found in the literature (Jones et al 1975, Seed and Montgomery 1989). Significant

results were identified which provided a new and interesting focus on the following factors:

(i) The level of respondents' involvement with different activities related to multiprofessional teamwork.

(ii) The relationship of theoretical perspectives to nurse education in urban and rural locations.

(iii) The extent to which schools of nursing located in urban and rural settings reflect a positive and flexible approach to practical skills assessment.

From the analysis there is evidence to suggest that location of facilities for mental handicap nurse education may well play an important part in determining the effectiveness of some essential functions of the curriculum. Of the three composite variables stated above two were shown to appear more effective within an urban focus. The exception was the factor dealing with positive and flexible approaches to practical skills assessment which appeared to be more likely to occur in a rural location. Clearly, there can be no categorical reasons given for the weighting of the results, but reasonable suggestions are offered by way of explanation. Further inquiry is necessary to determine the effect of location on educational outcomes, supervision, practical skills assessment, student morale and attrition rates.

CHAPTER 9

GROUP INTERVIEWS - ANALYSIS AND INTERPRETATION

This chapter provides an analysis of the data obtained from the series of group interviews carried out in support of the information gleaned from the questionnaires. An attempt is made to direct this analysis towards the overt as well as the hidden aspects of the responses.

The questions put to respective groups of students enabled them to respond openly about matters relating to the organisation of their professional preparation, and the role of assessment as a determinant of progress.

Primary Analysis of Data

Question 1

Interviewees were asked to describe how they viewed the School of Nursing. For example, is it a place set aside or apart from the areas used for practice? Are schools more concerned with theory, and did interviewees feel that practice areas should be integral to the school?

Evidence is provided by the interview data to suggest that the school is a base, a resource centre and for some a life line. It was said to be separate from the 'areas of work' and unrelated to the rest of the hospital or the wider community. There were strong indications from the data that it is a place into which students retreat from the rigours of work in order to receive theoretical instruction from tutors who may not always be in tune with day to day practicalities. As one interviewee said:

"It's more of a base, there is not much of our training that actually takes place here. Our training is more what we do on our outside placements".

"What we do in school tends to be the ideal".

Another interviewee indicated a broader understanding of the school and its role by stating that it is more about:

"tutors and courses as opposed to the actual building".

It is interesting to find that without a regular break from practice, students were of the opinion that they would be deprived of opportunities to rediscover their true identities, and some go on to say that the school represents an oasis or safe environment for them to do so. The dual role of the teacher as a catalyst of learning and also as a person who offers a life-line through sympathetic listening is highlighted by the students as being essential for their personal and professional well being. This is summarised by two interviewees who succinctly captured the feelings of those around them when they said:

"I go from the School of Nursing and always come back to it, and it is also a place where there is somebody to talk to where we are taught things, its a bit of a life-line really".

"I think the School should be a safe environment for us to talk about how we feel - sometimes we can't do that in the practice areas".

Question 2

A question was asked concerning the actual course of study being followed by the interviewees. The particular focus of the question centred on the perceived relationship between theory and practice. The terminology used to describe their respective views of the course was varied and their responses ranged from "following a set syllabus" to the much wider implications of a course that is "all embracing and involves the practical areas". Overall the knowledge base of mental handicap nursing and its relationship to practice was by and large understood by this group of the students. Evidence within the interviews exists to suggest that this relationship has improved considerably. Students spoke of being able to "branch out and explore things", and even though theory as taught by tutors, and practice as experienced outwith the School were said not always to be in harmony there was a feeling that a relationship does exist. It is as one student said of practical realities and theoretical concepts:

"It is a shock sometimes, but the relationship is apparent".

Synchronisation of the theoretical components of the course and the associated practical settings received criticism. Often during the interviews this association was described as disappointing and lacking in consistency. Indeed it was said that new students may experience a shock initially.

> "I think theory is what happens in the ideal world and when you get stuck into reality you come down to earth with a crash. I think you get to expect disappointments and not to be too shocked when it happens, but you might be shocked when you

first start studying - the young student will probably be shocked".

The same student suggested that the disappointment is acutely felt when, having been taught to do things in the correct way, ambition is thwarted by a lack of resources and consistency in the learning environment. Having been told by tutorial staff of the importance of repetition and consistency in skill development students expressed some disappointment when they discovered that certain negative forces work against this. For example, activities that were started in good faith were not supported, "good outcomes are not reinforced in the way that was hoped for". The interviews suggest that staff in the practice areas become disillusioned. It is reported that students have been told;

"You might have the new theory and the new ways, but the results remain the same."

Such an approach to modern nurse education was described in the interview as probably representing resistance to change. The students recognised that change would always be a powerful feature of nursing.

Question 3

Interviewees were asked to comment on their skills and whether these would require modification to meet the future needs of service consumers. For example, how would the increasing emphasis on community care affect the application of skilled nursing?

The interviewees spoke of a need for all those who take responsibility for student nurse education to accept that many and varied approaches now exist when creating a positive and therapeutic relationship

between a nurse and those she/he cares for. One could comment that enabling a person towards independence of life calls for a new direction in the application of skills and knowledge which may require improvisation and adaptation to prevailing circumstances. The interview responses were in accord with the questionnaire data regarding the belief that community nursing skills, teaching and learning, and therapeutic skills represent areas where flexibility would be important. In this context there remains overall support from the responses for the Nursing Process as being the universal key to most, if not all nursing scenarios. Responses in the interviews can be interpreted to support the view that in addition to its traditional function of assessing, planning, implementing and evaluating care, the Nursing Process has the added bonus of helping with relationship building, especially between the nurse and those receiving care, which often involves other informal carers such as parents and grandparents. Through selection of some of the interview data it can be demonstrated why the Nursing Process is so well liked.

"The Nursing Process is relevant, more so than ever before".

"It can be related to individual clients, or put to wider use within a multidisciplinary framework - it is that flexible".

"It's all I've ever known".

"It can be used to organise things in your own mind".

"We cannot do our jobs without involving others".

"Nursing skills need to be valued by the carers"

It can be inferred from the data that the Nursing Process is capable of being effective in numerous caring situations. It is a client/consumer centred process which creates possibilities for the student to apply skills and evaluate the outcomes through intelligent reflection. In this case the person receiving care becomes the means by which the student can reflect on the success or otherwise of intervention strategies. Skills can be improved and consolidated through reflection which in turn can generate novel solutions to difficult problems. From the data it can be interpreted that assessment and teaching of care skills should be closely aligned to the staged approach of the Nursing Process as a means of judging and guiding the students' reaction to caring situations.

Question 4

A question was asked concerning how nursing skills, in practical settings were assessed, in particular those skills associated with community, educational and therapeutic aspects of care.

The interviewees drew a comparison between assessment, education and training. It became an important issue during the interviews to recognise that training and education were seen as being separate from each other, and it was this and not the overall relationship between theory and practice that caused concern. Interviewees spoke of study blocks in School as being progressive yet at the same time distinct areas of preparation for examination success. They indicated that it was during the study blocks that education occurred, and training is what happens outwith the study periods when students are exposed to the practical work environment, and sometimes tutors lose sight of what their students are doing when undergoing practical experience.

One interviewee, who had recently undergone a management assessment carried out by a tutor said:

> "The skills that my tutor was looking for weren't the skills I was demonstrating".

When asked by the interviewer whether the assessor was expecting something other than what had been taught the reply was:

> "No, it was what I had been taught but it was not what I was doing".

The point being made was that assessment objectives as they were understood by the assessor were at odds with the expectations of the student and the practice area staff. It would seem that the problem here was not due to any lack of a relationship between theory and practice but more to a mismatch between the expectation one party had of the other. The general opinion was that tutorial involvement in practical assessments was not particularly welcomed by the students. As one of them said:

> "They (tutors) expect different things - it tends to be the ideal. You go into a place that has no care plans or anything and you will sit down and write a care plan that doesn't reflect what is happening on the ward". *(Taken from original statement).*

There were also reported conflicts over the use of certain objectives. During one teaching assessment a tutor was said to have demanded the adoption of behavioural approaches, and the student insisted on a more flexible or expressive approach. This resulted in an abortive

assessment which undoubtedly caused a stressed relationship between the two people concerned.

It would seem from the interviews that three differing sets of expectations exist regarding assessment performance.

1. Assessor expectations. (Tutorial staff not included in this description).

2. Tutorial expectations.

3. Self expectations - living up to standards and ideals.

As one student said:

> "its very hard to have standardised expectations of how students should perform - Assessors have different opinions to those held by teaching staff". *(Taken from original statement).*

Personal standards as an issue arose from the interviews especially with regard to practical skills assessment and the differing expectations of assessors.

Question 5 probed this by asking whether students perceived different expectations of standards during an assessment depending upon who was doing the assessment?

Because of the generation gap which often exists between an experienced assessor and an inexperienced student, there may be times when difficulties occur. The interviews give some indication that a culture gap exists brought about by a change in the socialising process experienced by

assessor and assessed. Values strongly held by one may not be as important to the other, and the message seems to be one of wanting flexibility when interpreting assessment outcomes, as these will inevitably be reflective of the changing philosophies and priorities of care ranging from the physical/clinical to the social/community.

Generally, students preferred to be assessed by practice based staff, which the students believed for most had resulted in a fair and objective assessment. However a number of important issues were raised during the interviews concerning the organisation of the assessments. Two obvious scenarios present themselves with regularity.

Scenario 1

The assessments are related to reality. That is, no special arrangements are made to improve the environment. In support of this observation one student said:

> "If you haven't got the staff this has to be written into the assessment, i.e. that you might have problems with staffing levels, resources, or the environment. You are always having to write contingencies into your assessment".

Scenario 2

The assessments are idealised through manipulation of the environment. As another student said:

> "Often the ward sister will make a visible effort to maintain decent staffing levels".

This was supported by two further comments:

"I've had the amount of staff allocated to those shifts. They have not been moved" (under normal circumstances they probably would have been)

"Everyone makes an effort - more than usually perhaps".

The debate surrounding these two scenarios seems to centre around the 'reality' factor. Students speak of the unreal situation typified by scenario 2 and that a 'set up' assessment does not reflect day to day reality. An important question raised by this view is, does it really matter whether a situation is manipulated or not? No matter what the conditions are they have to be managed, and there may be an argument that more staff and greater resources require a wider spectrum of management sophistication than scenario 1 situations. As one student said of practical assessments generally:

"They are learning experiences reflecting the skills we already have and give impetus to learning new skills".

In conclusion it is worth considering the work of Cross (1984) who implies that the bottom line of practical skills assessment is that essentially it should be carried out in the practical work situation, and it may well be irrelevant as to whether certain adjustments are made to the environment or not.

The Case for Continuous Assessment

One important conclusion which may be drawn is that individual standards of care can be evaluated through an assessment of how students react to situations which involve clients in real life situations. The evaluative process will measure the sophistication of the reaction which

should improve as the student becomes professionally mature through experience. It also reduces the concern expressed within the thesis regarding the need to provide students with an optimum learning environment for practical skills assessment, because the real issues are to be discovered within a client group living in a less than perfect world. The ideal environment rarely exists, and to create one purely for a student to show off a range of skills could deny opportunities for improvisation, adaptation and reflection. It also undermines the predictive validity of the assessment as a means of determining the potential for achieving success as a qualified practitioner. Simplistically speaking, if the outcome for the client is positive then the assessment has been successful. Measurement of the degree of success becomes a matter for discussion and reflection between student, assessor and the client where appropriate. Hence the need for student and assessor to share similar values and understandings if the dialogue is to be productive.

Students were asked their views on continuous assessment, and evidence within the interview data suggests that continuous assessment of practice seemed to offer them a better way of having their abilities judged. A student said:

> "You get rid of the unreal situation. Being assessed over three years would help maintain a better standard throughout - they couldn't manipulate the situation for three years". *(Taken from original statement).*

It was felt that because students and qualified staff had 'good days and bad days' these would balance out over a period of time. One could argue assessors who have been properly prepared to assess in their own work

areas are much more likely to be objective than someone who comes in from outside. Also it enables the student to develop a good professional relationship with an assessor which reduces the negative effect associated with the more traditional approach, especially the notorious institutional grapevine which often carries misinformation about assessors and their methods.

Question 6 focussed on self-assessment and the extent to which respondents found it useful.

The students were also enthusiastic about self assessment, but the evidence seemed to show a certain amount of misunderstanding surrounding its use. They gave an impression that informal self assessment occurred in an ad hoc way and did not have any real connection to the formal procedures, although the activities which passed for self assessment seemed to be beneficial. A selection of comments are as follows:

> "It's much more valuable to assess yourself".
>
> "There has to be a spark of honesty in yourself - it's so valuable, it suited me".
>
> "It's very demanding, it isn't a cop out at all".
>
> "You have to be honest with yourself, support and guidance is needed - it is very good".

Whilst the interviews did not probe further into the notion of self assessment, it is reasonable to suggest that a more indepth look at this aspect could form a useful research project.

Question 7 concentrated on the assessment of teaching and counselling skills.

Interviewees were asked to describe how they acquired the key skills associated with teaching and counselling and how these were assessed in practice.

During the interviews it became clear that the students were able to make comparisons between the respective skills associated with teaching and counselling. They identified that both activities rely on interpersonal processes which for most was taught and assessed in the confines of the school room rather than in the practice area. It was emphasised that "unless we are very, very good at it" counselling was not encouraged by ward staff. "We could muck up probably weeks or months of work". There was a consensus of opinion that as individuals they 'counselled' clients informally - not consciously except in some areas depending on the client group and the nature of their problems. Emphasis was placed on the value of observation when learning new skills. Even though much of the formal teaching of counselling was done in the classroom, students said how much they had picked up just by watching a skilled person at work. The following quotations seem to support this assertion:

> "You learn more (in practical areas) than anywhere else".
>
> "I've learnt a lot from practical experience".
>
> "I've had opportunities and learnt something just by the nature of the placements".

The following quotation takes the opposite view:

"I've learnt a lot of theory but I've not done any particular sort of counselling in practise".

It would appear that opportunities for learning counselling skills in the practical areas are variable and depend on stated policy, exposure to skilled staff and feedback from interested mentors.

On the other hand acquiring teaching skills does not appear to be so problematic to the students. The theory is taught in the classroom along with some practice, and the extent to which teaching was part of the nurse's role seemed to be reasonably well understood.

"Hopefully, as staff nurses we will be teaching a whole range of people".

"It's good that junior nurses are being taught as part of an assessment".

"(we use) some teaching skills for residents - at a slightly lower level". *(Taken from original statement).*

To sum up, assessment of teaching skills was carried out formally in the classroom and practice areas, and it seems to be a well established, accepted and natural part of the daily work requirement to teach others.

Secondary Analysis

Role Defensiveness in Relation to Skill Ownership

Throughout much of the interviews a hidden agenda became apparent and this will be examined here.

Elsewhere in the thesis reference is made to the changes taking place as a result of government policies relating to community care. In some cases this has led to role confusion and defensiveness. At a time when it is important for nurses to verbalise the contribution they could make to the evolving services in terms of skilled support to the consumer, they often find themselves in conflict. The following observation was offered by a student and seemed to typify a majority feeling:

> "People have to be constantly reminded that mental handicap nurses exist, and of the skills they offer". *(Taken from original quotation).*

Others offered views which indicate role confusion:

> "I very rarely use the term nurse to describe myself - if you do people get a totally wrong impression of you".

> "There is a special skill base but not necessarily in the sense that the general public understands it". *(Taken from original quotation).*

There is some comfort to be gained from saying what one's communal skills are, they act as a defense against outside attempts to reduce the status and importance of the role. The genericism versus specialism argument was addressed within the interviews. Views expressed by the students fell within the following general statements which indicate some disagreement:

(i) Nursing is not a proper description of the role.

(ii) Current skills require to become more specialised.

(iii) Strengths lay in a generalised skill profile.

(iv) Adaptability of skill profile to meet any situation in a wide variety of environments is required.

(v) Holistic care is the way forward.

Conflict is apparent regarding skill ownership. This was transmitted through the interviews in so much that nurses are being over protective of their role and becoming fearful of losing the specialist skills by default to other professions. Other worries and conflicts originate from the perceived effect that Project 2000 will have on the mental handicap nurses' role. Some interviewees felt quite strongly that Project 2000 would be biased towards general nursing, with the consequence of mental handicap nursing being, "lost or drowned". One quotation sums this up:

> "We may have to adapt to them (general nurses) rather than them to us".

Others saw the role in a clear and unambiguous fashion, several interviewees held strongly the view that people with mental handicap need carers with special skills - counselling, teaching, wider educational skills, social skills. It was also stated that nursing in the community was:

> "flying away from the medical model".

Nurses were perceived as practitioners in their own right, being able to manage a case load independently whilst at the same time having access to other members of the professional team.

The notion of independence as a practitioner, especially in the community seems to bring a requirement for restating the role of mental handicap nurse. A conclusion which could be drawn from this section is that 'nursing knowledge' is highly valued but the term 'nurse' is becoming redundant. Therefore the idea of being valued by the client and his/her family is possibly more important than the professional label which is attached to the carer.

Conclusion

Overall, the interviewees were committed and sincere people who represent the future of mental handicap nursing in whatever form it may take. They had much to say about their student career and the way they were expected to learn and develop as professionals. This short chapter has attempted an analysis of the interview transcripts with the added task of illuminating some of the covert factors which lie beneath the surface of mental handicap nurse education. These are important because they affect students' developmental processes and represent the culture into which they become socialised.

CHAPTER 10

CONCLUSIONS AND RECOMMENDATIONS

Introduction

Through adopting a student perspective on practical assessment it was the intention to research a viewpoint which hitherto had not been sought; and through the consumer's eyes to reach some conclusions regarding the worth of practical skills assessment in its present form. From the study there has emerged issues which collectively show that assessment of practical nursing skills is more than just a competency based exercise using a system of performance indicators to measure levels of expertise. These issues take mental handicap nursing beyond the simplistic need to possess sufficient skills, knowledge and understanding to function successfully in a particular or defined role.

The Primary Skills Set

The study has certainly produced clear evidence of the existence of primary skill sets which have evolved from within the profession. They are evidence of development from a medically defined role, to a social, person centred role, and can be found in various degrees of detail in every aspect of the mental handicap nurse's work. In themselves the skill bases are not unique, but the mixture in use is. Creating the right balance of skilled activities which at any one time will meet an individual's needs is at the heart of nursing generally, and mental handicap nursing in particular. The art of practical assessment is to provide reassurance to the student that she/he is gaining in competence and moving towards eventual qualification.

It also fulfils an obligation to the general public that standards are being maintained through rigorous testing of future practitioners.

Within the literature review, problems associated with 'what to assess' are addressed. Emerging from this is the imperative need for assessors to be in possession of a full understanding of the curriculum and its relationship to practice. As more becomes known about a field of activity within which nurses work, the greater the need for assessors to remain aware of their responsibility to stay abreast of developments. Each of the primary skill sets can be analysed to illustrate how mental handicap nursing has progressed since the devolvement of practical assessment. The respondents gave many useful insights into this progression, and in so doing have taken mental handicap nursing on, into its next phase of development. The statutory nursing body for England has adopted the primary skill sets to provide the focus for its branch programme in mental handicap nursing. This followed a process of testing to ensure their relevance to the modules for learning which had been stringently developed by a carefully chosen working group (see Appendix IX).

Of immense significance is the order of priority into which these primary skill sets fall. Counselling for care is considered to be the most important, and respondents make particular reference to bereavement counselling. It is now well documented that parents, and in particular the mother, experience emotions not dissimilar to those associated with the death of someone close, when a child with mental handicap is born to them. These emotions reflect the loss of a normal child and generally take the form of denial, anger and guilt. (Owens and Birchenall 1979) Supporting the whole family is now within the remit of mental handicap nurses, especially as the community is replacing the ward as the main operational

area. This one aspect alone will eventually redirect practical skills assessment along a more complex pathway than at present. It will require a new network of preparation and support for assessors which will enable them to carry out their responsibilities fully in the knowledge that they are up to date with current trends. Further reference to counselling and interpersonal skill development occurs later in the chapter.

Teaching skills and skills teaching are also high on the list. Creating and maintaining an environment within which people with mental handicap can live and develop, is a priority area for everyone concerned with their welfare. The very nature of mental handicap is such that learning difficulties are amplified, often to a high degree, and the reduction of these difficulties is at the centre of helping people gain a better quality of life. Before life skills can be taught to others, it is reasonable to expect those who do the teaching to have possession of some expertise in the practice of instruction, as well as experience of life. The data indicate that a majority of respondents entered nurse training following a period of employment elsewhere, a small proportion came direct from full time education. Preparation in the art and science of caring for others encompasses more than just a period of training, and a person's own experience of life will probably add considerably to the development of strategies aimed at coping with everyday difficulties. Within the text there is an example given of how a straightforward activity such as hiring a video film from a library has to be broken down into easily managed tasks. This is to enable the person with learning difficulties to achieve a particular objective, and is representative of the type of teaching which mental handicap nurses engage in. For most people, learning a new skill or a different way of doing something requires time for rehearsal and

reflection. The period of time can be greatly extended depending upon the degree of learning disability, and the type of environment within which learning is to take place.

Assessing the extent to which student nurses can facilitate learning involves numerous variables. These variables cover many aspects of teaching and learning, which in some cases are amplified to take account of the situation and the client. From the data there is a clear indication of those factors which respondents would wish to place under the umbrella of teaching skills. Issues for assessment are immediately raised when consideration is given to a skill base which contains such things as patience, consistency of approach, effective communication, counselling, understanding the person, and recognising potential. Each of these activities represent the humane element of mental handicap nursing. What has to be assessed is the nature and effectiveness of one person's interaction with another, the extent to which that interaction meets the set goals, and the extent to which the client has benefited from the encounter. This calls into question the mode through which practical skills assessment is conducted, in particular the amount of credence given to self assessment. The data indicate that opportunities for self assessment were not universally available, and the extent to which respondents were encouraged to voice opinions about their assessments was minimal. Clearly, it is essential for assessors to observe what is going on, but the ultimate decision regarding the outcome of an assessment should be a shared activity, the conclusion being that students have a greater say in their destiny.

