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UNIVERSITY OF SOUTHAMPTON

PATIENT ASSESSMENT OF NURSING CARE

by

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Thesis submitted in accordance with the regulations
for the Degree of Master of Philosophy

1983

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF EDUCATIONAL STUDIES

ADULT EDUCATION

Master of Philosophy

PATIENT ASSESSMENT OF NURSING CARE

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The overall aim of this exploratory study was to investigate the feasibility of patients as recipients of nursing care, assessing that care. The study was also concerned with the nurse learner's perception of her performance as care giver and how both patient's and nurse learner's perceptions would compare with that of the nurse teacher's assessment of the nursing care given.

The broad aim of the study incorporated the following research objectives:-

To identify aspects of nursing care which are important to patients and nurses and which can be assessed by them

To design a 'Patient Assessment of Nursing Care' assessment instrument

To explore the suitability of this method of assessment for use in formative assessment

To furnish information on which to base guidelines for future research.

The study design was formulated with an open empirical approach to the problem, in that there were no set hypotheses to be tested, no pre-design instruments and procedures to be used. The research was based on data obtained from patients' and nurses' responses for the purpose of developing a conceptual framework for understanding and explaining what takes place in giving and receiving nursing care in an assessment situation.

Analysis of the data suggested that the significance of this study lay in the preliminary development of an assessment instrument which is essentially a learning tool but which will certainly require further refinement before it can be used in isolation as a fully developed assessment instrument. However, the 'Patient Assessment of Nursing Care' instrument:-

demonstrated that patients' views about nursing care may be of considerable value in assessing nurses in the affective domain of nursing skills

encouraged the development of nurse learners' social and personal skills

provided a meaningful learning experience

helped to identify nurse learners' strengths, weaknesses and emerging needs

may be used alongside other assessment methods to provide additional information about nurse learners' progress

puts the teacher in the role of the facilitator of learning

The assessment instrument which has been developed as a result of this study is offered as a tentative prototype and a basis for further study by a research team.

ACKNOWLEDGEMENTS

I should like to express my thanks to Miss Vera Darling, Principal Officer of the Joint Board of Clinical Nursing Studies and members of the Joint Board for enabling this exploratory study to be undertaken in centres approved by the Joint Board.

The research was supervised by Professor Paul Fordham and I thank him for his guidance and support.

Special thanks to the many patients who participated in the study, particularly Biddy Shout, Ronald Thackrah and Tasha Williams who were also involved in the judging procedure in the preliminary study. I would like to express my gratitude to the nurse learners who willingly took part in the research and to the ward sisters for their co-operation in setting up the study.

I am indebted to the study co-ordinators who tackled a difficult exercise with great enthusiasm, Elizabeth Comely, Geraldine Ann Copsey, Audrey Davidson, Susan Dolan, Patricia Franklin, Lin Gibbs, Louisa Halliday, Sheila Heard, Sophie Hendriks, Eileen Illenden, Elizabeth Keighley, Diana Oates, Laila Orme and Patricia Turner.

My thanks also to my colleague John Caley who has given me encouragement, valuable advice and constructive criticism throughout the study.

I owe a special debt of gratitude to Dr Helen Macilwaine for statistical help and guidance when the data in the study were being analysed.

Last, but not least, I would like to express my special thanks to Veronica Walton for patiently typing and retyping the manuscript and for assisting with the presentation of data; without her help this thesis would never have materialised.

CHAPTER I: INTRODUCTION

HISTORICAL PERSPECTIVE

Nurse education has undergone considerable development over the past decade and is likely to undergo radical reappraisal and fundamental change in the coming decade following the passing of the Nurses, Midwives and Health Visitors Act 1979; this Act was itself derived from the Report of the Committee on Nursing (Briggs 1972) and the subsequent discussions on it. The Nurses, Midwives and Health Visitors Act dissolves the existing educational bodies and establishes the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. The UKCC together with four National Boards for England, Scotland, Wales and Northern Ireland will take the place of nine existing bodies responsible for registration, discipline and training of nurses, midwives and health visitors. For the first time the key responsibilities for the maintenance and enhancement of education, training and professional conduct of nurses, midwives and health visitors throughout the United Kingdom will be amalgamated. To understand the implications of the Nurses, Midwives and Health Visitors Act 1979 it is necessary to describe briefly the events which preceded the passing of the Act.