The Primary Skills Base identifies a relatively new and influential force which seeks to change permanently the direction taken by mental

handicap nursing in the future. Community nursing skills are already creating demands for curriculum change, and a move towards shared action planning with other professional groups appears to be the desired outcome favoured by the statutory nursing bodies. This will create a wider work arena for nurses, and involve them in multi-professional activities which is currently having the effect of sharpening up their contribution and identifying the role of nursing outwith the institution. Transferability of nursing skills and knowledge across the boundaries of care is an important factor, especially when students are expected to gain experience in a number of settings during their training. On this basis alone the goal posts for practical assessment are likely to be moved. If the profession expects its future practitioners to be capable of delivering high level care in a myriad of situations the standard approach to assessment may be ineffective. The need to apply nursing skills across professional boundaries will by inference require a re-appraisal of existing practice and the removal of outmoded and inappropriate elements from the curriculum. This study has generated data which suggest that many practical assessments are conducted from a narrowly defined institutional viewpoint. To some extent this is understandable especially as mental handicap nurse training and education is administered almost universally from hospital settings. The nine groups of students who took part in this study came from such a setting, and can be expected to reflect similar opinions on this aspect. However, they provided general support for a sharing of expertise between social service employees and mental handicap nurses, and identified a framework of knowledge and skill which they suggested could be shared. The common principles governing their choice of shared elements were also identified and include universals such as human rights, personal values, Individual Programme Planning, family dynamics,

and developing a therapeutic environment. These common principles offer a way forward towards a common language being developed throughout the network of care, which eventually would eliminate many of the problems associated with transferability of knowledge and skill.

Physical nursing skills are included as one of the six Primary Skill Bases, and respondents have been quite forthright in their insistence that shared elements between social workers and nurses must include essential physical caring skills. They make reference to 'basic nursing practice' and 'common approaches to caring', in which they include, feeding, positioning, managing challenging behaviour, epilepsy, and drug therapy. A need was also projected for the inclusion of biological sciences and first aid. An interesting reference was made in the data to the sharing of respective models of nursing and social work. Should a compatibility be found to exist at the level of models and philosophies, then an integrated approach to the care of people with mental handicap and their families would not only be possible but desirable. This requires further investigation.

The research process is given prominence as one of the Primary Skill Bases, yet the data raised doubts as to the extent to which it has permeated the curriculum. If, as seems likely, there is a lack of comprehension by many students of the nature of research and its place in the development of their professional understanding, further study is required to determine the general availability of relevant research reports, and how far below the surface of mental handicap nurse education does well informed research based activity occur. Through the inclusion of research based care, and the development of inquiry skills, in the Branch Programme for mental handicap nursing, the statutory body has declared its

expectations, and given notice of an intention to insist that students make use of relevant literature and research to inform practice. This is a key factor, and it will affect practical skills assessment in the future. The data indicate a possible difficulty in the uptake and use of research which, if reflected on a wider scale will place assessors and students in a quandary, especially if the mentors and role models are providing care which reflects custom and practice, rather than empirical findings.

The Learning Environment and its Implications for Practical Skills Assessment

The term 'assessment' is derived from the Latin ADSIDERE/ADSESSUM which literally means - sitting beside someone. It is also related to ASSIZES from which the notion of judgement arises. Blanchard (1988) writing about assessment says:

> 'If assessment begins when learning stops, its function is to select and reject, and it can have no proper formative value. For assessment to accompany and promote learning, it must be a means whereby students grow to understand how they come to be where they are now and how they might proceed.' (page 43)

A well constructed learning environment will emphasise formative values in assessment and thus enable each student to derive benefit from the experience. Taken from a nursing perspective, the learning environment embraces a complex arrangement of planned and unplanned activities which occur in a variety of settings. Making use of the term 'learning difficulties' when describing the overall problems associated with mental handicap, strongly reinforces the direction which should be taken when planning services for this section of society. The predominant aim of

these services is to enhance the quality of life for the client through a process which is fundamentally educational. Student nurses preparing for their professional role also undergo a process of education principally within the same environment as that used by the client. Within this environment, education is truly a reflexive concept with many perspectives being brought to bear. Students in this situation find themselves employing the many facets of education, training and coaching to bring about a change in the behaviour of their clients, whilst at the same time being exposed to a parallel set of educational experiences aimed at developing them as professional people.

This study places emphasis on the need to create learning environments which are supportive, facilitative and properly staffed. Where such environments exist there is every likelihood of harmony and a general keenness to meet the learning requirements of all those who live and work within them. The reality is that students can expect only a proportion of the ideal situation, and the study highlights many deficiencies as well as strengths in the day to day educational experiences of student nurses. Curriculum planners constantly strive for a positive and observable relationship between theory and practice. To achieve this, it is essential for there to be a discernible connection between what is taught in the classroom, and the practice of nursing as it occurs within the training areas. From the data it can be confidently stated that the relevance of theory to practice often misses the mark, indeed the question was raised regarding the existence of a 'hidden agenda' of theory. An agenda such as this would contain the knowledge necessary for the student to become street wise through the development of survival skills. The knowledge base for such skills is derived not from research and text books

but from within the student culture itself. Admittedly, within any institution of learning such an agenda will exist, and only becomes problematic when it subverts the course of study being undertaken.

The extent to which this has occurred throughout the sample is hard to tell, but some evidence pointing towards its existence is present within the study. For example, the criticism levelled at tutorial staff indicates a concern felt by the respondents in respect of them being out of date due to a lack of involvement at the point of care delivery. It would seem that a more acceptable approach to teaching could occur if the role was redefined to that of teacher/practitioner. This would also offset the views expressed regarding the actual School of Nursing itself, and how for some it is a bolt hole into which they escape from the rigours of ward work. For others it represents a safe environment within which to study, but the general feeling of separateness of the school from actual practice is a point strongly emphasised by the sample, and the deleterious effect this could have on assessment validity is brought sharply into focus.

Modern trends in nurse education have created a requirement for there to be an identified mentor or facilitator for each student. This is to ensure that students always have a qualified member of staff to whom they can turn for teaching, role modelling and overall support. Staff shortage, and in some cases, malaise and apathy towards students were said to act against effective mentoring. The many variables which determine the quality of a learning environment are afforded degrees of priority depending upon the educational approaches advocated by respective training institutions. The idealistic notion of assessment being an enabling function is questioned especially by the many respondents who described the falsifying process which accompanies practical skills assessment. It was

the original intention for assessment to fit naturally into the daily ward/ department activities, and provide opportunities for the student's competence to be judged against the backcloth of normal activity. There can be little doubt in some cases, that the educational programme is primarily concerned with being successful through passing examinations and assessments. The student's nursing abilities are measured against the hidden agenda which gauges effectiveness on how quickly jobs get done, which it could be argued reflects the true realities of nursing.

Different learning environments operate at different speeds. Respondents spoke of the constant pressure associated with hospital wards which offer care facilities to multiply handicapped residents. They compared the activity levels with those experienced during the community placement where the pace of life was much slower and more deliberately inclined towards a normal style of life. The relationship between opportunities for learning and the speed at which students are expected to assimilate and operationalise nursing skills appears highly variable depending upon the nature of care and the needs of those being cared for. Paradoxically, the client group requiring a greater concentration of individual nursing attention is often those who get least. Educational and therapeutic skills which are taught in theory, do not always receive the practice under controlled conditions to enable assimilation to occur.

The practice environment within which assessments are conducted has the propensity for instability, and it becomes easy to appreciate why efforts are often made to bring some kind of order to the situation. At various points within this report reference has been made to the rigour of assessment, and the factors which influence the direction taken by assessors when applying predetermined criteria to a student's performance.

Because of the nature of mental handicap nursing, and the requirement for it to be practised in a wide variety of settings, the difficulty of reaching agreement between assessors regarding the principal nursing behaviours to be assessed is clearly evident. The literature suggests that inter-assessor agreement on the assessment of nursing skills is difficult to obtain. There is always the possibility of an unstable practice environment which may be due to staffing deficiencies, the client group itself, interpersonal relationships and attitudes. Allied to this will be the inevitable differences in attitudes, expectations and perceptions of the assessors. If the data obtained through this study are reflective of the situation generally, it would appear that a significant number of assessors engage in self centred approaches which have little to do with enabling learners to demonstrate their skills.

Of equal significance are the forms of knowledge and associated practice which assessors seek to measure during individual assessments. It is strongly suggested from within the data that certain key skills such as counselling and teaching are acquired primarily by virtue of experiential activities conducted within the School of Nursing. Much less credence is given to the practice environment being a major determinant in the development of these skills, and therefore the complexities and diversities inherent within them may never be truly explored through the medium of assessment. An effective assessor would not only observe the nursing activities, but also reach a conclusion on the deeper understanding of why these activities are representative of sound nursing practice. A lesser person would assess only the highly specific, observable behaviours, without taking account of the wider dimensions necessary for a complete understanding of a particular skill base.

There is a danger that students are being taught techniques rather than all round skills. An example can be found in the data relating to counselling, in particular the activities associated with listening and responding. These activities engage the student and client in a face to face situation which is intended to define a problem and determine some way towards its reduction. Applying the skills of listening and responding to every day practice will place the student in situations which vary uniquely from client to client. To acquire these skills mainly from classroom simulation will not fully equip the student to operate effectively in the real situation - supervised practice is essential. There is evidence of some respondents not being permitted to practise their counselling skills on clients, this being the province of qualified nursing staff. Yet if interpersonal relationship skills feature strongly in the curriculum, especially where health and sex education is concerned, it seems counter productive for actual practice to be denied. In those cases where 'real life' practice was not forthcoming the reasons given reflected a desire to protect the client from inexperienced staff.

It would seem that the respondents view themselves as therapeutic beings who counsel, help and support their clients subconsciously, and they say that this aspect of the mental handicap nurse's role is generic to whatever setting they are in. The professional uniqueness of any caring group is determined by the basic skills and the application these have to the respective client. Mental handicap nursing has adopted a whole range of interpersonal and helping skills, and along with an emerging community involvement, has begun to take on a role that has worth and value in a wider arena. In one single, important aspect this development is no different from others which determine the future role, as it will create a

need for teachers and assessors to stay in tune with the changes in order to maintain substance and relevance within the curriculum. Additionally, it will require learning environments to become more creative in the uses made of scarce resources to promote informed and appropriate care, as well as relevant learning opportunities for students.

Amongst the many facets of a learning environment identified by respondents, there exists a thread of inconsistency requiring further discussion. Teachers of nurses who, by definition are trained to provide a skilled facilitative service to students across the theory/practice spectrum, only seem to do so for 4% of the sample. Issues raised from this relate to the continuity between teaching, practice, and assessment of skills, there is also the notion of feedback to students from people concerned with their education and training. Students learn from different people in various settings, and this learning should eventually equip them to discharge their professional role in a competent fashion. The data highlight a major departure from the accepted theories of adult learning which emphasise the importance of frequent and positive feedback. Relationships between teacher and student should be maintained through regular contact both during the classroom and practice phases of the course. It is well recognised that nursing, because of its apprenticeship approach to learning, divorces the student from his/her teacher for long periods of time. The teaching role is devolved to others who may or may not have the necessary skills, thus perpetuating the inconsistencies so often observed between theory, practice and relevant feedback.

Practical skills assessment becomes caught up in this spiral of inconsistency when teachers, who for a major part of their time remain confined to the physical proximity of the School of Nursing, appear on a

ward, or community placement to conduct an assessment. The assessment should take account of current practice and local procedures as they apply to the specific area. Questions are immediately raised concerning the suitability of a teacher in this situation, especially one who is rarely seen outside the school building. Respondents took the opportunity to comment on this aspect of their training and some criticism was made. From the data it would seem that educational support in the practice area is not taken as a particularly serious part of the teacher's function, and the relationship between them and the practical assessors is an issue requiring further study. The questions to be asked would revolve around the need to give ongoing support to the qualified staff through a link tutor system, and the support given to students who fail to meet assessment criteria, or who are failing generally.

Models of Nursing and Practical Skills Assessment

Following the inception of the 1982 Syllabus for Mental Handicap Nursing there has been an increasing use made of established models of nursing as a means of giving substance to professional practice. This development was undoubtedly attached to the mandatory requirement of the syllabus to construct courses around the framework of the Nursing Process, which at the time was new and innovative. The English National Board issued detailed guidelines for practical assessment which closely followed the Nursing Process format of care. Subsequent events and new developments have outstripped this rather rigid systematic approach to the assessment, planning, implementation and evaluation of care. Individual Programme Planning (IPP) is now in vogue which, according to its users, is a more sensitive and flexible way of identifying need, and planning action on a personal basis. It is said to contain the necessary ingredients for a

dynamic approach to care and support, and these are referenced in Chapter 5.

First impressions would suggest that the data have provided strong evidence to support the premise that models of nursing and Individual Programme Planning can co-exist in a harmonious partnership. In turn, where this partnership is in being, there should be a fertile learning environment within which clients receive well supported care, and students are exposed to creative and consistent learning opportunities. Within such an environment skills can be assessed based on known theory and practice. There is a certain element of inconsistency regarding the models of nursing in current use within the Schools of Nursing used for this research, and also the extent to which they are fully understood and employed. A likelihood exists to suggest that models of nursing may be confused with the Nursing Process, thus the overwhelming response in the affirmative when respondents were asked to say whether IPP and models of nursing enjoyed mutual co-existence may reflect a false picture.

This picture may be further confused when consideration is given to the data which describe a situation completely at variance with the view postulated by the Royal College of Nursing regarding the appropriateness of certain models. The respondents who stated that nurse education in their particular environment was allied to a model of nursing, succeeding in giving a picture reflecting an approach to care based on the activities of daily living. To some people this would be construed as inappropriate because of the connections with clinical nursing and patient dependency.

The Royal College of Nursing has put its considerable weight behind the adoption of a model which emphasises interpersonal processes and the

encouragement of personal responsibility for improving ones quality of life. This model of nursing is the one attributed to Hildegard E Peplau (1952), and is centred on the therapeutic interaction which occurs when patient and nurse strive to build a creative relationship. The accentuation is upon total care environments which could include the client's family, and the community within which they live, and it is clear why the Peplau model is projected as the most suitable way forward for mental handicap nursing. The knowledge base supporting this approach encompasses a broad spectrum of understanding rooted in a wide range of disciplines which collectively form a complex network of care. To assess the practical abilities of students who are working to this model would present assessors with the task of identifying the extent to which the therapeutic interaction between nurse and client had occurred.

Practical skills assessment in this situation presents an infinitely more difficult task than in the more straightforward style of care represented by models dealing solely with activities of daily living. From the data generated by this study it is only possible to speculate why the Peplau interactive model did not feature at all in the responses. It is possible for the Schools of Nursing to have generally adopted a particular model and transferred it across the entirety of the curriculum. The Roper, Logan and Tierney model appears to be the most popular, followed closely by the Henderson model, both of which are widely used in general nursing clinical environments. It would seem from this study that a clinical emphasis continues to exert its effect on mental handicap nursing despite attempts to redirect the bias towards a social, interactive model.

Situated within this are the seeds of misunderstanding and inconsistency with respect to expectations held by students regarding their

actual role. Cognitive dissonance was experienced by some respondents who wished to jettison the title 'nurse' and adopt some other means of describing the job they do. However, it is nursing skills that require to be assessed, and these will be determined by whichever model is employed. In those instances where individual assessors have a particular interest in a model of nursing other than the officially adopted one, it becomes a possibility for there to be a clash of interests. The study has not disclosed any major conflict areas between the assessors and respondents, but there is a suggestion of assessors manipulating the situation to reflect personal attitudes and approaches rather than those held by the student.

This can also happen in reverse, students will come to an assessment with their own personal set of values and skills which have been gained through exposure to certain experiences. The thread which runs consistently throughout the data set is the intra group disagreement on many important issues, which is a symptom of variable learning environments, teacher influence, personal attitudes and past experience. For students to hold strong views on any topic is usually a healthy outcome of professional education, but when these views are opposed to those held by an assessor, some sort of compromise will usually result. Because this study has shown the extent to which disagreement on professional issues can occur, it reinforces the need for assessment to be a two way activity, with both parties prepared to respect the other point of view. This assumes even greater importance once continuous assessment becomes more firmly established. A clear example of where future difficulties may occur can be seen in the variable attitudes recorded in respect of the approaches to people with profound mental and physical handicaps. These attitudes formed

a continuum within two extremes, representing no hope on one end, to a highly positive outlook on the other. Faced with this spread of opinion, assessors cannot afford to adopt a dogmatic stance, especially when the curriculum itself is constructed on adult educational lines.

The Research Data and its Relevance to Continuous Assessment of Practical Nursing Skills

This study has highlighted a definite lack of relationship between what students say they require in terms of educational support, and what they believe they actually receive. The variation in theory/practice relationships across the curriculum in most cases, has a ripple effect embracing the assessment process, which places question marks against the accuracy of practical skills assessment. It is unlikely for there to be a wholly perfect assessment, but where discernible and serious gaps are present in a system, it is in the best interests of students and assessors to reduce these to manageable proportions. The data have clearly shown that respondents agree in the majority, that ward based assessments are not the most effective way of allowing students to display their skills. They also agree that continuous assessment would be a viable alternative to current methods, but this creates expectations on the part of students and assessors which may be difficult to meet unless educational staff provide the necessary support. The provision of support will only be realised if the teaching staff become allied with the practice areas and associated staff, in a way that is not evident from this research.

It is necessary to focus on a deeper realisation of what is involved especially as none of the respondents had experienced continuous assessment, which possibly means neither had their assessors. According to

the data, the best sort of assessment is one which promotes learning, and is therefore educative by nature. There is of course the dual role of assessment to take into account when making statements about its purpose in the curriculum, that is the assessment of fitness to practice, and also as an agent of learning. It creates a need for summative and formative aspects of assessment to be clearly identified as a means of satisfying both the legal and educational demands. In particular, formative assessment will encourage students to plan ahead, comment and discuss, and reflect on their activities, assisted by assessors, teachers, peers and others with whom they are in regular contact. For many, this approach will create difficulties because the data suggest that interaction at this level is not occurring generally. The impression is that reorientation towards the educational philosophy of continuous assessment will be necessary for present assessors. It should also be recognised that a system which continuously assesses theory and practice demands a level of sophistication on the part of students not previously expected. The modern trend is towards a practitioner who is reflective and proactive, and much of this can be promoted through sensitive and valid assessment. Personal and professional reflection is a skill not easily acquired, it will develop through practice and effective mentoring. An exciting part of being assessed is for students to have a substantial say in their own destiny through an exploration of the causes and effects of their practice. (Blanchard 1988) Curriculum development in the future will be directed towards a common foundation programme and relevant branch programmes. In the case of mental handicap nursing the transition will require redirection towards the preparation of a practitioner who is able to show competence in a multi-professional environment. The data suggest that attitudes are not always positive towards students when they are gaining experience in a

multi-professional placement area. Also it suggests that practical skills assessment within the community is hit and miss because of the difficulties experienced when trying to define the nature of these skills.

For example, the Cumberlege Report on Neighbourhood Nursing (1986) described a profile of skilled activities which are associated with case load management. Individually the activities attracted a high response rate of respondents who said they had been taught the skills relating to case load management. (The single exception to this are the skills associated with interviewing.) Because of the institutional nature of the courses undertaken by the sample, these skills were not all taught as part of the community experience, and in this situation it becomes necessary for transfer to take place. Skills are developed through rehearsal and feedback, and tested through assessment, which places great responsibility on all parties concerned with practitioner preparation. This responsibility is largely to do with creating an eclectic nurse capable of intelligent application of his/her skills across a whole range of situations. The outcome of this study reinforces the view that assessment of practical skills is not simply a mechanistic activity determined by immovable criteria. It is an interactive process whereby one human being appraises another in situations which have their own brand of uniqueness, and the research strongly argues for this process to be carried out on a continuous basis.

Preparation of Assessors

As nursing education moves towards the next stage in its evolution, the expectation will be for more local control over curriculum, and skills assessment. Training institutions will have to determine the priority

attached to certain facets of the courses they offer, and also decide on the most appropriate means through which knowledge and skills can be taught. For example, Kenworthy and Nicklin (1989) advocate the experiential approach to teaching and assessing. These authors have based their approach on the work of Steinaker and Bell (1979) who developed an educational taxonomy within which the student is central to his/her own learning. This example illustrates the inextricable relationship between teaching, learning and assessment. Curriculum models invariably determine the mode of assessment, and the example cited above illustrates the importance of assessors having a depth of understanding regarding the models used in their respective training institutions. Emphasis and choice regarding what counts, and more important, what doesn't count as appropriate knowledge and skills, will invoke a requirement for assessors to be fully conversant with local trends.

This study has produced evidence which raises questions regarding the preparation of assessors, and the maintenance of their skills. It also obliquely questions the means through which assessors are appraised and supported by their employers. The notion of validity and reliability of assessment is constantly brought into focus throughout the study, and the setting up of Regional networking systems would probably provide a forum for the collating and dissemination of information. Such a forum would offset the parochialism associated with locally organised assessments, through insights into what happens elsewhere. Project 2000 will redirect the learning process through a different, and unfamiliar route. The practice of mental handicap nursing will take its direction from Regional Strategic Plans, a consequence of which will involve training institutions making the optimum use of scarce resources for educational purposes. Fewer

centres offering mental handicap nurse education will create a need for long established custom and practice to be reviewed, and for assessors to be prepared from a Regional, rather than a local blueprint.

Recommendations

The application of research findings to practice often promotes new thought, and may be instrumental in bringing about organisational change. Data from this study have been acquired mainly through a student perspective, and represent a view of practical skills assessment from a consumer orientation. In making recommendations it is assumed that readers will accept the limitations of data obtained from a sample of 86 students representing nine training institutions. However, from the evidence there emerges a probability for the findings to have relevance on a wider scale, therefore it is reasonable to make recommendations with this in mind.

The recommendations are related directly to the research question, and make reference to assessor competence, the validity of practical skills assessment, the learning environment, and the expected relationship between knowledge and practice.

1. The framework offered by the Primary Skill Sets should be developed further and applied to the practice of mental handicap nursing. This will have the effect of consolidating a specific body of knowledge and skill uniquely arranged to satisfy the demands of nursing education within the specialist entity. It will create a sound framework from which valid and reliable schemes of practical skills assessment can grow in the future, and remove the uncertainty associated with deciding what to assess. Students will be provided

with a broad platform from which they can demonstrate their growing competence.

2. Assessors should be given every opportunity to update their own knowledge and skill through a Regional network of preparation and support. This will have the effect of reducing parochialism associated with locally based preparation, and ensure a higher degree of consistency in the methods and approaches employed by individual assessors.

   In the likelihood of shared training with social workers and the move to community care it becomes advisable to extend the preparation of new assessors, and the update of established ones, into a wider arena. The research identifies common principles relating to shared training, and these could form a basis for the development of a common language for practical skills assessment.

3. Further work is needed whereby this common language can be consolidated into an eclectic and acceptable model of care across the multi-professional spectrum.

4. As continuous assessment of knowledge and practice becomes the norm, self and peer assessment within the practice domain is encouraged. The adult approach to education should be reflected through assessment, and the evidence from this study suggests that more democracy could be introduced into the assessment process.

5. Research findings need to be given a higher profile within the mental handicap nursing curriculum, and further work is indicated to determine the availability of relevant research reports. This study

points to a general lack of comprehension of the nature of research and its place in professional development. This means doing research and appreciating the knowledge created by research. In the light of Project 2000 it becomes necessary for this anomaly to be rectified.

6. The teacher/practitioner role requires further development as a means of enhancing and stabilising the conditions under which knowledge and practice become a related whole. This would have the effect of adding greater validity and reliability to practical skills assessment.

7. A wider investigation into the models of care in current use within mental handicap nursing is indicated. The models in use will determine the direction along which theory and practice is being utilised, and when applied to practical skills assessment may create expectations which produce a clash of interests between the assessor and the assessed.

CRITIQUE OF THE STUDY

This study makes use of the questionnaire and interview approach to data collection and analysis which by definition places the researcher in an interpretive position. From the outset it is well documented that research of the type used in this study makes no claims to categorical objectivity and generalizability. It places emphasis on personal attitudes and opinions and attempts to locate these within the wider structural features of the culture under investigation. In applying a description of this nature it is clear that whenever personal attitudes and opinions are central to the study there will always be inadequate pictures drawn, and incomplete conclusions made about the data.

The usefulness of the findings as a precursor to extensive change within a given system must be carefully evaluated before any action is forthcoming. For example, throughout the entire data set not only do differences occur across the spectrum of institutions used in the survey, but noticeable variations exists in respect of responses from within each institution. This signifies that caution is necessary when reaching some kind of judgement about the worth of the data, especially as educational institutions and teachers seem to differ in their effectiveness. (Gray, J and Jones B 1985).

The main sample for this study came from nine nurse training institutions each having its own culture and standards. In addition, a small number of respondents were on a lengthy secondment from a State security hospital to one of the institutions used in the research. This mix gives the study a certain amount of richness, but it also makes generalisation of the data rather difficult. The study does attempt to

reach some general conclusions based on the data analysis but it is recognised that reasons exist to suggest that no categorical truths can be claimed.

Data Collection

An eclectic approach to data collection was employed as a means of reducing subjectivity and increasing the validity of the research. This study has made use of a triangular approach as a way of providing a multi-dimensional picture of the subject area under investigation. The angles of approach principally employed were a preliminary study of views taken from a group of assessors, a pilot study, and a main bank of three questionnaires each of which sought different yet related data concerning skill assessment and its relationship to the training and education of nurses caring for people with mental handicap. The main bank of questionnaires were supported by a series of follow up group interviews. The interviews were carried out using a schedule derived from the questionnaire data, thus providing a comprehensive picture from which conclusions could be drawn.

The main questionnaires took their direction from the preliminary study, a literature review, and a detailed analysis of the role of the mental handicap nurse. Through reviewing the literature it became evident that British literature on the subject of practical assessment was scarce, and therefore a reliance had to be placed on foreign material especially American and Canadian. It is unlikely that this affected the research validity, as much of what was found agreed with the available British literature. It seems that the problems associated with student assessment are universally similar.

Collectively, the main bank of questionnaires surveyed the subject initially from a wide angled approach to the skill base underpinning competence, and eventually narrowing down to the specifics of assessment. It was anticipated that this would give the study depth and breadth of curricular information upon which conclusions regarding practical assessment could be located. What occurred in practice reflected something different, because the problem which occasioned the research turned out to be only one of a number of problems addressed by the data. Whilst these additional problems carried relevance to the research title they provoked discussion within the report which hitherto had not been anticipated. In particular the emergence of a new taxonomy of skill is arguably of greater significance than the principal thrust of the research.

The questionnaire design reflected a wish to provide opportunities for respondents to give a measured account of their strength of feeling towards certain factors. This was achieved through using a mixture of Likert type response scales and open questions. Overall this seemed to work satisfactorily but an alternative design of questionnaire making greater use of open questions may have yielded a richer source of data. This would have presented additional difficulties in the coding and interpretation of the data but it would have been beneficial to the final outcome of the report. An over reliance on the Likert type response scale can limit the ways in which the data are reported, and it was through a realisation of this that the value of follow up interviews became apparent.

The Interviews

In this particular study the interviews provided insight into both the overt and covert factors which determine the educational culture within which students work, learn and are assessed. The interviews were used as a means of giving an extra dimension to the data taken from the questionnaires, and in this respect they fit the common sense tradition of Powney and Watts (1987) in that research interviews are a relatively unproblematic means of gathering information. True, the mechanics of the interviews were straight forward. No one refused to be interviewed, access was granted readily, and accommodation with an appropriate power supply for the tape recorded was provided in each case. Problems of a moral nature exist when one questions the means through which interviewees are directed into addressing the requirements of the researcher. In this case the researcher by virtue of his professional standing represented authority, and despite efforts to minimise this it possibly inhibited the extent to which interviewees gave their true opinions on questions which provided openings for them to be critical of their training. For some however, it represented a golden opportunity for giving vent to things which displeased them. On one occasion a member of staff asked permission to sit in on the interviews. The reason for this was not clear, and eventually she was persuaded to leave on the basis that her presence would inhibit and restrict the students to the point where the data would probably have been unusable.

Another major issue concerning the researcher's influence is highlighted by Tomlinson (1989) when he describes how the social influence set up by the narrow pursuance of an interview schedule may create unawareness of the non-verbal messages and reactions coming from the

interviewees. Yet on the other hand to overdo the facilitative function may leave interviewers short of the time necessary to complete their agenda. As Tomlinson points out, for research interviewing to function effectively it requires to attend to both aspects. He states:

> 'Whatever the eventual aim of research interviewing in a particular case, by its nature as a "conversational encounter to some purpose" as Powney and Watts (1987) nicely put it, it does so by way of eliciting cognitive resources.' (page 157)

The interviews revolved around a specific schedule controlled by the interviewer. A time limit was imposed for the main purpose of reducing irrelevant small talk and keeping everyone, including the interviewer to the agenda. Having a time limit also reduced the amount of transcribing which is enormously consuming of time and money. These practical considerations must have affected the outcomes of the interviews, possibly in a positive manner. Despite these constraints it was possible to identify material which represented the hidden agenda of the interviews, so it would seem that some degree of balance was achieved.

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APPENDIX I : EXAMPLES OF PRACTICAL ASSESSMENT CRITERIA

NURSE EDUCATION CENTRE

TEST RECORD

'A'

Name of Student ..... Index No. .....

Month of Course ..... Date of examination .....

General Aim: To asess the performance of the student in the implementation of Nursing Care, according to an agreed 'Care Plan' relating to the needs of ONE individual throughout A DAY.

Test Preparation Information and Interview:

Relative Comments by Examiner:

Examiner's Signature .....

Student's Signature .....

Examiner's

Observation Record Details

	Period of Observation	Subjects Area and Comments
Implementation Nursing Care Plan		

EVALUATION SPECIFICATIONS

ITEM	SATISFACTORY GRADE	COMMENTS
1. Utilisation of Resources		
2. Provision of Care		
3. Psycho-Social		
4. Educational		
5. Occupational & Recreational		
6. Communication		

	PASS	REFER	FAIL
FINAL OVERALL GRADING			

Any ONE major area within the test considered to be below standard will constitute referral procedure.

Final Interview Marks;

I DO CLEARLY UNDERSTAND THAT SHOULD I FAIL AS ASSESSMENT FOR THE THIRD AND FINAL TIME THIS WILL RESULT IN MY AUTOMATIC DISCONTINUATION FROM NURSE TRAINING.

Signature of Student .....:. Name of Examiner: .....

Date: ..... Signature of Examiner .....

NURSE EDUCATION CENTRE

TEST RECORD

'B'

Name of Student ..... Index No. .....

Month of Course ..... Date of examination .....

General Aim: To assess the performance of the Student Nurse in:-

(a) Planning an aspect of Nursing Care for a chosen individual to be implemented over ONE WEEK.

(b) Implementing

(i) this planned Nursing Care;
(ii) other planned Nursing Care for the chosen individual
(iii) Nursing Care for other individuals where relevant.

(c) Evaluating the effectiveness of the specified aspect of Nursing Care delivered to the chosen individual.

Test preparation Information and Interview:

Relative comments by Examiner:

Care Review Date: .....

Aspect Identified for Test:

Examiner's Signature .....

Support Examiner's Signature .....

Student's Signature .....

EVALUATION SPECIFICATIONS

ITEM	SATISFACTORY GRADE	COMMENTS
'A' Planning Care		
(a) Formulation		
(b) presentation		
'B' Implementation of Care		
(1) Utilisation of Resources		
(2) Provision of Care		
(3) Psycho-Social		
(4) Educational		
(5) Occupational & Recreational		
(6) Communication		
'C' Evaluation of Care		

	PASS	REFER	FAIL
FINAL OVERALL GRADING			

Any ONE Major area within the test considered to be below standard will constitute referral procedure.

Final Interview Remarks.

I DO CLEARLY UNDERSTAND THAT SHOULD I FAIL AN ASSESSMENT FOR THE THIRD AND FINAL TIME THIS WILL RESULT IN MY AUTOMATIC DISCONTINUATION FROM NURSE TRAINING.

Signature of Student: .....:.... Name of Examiner .....

Date: ..... Signature of Examiner: .....

Date: .....

In the event of unforseen circumstnaces whereby a replacement Examiner is required, accepting all conditions of the test to date. In the first instance, authority can only be given by the Senior Nurse Education in writing. Secondly, permission must also be given by the student in writing. thirdly, acceptance in writing by the replacmeent examiner.

Senior Nurse Education	Student Nurse	Examiner No. 2
.....	.....	.....

Examiner's Daily

Observation Record Details

	Dates	Times: From/To	Comments
Planning Care			
Implementation of Care			
Evaluation of Care			

✓ Below when satisfactorily completed

Planning Care	Implementation of Care	Evaluation of Care

NURSE EDUCATION CENTRE

TEST RECORD

'C'

Name of Student ..... Index No. .....

Month of Course ..... Date of Examination .....

General aim: To assess the performance of the Student Nurse over an optimum period of THREE WEEKS, up to a maximum of FOUR WEEKS in:-

(a) Assessing and Planning the nursing care required to meet the needs of a chosen individual.

(b) Implementing for a minimum of TWO WEEKS within the maximum allowed period:

(i) the individuals planned nursing care;

(ii) also the nursing care planned for other individuals where relevant.

(c) Evaluating the effectiveness of the care given to meet the needs of the chosen individual.

(d) Assessment of competency in the care and administration of drugs, together with a full understanding of the legal requirements. This will be assessed throughout the agreed time of this test.

Test preparation Information and Interview:

Relative Comments by Examiner:

Examiner's Signature: .....

Support Examiner's Signature: .....

Student's Signature: .....

EVALUATION SPECIFICATIONS

ITEM	SATISFACTORY GRADE	COMMENTS
'A' Assessment/Planning Information		
a) Indication of Client's needs		
b) Sources of		
c) Methods of obtaining		
d) Verification		
e) Communication		
f) Analyse and Interpretation		
'B' Implementation of Care		
'C' Evaluation		
'D' a) Administration of medication procedure		
b) Knowledge of Drugs		
c) Legal requirements (Relevant Acts).		

	PASS	REFER	FAIL
FINAL OVERALLL GRADING			

Any ONE major area within the test considered to be below standard will constitute referral procedure.

Final interview remarks

I DO CLEARLY UNDERSTAND THAT SHOULD I FAIL AN ASSESSMENT FOR THE THIRD AND FINAL TIME THIS WILL RESULT IN MY AUTOMATIC DISCONTINUATION FROM NURSE TRAINING.

Signature of Student ..... Name of Examiner .....

Date: ..... Signature of Examiner .....

Date: .....

In the event of unforseen circumstances whereby a replacement Examiner is required, accepting all conditions of the test to date: In the first instance, authority can only be given by the Senior Nurse Education in writing. Secondly, permission must also be given by the student in writing. Thirdly, acceptance in writing by the replacement examiner.

Senior Nurse Education	Student Nurse	Examiner No.2
.....	.....	.....

EVALUATION SPECIFICATIONS

ITEM	SATISFACTORY GRADE	COMMENTS
'A' Assessment/Planning Information		
a) Indication of Client's needs		
b) Sources of		
c) Methods of obtaining		
d) Verification		
e) Communication		
f) Analyse and Interpretation		
'B' Implementation of Care		
'C' Evaluation		
'D' a) Administration of medication procedure		
b) Knowledge of Drugs		
c) Legal requirements (Relevant Acts).		

	PASS	REFER	FAIL
FINAL OVERALLL GRADING			

Any ONE major area within the test considered to be below standard will constitute referral procedure.

Final interview remarks

I DO CLEARLY UNDERSTAND THAT SHOULD I FAIL AN ASSESSMENT FOR THE THIRD AND FINAL TIME THIS WILL RESULT IN MY AUTOMATIC DISCONTINUATION FROM NURSE TRAINING.

Signature of Student ..... Name of Examiner .....

Date: ..... Signature of Examiner .....

Date: .....

In the event of unforseen circumstances whereby a replacement Examiner is required, accepting all conditions of the test to date: In the first instance, authority can only be given by the Senior Nurse Education in writing. Secondly, permission must also be given by the student in writing. Thirdly, acceptance in writing by the replacement examiner.

Senior Nurse Education	Student Nurse	Examiner No.2
.....	.....	.....

Examiner's Daily

Observation Record Details

	Dates	Times: From/To	Comments
ASSESSMENT			
PLANNING CARE			
IMPLEMENTATION OF CARE			

✓ Below when satisfactorily completed:

Assessment	Planning Care	Implementation of Care

Continued .....

Examiner's Daily

Observation Record Details

	Dates	Times: From/To	Comments
EVALUATION OF CARE			
ADMINISTRATION AND CARE OF MEDICATION			

✓ Below when satisfactorily completed:

Evaluation of Care	Administation and Care of Medication

NURSE EDUCATION CENTRE

TEST RECORD

'D'

Name of Student ..... Index No. .....

Month of Course ..... Date of Examination .....

General Aim: to assess the student nurse's performance, over a period of TWO WEEKS in:-

(a) Co-ordinating the care within the framework of existing care plans, for aspects of care for a group of 4-6 individuals.

(b) Organising and supervising the care team in the provision of care for these individuals.

(c) Implementing care for these, and other individuals where relevant.

(d) Evaluating the effectiveness of the nursing care delivered to the group of 4-6 individuals.

(e) Teaching (related subjects of mental handicap care).

Test Preparation Information and Interview:

Identified Teaching Programme:

Relative Comments by Examiner:

Examiner's Signature .....

Support Examiner's Signature .....

Student's Signature .....

EVALUATION SPECIFICATIONS

ITEM	SATISFACTORY GRADE	COMMENTS
'A' Co-ordinating Care		
'B' Organising		
'C' Implementation of Care Plans		
'D' Evaluation of Care		
'E' Teaching		

	PASS	REFER	FAIL
FINAL OVERALL GRADING			

Any ONE Major area within the test considered to be below standard will constitute referral procedure;

Final Interview Remarks:

I DO CLEARLY UNDERSTAND THAT SHOULD I FAIL AN ASSESSMENT FOR THE THIRD AND FINAL TIME THIS WILL RESULT IN MY AUTOMATIC DISCONTINUATION FROM NURSE TRAINING.

Signature of Student ..... Name of Examiner .....

Date ..... Signature of Examiner .....

Date .....

In the event of unforseen circumstances whereby a replacement examiner is required, accepting all conditions of the test to date: In the first instance, authority can only be given by the Senior Nurse Education in writing. Secondly, permission must also be given by the student in writing. Thirdly, acceptance in writing by the replacement examiner.

Senior Nurse Education	Student Nurse	Examiner No. 2
.....	.....	.....

APPENDIX II : ASSESSOR'S QUESTIONNAIRE

LEARNER ASSESSMENT - MENTAL HANDICAP NURSING

The following questions are intended to seek the views of experienced qualified RNMH nurses concerning the assessment of student nurses' practical competence. It is also intended to ask your opinion of current 'Art of Examining' courses and their relevance to the new practical tests.

The data gained from this exercise will be used in the development of detailed research instruments. These instruments are to be used for investigating the value of practical assessment, its validity and reliability, and the value of preparatory courses for assessors.

PLEASE ENTER YOUR DESIGNATION HERE 1-2
(eg Charge Nurse, Ward Sister, Tutor etc)

PLEASE ANSWER THE QUESTIONS BY PLACING A TICK AT THE SIDE OF THE APPROPRIATE RESPONSE.

1. Do you feel that student nurse training is **PRIMARILY** concerned with passing examinations?

YES	NO	NO OPINION	3
1	2	3	

2. Do you feel that practical assessment by ward staff is the most effective way of measuring learner competence?

YES	NO	NO OPINION	4
1	2	3	

3. Should learners be encouraged to plan and carry out their own self assessment?

YES	NO	NO OPINION	5
1	2	3	

4. Do you believe that continuous practical assessment is a viable alternative to the method currently in use?

YES	NO	NO OPINION	6
1	2	3	

5. In the main are learners adequately prepared to undertake their practical assessments?

YES	NO	NO OPINION	7
1	2	3	

6. Is nurse training in your particular school based on a specific model of nursing?

YES	NO	NO OPINION	8
1	2	3	

If you answer **YES** to Question 6 please say which model is in use:

7. Are care studies used as a means of practical assessment in your particular School of Nursing?

YES	NO	NO OPINION	9
1	2	3	

8. Are specific skills associated with observation taught in your particular School of Nursing?

YES	NO	NO OPINION	10
1	2	3	

If you answer **YES** to Question 8 please say what these skills are:

9. Do prestated behavioural objectives influence your personal teaching style?

YES	NO	NO OPINION	11
1	2	3	

10. Do you find that practical assessments fit naturally and realistically into daily ward activities?

YES	NO	NO OPINION	12
1	2	3	

11. Have you attended an 'Art of Examining' course?

YES	NO	NO OPINION	13
1	2	3	

If your answer to Question 11 is **NO** thank you for your help, the Questionnaire is now completed.

12. If the answer to Question 11 is **YES** do you feel adequately prepared to carry out the task of practical assessment?

YES	NO	NO OPINION	14
1	2	3	

13. Have you ever referred a learner in a practical assessment?

YES	NO	15
1	2	

If the answer to Question 13 is **YES** please describe your feelings at the time.

THANK YOU FOR YOUR HELP.

PETER BIRCHENALL

PLEASE ADD ANY COMMENTS OR INFORMATION BELOW:

APPENDIX III

MENTAL HANDICAP NURSING : STUDENT ASSESSMENT

A REVIEW OF THE OPINIONS OF 43 EXPERIENCED QUALIFIED NURSES

		YES	NO	NO OPINION	NO ANSWER
Q1.	Do you feel that student nurse training is primarily concerned with passing examinations?	34.9% 15	65.1% 28	0	0
Q2.	Do you feel that practical assessment by ward staff is the most effective way of measuring learner competence?	48.8% 21	41.9% 18	7% 3	2.3% 1
Q3.	Should learners be encouraged to plan and carry out their own self assessment?	81.4% 35	16.3% 7	2.3% 1	0
Q4.	Do you believe that continuous practical assessment is a viable alternative to the method currently in use?	86% 37	9.3% 4	2.3% 1	2.3% 1
Q5.	In the main are learners adequately prepared to undertake their practical assessments?	74.4% 32	23.3% 10	2.3% 1	0

		YES	NO	DON'T KNOW	NO ANSWER
Q6.	Is nurse training in your particular school based on a specific model of nursing?	34.9% 15	44.2% 19	18.6% 8	2.3% 1
Q7.	Are care studies used as a means of practical assessment in your particular school?	55.8% 24	39.5% 17	2.3% 1	2.3% 1
Q8.	Are particular skills associated with observation taught in your particular school?	41.9% 18	21% 9	32.5% 14	4.6% 2

		YES	NO	NO OPINION	NO ANSWER
Q9.	Do prestated behavioural objectives influence your personal teaching style?	51.2% 22	39.5% 17	4.7% 2	4.7% 2
Q10.	Do you find that practical assessments fit naturally and realistically into the daily ward activities?	48.8% 21	48.8% 21	0	2.3% 1
Q11.	Have you attended an 'Art in Examining' course?	90.7% 39	9.3% 4	0	0

		YES (N = 39)	NO	NO OPINION	INELIGIBLE
Q12.	If the answer to Question 11 is YES do you feel adequately prepared to carry out the task of practical assessment?	82.1% 32	17.9% 7	0	4
Q13.	Have you ever referred a learner in a practical assessment?	61.5% 24	38.5% 15	0	4

RESEARCH QUESTIONNAIRES

BIOGRAPHICAL DATA

The data collected from the questionnaires will be collated under predetermined headings. Cross referencing will include a number of important variables relating to your personal biographical profile. You are invited to provide such a profile by answering the questions below.

Please feel under no obligation to answer any questions should you consider it to be inappropriate.

OFFICE USE ONLY

IDENTITY

v1 Place of employment 1-3

v2 Your current status .....

v3 **AGE** **Please Circle**

18 - 21	1
22 - 29	2
30 - 39	3
Over 39	4

4

v4 **SEX**

Male	1
Female	2

5

v5 **PREVIOUS JOB EXPERIENCE** Please state below the nature of previous employment

6

v6 **OTHER NURSING QUALIFICATIONS** Please list below

7-8

v7	MARITAL STATUS	Please Circle	
	Married	1	
	Single	2	
	Widowed	3	9
	Divorced/Separated	4	
	Refuse to Answer	5	

v8	CHILDREN	Please Circle	
	YES	1	10
	NO	2	

FOLLOW-UP INTERVIEW

It may be advisable to clarify certain aspects related to the overall responses. Should this be the case may I interview you at a later date?

YES

NO

If you answer 'YES' please indicate below your name and where you can be contacted.

Thank you.