During the eighteenth century increasing awareness of the needs of the sick who were also poor, led to the development of new hospitals built and supported entirely by voluntary contributions. However, the voluntary hospital system could not cope adequately with the large numbers of sick people. As a result workhouses (established following the Poor Law Amendment Act of 1834) were inundated with patients for whom they were not intended. The purpose of workhouses was to provide accommodation for those in need, including the destitute, orphans, elderly, widows and the mentally ill, and not to provide treatment for the sick (Bendall and Raybould 1969).

The nineteenth century saw the development of many specialised hospitals for specific treatment of diseases like chest, heart, skin, eyes, ear, nose and throat and fevers; there were also special hospitals for women. Many were built by local authorities because

general hospitals were unable to accommodate those in need of special treatment (Abel-Smith 1964). Further development took place and by the early twentieth century patients were being treated in both voluntary hospitals and local authority hospitals.

Organised training began in parallel with the growth of hospital buildings but this was initially confined to the voluntary hospitals and special hospitals. Before nurse training was established, sick people were often cared for by the family, religious orders or the domestic servant class (Abel-Smith 1964). In the early nineteenth century the notion of nursing as a professional activity emerged at the time marked by the interventions of Florence Nightingale. Following the institution of nurse training, particularly of the Nightingale Training School in 1860 there began a long struggle for State Registration. In 1919, separate Registration Acts for England and Wales, for Scotland and for Ireland, were necessary at that period in history as each country had a separate Ministry of Health (Bendall and Raybould 1969).

The Act for England and Wales created the General Nursing Council for England and Wales which was given the responsibility for maintaining a register of nurses in the following main areas of nursing: general, paediatric, psychiatry and mental subnormality. The GNC is also responsible for controlling standards of training, assessment of learning and professional discipline. These functions will continue to apply until the 1979 Act comes into force in 1983.

In the past the unsatisfactory state of nurse education has been reported in major pieces of work undertaken by Committees; the Nursing Reconstruction Committee (Horder 1942, 1943, 1949), the Report of the Working Party on the Recruitment and Training of Nurses (The Wood Report 1947), A Reform of Nursing Education (The Platt Report 1964) and more recently the Report of the Committee on Nursing (The Briggs Report 1972). The Horder Reports and the Wood Report both dealt inter alia, with nurse training and provoked a wide variety of responses. The Wood Report recommended student status for nurses in training in order to alleviate the problem of a high wastage rate, whilst the Horder Reports emphasised the need to retain the services of trained staff. The Platt Report recommended the separation of nurse education from service. These Reports have been debated and

abandoned, in most cases for financial reasons.

In discussing the history of nurse education White (1982) points out that in the past it had been cheaper to service hospitals with a constant supply of nurse learners than to employ these same nurses after the completion of training. This resulted in a high turnover of trained nurses. The emphasis on the need to attract nurse learners which characterised the Wood Report is therefore understandable. In contrast, the Horder Committee emphasised the need to retain the services of trained nurses which could be interpreted as a reflection of the concern of professional organisations. The dilemma that faced the profession at that time was first of all, the need to provide an economical labour force for the hospitals and secondly, the desire to protect the position of the trained nurse. The discussions about the funding and status of nurse learners and the separation of nurse education from service has continued throughout the years. The service interests of the delivery of care seem always to over-rule the educational interests of learners preparing to enter the profession. However, the Briggs Report (1972) urged the setting up of a single body responsible for professional standards, education and discipline in nursing and midwifery as a structural basis for a fundamental recasting of nurse education which it further recommended should be regarded as a continuing process, with continuity and co-ordination of education between classroom and the clinical field and greater involvement of teachers in the service setting. The structural recommendations of this Report are currently being implemented now by the setting up of the UKCC and the four National Boards for England, Wales, Scotland and Northern Ireland under the terms of the Nurses, Midwives and Health Visitors Act (1979). The present organisations responsible for nurse education will cease to exist after the appointed day in 1983 and the new bodies will become responsible.

The Nurses, Midwives and Health Visitors Act 1979 will profoundly affect the regulation, education and training of nurses immediately after the time when the reorganisation of the National Health Service (1982) has brought about significant changes in the structure of the nursing service. Amongst the chief functions of the UKCC, set up by the 1979 Act will be:-

> 'to establish and improve standards of training and professional conduct for nurses, midwives

> and health visitors' (Nurses, Midwives and Health Visitors Act 1979)

This responsibility is a broad one, but the UKCC will be concerned to ensure that the minimum standards are maintained to govern the kinds and levels of education for those seeking registration, and that the necessary rules to regulate education and training for professional practice are formulated.