THE QUESTIONNAIRE BANK

Questionnaire One

Providing a Skill Base for the Development of Nursing Competence

Questionnaire Two

The Development of Nursing Skills

Questionnaire Three

Assessment of Practical Nursing Skills

QUESTIONNAIRE ONE

Providing a Skill Base for the Development of Nursing Competence

Please consider the following 13 statements and indicate the strength of your agreement or disagreement with each by circling the number that reflects most closely your own opinion. There are, of course, no right or wrong answers - only a range of equally valid opinion.

		Strongly Agree	Agree	Disagree	Strongly Disagree	OFFICE USE ONLY
1. (v9)	**Special** nursing skills are an essential feature of mental handicap nursing.	4	3	2	1	11
	If your response indicates a measure of agreement with Statement 1, please indicate below some of the more explicit skills involved.					
2. (v10)	The theoretical aspects of my course were not always relevant to the practical situation.	4	3	2	1	12
3. (v11)	During my practical placements there have been times when I was expected to carry out skilled activities not underpinned by the theoretical content of the course (eg behaviour modification).	4	3	2	1	13
	If your response indicates a measure of agreement with Statement 3, please indicate below the nature of these activities.					

		Strongly Agree	Agree	Disagree	Strongly Disagree	OFFICE USE ONLY
4. (v12)	During my course sufficient emphasis has been given to the **integration** of theory and practice.	4	3	2	1	14
5. (v13)	Modern care practices demand that RNMH qualified nurses have a substantial profile of skill in community, educational, and therapeutic aspects of care.	4	3	2	1	15
6. (v14)	The essential framework of care offered by the Nursing Process was a feature of your course.	4	3	2	1	16
7. (v15)	Individual care planning based on an appropriate model of nursing is encouraged within the school of nursing.	4	3	2	1	17
8. (v16)	The theory and practice of care associated with normalisation and independent community living featured prominently in my course.	4	3	2	1	18
9. (v17)	Health education and sex education for people with mental handicap featured strongly in my course.	4	3	2	1	19
10. (v18)	Community, educational and therapeutic aspects of care featured largely in my course.	4	3	2	1	20
11. (v19)	Individual care planning based on an appropriate model of nursing is not encouraged within the service area (including the community).	4	3	2	1	21
12. (v20)	It would be advantageous for mental handicap nursing and social work to share common elements in basic training.	4	3	2	1	22
	If your response indicates a measure of agreement with Statement 12, please indicate below the nature of these common elements					

There are several basic skills associated with **case load management**, six of the most important are presented in Question 13 a-f. Please indicate your strength of agreement with the overall statement in Question 13 for each of the basic skills.

13. My course has **not** equipped me with the following skills:

		Strongly Agree	Agree	Disagree	Strongly Disagree	OFFICE USE ONLY
a) (v21)	Interviewing skills.	4	3	2	1	23
b) (v22)	Setting aims and objectives for care.	4	3	2	1	24
c) (v23)	Planning and determining priorities for care.	4	3	2	1	25
d) (v24)	Counselling - listening and responding.	4	3	2	1	26
e) (v25)	Reviewing outcomes of nursing action.	4	3	2	1	27
f) (v26)	An understanding of family dynamics.	4	3	2	1	28

END OF QUESTIONNAIRE ONE

Please proceed to questionnaire TWO. Read the instructions carefully before responding to the statements.

QUESTIONNAIRE TWO

The Development of Nursing Skills

Please consider the following 24 statements which relate directly to the development of mental handicap nursing skills. The responses required of you are varied and you should read the instructions carefully before indicating your feelings towards the statements.

For your added information the basic elements of skill development are listed below, and it is from these elements that this section of the questionnaire has been devised.

a) Skilled nursing involves a complex organisation and co-ordination of many differing activities.

b) A skilled nursing performance is dependent on feedback from a variety of sources.

c) Nursing skills become more accurately and smoothly performed with suitable practice, ideally under supervision.

---

i) **PLEASE RESPOND TO THE FOLLOWING QUESTIONS BY CIRCLING THE RELEVANT NUMBER**

ii) **SEVERAL OF THE QUESTIONS MAY REQUIRE AN ADDITIONAL RESPONSE FROM YOU. SPACE HAS BEEN ALLOCATED, WHERE APPROPRIATE, FOR THIS PURPOSE**

FOR OFFICE USE ONLY

1. (v27) Have your tutors taught you the theory of skill development?

YES	1	
NO	2	29
DON'T KNOW	3	

If 'YES' would you please describe an example of skilled mental handicap nursing involving several related activities.

FOR OFFICE USE ONLY

2. (v28) Have your tutors emphasised the importance of practising skills under qualified supervision?

YES	1	
NO	2	30
DON'T KNOW	3	

3. (v29) During your **hospital practical** placements from whom did you **most frequently** receive positive/helpful feedback regarding your skill development? (Circle one number only)

Teaching staff from the school of nursing	1	
Qualified nursing staff from the ward	2	
Unqualified care staff	3	31
Qualified staff (other than nurses) please specify	4	
I did not receive any feedback regarding my skill development	5	

FOR OFFICE USE ONLY

4. (v30) During your **community practical** placements from whom did you **usually** receive positive/helpful feedback regarding your skill development? (Circle one number only)

Teaching staff from the school of nursing	1	
Qualified community mental handicap nurses	2	
Qualified (non-mental handicap) nurses	3	32
Unqualified care staff	4	
Qualified staff (other than nurses) please specify	5	
I did not receive any feedback regarding my skill development	6	

5. (v31) During your practical placements have you **for most of your time** been placed in care situations which enabled you to practise your nursing skills under qualified supervision?

YES	1	
		33
NO	2	

If **'NO'** please give brief details in the space below.

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6. (v32) Mental handicap nursing involves teaching self help skills to residents. Do you feel that you have the teaching ability to adequately meet the requirements of individually designed programmes for your residents?

YES	1	34
NO	2	
NOT SURE	3	

7a) (v33) If you answered **'YES'** to question 6 please indicate below those teaching skills which you consider to be **most** important.

35

7b) (v34) If you answered **'NO'** or **'NOT SURE'** to question 6 please indicate below where you feel deficient in respect of your teaching ability.

36

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8. (v35) Logical thinking and problem solving abilities are essential ingredients for independent living. Please circle the appropriate response.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	
5	4	3	2	1	37

9. (v36) Do you believe that profoundly mentally handicapped people can develop the skills required for logical thought and problem solving?

YES	1	38
NO	2	

(v37) If you answer **'YES'** please describe below how you feel this can be achieved. 39 (Yes)

(v38) If you answer **'NO'** please describe below why you feel this way. 40 (No)

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10. (v39) Do you feel that **ALL** profoundly mentally handicapped people are capable of achieving some measure of independence?

YES	1	41
NO	2	

(v40) Please justify your answer below. 42
(v41) (Yes) 43 (No)

11. (v42) For people to achieve independence they require good role models. Have you been taught the skills of role modelling?

YES	1	44
NO	2	

12. (v43) People with learning difficulties may find it hard to form relationships, and therefore express a need to be involved in planned and unplanned interactive situations.

Did your course make you aware of this?

YES	1	45
NO	2	

13. (v44) If **'YES'** how was this achieved? (Please use the space below for your answer.) 46

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14. (v45) Have you been taught the skills of listening and responding to individual's perceived needs.

YES 1

NO 2

47

15. (v46) If **'YES'** how was this achieved? (Please use the space below for your answer

48

16. (v47) Working with others in a multi professional team calls for the skills of leadership.

Were you taught these skills during your course?

YES 1

NO 2

49

17. (v48) If **'YES'** how was this achieved? (Please use the space below for your answer.)

50

18. (v49) Have you been taught the skills of 'profiling'?

YES 1

NO 2

51

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19. (v50) If **'YES'** how was this achieved? (Please use the space below for your answer.)

52

20. (v51) Have you been involved as a member of a case conference?

YES 1

53

NO 2

21. (v52) If **'YES'** describe below what this experience gave you in terms of understanding the nursing role.

54

22. (v53) Were valid research findings used in your course to underpin practical skills development eg the skills of behaviour modification?

YES 1

55

NO 2

23. (v54) Skills, knowledge and values in mental handicap nursing are inter-related. Has this approach been taken in your professional development?

YES 1

56

NO 2

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24. (v55) Is nurse education in your particular school based on a specific model of nursing?

YES	1	
NO	2	57
DON'T KNOW	3	

If you answer **'YES'** to question 24 indicate which model is in use from the list below. (Please circle the appropriate number(s).)

(v56)	Roper, Logan and Tierney	1	58
(v57)	Peplau	2	59
(v58)	Henderson	3	60
(v59)	Roy Adaptation	4	61
(v60)	Rheil	5	62
(v61)	King Interaction	6	63
(v62)	Orem	7	64
(v63)	Other - Please specify	8	65

END OF QUESTIONNAIRE 2

Please proceed to QUESTIONNAIRE 3

QUESTIONNAIRE THREE

Assessment of Practical Nursing Skills

Please consider the following 19 **statements** and indicate the strength of your agreement or disagreement with each by circling the number that reflects most closely your own opinion. As in previous sections there are no right or wrong answers - only a range of equally valid opinion.

		Strongly Agree	Agree	Disagree	Strongly Disagree	OFFICE USE ONLY
1. (v64)	Nurse education is **PRIMARILY** concerned with passing examinations.	4	3	2	1	66
2. (v65)	Practical assessment by ward staff is **NOT** the most effective way of measuring learner competence.	4	3	2	1	67
3. (v66)	Continuous practical assessment is **NOT** a viable alternative to the ward based tests.	4	3	2	1	68
4. (v67)	Practical assessments usually fit naturally and realistically into the daily work activities.	4	3	2	1	69
5. (v68)	Assessors appear to be well prepared for their role.	4	3	2	1	70
6. (v69)	Practical assessment usually reflects the attitudes and approaches to care held by the assessor, rather than enabling learners to demonstrate their individual skills.	4	3	2	1	71
7. (v70)	Each of your practical assessments have identified strengths as well as weaknesses in your nursing skills.	4	3	2	1	72
8. (v71)	Personal values cannot be adequately measured through ward based practical assessment.	4	3	2	1	73
9. (v72)	You are always encouraged to voice your opinions regarding practical assessment.	4	3	2	1	74
10. (v73)	Care studies are used in your school of nursing as one of the means by which practical assessment is achieved.	4	3	2	1	75

	Strongly Agree	Agree	Disagree	Strongly Disagree	OFFICE USE ONLY
11. (v74) Practical assessment is a worthwhile learning experience.	4	3	2	1	76
12. (v75) Practical assessment is heavily biased towards hospital rather than community care.	4	3	2	1	77
13. (v76) Practical assessment should concentrate only on psychomotor skills.	4	3	2	1	78
	Always	**Sometimes**	**Rarely**	**Never**	
14. (v77) Ward reports constantly gave an accurate reflection on my abilities.	4	3	2	1	79
15. (v78) In the main, I was adequately prepared to undertake practical assessments.	4	3	2	1	80
16. (v79) I was encouraged to plan and carry out self assessment.	4	3	2	1	81
17. (v80) My practical assessments provided ample opportunities to express a wide range of skills.	4	3	2	1	82
18. (v81) My practical assessments were primarily concerned with **relevant** nursing knowledge.	4	3	2	1	83
19. (v82) Prior to an assessment, I was aware of the actual skills to be assessed.	4	3	2	1	84

You have now completed the 3rd and final questionnaire. May I thank you for agreeing to participate in this research.

Peter Birchenall
Post-Graduate Student
University of Hull

APPENDIX V

SCHEDULE FOR FOLLOW UP INTERVIEWS

1. Respondents were asked to describe how they viewed the School of Nursing. For example, was it a place set apart from the practice area, and dealt only with theory? Did they have any opinions on the practice area being an integral part of the School of Nursing?

   How would they describe their course of study - was there a direct relationship between theory and practice?

2. Will existing skills acquired during the training period require modification to meet future needs? For example, working in community settings as opposed to working within an institutional environment.

3. How were community, educational, and therapeutic skills assessed in practice?

4. How do assessors differ in relation to their styles and expected standards? Did these differences affect performance during assessment?

5. Please describe in detail how your teaching and counselling skills were assessed.

6. Please describe the means through which you acquired your teaching skills.

7. Does the Nursing Process offer any relevance to today's service?

These areas for questioning were intended to provide a spring board, and other issues arose which provoked discussion. The interviews were recorded, transcribed and used to illustrate the data taken from the questionnaires.

APPENDIX VI

GROUP INTERVIEW 1

PB To go back to that first question, just how do you understand the meaning of School of Nursing, what does it mean to you. Who is going to start?

To me, the School of Nursing is a base, I go out to the various placements, but I go from the School of Nursing and always come back to it and it is also a place where there is somebody to talk to where we are taught things, its a bit of a lifeline really.

PB Anyone want to add to that?

I see it as a resource centre as well, where any information that you require you can gain.

PB So basically then we have got a lifeline and a resource centre, what else is it?

Its a place of ongoing education as well, if there are things that we want a bit like a resource centre, but also after we have qualified to be a place to carry on our education.

PB Yes alright, so do you see it as a building or a place separate from the practice areas, what do you think?

I see it as separate from the practice areas, because sort of for us it is really. It is different for us because we have this Nurse Education Centre here, but there is also the School of Nursing in the town and we have the two, if we were in town I would see us as separate from the areas we work. I think the School should be a safe environment as well for us to kind of

talk about how we feel you know, sometimes we can't do that in the practice areas and I think the School should be a safe environment to do that in.

PB Yes. What about the course of study which you have nearly finished, what do you understand now when you look back over that time? What has it meant to you?

You mean predominantly it has been following a set syllabus (yes) although I think it has also provided areas where we can branch out and explore perhaps issues not covered in the syllabus as well. Our course of study has been quite all embracing of a lot of different areas as well as the ones laid down in the syllabus.

PB Can I prompt you and ask you whether or not what has just been said applies to each and everyone of you, is that how you all understand it?

I think I would agree with that.

Yes I think I would

PB Can we look at it in some more depth? A few minutes ago you said that the School of Nursing was set apart, was a building with resources and people in it that was set apart just for a certain purpose from service, from the actual wards and from the community service. Do you think that the course of study has that definition also?

No, I think it also involves practical areas, working on practical areas as our study. The only places that I work on with my drug programme plans is actually on the practice area and involving people living there.

PB Right. Now in your questionnaires you did say that theory and practice did form a large element of your studies, that the correlation between the two was of vital importance. Do you think that that has happened in the last three years?

Not always, it depends very much which area you are on, you know. Quite often the theory and the actual hands on practice can be two entirely different things and then it is a shock (yes).

It is more of a disappointment I think than a shock I think that the main thing you have is that you are taught how to do something properly and in the right way and you lack the means to do what you have actually been told that you could do or would do or would be available to do. The other thing is I think it is that we have been told a lot about consistency, things happening time after time to allow people to learn, but there hasn't been a consistency which has meant that the things that we started in good faith, hadn't always had the reinforcing good outcomes that we hoped they would and in fact sometimes staff have become more disillusioned they have said yes you might have the new theory and the new ways, but the results being the same.

I think theory sometimes tends to be this is what happens in the ideal world and when you get stuck into reality you come down to earth with a crash sometimes, yes. I think you get to expect disappointments sometimes and not to be too shocked when it happens, but you might be shocked when you first start studying, you know the young student will probably be shocked. We are taught in introductory block this is what happens, you go here, this is what happens and this happens and you write this and you do that and everybody works together, exactly, you know it doesn't always happen, yes.

PB Right, perhaps we can skip a couple of these and come back to them because they are not in any order. Now you have explained that, can I ask you about then the practical assessment? It is part of a mandatory requirement that you are assessed in practice as well as in theory, would you feel that your assessments have reflected your skills and your practice or have they been something other than that?

I think something other than that, I think that the assessments reflect a lot of the schools, (study blocks) they are also a stepping board to more schools and to others to add to what they have already got so each new assessment sort of takes us further in our school development.

They are learning experience themselves as well as reflecting the skills we already have they kind of give the impetus to learn new skills.

I think the first two are totally, they appear to me to be more realistic they are set up, if you understand what I mean by set up, they do not reflect what happens they are set up, but I found the third one in the area I did mine, it seemed quite natural to be doing that but the first two were definitely set up.

PB Yes, yes I see what you mean.

I disagree, I think the first one gets you implementing care was natural, it was stressful in the fact that it was the first one and I think that all of us feel now coming up to the last one, it is not as threatening as before we had started doing them because they are to some extent a known quantity, but the first one to me was very real, it was very ordinary, it was you know one days care which to me is a very natural thing. I found that I was assessed all the time by a member of the school staff rather than by someone actually working on the area that in itself made everything totally unsure, because the tutor had expectations that the ward would be

such and such and it wasn't and you couldn't square the two so you had the tutor pulling one way saying to pass your assessment you need to demonstrate X, Y and Z and a living area saying today you are in charge, which happened to me during my Test B and I was in notional charge with someone in admin nominally supervising me from down the corridor for 3/5 of my assessment, so obviously the skills that mainly my tutor was looking for weren't the skills I was demonstrating, I was demonstrating management skills.

PB Right. Can we take that a stage further, we have just heard now some positive and some less than positive aspects of assessment, it is important that I am clear that within your theoretical training and your practical training there have been some discrepancies in the mix of theory and practice. Would you in retrospect feel that perhaps those discrepancies might have found their way into your assessment, that in fact there were times, as you have just explained, that the assessor was assessing something which in your mind was not real, which was not really what you had been taught, that they were expecting something different?

No, it was what you were taught, it was not necessarily what you were doing.

PB Right, there is the difference then. Have you got an example?

I think it depends who is assessing you, I really do. For my last assessment the person assessing me spent time with me but at the end of the day I passed or failed myself, between us we looked at the criteria and I pointed out how I thought I had met the criteria or I hadn't now that it is much more valuable to assess yourself, because if you have any spark of honesty in yourself then you come across and say well I did do this or I

didn't do this, because you are only cheating yourself then and to me it is so valuable and I preferred that, it suited me.

Yes I do the same thing as well.

PB So self assessment, you like it?

Yes, it is very demanding though, it isn't a cop out at all.

No, because you have to be honest with yourself. You also need support and guidance while you are doing it, but that is the way to do it, in my book anyway. It is a very good assessment.

PB But that hasn't happened to all of you then I take it?

No, I can remember being assessed at one place by a member of staff from the School of Nursing and they expect very different things, you know it tends to be again the ideal, this is what should be happening and you go onto a place that has no care plans or anything and for this assessment you will sit down and write a care plan but that is, not sort of, it doesn't reflect what is happening on the ward which an assessment should, you shouldn't have to set a false situation.

That is right.

But then again that last assessment that I did I was assessed by a person who actually worked within that area and the expectations are very different and the sort of assessment was tailored to fit to that area, well don't do this so that's not applicable but you don't have to satisfy every single criteria if it's not applicable, it's not applicable to what's going on.

I think the key note is that the assessor must be realistic and flexible and as long as they are then I don't think in some ways it doesn't matter

whether it's from the School of Nursing or a person who works there, as long as they can be flexible and realistic and see that things are not black and white they are grey in between.

I have noticed a change in sort of ideas between two different assessments with say writing up objectives, last year when I did my second assessment all the objectives had to be sort of precise, who will do what and what conditions and to what degree assessed and the last assessment it had all changed, you could be a little more flexible you didn't have to be as strict.

I think they have always been flexible, I think who will do what tends to apply to a very structured teaching skill but you can have social objectives and intellectual objectives which you can't have who will do what, so.

That is what I say now, but last year everyone was ramming it down our necks that we had to do it like that, you know we did that workshop, a goal planning workshop on objectives.

I remember having an argument with a tutor about that when it came to my second assessment because he came to kind of guide me down on the work area and he was very behaviourally orientated and I just told him to go in the end because the strictly behavioural objectives just weren't relevant to what that person needed at that time, and in fact the Charge Nurse backed me up and said that he was very pleased that I had written more expressive objectives rather than behavioural ones, but it was very distressing undergoing an assessment, getting ready, preparing for the assessment when you were kind of getting that sort of conflict between you and a tutor.

PB I think what I find interesting is the use of the term expressive and behavioural, although they are specific terms aren't they, that have

a specific definition in education, that the Charge Nurse who was not a tutor I gather in fact knew about the difference, which I think is good.

The School's now giving us expressive objectives more than setting (?? three voices at once).

That's right they are now, yes.

PB So it has filtered down hasn't it then into the practice areas. Do you find it is filtering into your community practice as much as it is say perhaps in the institution? What I am saying is do your community people, those who support you in the community when you are training, understand the course?

No, I really don't, it depends who they are, what sort of background they have got, where they have come from, but I would say on the whole my, again I can only speak personally, my community placements have been a laugh a minute, they really have.

PB Well if we take the modern approaches then that community is the place where it will happen in the future, when the hospitals as we know them will not exist in the next few years, they will all be gone, I am just concerned that perhaps the people who are there to supervise and assess and monitor you may not understand the nature of your training.

It's a possibility, it's always a possibility, but I think one of the good things about the last year in particular is that we have had Fridays together as a group where we can tell our tutors some things that are going wrong on the placement and our tutors visit far more regularly than ever they did before, I mean it's rare now for you to go three weeks without

seeing someone from the School whereas before you could go months, you know you only saw someone from the School if you were in trouble, or they happened to be going there to arrange something else and I think that School should come down into the areas more however I do worry that general tutors come on and work with students on the area, you know what I mean, teach specific skills and our tutors don't always, or very rarely come down and actually teach anything on an area.

PB Can I take that up then and move into another point in relation to the feedback from the questionnaires regarding your teaching and your counselling skills, because the term teaching is a fundamental term in mental handicap nursing, you are teachers and you have to be taught by teachers, simply because the job that you do means that you are working with people who require some measure of teaching. Now those skills are fundamental to your future and counselling skills obviously feature high too. Have you been assessed in either of those two major areas?

I think nearly all of us have in this third assessment, the sub test is teaching the other one is on drugs, it's a choice as to which one we do first, I think most of us did teaching first and we were assessed on that.

One half hour teaching session to be assessed upon does not show your skills or lack of skills in any shape or form.

But over the three years every time we are in School, each one of us has to do a teaching session on something, we have also done the DDY course which is teaching.

And there is also feedback as well from the people that you are working among on the practical areas and I think I have learnt more from that than

anything else, you know from the feedback from the staff on the practical areas.

PB Does that apply to your counselling skills as well because they are different aren't they?

I have learnt a lot from practical experience.

I don't think I have, no.

No, I don't feel I have, I have learnt a lot about the theory but I have not done any particular sort of counselling in practice.

But I feel I have had opportunities to, I feel to have learnt something more as well, just by the nature of the placements that's all.

I think it is very difficult to assess someone in a counselling situation due to the fact of the nature of what it is, one to one sort of thing.

PB So how were you, how do you assess then that you are competent in that area? What have you got to tell you that?

I think if you feel confident and you feel that you have the ability to sit down and talk to somebody about a problem, I think that is how you have to get round it, because like he says, in a counselling situation you can't have someone sitting in with you listening to.

I don't see counselling like that, I think it can be like that, but I see counselling, I counsel every single day. It may not be a conscious counselling session but just conversation with a man I am working with, or I am explaining something, he's explaining why he can't do it or why he hasn't, it's a kind of counselling of a, it's not a set up, you use it every day.

But you can't say right I am going to counsel so and so tomorrow can you come and assess me.

Oh no no. A counselling skill is such an ongoing everyday, I know you can have specific counselling sessions on a specific subject but I think you use it I think it's a communication.

It can be the way if anything we are assessed on it is from role play, seeing ourselves on video and watching how we do it ourselves and getting feedback and that's probably the only way, plus ***** when I was interviewing someone with a checklist and going through it, likes dislikes and there was an assessor there, that kind of situation you know it was basic asking basic questions and listening to what he was saying. That was the closest.

If you put a care plan together and you are assessing an individual, you are counselling then and the professionals that work or are involved with that individual are using counselling skills then all the time.

I think we do use them. We know whether we are good listeners or not, I think some people do tend to get people coming to them with bits and pieces and when you know the people come to you and start talking to you about you and your own private life like some people come very quietly to you and you never talk about it to anyone else but I think that it does help them a little, I don't know, I think we have spent a lot of time doing counselling, funnily enough I feel that a lot of us are more able to counsel than we are to teach.

PB Can I finally, and then we will stop because I am conscious of taking up a lot of your time already. Can you tell me about your assessors, no names of course, but a general personal feeling about how they responded to you?

I have enjoyed my assessors, I have found them very easy to talk to, if I have had any problems I have gone to, you know I haven't worried about talking to them about that at all, I haven't felt under a microscope. I have had a very good relationship with them, no complaints whatsoever.

PB Good. That's what I like to hear, does that apply to everyone?

No, definitely not.

It does me.

It does me.

No, I have had the same assessor every time and before each assessment I have felt that what the person wanted from me wasn't real, wasn't what would be expected from the area itself and was partly based upon this person's own personal interest on specific subjects. Having said that, during and after each assessment the assessor has been marvellously fair, very keen, very helpful, has given me a lot of good advice both during it and after it, but it has been the wind up before it, ie I have had to fit the frame to what he wants to see, right, and then once I had done that, altered part of the reality to fit what he wanted to see, he has been fabulous, but I had to alter the frame every time to fit three totally different areas and I think that that's why it has been stressful for me because you know, you are altering it.

PB Can we just spend a couple of minutes talking about your assessments in the community? You have indicated that you have all been assessed in the community at some stage, can you tell me something about the assessment, who did it, what was it about? What did it comprise of?

I don't understand what you mean.

PB Right let's go back again then. What was being assessed?

My skills.

PB In what?

In, I think my skills in assessing an individual, planning things, all four really, plan, implement and evaluate. Our communication as well.

But it was how I put it together, why I put it together.

PB Do you feel that for people to assess you in the community they should themselves have had experience in the community?

My assessor on community was a person who used to work there, she is a clinical tutor now.

Yes.

So she had plenty of experience, I don't know whether that counted or not.

PB Yes I should think so.

It probably did. I think if you have worked there or you are working there, then sometimes then you can be sucked in into accepting what's happening, you know bad practice and all if you know what I mean, then you can limit what you are testing because you see what you expect to see and I think sometimes having a tutor from School makes you raise your own standard to some extent, in the sense that they are looking for more from you.

I disagree with that. I don't consciously ever raise my standards, I hope I never let them drop.

You could argue the other way though that a person who has worked in a place knows the person in fact well enough to know that if your objectives are misguided then it shows the assessment perhaps was not done in the correct manner.

So one of the skills then is relationship building which is an important thing but it is not necessarily writ large.

In a way I wonder if assessments should be looking at the person you are working with as opposed to you, or looking at the two together, because they are the person that has either gained or lost from what you have done, so although its important to assess the skills, the student's skills, by looking at other individuals you should be able to see something in them as well. It shouldn't just be....

PB Yes that is a good point, do you think that assessment then makes you selfish?

It can do yes.

Focussing on yourself.

Oh gosh yes, I must pass this, yes of course you do and all the people around you are kind of honing in on.... In a sense you prime them don't you, which is awful really.

Yes, yes and people say, we'll say a good word for you and stuff like that and of course they do. We are doing the assessment tomorrow and it would be nice to get one. (a good word).

PB So assessment is really a selfish exercise?

Yes.

And as you say, sometimes it is very artificial.

Some people I've worked with say what they have got from it and if they have gained from it, then you are not doing too badly.

I think that you do do that in the assessment though, I think a lot of the gain of a good test or a good assessment or a good placement is that you have worked with someone you liked and you get on with them and you talk to them and that comes through in an assessment.

You can also do so much damage to that individual because you then withdraw.

It is just like hit and run isn't it.

Of course it is, and is it fair to the person you are working with that I have done this week of intense whatever and then thank you very much that was lovely I'm only here another three weeks, morally it's not right.

Well I didn't do that.

PB Well you are not supposed to do it that way.

You are not supposed to but you do.

I disagree I didn't.

But you do because that's what they want.

No I didn't.

Oh you do.

That's why mine was extended.

Because you are keeping that extra eye on what's going on you know you tend to buzz round that person more than you would do in any other day, even if you are not doing it consciously, you know, you see that person sat down and you think oh God I am doing the assessment and he shouldn't be sitting there doing nothing, you know, we will go for a walk or....

Yes well it shows that you are working with that person as you should be, but what it also shows is that the other people are losing out, I think it shows that say during the rest of your time on your placement there that if you are making an extra effort during the one week that there is something wrong about the rest of the weeks that you aren't making it, effort for people. That shows up as well.

I think sometimes as well it depends on where you do your assessment, the people that you are working with don't always appreciate what the assessment is and what it is about and you try and plan it so that when you have left that area whatever you have started will hopefully carry on when you have gone, so you have to be realistic about what you set up in the first place, but for example if you set up a care plan from scratch keep it so that it will carry on when you have gone, people still that you are working with that haven't had any form of training do not understand and I did this for an assessment and a fortnight later they rang up and said by the way you left all them notes behind you, you have forgotten them, so I hadn't done me job properly had I? Because if I had they would have understood that this was there to carry on when I had gone, so it is a fault.

But I made that point, I had a real good talk and made it quite clear and then simplified it because for the purposes of assessment I had to perhaps write a few more objectives than I would you know for them, that was realistic for them, but then at the end of the assessment, we kind of had a

meeting afterwards, the staff that were working with this particular gentleman, and we tried to simplify it down for their purposes, not in a condescending sort of way but something that was workable for them in their actual setting at that time.

Sometimes there is not so much you can do, you can't teach everybody.

But I think in all fairness the people that you were working with in the community did have some experience, you know, some of them have worked here, some of them you knew.

The actual people I am talking about in this instance, that person's key worker and stuff, felt very unsure about the whole objective, she hadn't had that much experience, you know.

Fair comment then.

PB Well thank you very much, that's been great. This interview was concluded.

APPENDIX VII

GROUP INTERVIEW 2

PB What is the School of Nursing?

You see it more as the actual tutors and the courses as opposed to the building.

It's more of a base, there is not that much of our training that actually takes place here. Our training is more what we do on our outside placements.

PB So the actual building is a place you come to for lectures and seminars?

Mmm yes.

PB The actual term 'course', is it something you do here in the school building, or is it something you do elsewhere?

The course is the whole three years - simple as that.

PB So where ever you are you are on a course?

What we do on the placement is supposed to be related to what we've learnt in our study blocks.

PB Do you find that there is a relationship between what you do here and what you do out in the practice area?

Usually.

There are certain notable exceptions but the majority of time what you learn in School is modified to what is pertinent.

PB Its modified in what respect?

If the wards are so understaffed then you are not able to do how you have learnt in theory so you modify what you have learnt in theory to be acceptable in practice.

What we do in School tends to be the ideals, what we do in an ideal situation.

PB When you are being assessed do you find that the assessment is related to how it should be or how it actually is?

How it actually is?

I would say it depends on what assessments you have done.

It tends to be a more idealistic situation because people will try and arrange things so that you have got more resources.

My assessments haven't been like that, mine have been on the resources and the staffing levels that have been on the villa that week, with no extras so to speak.

You often see ward sister or whatever making a visible effort to try and maintain a decent staff level. We have a student doing assessment so could you please leave us on four or three or whatever. So therefore at the end of the day you can be restricted by practice, and if you haven't got the staff, that has to be written into your assessment that you might have problems with staffing levels, resources, environmental problems and so on. So you are always having to write contingencies into your assessment. I don't think any body has done an assessment ideally.

Every assessment I've done I've had the amount of staff that have been allocated on those shifts. They have actually been able to staff on the

villas, they have not been moved, so that's quite idealistic because if you've got the four staff on then you can go into town so you can do what you was wanting to do. For most of mine I've found that if you could do that every week it would be brilliant because everybody makes an effort - more of an effort than perhaps usually.

I've had better resources on my assessment to begin with and then towards the end of the week people are still being moved but the assessors take that into account when they are assessing you, how you cope with those problems.

PB In retrospect, have you any real moans and groans about your assessment in terms of fairness and objectivity?

I think the strain between the idealistic situation and the actual conditions that we have had to put up with has been quite a big strain. Because the assessors do allow for that but you are still expecting it for yourself that you are going to live up to those ideals.

It's very hard to say anybody is to blame but its very hard to have standardised expectancies of how students should perform - the assessors have very different opinions and there is often quite a difference between how the School expect us to perform and what the assessor is expecting.

Well, I saw the difference in assessors, I mean you have some assessors who will stay five paces behind you for the full week and you've got others that will try and just keep it as normal as possible. They will be discrete and not put you under pressure, but really they have got to work themselves out because we are the first ones to do these assessments, so they are still having teething problems.

PB The first ones to do which assessments?

These new practical assessments. The first one's a day, the second one's a week, the third one's two weeks.

PB You haven't done continuous assessment yet have you?

No

PB Do you think continuous assessment will make an improvement?

Yes, it would be a lot better than it is at the moment.

PB Why do you say that?

Because in a way you are constantly being assessed. The standards you have to reach have got to be continually good. Being assessed on a particular whatever for a week, you can chuck anything into it, but if you are being monitored all the time on everything you do, I think eventually turns out a lot better. You get a better idea of what the person's like as well.

You can get people who work really hard and come across as really caring during a week's assessment but the rest of the time they may not be interested in the residents at all.

PB You did mention earlier about the style of the assessor, how they differ, some allowed you to be assessed objectively, others tend to look over your shoulder a lot of the time. Some give you freedom, others tie you down. How do you think things are going to change with continuous assessment?

Well because over a long period of time it wouldn't be possible for an assessor who looks over your shoulder all of the time to do that, because she or he is probably deputy sister or charge nurse they have also got a ward to run. If they are looking over your shoulder for the whole 12 weeks you are on a placement they would not be able to get their job done either.

PB So that means you have got to be involved in assessing yourselves and each other in a way that you are probably not doing now. Would you feel confident in having to do that? I'm talking about peer and self assessment.

I think we do that quite a lot already in our course. A lot of the course is based on personal development and looking at how we react in various situations.

I think our standards are probably much much more similar because we have gone through it as a group from 1985 right through. Our standards when we are taught together are probably very similar. I don't think there would be that much difference in what we would call good practice. Whereas one assessor might have been in a job 30 years and be very institutionalised another might be full of get up and go who has just qualified. You have a vast difference but we are all at the same stage.

PB So you feel that you could assess each other then, and accept it?

Well we have to do that within the personal development games that we do. I mean quite often it's a character assassination of each other and then a build up. We do a lot of those. It's a bit hard at first but if you think about it it's usually right.

You kind of get rid of that unreal situation as well, though often the assessments are a very false situation and I think if you are being assessed over three years it would help maintain a better standard throughout.

I feel the same, that it is too much of an unreal situation. In my assessment I've always had adequate amounts of staff and things have been arranged so that I can do what I want. But if you got it down to three

years they couldn't do that for three years, you would have to see how you coped in a situation.

PB Are your current skills sufficient for meeting the needs of a modern service?

They need to become more specialised.

The skills that we learn are good we need to improve on them.

The dangers are that people are getting very protective about what their job description is. An occupational therapist will say that this is my role; a social worker will say this is my role. If we're not careful because we do little things, little bits of what other peoples jobs are as specialisation we are in danger of having our skills just taken away. I think we should specialise and say 'I have a specialist skill in - as my role as a mental handicap nurse'. I think the job definition is going to get smaller and smaller and smaller.

I would say that our strength is that our skills are generalised, that we have been trained and that we have skills that can be adapted to any situation and environment, they are not purely based on say ward work or whatever, I think that makes us look at things more holistically; we can sort of help out in all kinds of situations or refer to other professionals.

Well that's how we see our strengths but that's how we are losing out. When we were on community there was a case of a psychology fellow, a psychologist studying.... and you sort of find yourself (asking) what is our role?

You see we act as facilitator, increasingly that's what we are going to become.

PB A facilitator of what?

Other services, we can say that we need some psychology input and what not, but the psychologist isn't going to take it lying down if you start doing his behaviour analysis and what not. He will tell you what you need to do and then we pick up again.

PB So the actual term nurse doesn't seem to fit into all of that does it? Is that the word that you would want to use to describe what you want to do in the future?

I wouldn't say that was a proper description.

PB No? I think one of you actually wrote that in your questionnaire, one of you said that nursing is not the term that we would be using in the future.

I very rarely do use the term nurse to describe myself, I don't see myself as a nurse.

PB What do you see yourself as then?

I haven't worked that one out yet.

I think there is too much stigma; if you use the term nurse people get a totally wrong impression of you.

PB Can I come back to the means by which you were assessed? Teaching and counselling skill are the two main elements as I mentioned earlier when I was introducing this session to you. Can you think back over your training and tell me how your teaching skills and your counselling skills were actually assessed in practice?

They have mainly been within the School although the teaching assessment we have done teaching sessions to each other in School but our last assessment involved a teaching session with somebody related to the villa that we were on - either the NAs, or parents, or the actual residents. So actual teaching sessions we've done in the School and we have been assessed on it during our final assessment.

In some of the other assessments where somebody has had a particular problem there might have been teaching involved in that - clinical teaching.

PB What about counselling?

In theory (theory based) - we've done role play.

PB Considering that the majority of people that responded to this questionnaire, and there was a lot of them, said that counselling is now the top skill followed by teaching.

I think that the wards are very unwilling to let you loose on counselling until you are qualified. A place that springs to mind evaded on going counselling - only mildly mentally handicapped people were able to understand the implications and things. But we were allowed to observe but not encouraged to counsel because it was for the qualified staff so you are seeing it done, knowing how you would do it but not being given the chance.

I think that you do counsel without knowing it on the ward, on the villa if the resident has a problem I think that you do tend to counsel now without knowing it or without realising it yourself.

PB Yes.

There are skills of counselling that you are taught and use without actually counselling somebody ie not being biased; not forming opinions about someone; having an open mind, stuff like that. I think the actual skill of counselling as it's held to be, helping somebody work out their own problems is again a specialist skill, you can actually do degrees in counselling, that is why again we just touch on it and unless we are very very good when we are counselling somebody on a dodgy subject we could ruin.... I think that was the thing on this unit, one wrong word from us as inexperienced counsellors would have mucked up possibly weeks or months.

I think it is something that is very difficult, you can learn the basics and you can look at other people's counselling and see why something was effective or why something was ineffective but it is the actual experience that you need for counselling, you need to actually get out there and do it. Like with the role play and everything that we've done in School its been very difficult because it was so unreal.

PB Can I just have one more tilt at this and ask as part of your practical assessments were any of you actually assessed in a counselling role?

The only thing is your on going counselling. The last assessment was management of a group of residents for a week and you've got, well I presume everyone got the continual problems with the same people so you are constantly counselling but not in a counselling way.

Informal.

Yes, but I mean that sort of on going counselling - why are you doing this its your home bla, bla, you are sensitive not specifically as a counselling assessment.

PB OK, right we will move on, thank you. The Nursing Process. The 1983 Syllabus is actually written around the Nursing Process. I think of all those who answered the questionnaire 99% of the respondents said that their course contained large chunks of the Nursing Process. Yours will have done so because it is based on the 1982 Syllabus. Do you think it is relevant now to today's service?

More so than ever before. Because it is the main way of informing everybody related with that particular client and getting information across. As things become more multi-disciplinary out in the community you are going to need the central data information.

It's all we've ever known, it's the way that you do things isn't it. That's the way that I organise things now you know, whatever I'm going to do with my work. If there was something else that concentrated on everything like the Nursing Process does but did it in a different way perhaps, then you might do it that way.

It's how you use it. It doesn't have to be inflexible, you don't have to write things down with it, you can use the Nursing Process just to organise things in your mind or whatever.

It's such a logical framework isn't it, you can put everything into a Nursing Process can't you?

PB Is there anything you would like to say to me about your training that I have not touched on?

You can have one of these reports, we are dishing them out willy nilly.

(This comment relates to a student evaluation of the training period.)

In the same way that we are taught? Consistency of approach and so on. Then the way we are taught there has to be a consistent approach. I think we've found the odd little thing, like, we've had changes in tutors, you know it would be much more consistent to have a tutor solely responsible for our three year course. Things like that! Consistency in the way that assessors assess all the way through.

It leaves me a bit worried for the future because when I look at the way our training has gone, information that I've had about training in the past I think the majority of the moves have been in the right direction when you talked about continuous assessment and things like that, and yet all the mental handicap side opinions of these things don't seem to matter that much because we are going to Project 2000 which is mainly general based and I don't think our opinions on how training should go matter that much.

It's going to form a very small percentage of nursing - six or seven per cent.

We are going to be lost, drowned.

I think in a complete nursing course our way of doing things is going to have to adapt to them rather than them adapting.

PB Do mentally handicapped people need nurses?

They need people with special skills.

Nurses in mental handicap.

PB So there is a special skill base then?

Yes, not necessarily a nursing skill base in the sense that the general public understands it.

PB What are they then?

Counselling (laughter). Teaching.

Educational, social.

Whereas we differ in the main, from general, is that we rely on using relatives we rely on having other people there. If it's going to the community the emphasis is on keeping people at home and helping that family cope. We can't do our job without others - that's the difference. As long as we are valued by the carers, by people who need our skills in the community then we are in employment, we are seen as being valued.

PB So for you to be valued they have to know what you have on offer?

You have to keep telling people.

They have to know we exist - what we offer.

PB I'm going to probe. What do you have to offer that is of value to them?

I would say a general all round experience in every area that could possibly be to do with the mentally handicapped. So anything they have problems with or need to know about if we don't know the answers ourselves we know the people to go to and we can find out.

Like a professional we will always have an answer for something.

Parents and families will often say that they thing that helps them most is meeting somebody that's gone through it before and we might have seen someone going through those particular problems before or we might be able to put them in touch with other families.

Again, its facilitating.

PB It is a highly complex job being a facilitator, you have to have so much at your fingertips.

I think that is where we fly off away from medical models. There, nobody else can help them they are solely responsible for helping somebody. They (the general nurse) have the medical team as it were.

I think we found that when we went on community mental handicap placements. The community nurses seem so skilled they seem to be like the culmination of all our skills in the community nurse because they work on their own, they've got their own case load and they are like the access point to so many other services.

PB One of the things that came out of the questionnaires in relation to case load management was the skills of interviewing. A very large percentage of respondents to the questionnaire said they had never been taught the skills of interviewing at all during their course of training and yet it is basic and fundamental isn't it, to what you do?

You mean in terms of initial assessment?

PB Yes, you are in the people business, every day of your working lives you talk to people.

I think its terminology again isn't it. We are saying that in terms of assessment what is the first step that a community nurse would take.

PB But the term 'interviewing' with all its special skills and nuances is a special term isn't it, perhaps one you no longer feel you need to use, you just feel the word assessment covers everything?

I think you probably include that in general counselling terms as well. It's the same skills really isn't it.

PB I'll stop now. Thank you.

APPENDIX VIII

GROUP INTERVIEW 3

PB Looking back over your three years training how do you perceived the School of Nursing? What does it mean to you? (Lengthy pause)

Prompt: Is it just this building?

Yes, this building I think of. I don't seem to relate it to the rest of the hospital you know. This is where we come and do our little bit then we go and work on the ward. It's sort of different to the rest of it.

PB Anyone else feel that way or does anyone feel different to that?

I do sometimes, it depends if what you learn actually in block can be followed on on the wards. Sometimes we learn things too late if you know what I mean, we learn things like if we had learnt in the past could have been beneficial beforehand. On the other hand I think we learn some things that you can actually then go out and (practice) it on the ward if you know what I mean.

PB Let me ask a further question. Do you think that the knowledge gained in this building is wholly applicable to the work that you do out there in the hospital?

It is in theory but it doesn't always work out that way.

I think it's unrealistic in some aspects.

PB Why

Because I think some of the things that we are taught in here just don't occur on the wards, whether or not they should is another matter, but they don't.

PB You are reflecting accurately some of the problems other students have faced. Not just here in the past but elsewhere also. What information, what knowledge is of no use to you?

I wouldn't say its of no use but you are taught the ideal situation here but there are so many variables out on the ward that you can't say that it is directly applicable.

You like learn the basics here, how it should be, whereas you go out on the wards and you learn how it actually is.

PB The difference should be negligible in all honesty.

Its people, its individuals out on the ward, you can't apply direct theory to individuals.

PB Are you talking about the nursing staff or the residents?

Both.

PB Can you enlarge on that a bit?

Well it's down to personality, you may be taught how to do things and how things should be done but you go out on the ward and the residents and the staff are so totally different from each other that you can't approach one person how you would approach somebody else, so you can't be taught all the situations.

The teachers teach you about dealing with potentially violent residents like, they show you films and there's hundreds of staff running from

everywhere. You get on to the ward and there's three of you, so how can you apply the things they've taught you when you haven't got half the things to deal with it?

PB Do you feel that you are being taught in a way that is preparing you for a job which isn't there? Is the job different to that which you are led to believe in the School of Nursing?