BACKGROUND TO THE STUDY

Professional concern with the maintenance of standards of care in the specialist areas of clinical nursing was one of the prime motivating factors which led to the establishment of the Joint Board of Clinical Nursing Studies in 1970 with the following terms of reference:-

> 'To consider and advise on the needs of nurses and midwives for post-certificate clinical training in specialised departments of the hospital service in England and Wales and to co-ordinate and supervise the courses provided as a result of such advice.' (Review of the Work of the Joint Board of Clinical Nursing Studies 1970-1980, p 7)

The year before the reorganisation of the National Health Service in 1974 it was necessary to widen this remit in order to include nurses working in the community.

The objective of the Joint Board is to establish and supervise post basic education in clinical specialties on a national basis, thereby contributing to the professional and personal development of nurses and midwives. The philosophy underlying every aspect of the Joint Board's work has been the belief that post basic clinical nurse education should improve the quality of care given to patients. It is not easy to prove that it does so, but it is reasonable to suppose that appropriate training will help to ensure that the nurse is better equipped for her task and that the patient will benefit.

A wide variety of post basic courses for nurses and midwives has been developed over the last decade by the Joint Board. At the present time these courses are not under statutory control, but courses have to be approved by the Joint Board and the certificates and statements awarded are held in esteem by the nursing profession

(English National Board for Nursing, Midwifery and Health Visiting, Information Bulletin Number 4). Some 80 different courses have been developed and approximately 300 centres are currently approved to run such courses in England. Approximately 2,000 nurses, midwives and health visitors are currently undertaking such courses. In the main, centres are approved within localities where there are schools of nursing and/or midwifery, but a small number are in further and higher education centres, in hospices, or run by the Royal College of Nursing.

Curriculum Development by the Joint Board

The approach to curriculum development adopted by the Joint Board derives largely from the 'objectives model' first proposed by Tyler (1949) and developed by many educationalists including Bloom (1956), Mager (1962), Krathwohl, Bloom and Masia (1964), Popham and Baker (1970) and Rowntree (1974).

Tyler's (1949) formula for stating objectives is to express them in terms which identify both kinds of behaviour to be developed in the learner and the content or area of life in which this behaviour is to operate. Tyler (1949) also states that objectives can be defined with sufficient clarity that the kind of behaviour the learner is expected to acquire can not only be recognised but precisely specified. This is the classic definition of a behavioural objective.

One of the major contributions to the study of objectives is the attempt to produce a taxonomy of educational objectives by Bloom (1956) and Krathwohl, Bloom and Masia (1964). This taxonomy is in two volumes, the first covering the cognitive domain and the second the affective domain. A third volume on the psychomotor domain has not been produced. The taxonomy is designed to be a classification of learner behaviours which represent the intended outcome of the educational process and does not attempt to classify the instructional methods used by teachers or the ways in which they relate to learners, or the different types of instructional materials teachers use. It classifies the intended behaviour of learners - the ways in which individuals are to act, think or feel as a result of participating in some unit of learning.

The work on the objectives model of curriculum theory has been extensive and one line of development has been concerned with precision, clarity and specificity (Mager 1962, Popham and Baker 1970). However, there has been some reaction against too precise specification of objectives; one reason is that it is a means of advancing learners' performances without improving teachers' personal and professional qualities.

Rowntree (1974) contends that there are four main areas of benefit from stating behavioural objectives; communications, content and structure, teaching and learning methods, assessment and evaluation. Rowntree (1974) argues that first of all objectives enable teachers to communicate the intentions of teaching and learning to the learner as well as enabling the teacher to discuss educational intentions with colleagues. Secondly, they help the teacher to select and structure the content of teaching by enabling them to delineate the important topic areas and sequence attainment by building and developing later objectives out of the earlier ones. Thirdly, objectives help the teacher to decide on appropriate learning activities and teaching media. It is only when the teacher knows what the learners should be able to do as a result of learning that a decision can be made about the type of experience they should have and which are the most appropriate teaching materials. The fourth and final value is that they give direction as to the most appropriate means of assessment of learning and of course evaluation; the specificity of the objective helps to ensure that the methods of assessment and evaluation are appropriate to the skills being tested.