Not always, but I think it's different sometimes to what they perceive that it is you know, because some of these people haven't been on the ward for quite a long time, and it is different to how they imagine it, or how it was when they were working on the wards.

PB So it's this people business again isn't it? They tend to inject their persona into your training. So just to encapsulate this the School of Nursing is, as far as most of you are concerned, the place where you come for your top up, your theory. Out there wherever that is, whether it is the community or the hospital, that is a different place?

It is for me, yes.

PB Is it for all of you?

I think it is, because for most of the time you are actually taught what you don't find you can use in some situations, it's not practical to use some of the theories you are taught.

PB Can I move on? Those three areas of skill, community nursing, educational aspects ie teaching skills and skills teaching, and therapeutic skills are possibly the main areas at the present time, would you agree? Have you all been involved in these three areas?

Yes. (Lots of nods in agreement.)

PB What are these skills that people talk about in the community? What does it mean to you?

Working in small homely units.

PB Do you think you need different skills to work in that situation?

I think you might, because I found it difficult when I went to my community place to actually sit back and let everybody do everything themselves, you know what I mean? I find it hard not to get involved because like you come here and there is a ward of 20 and you go into a group home where there is about eight and you are used to just rushing around doing this that and the other and I find it hard just to be laid back and to actually encourage them to do it all the more though you do do it here it seems to be on a greater scale out there, you know like I got worried about silly things like that. I was thinking, oh dear because I'm not used to doing it up here (the hospital) you see.

PB Have you ever met the term 'facilitator'?

(Everyone shook their heads.)

Interviewer explained the meaning and linked it to the previous responses.

PB When you are rushing around in the hospital does that infer that you are short of staff?

Yes (overall agreement).

PB Does that mean that as students you have worked unsupervised?

Yes (overall agreement).

It's got a lot worse but it depends which wards you are on.

There does seem to have been quite a lot of qualified staff leave and out of all the staff nurses who have recently qualified there is only one left, and he's leaving in four weeks. The newly qualified staff aren't staying, even the older ones are leaving.

PB Most of your assessments have been performed by the qualified staff on the wards?

General agreement.

PB I would like you to tell me about these assessments based on what you have already said, staffing difficulties will always be with us, I am quite aware of that but have your practical assessments been in the first instance, fair?

General agreement that assessments have been fair.

PB That's good to know. Has the situation in each of them been contrived or have the assessments been part of the general day to day running of the ward, or did you have to get geared up for them?

We had to get geared up for them.

It's a little bit of both because you can't say that if you do set a routine you can't say that you are going to stick to that, again its back to people again, things change from day to day, so you can't say what's going to happen on a certain day. You do try and work situations into it.

PB Do you think that nursing education is about passing exams?

General agreement.

I think that's what they are doing here, they are teaching us to get through the exams.

PB You feel then that this School of Nursing is about passing exams?

Yes that's what they are doing with us, they are teaching us to get through the exam. Well at the same time they might be teaching us theories what we could use when we qualify but I think the main idea of the School is to get you through the exam.

That's no detriment to the School, I think its the same wherever you go.

That's what their aim is, they want us to qualify.

PB Yes they do. Perhaps they want you to qualify though as skilled competent all round nurses and not just people with the ability to pass an exam.

If that's true surely they wouldn't have such high entrance requirements in the first place.

PB Good point.

PB What about your assessors then, have they in the main been kind to you.

Yes, mine were.

Lengthy pause here.

PB If they haven't say so.

There was one of mine that wasn't up to scratch I didn't think, well I didn't think a lot of this person.

PB Up to scratch?

Not being up to scratch, I think its the way she actually went about the assessment that put me on edge and I was all the more nervous you know. Well I've had other assessors that have been just as though they were there you know, saying carry on regardless and pretend I'm not here which is how I would have liked it yet they talked to me in a friendly way not as though I was actually being examined, which I was, but they were quite laid back about it yet they were observing everything I was doing and it made me feel more relaxed and it made everybody else as well. But there was one that even the other staff on the ward were all, you know, its not very nice like that.

PB That's a one off is it?

Yes, just that one, all the others I've had have been fine.

The other ward staff were more on edge than I was when I did mine. They seem to see that if I failed it would be a mark down on their side so they made me more on edge because they were sort of panicking the day beforehand and panicking on the morning and that just made me worse I was alright until they started and I just got...

PB That's an interesting observation because its all to do with the environment you are working in isn't it. It effects everyone, the ripples spread out.

One of my assessors was late he was about 20 minutes late on my ward management day, we did the bed round and everything and I was fine and the acting ward sister was pacing up and down outside the office and I said to her ' for God's sake go and sit down', and she said, 'I've smoked about 20 fags', and she was saying, 'he's late, he's late, as if it were her assessment, it wasn't and then when he did actually come I was sort of on edge then, and I had been fine up until then, I'd been fairly calm.

PB Now a very important question at this stage. Do you think that continuous assessment will reduce some of these anxieties and some of these difficulties which naturally occur when people are taking a one off examination or assessment?

I think so, you can't be on edge for the whole length of time, you can't be on edge for, is it four weeks now?

They all last different times don't they, there's one lasts a day...

I think its bound to though in't it because as time goes on you are bound to get easier about it aren't you I think if I have a bad day tomorrow (the respondent probably meant today) I might have a better day tomorrow you know, it will be easier to get actually there won't it.

I mean if you work with them all the time you can just get it into your head that it's another normal day kind of thing. The more you keep working towards it you just more or less like just slot in.

It's more difficult when you actually have an outside assessor who's strange to the ward. Where as if like now the staff nurses are actually taking the assessors course they're going to be just assessing you while you are on their ward they're going to know what you're like anyway, so hopefully it should ease, it should balance itself out. Whereas now its like your performance on that day you know, you could have a really bad day and everything could go totally wrong and they could get a really false impression of you, whereas if its sort of continuous they might think oh well she's not as bad as we first thought.

But then again you see I mean if you don't get on with somebody you know what I mean, that could interfere because that's one way I wouldn't like it if you didn't get on with certain people and they were perhaps even doing

your assessment. I mean they could be biased or anything towards you, the final result you see, but on the other hand I see it could work quite well.

PB Yes there are pros and cons in all of these things because continuous assessment really does mean that you should be allocated to a mentor or someone who is going to look after you while you are actually in that area. They should in fact be the primary assessor, but at the moment its not like that, people are appointed as assessors aren't they and then they come and do it at the time, either the ward sister or one of the managers or even someone from the School may come and do the assessment, it's a bit hit and miss like that at the moment but with continuous assessment we hope that it will be a lot more continuous, smooth and valid. OK, what about the styles of assessment that you have been exposed to over the last three years or so, you've met different assessors and you have just described styles of assessment, you are going to be assessors in the future I think, most of you. What have you learned from being assessed that's going to effect the way that you will assess? What are the qualities?

I think that as B...y said its better off it they just say well look you know I'll be here but I'm not going to get involved and what have you, you're better to just stand off and watch what they're doing and let them get on with it and sort of ask questions afterwards, because some of them ask questions while you're doing things and its very difficult to concentrate on what you're doing when they're asking questions you know. You're having to answer them at the same time, I think it puts you out of your swing a bit you know.

PB So that's a style of assessment that's probably not a good way of doing it. That is what you are saying is it?

Yea, yea.

PB General prompt here to a group member who has yet to contribute.

I think my views are the same as J...'s, if people are on at you all the time you feel more uneasy.

PB That's happened to you has it?

Yea, I think its better when you know the assessor as well, know of, but I've had an assessor I didn't know at all and I was a bit edgy about that.

PB I bet you were, has that happened to anyone else?

Unanimous agreement amongst the group.

PB Were you prepared beforehand for the assessment, or did it just happen in that case?

What do you mean did we know who the assessor was going to be?

PB Yes.

Yes a bit of paper, but I mean if you don't know the person you have to sort of ask around and then you get all the feedback about, who, that's a bad one or that'll be really stiff and then you really worry, but if someone says they're easy you think they might not be.

PB They are never easy for you personally are they?

It's alright when you've taken it and then look back.

PB When that happened to you, you got this bit of paper that told you who the assessor was going to be, did that person contact you to prepare you for the assessment?

Universal 'no'.

They just turn up on the day.

Unless you have any written plan to give him beforehand.

I still gave him mine on the actual day.

Yes, I did.

PB After the assessment, did you get any feedback on how well you have done?

Did people take the time to ask you what you had learned from this experience?

Several yes, several no.

I've had all through 'perhaps you should do this, perhaps you should do that, and I like the way you did this, how did you feel about this that and the other'. I got asked questions afterwards about the actual assessment itself.

PB What about reflecting on the experience, taking time after the shock subsides and you have stopped shaking, and you have been told you've passed. Reflecting on it and saying I really learned something from this, has this been an exercise which you have been encouraged to do?

Yes, I had one of the tutors from the School for my assessment and he did, he was very good.

PB That's someone with an educational background, someone who should be doing that, you would expect that person to do that wouldn't you. I'm talking about your average ward sister.

I had a ward sister for my management (assessment) and she was very good she sort of sat and spoke to me afterwards because I hadn't met her before and we just and sort of talked generally you know, she said 'I like to sit and talk to the people I've assessed afterwards so they don't sort of think I'm just an assessor', and she asked what I'd learned and what I'd got out of it and what I would like to change on the ward if I could, you know at a general level, she was really nice.

PB That's how it should be. So it varies a bit, there are some people who will do that, other people that won't.

The teaching staff do, certain ward staff do, other ward staff don't.

It just shows whether they enjoy assessing or not, whether its a bind to them or whether they enjoy what they're doing.

PB Can I ask you briefly if you can describe to me how your teaching and counselling skills were assessed specifically?

I think really my teaching (assessment) was one of the falsest lessons that I've done because I don't think really you'd sit a resident down, because I did hydrotherapy, and I did this session when I took a resident into the pool and what have you, and I taught this junior nurse. I don't think you'd do that in a normal situation.

PB Right. Is that a feeling shared by anyone else?

It just depends exactly what you are teaching, because some things you have to sit down and go through with them.

I think its good in the future that we may be teaching junior nurses and not just residents. Hopefully when we become staff nurses we will be teaching a whole range of people. I think you still possess the same

teaching skills but on a different level. If you're aiming it at residents you might aim it at a slightly lower level than at the nurses.

PB Have you been deliberately taught how to teach in your training, or is it something you have picked up along the way?

We've been taught quite a few of the skills that go along with it.

But then I think in turn you sort of pick up your own way of teaching, you pick little bits out from what you've actually been taught, but you do your own little bit, you know.

PB What about counselling? The research is showing that counselling is number one in terms of the skill base for mental handicap nursing, including bereavement counselling. Has this consciously been taught to you?

I think we did it in role play.

PB Does it happen on the wards that you can apply some counselling skills?

I think you are doing it virtually all the time, not consciously.

I think you are conscious of it on probably more wards than others, depending on your residents again.

PB Can you counsel unconsciously?

If you know that someone's got a specific problem and you are aware of it then I think yes you do gear your counselling towards that problem. Sometimes you may do it without actually realising, you're probably just offering not advice but in a roundabout way, or you could do it sort of

more directly, sort of try consciously to bring the person out of themselves.

PB What about the parents and relatives of the residents, do you have much to do with them?

You don't get a lot of chance, you're told to take them to whoever's in charge, and I think generally they want to speak to whoever's in charge.

PB You are going to be in charge aren't you in a few weeks time.

Yes, but the parents tend to know the regular ward staff, if you're drifting in and out from ward to ward you don't have chance to really get to know them.

PB So you were taught counselling skills here in this building were you? I just need to know a bit more from your point of view how the skills are taught in the ward because the vast majority of your work is out there isn't it?

But you also observe what the other staff do don't you, you observe them, you know how they sort of approach different situations and how they counsel people. I think you learn a lot from ward staff. Then again, back to people, different people have different ways of doing it, so I think its up to you then to decide which way you want to adopt it.

PB Have you been taught any particular model of counselling?

No (general consensus).

PB Have you been taught any particular model of nursing?

(A very long silence followed by muttered comments and embarrassed laughter).

PB The last people I interviewed here gave exactly the same response. Finally then while we are talking about nursing models, although the nursing process is not a model its still very much part of the scene isn't it and 99% of my respondents said that their training course involved the nursing process as yours has done because it is part of the 1982 syllabus and is a necessity. Is it still relevant do you think?

Yes I think so (general agreement).

PB Why do you say that?

Because it relates so much to your residents doesn't it, its a teaching thing, you are looking at them all the time and trying to involve them.

It gives you a basis, its what you are geared towards isn't it.

That is if you stick to the routine that the Nursing Process lays down, if you're aware of all the areas then you can work round it.

PB Are your residents becoming more dependent upon you as time goes by or are the best ones going and those that require more nursing are staying?

Yes, I think we've seen that more than many really. When we started there were quite a lot of residents but now we've lost quite a lot. I think we've noticed it a lot more than others.

PB So the Nursing Process format, the four bits of it relate probably to the high dependency resident in a very positive way. The assessment, planning and carrying out of care and the evaluation, all seem to fit.

Anything finally?

No response. End

APPENDIX IX

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING

MENTAL HANDICAP NURSING

BRANCH PROGRAMME - DEVELOPMENTAL STAGES

Stage 1 : Determining the Primary Skill Base

Research has demonstrated the existence of well defined sets of primary skills around which the role of the nurse can be established, Birchenall (1988). These skill sets fall into six categories:

(a) Counselling for care.

(b) Communication - understanding the person in the management of self and others.

(c) Teaching skills/skills teaching - creating a positive therapeutic environment.

(d) Community skills - managing a case load/family care skills.

(e) Research skills.

(f) Physical nursing skills.

It appears that a prerequisite for successful role performance can be represented by these interpersonal skills which are considered to be important when working with others. This is particularly true when developing effective relationships in a therapeutic or enabling situation. The overriding concern for planners of the Branch Programme has been to encourage such skills associated with responsiveness to a person's needs, personal valuing of the disabled person and normative principles.

Stage 2 : Determining Modules for Learning

'Stand alone' modules which have the facility for integration are the essential components of the programme. Their origins are derived from within the learning outcomes of pre-registration nursing education, as stated by the UKCC. Each of the 12 modules carries a defined statement of competence. The Primary Skill Bases have a complement of discrete skills employed to identify key elements allied to the aims of each module. In turn, the key elements form the knowledge profile and give direction to strategies for teaching and learning. Each module is linked with the CFP to provide curriculum continuity.

Stage 3 : Content of the Programme

Stage 3 represents the 12 modules, complete with competency statements and key elements. Flexibility is incorporated within the programme to allow freedom of interpretation in accord with local needs. The interchangeable nature of each module provides for maximum effectiveness within the stated competencies.

Stage 4 : Performance Assessment Criteria

Continuous assessment of theory and practice will be the most suitable mode of performance measurement. The programme design gives curriculum planning teams an opportunity to incorporate summative and formative assessment criteria as an integral whole. This will have the dual function of (a) assessing competence, and (b) enhancement of learning.

This Process of Design is represented diagrammatically overleaf.

BRANCH PROGRAMME - STAGES OF DEVELOPMENT

Six Primary Skill Sets

(determined through research)

Modules of Learning

Discrete skills integrated with Primary

Skill Sets and stated competencies

Content of Branch Programme

Determined by skills and knowledge related to each module through:

(a) Clear points of identification with CFP

(b) Primary skill sets with related discrete skills.

(c) Integrated/stand alone modules.

Performance Assessment Criteria

Continuously assessed in alignment with ENB guidelines

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V3 Age of Respondents

V1	V3 COUNT / ROW PCT	18-21 (1)	22-29 (2)	30-39 (3)	Over 39 (4)	ROW TOTAL
Location 1			9 81.8	2 18.2		11 13.8
Location 2		6 42.9	7 50.0	1 7.1		14 17.5
Location 3		2 18.2	7 63.6	1 9.1	1 9.1	11 13.8
Location 4		1 20.0	3 60.0	1 20.0		5 6.3
Location 5		1 20.0	2 40.0	2 40.0		5 6.3
Location 6		4 57.1	3 42.9			7 8.8
Location 7		1 25.0	3 75.0			4 5.0
Location 8		7 58.3	3 25.0	2 16.7		12 15.0
Location 9		5 45.5	5 45.5	1 9.1		11 13.8
	COLUMN TOTAL	27 33.8	42 52.5	10 12.5	1 1.3	80 100.0

Table 1: Respondents' Age Range

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V4 Gender

V1	V4 Male (1)	V4 Female (2)	ROW TOTAL
Location 1	1 9.1	10 90.9	11 13.8
Location 2	3 21.4	11 78.6	14 17.5
Location 3	4 36.4	7 63.6	11 13.8
Location 4		5 100.0	5 6.3
Location 5	2 40.0	3 60.0	5 6.3
Location 6		7 100.0	7 8.8
Location 7	2 50.0	2 50.0	4 5.0
Location 8	3 25.0	9 75.0	12 15.0
Location 9	3 27.3	8 72.7	11 13.8
COLUMN TOTAL	18 22.5	62 77.5	80 100.0

Table 2: Respondents' Gender

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V5 Previous Occupation

V1	COUNT / ROW PCT	V5 No Response 0	Office: Indust: Sales 1	From FT Educ. 2	Nursing: Caring: Vol Work 3	Other- Incl. HM Forces 4	ROW TOTAL
Location 1			3 30.0	1 10.0	6 60.0		10 13.2
Location 2			5 38.5		7 53.8	1 7.7	13 17.1
Location 3			1 9.1	3 27.3	7 63.6		11 14.5
Location 4			4 80.0	1 20.0			5 6.6
Location 5		.	1 20.0	1 20.0	1 20.0	2 40.0	5 6.6
Location 6		2 28.6	4 57.1		1 14.3		7 9.2
Location 7			2 50.0		2 50.0		4 5.3
Location 8		3 25.0	6 50.0	1 8.3	2 16.7		12 15.8
Location 9			3 33.3		6 66.7		9 11.8
	COLUMN TOTAL	5 6.6	29 38.2	7 9.2	32 42.1	3 3.9	76 100.0

Number of Missing Observations: 4

Table 3: Respondents' previous occupation

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V9 Special Nursing Skills

V1	V9 disagree (1)	V9 agree (2)	ROW TOTAL
Location 1		11 100.0	11 13.8
Location 2		14 100.0	14 17.5
Location 3		11 100.0	11 13.8
Location 4		5 100.0	5 6.3
Location 5	2 40.0	3 60.0	5 6.3
Location 6	3 42.9	4 57.1	7 8.8
Location 7		4 100.0	4 5.0
Location 8	2 16.7	10 83.3	12 15.0
Location 9	2 18.2	9 81.8	11 13.8
COLUMN TOTAL	9 11.3	71 88.8	80 100.0

Table 4: Special nursing skills are an essential feature of mental handicap nursing.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V10 Theoretical Aspects of Nursing

V1	COUNT / ROW PCT	V10 disagree (1)	V10 agree (2)	ROW TOTAL
Location 1		1 / 9.1	10 / 90.9	11 / 13.9
Location 2			14 / 100.0	14 / 17.7
Location 3		7 / 63.6	4 / 36.4	11 / 13.9
Location 4			5 / 100.0	5 / 6.3
Location 5		1 / 20.0	4 / 80.0	5 / 6.3
Location 6		2 / 33.3	4 / 66.7	6 / 7.6
Location 7		2 / 50.0	2 / 50.0	4 / 5.1
Location 8		2 / 16.7	10 / 83.3	12 / 15.2
Location 9		1 / 9.1	10 / 90.9	11 / 13.9
	COLUMN TOTAL	16 / 20.3	63 / 79.7	79 / 100.0

Number of Missing Observations = 1

Table 5: The theoretical aspects of my course were not always relevant to the practical situation.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V11 Practice: Theory Relationship

V1	COUNT / ROW PCT	V11: 1 (disagree)	V11: 2 (agree)	ROW TOTAL
Location 1		7	3	10
		70.0	30.0	13.0
Location 2		9	4	13
		69.2	30.8	16.9
Location 3		9	2	11
		81.8	18.2	14.3
Location 4		5		5
		100.0		6.5
Location 5		5		5
		100.0		6.5
Location 6		5	1	6
		83.3	16.7	7.8
Location 7		4		4
		100.0		5.2
Location 8		8	4	12
		66.7	33.3	15.6
Location 9		2	9	11
		18.2	81.8	14.3
	COLUMN TOTAL	54	23	77
		70.1	29.9	100.0

Number of Missing Observations: 3

Table 6: During my practical placements there has been times when I was expected to carry out skilled activities not underpinned by the theoretical content of the course (eg Behaviour modification).