The objectives model of curriculum development has been a very contentious issue over the years, particularly in the area of affective objectives and the high level cognitive objectives. This is one of the key problems put forward by Eisner (1967) and Stenhouse (1975) both of whom seem to prefer the process model of curriculum development, which has its goals centred around the process of learning, rather than around the product of learning, in other words, they prefer structuring courses around broadly based aims rather than precise behavioural objectives which emphasise what the learner is going to perform as a result of the course. Stenhouse (1975) says the process model raises problems for the assessment of learners' work, because in its logically pure form it implies that in assessment or appraisal,

the teacher ought to be a critic, not a marker. Stenhouse (1975) further states that the activity in which teacher and learners are engaged has standards and criteria immanent in it and the task of appraisal is that of improving learners' capacity to work to such criteria by critical reaction to completed work. The process model therefore is a critical model, not a marking model and could not be directed towards an examination as an objective. If it were, the quality would be lost as the level of the examination would be of supreme importance and the standards immanent in the subject would be secondary. The process-based curriculum pursues understanding rather than grades; is committed to teacher development and rests on teacher judgment rather than on teacher direction.

The objectives model would seem the appropriate one for Joint Board curricula where the emphasis is on the development of clinical skills. For example, the profession's expectations of a nurse who has completed Joint Board course number 297 - Care of the Elderly and Geriatric Nursing are as follows:-

> 'the nurse will be skilled in the initial and continuous assessment of the physical, psychological and social needs of the elderly in the community and in hospital
>
> the nurse will be skilled in planning, carrying out and evaluating nursing care programmes for the elderly in the community and in the hospital
>
> the nurse will function effectively as a member of the multi-disciplinary team providing care for the elderly
>
> the nurse will be skilled in communication and in establishing good relationships with the elderly person and his family and with colleagues in the multi-disciplinary team
>
> the nurse will have knowledge of and interest in basic teaching methods
>
> the nurse will have an understanding of the management and organisation of the services for the elderly.' (Joint Board of Clinical Nursing Studies, Outline Curriculum Number 297, 1981)

The practice of nursing is an amalgam of cognitive, affective and psychomotor skills, in other words, thinking, feeling and doing. As a great deal of emphasis lies in the 'doing' aspect and a 'qualification'

in nursing implies a safe standard of nursing practice, and exists for the protection of the public, the objectives model can be held to be more appropriate.

Assessment: Joint Board Policy

The policy of the Joint Board on the assessment of the objectives outlined in the course curricula is one of progressive assessment which is interpreted by the Joint Board as:-

> 'a planned series of formal and informal assessments based upon detailed objectives for the theoretical and clinical aspects of the course.' (Assessment Strategy 1982)

The policy of progressive assessment draws upon the theoretical analysis of educational objectives developed by Bloom (1956). The goals for assessing achievement of educational objectives can be summative or formative. Bloom, Hastings and Madaus (1971) define summative assessment as one which provides a measure of the learning outcome of the entire course for the purposes of information and decision making, whereas formative assessments provide feedback on the learners' progress during the course.

The responsibility for planning assessment of course members has been delegated to the course planning team at each of the 300 plus approved centres. The purpose of a course is to enable an individual to function at a high level of skill within a specific clinical setting. The approved centre has considerable responsibility to develop and use valid and reliable methods of assessment. These will enable the competence of the course member to be assessed throughout in various ways to ensure that the objectives are met.

In designing an assessment strategy the course planning teams at approved centres are mainly concerned with the assessments during the course. However, consideration may be given to conducting assessments after completing the course. Assessments before the course begins are most likely to be selection assessments which are used at interview and help to evaluate the applicant's potential for successful completion of the course, whereas assessments at the beginning of a course are used primarily as a means of assessing

knowledge although selected skills and attitudes can also be assessed. The assessments can be prepared in such a way to indicate whether the prerequisite skills, knowledge and attitudes acquired during basic nurse training or as a result of subsequent experience have been retained to a sufficiently high standard. The assessments may also indicate whether the course member already has some of the skills, knowledge and attitudes of the specialty. Assessments are also planned to take place before a unit of learning and include theory and practice based on the defined objectives for the unit; indicates how much the course member already knows about that unit of learning; provides the teachers with information on individual needs and also helps the course member monitor their progress towards achievement of the objectives of the unit.