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V12 Integration of Theory with Practice

V1	COUNT / ROW PCT	V12 disagree (1)	V12 agree (2)	ROW TOTAL
Location 1		5 / 45.5	6 / 54.5	11 / 13.9
Location 2		6 / 42.9	8 / 57.1	14 / 17.7
Location 3		3 / 30.0	7 / 70.0	10 / 12.7
Location 4		4 / 80.0	1 / 20.0	5 / 6.3
Location 5		1 / 20.0	4 / 80.0	5 / 6.3
Location 6		1 / 14.3	6 / 85.7	7 / 8.9
Location 7			4 / 100.0	4 / 5.1
Location 8		3 / 25.0	9 / 75.0	12 / 15.2
Location 9		5 / 45.5	6 / 54.5	11 / 13.9
	COLUMN TOTAL	28 / 35.4	51 / 64.6	79 / 100.0

Number of Missing Observations: 1

Table 7: During my course sufficient emphasis has been given to the integration of theory and practice.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V13 Modern Care Practices

V1	COUNT / ROW PCT	V13 disagree (1)	V13 agree (2)	ROW TOTAL
Location 1			11 100.0	11 13.8
Location 2		1 7.1	13 92.9	14 17.5
Location 3			11 100.0	11 13.8
Location 4			5 100.0	5 6.3
Location 5		1 20.0	4 80.0	5 6.3
Location 6			7 100.0	7 8.8
Location 7			4 100.0	4 5.0
Location 8			12 100.0	12 15.0
Location 9			11 100.0	11 13.8
	COLUMN TOTAL	2 2.5	78 97.5	80 100.0

Table 8: Modern care practices demand that RNMH qualified nurses have a substantial profile of skill in community, educational, and theraputic aspects of care.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V14 The Nursing Process

V1	V14 COUNT / ROW PCT	disagree 1	agree 2	ROW TOTAL
Location 1		1 9.1	10 90.9	11 13.8
Location 2			14 100.0	14 17.5
Location 3		1 9.1	10 90.9	11 13.8
Location 4			5 100.0	5 6.3
Location 5			5 100.0	5 6.3
Location 6			7 100.0	7 8.8
Location 7			4 100.0	4 5.0
Location 8			12 100.0	12 15.0
Location 9			11 100.0	11 13.8
	COLUMN TOTAL	2 2.5	78 97.5	80 100.0

Table 9: The essential framework of care offered by the Nursing Process was a feature of your course.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V15 Individual Care Planning

V1	COUNT / ROW PCT	V15 disagree (1)	V15 agree (2)	ROW TOTAL
Location 1			11 100.0	11 13.8
Location 2		1 7.1	13 92.9	14 17.5
Location 3			11 100.0	11 13.8
Location 4			5 100.0	5 6.3
Location 5		1 20.0	4 80.0	5 6.3
Location 6			7 100.0	7 8.8
Location 7			4 100.0	4 5.0
Location 8			12 100.0	12 15.0
Location 9			11 100.0	11 13.8
	COLUMN TOTAL	2 2.5	78 97.5	80 100.0

Table 10: Individual care planning based on an appropriate model of nursing is encouraged within the school of nursing.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V16 Normalisation: Independent Living

V1	COUNT / ROW PCT	V16 disagree (1)	V16 agree (2)	ROW TOTAL
Location 1		1	10	11
		9.1	90.9	13.9
Location 2			14	14
			100.0	17.7
Location 3		3	8	11
		27.3	72.7	13.9
Location 4			5	5
			100.0	6.3
Location 5			5	5
			100.0	6.3
Location 6			7	7
			100.0	8.9
Location 7			4	4
			100.0	5.1
Location 8		1	11	12
		8.3	91.7	15.2
Location 9		1	9	10
		10.0	90.0	12.7
	COLUMN TOTAL	6	73	79
		7.6	92.4	100.0

Number of Missing Observations: 1

Table 11: The theory and practice of care associated with normalisation and independent community living featured prominently in my course.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V17 Health: Sex Education

V1	COUNT / ROW PCT	V17 disagree (1)	V17 agree (2)	ROW TOTAL
Location 1		5	6	11
		45.5	54.5	13.9
Location 2		5	9	14
		35.7	64.3	17.7
Location 3		5	5	10
		50.0	50.0	12.7
Location 4			5	5
			100.0	6.3
Location 5		1	4	5
		20.0	80.0	6.3
Location 6		1	6	7
		14.3	85.7	8.9
Location 7			4	4
			100.0	5.1
Location 8		6	6	12
		50.0	50.0	15.2
Location 9		4	7	11
		36.4	63.6	13.9
	COLUMN TOTAL	27	52	79
		34.2	65.8	100.0

Number of Missing Observations: 1

Table 12: Health education and sex education for people with mental handicap featured strongly in my course.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V18 Comm. Education and Theraputic Care Aspects.

V1	V18 COUNT / ROW PCT	disagree 1	agree 2	ROW TOTAL
Location 1		1 9.1	10 90.9	11 13.8
Location 2		1 7.1	13 92.9	14 17.5
Location 3			11 100.0	11 13.8
Location 4		2 40.0	3 60.0	5 6.3
Location 5			5 100.0	5 6.3
Location 6			7 100.0	7 8.8
Location 7			4 100.0	4 5.0
Location 8			12 100.0	12 15.0
Location 9			11 100.0	11 13.8
	COLUMN TOTAL	4 5.0	76 95.0	80 100.0

Table 13: Community, educational and theraputic aspects of care featured largely in my course.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V19 Individual Care Planning: Service

V1	COUNT / ROW PCT	V19 disagree (1)	V19 agree (2)	ROW TOTAL
Location 1		9	2	11
		81.8	18.2	13.8
Location 2		8	6	14
		57.1	42.9	17.5
Location 3		10	1	11
		90.9	9.1	13.8
Location 4		3	2	5
		60.0	40.0	6.3
Location 5		5		5
		100.0		6.3
Location 6		7		7
		100.0		8.8
Location 7		4		4
		100.0		5.0
Location 8		8	4	12
		66.7	33.3	15.0
Location 9		9	2	11
		81.8	18.2	13.8
	COLUMN TOTAL	63	17	80
		78.8	21.3	100.0

Table 14: Individual care planning based on an appropriate model of nursing is not encouraged within the service area (including the community).

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V20 Shared Training

V1	COUNT / ROW PCT	V20 disagree (1)	V20 agree (2)	ROW TOTAL
Location 1		3	8	11
		27.3	72.7	13.8
Location 2		1	13	14
		7.1	92.9	17.5
Location 3		4	7	11
		36.4	63.6	13.8
Location 4			5	5
			100.0	6.3
Location 5			5	5
			100.0	6.3
Location 6			7	7
			100.0	8.8
Location 7			4	4
			100.0	5.0
Location 8			12	12
			100.0	15.0
Location 9		1	10	11
		9.1	90.9	13.8
	COLUMN TOTAL	9	71	80
		11.3	88.8	100.0

Table 15: It would be advantageous for mental handicap nursing and social work to share common elements in basic training.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V21 Case Load Management: Interviewing

V1	V21 COUNT / ROW PCT	disagree 1	agree 2	ROW TOTAL
Location 1		2	9	11
		18.2	81.8	13.9
Location 2		3	11	14
		21.4	78.6	17.7
Location 3		5	6	11
		45.5	54.5	13.9
Location 4			5	5
			100.0	6.3
Location 5		5		5
		100.0		6.3
Location 6		4	3	7
		57.1	42.9	8.9
Location 7		2	2	4
		50.0	50.0	5.1
Location 8		6	6	12
		50.0	50.0	15.2
Location 9		4	6	10
		40.0	60.0	12.7
	COLUMN TOTAL	31	48	79
		39.2	60.8	100.0

Number of Missing Observations: 1

Table 16: My course has not equipped me with the following skills:
The skills of interviewing.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V22 Case Load Management: Aims and Objective

		V22		
	COUNT / ROW PCT	disagree 1	agree 2	ROW TOTAL
V1				
Location 1		11 100.0		11 13.8
Location 2		12 85.7	2 14.3	14 17.5
Location 3		11 100.0		11 13.8
Location 4		5 100.0		5 6.3
Location 5		5 100.0		5 6.3
Location 6		7 100.0		7 8.8
Location 7		4 100.0		4 5.0
Location 8		11 91.7	1 8.3	12 15.0
Location 9		10 90.9	1 9.1	11 13.8
	COLUMN TOTAL	76 95.0	4 5.0	80 100.0

Table 17: My course has not equipped me with the following skills:
Setting aims and objectives for care.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V23 Case Load Management: Priorities for Care.

V1	COUNT / ROW PCT	V23 disagree (1)	V23 agree (2)	ROW TOTAL
Location 1		11 / 100.0		11 / 13.8
Location 2		11 / 78.6	3 / 21.4	14 / 17.5
Location 3		11 / 100.0		11 / 13.8
Location 4		5 / 100.0		5 / 6.3
Location 5		4 / 80.0	1 / 20.0	5 / 6.3
Location 6		7 / 100.0		7 / 8.8
Location 7		4 / 100.0		4 / 5.0
Location 8		11 / 91.7	1 / 8.3	12 / 15.0
Location 9		10 / 90.9	1 / 9.1	11 / 13.8
	COLUMN TOTAL	74 / 92.5	6 / 7.5	80 / 100.0

Table 18: My course has not equipped me with the following skills: Planning and determining priorities for care.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V24 Case Load Management: Counselling

V1	COUNT / ROW PCT	V24 disagree (1)	V24 agree (2)	ROW TOTAL
Location 1		8 / 72.7	3 / 27.3	11 / 13.8
Location 2		11 / 78.6	3 / 21.4	14 / 17.5
Location 3		7 / 63.6	4 / 36.4	11 / 13.8
Location 4		5 / 100.0		5 / 6.3
Location 5		5 / 100.0		5 / 6.3
Location 6		7 / 100.0		7 / 8.8
Location 7		4 / 100.0		4 / 5.0
Location 8		11 / 91.7	1 / 8.3	12
Location 9		10 / 90.9	1 / 9.1	11 / 13.8
	COLUMN TOTAL	68 / 85.0	12 / 15.0	80 / 100.0

Table 19: My course has not equipped me with the following skills:
Counselling - listening and responding.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V25 Case Load Management: Outcomes of Nursing.

V1	COUNT / ROW PCT	V25 disagree (1)	V25 agree (2)	ROW TOTAL
Location 1		8 72.7	3 27.3	11 13.9
Location 2		12 85.7	2 14.3	14 17.7
Location 3		8 72.7	3 27.3	11 13.9
Location 4		5 100.0		5 6.3
Location 5		5 100.0		5 6.3
Location 6		7 100.0		7 8.9
Location 7		3 75.0	1 25.0	4 5.1
Location 8		11 91.7	1 8.3	12 15.2
Location 9		8 80.0	2 20.0	10 12.7
	COLUMN TOTAL	67 84.8	12 15.2	79 100.0

Number of Missing Observations: 1

Table 20: My course has not equipped me with the following skills:
Reviewing outcomes of care.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V26 Case Load Management: Family Dynamics

V1	COUNT / ROW PCT	V26 disagree (1)	V26 agree (2)	ROW TOTAL
Location 1		6 / 54.5	5 / 45.5	11 / 13.9
Location 2		7 / 50.0	7 / 50.0	14 / 17.7
Location 3		9 / 81.8	2 / 18.2	11 / 13.9
Location 4		4 / 80.0	1 / 20.0	5 / 6.3
Location 5		5 / 100.0		5 / 6.3
Location 6		7 / 100.0		7 / 8.9
Location 7		4 / 100.0		4 / 5.1
Location 8		10 / 83.3	2 / 16.7	12 / 15.2
Location 9		5 / 50.0	5 / 50.0	10 / 12.7
	COLUMN TOTAL	57 / 72.2	22 / 27.8	79 / 100.0

Number of Missing Observations: 1

Table 21: My course has not equipped me with the following skills:
An understanding of family dynamics.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V27 Skill Development.

V1	COUNT / ROW PCT	V27 Yes (1)	No (2)	Don't Know (3)	ROW TOTAL
Location 1		7 63.6	3 27.3	1 9.1	11 13.9
Location 2		7 50.0	2 14.3	5 35.7	14 17.7
Location 3		9 81.8	2 18.2		11 13.9
Location 4			2 40.0	3 60.0	5 6.3
Location 5		4 80.0		1 20.0	5 6.3
Location 6		1 16.7	1 16.7	4 66.7	6 7.6
Location 7				4 100.0	4 5.1
Location 8		4 33.3	3 25.0	5 41.7	12 15.2
Location 9		2 18.2	5 45.5	4 36.4	11 13.9
	COLUMN TOTAL	34 43.0	18 22.8	27 34.2	79 100.0

Number of Missing Observations: 1

Table 22: Have your tutors taught you the theory of skill development?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V28 Supervised Practice.

V1	COUNT / ROW PCT	V28 Yes 1	No 2	Don't Know 3	ROW TOTAL
Location 1		10 90.9	1 9.1		11 13.8
Location 2		9 64.3	4 28.6	1 7.1	14 17.5
Location 3		10 90.9	1 9.1		11 13.8
Location 4		3 60.0	2 40.0		5 6.3
Location 5		5 100.0			5 6.3
Location 6		5 71.4	1 14.3	1 14.3	7 8.8
Location 7		2 50.0	2 50.0		4 5.0
Location 8		11 91.7		1 8.3	12 15.0
Location 9		11 100.0			11 13.8
	COLUMN TOTAL	66 82.5	11 13.8	3 3.8	80 100.0

Table 23: Have your tutors emphasised the importance of practising skills under qualified supervision?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V29 Feedback: Hospital Placement

V1	V29 COUNT / ROW PCT	Teaching staff 1	Nursing staff 2	Unqual. staff 3	No feedback 5	More than one 9	ROW TOTAL
Location 1			8		1	2	11
			72.7		9.1	18.2	13.8
Location 2		3	8	1	1	1	14
		21.4	57.1	7.1	7.1	7.1	17.5
Location 3			7			4	11
			63.6			36.4	13.8
Location 4			5				5
			100.0				6.3
Location 5			5				5
			100.0				6.3
Location 6		1	4			2	7
		14.3	57.1			28.6	8.8
Location 7		2	2				4
		50.0	50.0				5.0
Location 8			9	2	1		12
			75.0	16.7	8.3		15.0
Location 9		1	8	2			11
		9.1	72.7	18.2			13.8
COLUMN TOTAL		7	56	5	3	9	80
		8.8	70.0	6.3	3.8	11.3	100.0

Table 24: During your hospital practical placements from whom did you most frequently receive positive/helpful feedback regarding your skill development?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V30 Feedback: Community Placement

V1	V30 Teaching staff 1	Qual. CMHN 2	Non-CMHN & qual. others 3	Unqual. staff 4	No feed-back 5	More than one 9	ROW TOTAL
Location 1		5 45.5			3 27.3	3 27.3	11 14.3
Location 2		11 78.6			2 14.3	1 7.1	14 18.2
Location 3		4 40.0	2 20.0		1 10.0	3 30.0	10 13.0
Location 4		3 60.0		1 20.0	1 20.0		5 6.5
Location 5		5 100.0					5 6.5
Location 6	1 14.3	2 28.6	3 42.9			1 14.3	7 9.1
Location 7		3 75.0				1 25.0	4 5.2
Location 8		8 72.7	1 9.1		2 18.2		11 14.3
Location 9	2 20.0	5 50.0	1 10.0	2 20.0			10 13.0
COLUMN TOTAL	3 3.9	46 59.7	7 9.1	3 3.9	9 11.7	9 11.7	77 100.0

NUMBER OF MISSING OBSERVATIONS = 3

Table 25: During your community practical placement from whom did you usually receive positive/helpful feedback regarding your skill development?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V31 Practice under Supervision

V1	COUNT / ROW PCT	V31 Yes (1)	V31 No (2)	ROW TOTAL
Location 1		9 / 81.8	2 / 18.2	11 / 13.9
Location 2		11 / 78.6	3 / 21.4	14 / 17.7
Location 3		9 / 81.8	2 / 18.2	11 / 13.9
Location 4			5 / 100.0	5 / 6.3
Location 5		4 / 100.0		4 / 5.1
Location 6		7 / 100.0		7 / 8.9
Location 7		4 / 100.0		4 / 5.1
Location 8		12 / 100.0		12 / 15.2
Location 9		9 / 81.8	2 / 18.2	11 / 13.9
	COLUMN TOTAL	65 / 82.3	14 / 17.7	79 / 100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 26: During your practical placements have you for most of your time been placed in care situations which enabled you to practice your nursing skills under qualified supervision?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V32 Teaching Skills

V1	COUNT / ROW PCT	V32 Yes (1)	No (2)	Not Sure (3)	ROW TOTAL
Location 1		6 54.5	1 9.1	4 36.4	11 13.8
Location 2		11 78.6		3 21.4	14 17.5
Location 3		11 100.0			11 13.8
Location 4		3 60.0		2 40.0	5 6.3
Location 5		5 100.0			5 6.3
Location 6		6 85.7		1 14.3	7 8.8
Location 7		4 100.0			4 5.0
Location 8		10 83.3	1 8.3	1 8.3	12 15.0
Location 9		8 72.7	1 9.1	2 18.2	11 13.8
	COLUMN TOTAL	64 80.0	3 3.8	13 16.3	80 100.0

Table 27: Mental handicap nursing involves teaching self help skills to residents. Do you feel that you have the teaching ability to adequately meet the requirements of individually designed programmes for your residents?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V35 Ingredients for Independent Living

V1	COUNT / ROW PCT	V35 Disagree 1	Not Sure 2	Agree 3	ROW TOTAL
Location 1		1 9.1		10 90.9	11 13.8
Location 2		2 14.3	1 7.1	11 78.6	14 17.5
Location 3				11 100.0	11 13.8
Location 4				5 100.0	5 6.3
Location 5		1 20.0		4 80.0	5 6.3
Location 6		2 28.6		5 71.4	7 8.8
Location 7		1 25.0	1 25.0	2 50.0	4 5.0
Location 8			2 16.7	10 83.3	12 15.0
Location 9		1 9.1	1 9.1	9 81.8	11 13.8
	COLUMN TOTAL	8 10.0	5 6.3	67 83.8	80 100.0

Table 28: Logical thinking and problem solving abilities are essential ingredients for independent living. Please circle the appropriate response.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V36 Logical Thought and Problem Solving

V1	COUNT / ROW PCT	V36 Yes (1)	V36 No (2)	ROW TOTAL
Location 1		4 / 36.4	7 / 63.6	11 / 14.5
Location 2		5 / 38.5	8 / 61.5	13 / 17.1
Location 3		3 / 33.3	6 / 66.7	9 / 11.8
Location 4			4 / 100.0	4 / 5.3
Location 5		3 / 60.0	2 / 40.0	5 / 6.6
Location 6		3 / 42.9	4 / 57.1	7 / 9.2
Location 7		2 / 50.0	2 / 50.0	4 / 5.3
Location 8		5 / 41.7	7 / 58.3	12 / 15.8
Location 9		4 / 36.4	7 / 63.6	11 / 14.5
	COLUMN TOTAL	29 / 38.2	47 / 61.8	76 / 100.0

Number of Missing Observations: 4

Table 29: Do you believe that profoundly mentally handicapped people can develop the skills required for logical thought and problem solving?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V39 Are Clients Capable of Independent Living?

V1	COUNT / ROW PCT	V39 Yes (1)	V39 No (2)	ROW TOTAL
Location 1		8 / 72.7	3 / 27.3	11 / 14.1
Location 2		9 / 64.3	5 / 35.7	14 / 17.9
Location 3		9 / 81.8	2 / 18.2	11 / 14.1
Location 4		5 / 100.0		5 / 6.4
Location 5		5 / 100.0		5 / 6.4
Location 6		6 / 85.7	1 / 14.3	7 / 9.0
Location 7		4 / 100.0		4 / 5.1
Location 8		8 / 72.7	3 / 27.3	11 / 14.1
Location 9		8 / 80.0	2 / 20.0	10 / 12.8
	COLUMN TOTAL	62 / 79.5	16 / 20.5	78 / 100.0

NUMBER OF MISSING OBSERVATIONS = 2

Table 30: Do you feel that all profoundly mentally handicapped people are capable of achieving some measure of independence?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V42 Role Modelling Skills

V1	COUNT / ROW PCT	V42 Yes (1)	V42 No (2)	ROW TOTAL
Location 1		7 / 63.6	4 / 36.4	11 / 13.8
Location 2		12 / 85.7	2 / 14.3	14 / 17.5
Location 3		9 / 81.8	2 / 18.2	11 / 13.8
Location 4		4 / 80.0	1 / 20.0	5 / 6.3
Location 5		5 / 100.0		5 / 6.3
Location 6		7 / 100.0		7 / 8.8
Location 7		4 / 100.0		4 / 5.0
Location 8		11 / 91.7	1 / 8.3	12 / 15.0
Location 9		5 / 45.5	6 / 54.5	11 / 13.8
	COLUMN TOTAL	64 / 80.0	16 / 20.0	80 / 100.0

Table 31: For people to achieve independence they require good role models. Have you been taught the skills of role modelling?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V43 Awareness of Relationships

V1	V43 COUNT / ROW PCT	Yes 1	No 2	ROW TOTAL
Location 1		8	3	11
		72.7	27.3	14.1
Location 2		12	2	14
		85.7	14.3	17.9
Location 3		8	2	10
		80.0	20.0	12.8
Location 4		3	2	5
		60.0	40.0	6.4
Location 5		5		5
		100.0		6.4
Location 6		7		7
		100.0		9.0
Location 7		2	1	3
		66.7	33.3	3.8
Location 8		11	1	12
		91.7	8.3	15.4
Location 9		3	8	11
		27.3	72.7	14.1
COLUMN TOTAL		59	19	78
		75.6	24.4	100.0

NUMBER OF MISSING OBSERVATIONS = 2

Table 32: People with learning difficulties may find it hard to form relationships, and therefore express a need to be involved in planned and unplanned interactive situations. Did your course make you aware of this?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V45 Listening and Responding

V1	COUNT / ROW PCT	V45 Yes (1)	V45 No (2)	ROW TOTAL
Location 1		8 / 72.7	3 / 27.3	11 / 13.8
Location 2		12 / 85.7	2 / 14.3	14 / 17.5
Location 3		10 / 90.9	1 / 9.1	11 / 13.8
Location 4		5 / 100.0		5 / 6.3
Location 5		5 / 100.0		5 / 6.3
Location 6		7 / 100.0		7 / 8.8
Location 7		4 / 100.0		4 / 5.0
Location 8		11 / 91.7	1 / 8.3	12 / 15.0
Location 9		9 / 81.8	2 / 18.2	11 / 13.8
COLUMN TOTAL		71 / 88.8	9 / 11.3	80 / 100.0

Table 33: Have you been taught the skills of listening and responding to individual's perceived needs?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V47 Leadership Skills

V1	COUNT / ROW PCT	V47 Yes (1)	V47 No (2)	ROW TOTAL
Location 1		8 / 72.7	3 / 27.3	11 / 14.3
Location 2		8 / 57.1	6 / 42.9	14 / 18.2
Location 3		5 / 50.0	5 / 50.0	10 / 13.0
Location 4			5 / 100.0	5 / 6.5
Location 5		3 / 60.0	2 / 40.0	5 / 6.5
Location 6		5 / 71.4	2 / 28.6	7 / 9.1
Location 7		4 / 100.0		4 / 5.2
Location 8		7 / 63.6	4 / 36.4	11 / 14.3
Location 9		2 / 20.0	8 / 80.0	10 / 13.0
	COLUMN TOTAL	42 / 54.5	35 / 45.5	77 / 100.0

NUMBER OF MISSING OBSERVATIONS = 3

Table 34: Working with others in a multi professional team calls for the skills of leadership. Were you taught these skills during your course?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V49 Profiling Skills

V1	COUNT / ROW PCT	V49 Yes (1)	V49 No (2)	ROW TOTAL
Location 1		3 / 30.0	7 / 70.0	10 / 13.9
Location 2		5 / 38.5	8 / 61.5	13 / 18.1
Location 3		2 / 20.0	8 / 80.0	10 / 13.9
Location 4			5 / 100.0	5 / 6.9
Location 5		3 / 60.0	2 / 40.0	5 / 6.9
Location 6		1 / 25.0	3 / 75.0	4 / 5.6
Location 7			4 / 100.0	4 / 5.6
Location 8			11 / 100.0	11 / 15.3
Location 9			10 / 100.0	10 / 13.9
	COLUMN TOTAL	14 / 19.4	58 / 80.6	72 / 100.0

NUMBER OF MISSING OBSERVATIONS = 8

Table 35: Have you been taught the skills of 'profiling'?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V51 Case Conference Membership

V1 / COUNT / ROW PCT	V51 Yes (1)	V51 No (2)	ROW TOTAL
Location 1	9	2	11
	81.8	18.2	13.8
Location 2	14		14
	100.0		17.5
Location 3	9	2	11
	81.8	18.2	13.8
Location 4	3	2	5
	60.0	40.0	6.3
Location 5	5		5
	100.0		6.3
Location 6	4	3	7
	57.1	42.9	8.8
Location 7	4		4
	100.0		5.0
Location 8	10	2	12
	83.3	16.7	15.0
Location 9	6	5	11
	54.5	45.5	13.8
COLUMN TOTAL	64	16	80
	80.0	20.0	100.0

Table 36: Have you been involved as a member of a case conference?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V53 Awareness of Research Findings

V1	COUNT / ROW PCT	V53 Yes (1)	V53 No (2)	ROW TOTAL
Location 1		9 / 81.8	2 / 18.2	11 / 13.9
Location 2		10 / 71.4	4 / 28.6	14 / 17.7
Location 3		7 / 63.6	4 / 36.4	11 / 13.9
Location 4		3 / 60.0	2 / 40.0	5 / 6.3
Location 5		4 / 80.0	1 / 20.0	5 / 6.3
Location 6		4 / 57.1	3 / 42.9	7 / 8.9
Location 7		4 / 100.0		4 / 5.1
Location 8		8 / 72.7	3 / 27.3	11 / 13.9
Location 9		5 / 45.5	6 / 54.5	11 / 13.9
	COLUMN TOTAL	54 / 68.4	25 / 31.6	79 / 100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 37: Were valid research findings used in your course to underpin practical skills development eg. The skills of behaviour modification?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V54 Mental Handicap Nursing: Related Components

V1	COUNT / ROW PCT	V54 Yes (1)	V54 No (2)	ROW TOTAL
Location 1		8 / 80.0	2 / 20.0	10 / 12.7
Location 2		13 / 92.9	1 / 7.1	14 / 17.7
Location 3		11 / 100.0		11 / 13.9
Location 4		5 / 100.0		5 / 6.3
Location 5		5 / 100.0		5 / 6.3
Location 6		7 / 100.0		7 / 8.9
Location 7		4 / 100.0		4 / 5.1
Location 8		12 / 100.0		12 / 15.2
Location 9		9 / 81.8	2 / 18.2	11 / 13.9
	COLUMN TOTAL	74 / 93.7	5 / 6.3	79 / 100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 38: Skills knowledge and values in mental handicap nursing are inter-related. Has this approach been taken in your professional development?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V55 Models of Nursing

V1	COUNT / ROW PCT	V55 Yes (1)	No (2)	Don't know (3)	ROW TOTAL
Location 1		4	2	5	11
		36.4	18.2	45.5	13.9
Location 2		3	11		14
		21.4	78.6		17.7
Location 3		5	3	2	10
		50.0	30.0	20.0	12.7
Location 4		5			5
		100.0			6.3
Location 5		2	3		5
		40.0	60.0		6.3
Location 6			6	1	7
			85.7	14.3	8.9
Location 7		3	1		4
		75.0	25.0		5.1
Location 8		11	1		12
		91.7	8.3		15.2
Location 9		4	3	4	11
		36.4	27.3	36.4	13.9
COLUMN TOTAL		37	30	12	79
		46.8	38.0	15.2	100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 39: Is nurse education in your particular school based on a specific model of nursing?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V56 Roper's Model

V1	COUNT / ROW PCT	V56: Roper (1)	ROW TOTAL
Location 1		3 / 100.0	3 / 9.1
Location 2		3 / 100.0	3 / 9.1
Location 3		5 / 100.0	5 / 15.2
Location 4		5 / 100.0	5 / 15.2
Location 5		1 / 100.0	1 / 3.0
Location 7		3 / 100.0	3 / 9.1
Location 8		11 / 100.0	11 / 33.3
Location 9		2 / 100.0	2 / 6.1
	COLUMN TOTAL	33 / 100.0	33 / 100.0

NUMBER OF MISSING OBSERVATIONS = 47

Table 40: Model in use - Roper

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V58 Henderson's Model

V1	COUNT / ROW PCT	V58 Henderson 3	ROW TOTAL
Location 1		3 / 100.0	3 / 12.5
Location 2		2 / 100.0	2 / 8.3
Location 3		1 / 100.0	1 / 4.2
Location 4		2 / 100.0	2 / 8.3
Location 5		3 / 100.0	3 / 12.5
Location 7		3 / 100.0	3 / 12.5
Location 8		6 / 100.0	6 / 25.0
Location 9		4 / 100.0	4 / 16.7
	COLUMN TOTAL	24 / 100.0	24 / 100.0

NUMBER OF MISSING OBSERVATIONS = 56

Table 41: Model in use - Henderson.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V59 Roy Adaptation Model

V1	COUNT / ROW PCT	V59 Roy Adap-tation 4	ROW TOTAL
Location 1		1 / 100.0	1 / 11.1
Location 2		1 / 100.0	1 / 11.1
Location 5		1 / 100.0	1 / 11.1
Location 8		6 / 100.0	6 / 66.7
	COLUMN TOTAL	9 / 100.0	9 / 100.0

NUMBER OF MISSING OBSERVATIONS = 71

Table 42: Model in use - Roy Adaptation

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V62 Orem's Model

	V62	
COUNT / ROW PCT	Orem	ROW TOTAL
	7	
V1		
Location 2	3 / 100.0	3 / 33.3
Location 8	6 / 100.0	6 / 66.7
COLUMN TOTAL	9 / 100.0	9 / 100.0

NUMBER OF MISSING OBSERVATIONS = 71

Table 43(i): Model in Use - Orem

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V63 Models - Other

	V63	
COUNT / ROW PCT	Other Models	ROW TOTAL
	8	
V1		
Location 1	4 / 100.0	4 / 44.4
Location 8	5 / 100.0	5 / 55.6
COLUMN TOTAL	9 / 100.0	9 / 100.0

NUMBER OF MISSING OBSERVATIONS = 71

Table 43(ii): Other Models in Use

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V64 Nurse Education Is About Passing Exams

V1 / COUNT / ROW PCT	V64 Disagree 1	V64 Agree 2	ROW TOTAL
Location 1	4 36.4	7 63.6	11 13.8
Location 2	8 57.1	6 42.9	14 17.5
Location 3	10 90.9	1 9.1	11 13.8
Location 4	3 60.0	2 40.0	5 6.3
Location 5	5 100.0		5 6.3
Location 6	6 85.7	1 14.3	7 8.8
Location 7	3 75.0	1 25.0	4 5.0
Location 8	7 58.3	5 41.7	12 15.0
Location 9	3 27.3	8 72.7	11 13.8
COLUMN TOTAL	49 61.3	31 38.8	80 100.0

Table 44: Nurse education is primarily concerned with passing examinations.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V65 Practical Assessment: Ward Staff

V1	COUNT / ROW PCT	V65 Disagree 1	V65 Agree 2	ROW TOTAL
Location 1		4	7	11
		36.4	63.6	13.8
Location 2		6	8	14
		42.9	57.1	17.5
Location 3		4	7	11
		36.4	63.6	13.8
Location 4		1	4	5
		20.0	80.0	6.3
Location 5		2	3	5
		40.0	60.0	6.3
Location 6			7	7
			100.0	8.8
Location 7		4		4
		100.0		5.0
Location 8		6	6	12
		50.0	50.0	15.0
Location 9		5	6	11
		45.5	54.5	13.8
COLUMN TOTAL		32	48	80
		40.0	60.0	100.0

Table 45: Practical assessment by ward staff is not the most effective way of measuring learner competence.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V66 Continuous Assessment

V1	V66 Disagree (1)	V66 Agree (2)	ROW TOTAL
Location 1	11		11
	100.0		13.9
Location 2	13	1	14
	92.9	7.1	17.7
Location 3	8	2	10
	80.0	20.0	12.7
Location 4	4	1	5
	80.0	20.0	6.3
Location 5	5		5
	100.0		6.3
Location 6	6	1	7
	85.7	14.3	8.9
Location 7	4		4
	100.0		5.1
Location 8	12		12
	100.0		15.2
Location 9	9	2	11
	81.8	18.2	13.9
COLUMN TOTAL	72	7	79
	91.1	8.9	100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 46: Continuous practical assessment is not a viable alternative to the ward based tests.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V67 Assessments Fit Daily Activities

V1	V67 Disagree (1)	V67 Agree (2)	ROW TOTAL
Location 1	5 / 45.5	6 / 54.5	11 / 13.8
Location 2	10 / 71.4	4 / 28.6	14 / 17.5
Location 3	7 / 63.6	4 / 36.4	11 / 13.8
Location 4	5 / 100.0		5 / 6.3
Location 5		5 / 100.0	5 / 6.3
Location 6	6 / 85.7	1 / 14.3	7 / 8.8
Location 7	3 / 75.0	1 / 25.0	4 / 5.0
Location 8	10 / 83.3	2 / 16.7	12 / 15.0
Location 9	6 / 54.5	5 / 45.5	11 / 13.8
COLUMN TOTAL	52 / 65.0	28 / 35.0	80 / 100.0

Table 47: Practical assessments usually fit naturally and realistically into the daily work activities.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V68 Assessor Preparation

V1	V68 Disagree 1	V68 Agree 2	ROW TOTAL
Location 1	5 / 45.5	6 / 54.5	11 / 13.9
Location 2	4 / 28.6	10 / 71.4	14 / 17.7
Location 3	1 / 9.1	10 / 90.9	11 / 13.9
Location 4	1 / 20.0	4 / 80.0	5 / 6.3
Location 5	1 / 20.0	4 / 80.0	5 / 6.3
Location 6	1 / 14.3	6 / 85.7	7 / 8.9
Location 7	3 / 75.0	1 / 25.0	4 / 5.1
Location 8	9 / 75.0	3 / 25.0	12 / 15.2
Location 9	3 / 30.0	7 / 70.0	10 / 12.7
COLUMN TOTAL	28 / 35.4	51 / 64.6	79 / 100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 48: Assessors appear to be well prepared for their role.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V69 Assessor Attitudes and Approaches

V1	V69 Disagree (1)	V69 Agree (2)	ROW TOTAL
Location 1	7 / 63.6	4 / 36.4	11 / 13.8
Location 2	6 / 42.9	8 / 57.1	14 / 17.5
Location 3	4 / 36.4	7 / 63.6	11 / 13.8
Location 4	3 / 60.0	2 / 40.0	5 / 6.3
Location 5	3 / 60.0	2 / 40.0	5 / 6.3
Location 6	4 / 57.1	3 / 42.9	7 / 8.8
Location 7	1 / 25.0	3 / 75.0	4 / 5.0
Location 8	4 / 33.3	8 / 66.7	12 / 15.0
Location 9	2 / 18.2	9 / 81.8	11 / 13.8
COLUMN TOTAL	34 / 42.5	46 / 57.5	80 / 100.0

Table 49: Practical assessment usually reflects the attitudes and approaches to care held by the assessor, rather than enabling learners to demonstrate their individual skills.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V70 Practical Assessment: Student Strengths

V1 / COUNT / ROW PCT	V70 Disagree 1	V70 Agree 2	ROW TOTAL
Location 1	4 / 36.4	7 / 63.6	11 / 13.9
Location 2	1 / 7.1	13 / 92.9	14 / 17.7
Location 3	1 / 10.0	9 / 90.0	10 / 12.7
Location 4		5 / 100.0	5 / 6.3
Location 5		5 / 100.0	5 / 6.3
Location 6	2 / 28.6	5 / 71.4	7 / 8.9
Location 7	1 / 25.0	3 / 75.0	4 / 5.1
Location 8	1 / 8.3	11 / 91.7	12 / 15.2
Location 9	1 / 9.1	10 / 90.9	11 / 13.9
COLUMN TOTAL	11 / 13.9	68 / 86.1	79 / 100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 50: Each of your practical assessments have identified strengths as well as weaknesses in your nursing skills.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V71 Practical Assessment: Personal Values

V1	V71 COUNT / ROW PCT	Disagree 1	Agree 2	ROW TOTAL
Location 1		1	9	10
		10.0	90.0	12.7
Location 2		2	12	14
		14.3	85.7	17.7
Location 3		3	8	11
		27.3	72.7	13.9
Location 4		2	3	5
		40.0	60.0	6.3
Location 5		1	4	5
		20.0	80.0	6.3
Location 6		1	6	7
		14.3	85.7	8.9
Location 7		1	3	4
		25.0	75.0	5.1
Location 8		6	6	12
		50.0	50.0	15.2
Location 9		4	7	11
		36.4	63.6	13.9
	COLUMN TOTAL	21	58	79
		26.6	73.4	100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 51: Personal values cannot be adequately measured through ward based practical assessment.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V72 Practical Assessment: Personal Opinions

V1	V72 Disagree (1)	V72 Agree (2)	ROW TOTAL
Location 1	5	6	11
	45.5	54.5	13.8
Location 2	11	3	14
	78.6	21.4	17.5
Location 3	7	4	11
	63.6	36.4	13.8
Location 4	5		5
	100.0		6.3
Location 5	1	4	5
	20.0	80.0	6.3
Location 6	4	3	7
	57.1	42.9	8.8
Location 7	1	3	4
	25.0	75.0	5.0
Location 8	3	9	12
	25.0	75.0	15.0
Location 9	9	2	11
	81.8	18.2	13.8
COLUMN TOTAL	46	34	80
	57.5	42.5	100.0

Table 52: You are always encouraged to voice your opinions regarding practical assessment.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V73 Practical Assessment: Use of Care Studies

V1 / COUNT / ROW PCT	V73 Disagree 1	V73 Agree 2	ROW TOTAL
Location 1	8 80.0	2 20.0	10 12.8
Location 2	7 50.0	7 50.0	14 17.9
Location 3	4 40.0	6 60.0	10 12.8
Location 4	4 80.0	1 20.0	5 6.4
Location 5	2 40.0	3 60.0	5 6.4
Location 6	4 57.1	3 42.9	7 9.0
Location 7	3 75.0	1 25.0	4 5.1
Location 8	9 75.0	3 25.0	12 15.4
Location 9	2 18.2	9 81.8	11 14.1
COLUMN TOTAL	43 55.1	35 44.9	78 100.0

NUMBER OF MISSING OBSERVATIONS = 2

Table 53: Care studies are used in your school of nursing as one of the means by which practical assessment is achieved.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V74 Practical Assessment: Learning Experience

V1	V74 Disagree 1	V74 Agree 2	ROW TOTAL
Location 1	2 / 18.2	9 / 81.8	11 / 13.9
Location 2	5 / 35.7	9 / 64.3	14 / 17.7
Location 3	2 / 18.2	9 / 81.8	11 / 13.9
Location 4	3 / 60.0	2 / 40.0	5 / 6.3
Location 5		5 / 100.0	5 / 6.3
Location 6	4 / 57.1	3 / 42.9	7 / 8.9
Location 7		4 / 100.0	4 / 5.1
Location 8	2 / 16.7	10 / 83.3	12 / 15.2
Location 9	2 / 20.0	8 / 80.0	10 / 12.7
COLUMN TOTAL	20 / 25.3	59 / 74.7	79 / 100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 54: Practical assessment is a worthwhile learning experience.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V75 Practical Assessment: Hospital Bias

V1	V75 Disagree (1)	V75 Agree (2)	ROW TOTAL
Location 1	2 / 18.2	9 / 81.8	11 / 13.9
Location 2		14 / 100.0	14 / 17.7
Location 3	1 / 10.0	9 / 90.0	10 / 12.7
Location 4		5 / 100.0	5 / 6.3
Location 5	5 / 100.0		5 / 6.3
Location 6	2 / 28.6	5 / 71.4	7 / 8.9
Location 7	1 / 25.0	3 / 75.0	4 / 5.1
Location 8	2 / 16.7	10 / 83.3	12 / 15.2
Location 9	1 / 9.1	10 / 90.9	11 / 13.9
COLUMN TOTAL	14 / 17.7	65 / 82.3	79 / 100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 55: Practical assessment is heavily biased towards hospital rather than community care.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V76 Practical Assessment: Psychomotor Skills

V1	V76 Disagree 1	V76 Agree 2	ROW TOTAL
Location 1	10	1	11
	90.9	9.1	14.3
Location 2	12		12
	100.0		15.6
Location 3	10		10
	100.0		13.0
Location 4	3	2	5
	60.0	40.0	6.5
Location 5	5		5
	100.0		6.5
Location 6	6	1	7
	85.7	14.3	9.1
Location 7	3	1	4
	75.0	25.0	5.2
Location 8	12		12
	100.0		15.6
Location 9	8	3	11
	72.7	27.3	14.3
COLUMN TOTAL	69	8	77
	89.6	10.4	100.0

NUMBER OF MISSING OBSERVATIONS = 3

Table 56: Practical assessment should concentrate only on psycho motor skills?

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V77 Practical Assessment: Ward Reports

V1	COUNT / ROW PCT	V77 Infrequently 1	V77 Frequently 2	ROW TOTAL
Location 1		1	10	11
		9.1	90.9	13.8
Location 2		1	13	14
		7.1	92.9	17.5
Location 3		3	8	11
		27.3	72.7	13.8
Location 4		2	3	5
		40.0	60.0	6.3
Location 5			5	5
			100.0	6.3
Location 6		1	6	7
		14.3	85.7	8.8
Location 7		1	3	4
		25.0	75.0	5.0
Location 8		3	9	12
		25.0	75.0	15.0
Location 9			11	11
			100.0	13.8
COLUMN TOTAL		12	68	80
		15.0	85.0	100.0

Table 57: Ward reports constantly gave an accurate reflection on my abilities.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V78 Practical Assessment: Student Preparation

V1	V78 Infrequently 1	V78 Frequently 2	ROW TOTAL
Location 1	2 / 18.2	9 / 81.8	11 / 13.8
Location 2	2 / 14.3	12 / 85.7	14 / 17.5
Location 3	1 / 9.1	10 / 90.9	11 / 13.8
Location 4		5 / 100.0	5 / 6.3
Location 5		5 / 100.0	5 / 6.3
Location 6		7 / 100.0	7 / 8.8
Location 7		4 / 100.0	4 / 5.0
Location 8	3 / 25.0	9 / 75.0	12 / 15.0
Location 9	5 / 45.5	6 / 54.5	11 / 13.8
COLUMN TOTAL	13 / 16.3	67 / 83.8	80 / 100.0

Table 58: In the main, I was adequately prepared to undertake practical assessments.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V79 Practical Assessment: Self Assessment

V1	V79 Infrequently 1	V79 Frequently 2	ROW TOTAL
Location 1	4 / 36.4	7 / 63.6	11 / 13.8
Location 2	11 / 78.6	3 / 21.4	14 / 17.5
Location 3	4 / 36.4	7 / 63.6	11 / 13.8
Location 4	4 / 80.0	1 / 20.0	5 / 6.3
Location 5	1 / 20.0	4 / 80.0	5 / 6.3
Location 6		7 / 100.0	7 / 8.8
Location 7	3 / 75.0	1 / 25.0	4 / 5.0
Location 8	7 / 58.3	5 / 41.7	12 / 15.0
Location 9	6 / 54.5	5 / 45.5	11 / 13.8
COLUMN TOTAL	40 / 50.0	40 / 50.0	80 / 100.0

Table 59: I was encouraged to plan and carry out self assessment.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V80 Practical Assessment: Skills Expression

V1	COUNT / ROW PCT	V80 Infrequently 1	V80 Frequently 2	ROW TOTAL
Location 1		4	7	11
		36.4	63.6	13.9
Location 2		8	6	14
		57.1	42.9	17.7
Location 3			11	11
			100.0	13.9
Location 4		3	2	5
		60.0	40.0	6.3
Location 5			5	5
			100.0	6.3
Location 6			7	7
			100.0	8.9
Location 7		2	2	4
		50.0	50.0	5.1
Location 8		2	10	12
		16.7	83.3	15.2
Location 9		6	4	10
		60.0	40.0	12.7
COLUMN TOTAL		25	54	79
		31.6	68.4	100.0

NUMBER OF MISSING OBSERVATIONS = 1

Table 60: My practical assessments provided ample opportunities to express a wide range of skills.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V81 Practical Assessment: Relevant Knowledge

V1	V81 Infrequently (1)	V81 Frequently (2)	ROW TOTAL
Location 1	2 / 18.2	9 / 81.8	11 / 13.8
Location 2	3 / 21.4	11 / 78.6	14 / 17.5
Location 3	1 / 9.1	10 / 90.9	11 / 13.8
Location 4	1 / 20.0	4 / 80.0	5 / 6.3
Location 5		5 / 100.0	5 / 6.3
Location 6		7 / 100.0	7 / 8.8
Location 7		4 / 100.0	4 / 5.0
Location 8	4 / 33.3	8 / 66.7	12 / 15.0
Location 9	1 / 9.1	10 / 90.9	11 / 13.8
COLUMN TOTAL	12 / 15.0	68 / 85.0	80 / 100.0

Table 61: My practical assessments were primarily concerned with relevant nursing knowledge.

C R O S S T A B U L A T I O N O F

V1 Location of Schools of Nursing BY
V82 Awareness of Skills Assessed

V1	COUNT / ROW PCT	V82 Infrequently 1	V82 Frequently 2	ROW TOTAL
Location 1			11	11
			100.0	13.8
Location 2		1	13	14
		7.1	92.9	17.5
Location 3			11	11
			100.0	13.8
Location 4			5	5
			100.0	6.3
Location 5			5	5
			100.0	6.3
Location 6			7	7
			100.0	8.8
Location 7		2	2	4
		50.0	50.0	5.0
Location 8		3	9	12
		25.0	75.0	15.0
Location 9		3	8	11
		27.3	72.7	13.8
COLUMN TOTAL		9	71	80
		11.3	88.8	100.0

Table 62: Prior to an assessment, I was aware of the actual skills to be assessed.