The information gained from these two types of assessment helps the teaching staff to identify those course members who need remedial teaching or for whom an adjustment should be made to the course programme because certain objectives have already been achieved.

Assessment on completion of a unit of learning seeks to ascertain whether the objectives have been achieved or whether further learning and teaching is needed before the unit can be regarded as having been satisfactorily completed by each course member. It does not however, obviate the need for other assessments during a unit of learning, especially if the unit extends over a long period of time.

Follow up of course members takes place after the course has finished and involves setting target objectives for the self development of the nurse. These should be set by the course member towards the end of the course. Achievement of the nurse's target objectives should be regularly reviewed by nursing staff where the nurse is working (Joint Board of Clinical Nursing Studies: Assessment Strategy 1982).

Examples of the planning of assessments carried out at centres are given in Appendix 1 (page 174). The first example illustrates the assessment strategy for a course in accident and emergency nursing and the second example shows the detailed planning of one unit of learning in a geriatric nursing course.

RATIONALE OF THE STUDY

The assessment of clinical nursing practice is an important yet insufficiently researched area of nursing. In Britain, the most significant piece of work has been carried out by Bendall (1975) in a study which showed incompatibility between what was taught in the classroom and what was practised on the wards. There was conflict between 'ideal theory' and 'real practice'. Hunt (1974) and Hend (1975) also report this conflict. Boreham (1978) attempted to develop a taxonomy of clinical skills and the most recent research studies to be carried out in the area of nurse assessment were two surveys of assessment methods employed on Joint Board courses conducted by Bridge and Clamp (unpublished 1979) and Scott (unpublished 1982). These studies will be discussed in detail in Chapter III.

Researchers have noted the scarcity of nurse education research:-

> 'there is little research illuminating the situation within nurse training, except, in the field of recruitment and wastage' (Bendall 1975, p 11)

> 'because of the dearth of studies on the process of learning and teaching nurses, the first phase had of necessity, to be an exploratory one' (Marson 1981, p 4)

It is from this background of assessment of clinical nursing practice that this study has evolved.

AIM OF THE STUDY

This study was to be an exploratory investigation of the possibility that patients may be asked for their opinions of the performance of nurses undertaking Joint Board courses. Would it be feasible to ask patients to assess the nurse as a care-giver from their own unique and special perspective? Further, how would such patient assessments compare with the assessment of the nurse learner and the nurse teacher? This study was designed to explore the possibility of developing a standardised tool which could be used by patients, nurse learners and nurse teachers. Such an assessment tool would allow for the comparison of the three perspectives, the care-giver, the cared-for and the teacher of caring. The patient, it was

believed, could have some unique and special insight into the process of caring which has not yet been utilised as a resource in the educational assessment of nurses.

For the purpose of this study, patient assessment is defined by the researcher as:-

> a learning experience in which different perspectives are obtained to help the nurse gain insight into her own reactions, how patients feel about their conditions, what kind of nursing care they receive and how it could be improved.

Assessments are carried out by three people, the patient, the nurse learner and a nurse teacher. This type of assessment is designed to facilitate learning and should be developed and used alongside other assessment tools and not used in isolation. It is essentially a diagnostic appraisal, not a grading or marking assessment even though it may use test measurements or observations provided by assessment, and is not intended to be directed towards an examination as an objective.

The study will incorporate the following research objectives:-

To identify aspects of nursing care which are important to patients and nurses and which can be assessed by them

To design a 'Patient Assessment of Nursing Care' assessment instrument

To explore the suitability of this method of assessment for use in formative assessment

To furnish information on which to base guidelines for future research.

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CHAPTER II: STATEMENT OF THE PROBLEM

There are many methods of gathering data about a nurse learning the practice of nursing. In each case, one method by itself is of little value. It is only when nursing care is viewed from all facets, that a total picture will emerge.

PAST, PRESENT AND FUTURE TRENDS IN HEALTH CARE

The history of public and preventive medicine in Britain is an integral part of social history over the last two hundred years. By the mid-eighteenth century, medicine had been intensely individual and almost completely palliative in character. It was a time of social change, of great interrelated agricultural and industrial revolutions. The pattern of life changed completely over the years and by the start of the twentieth century a completely different stage in preventive medical history commenced, that of the development of the personal preventive health services.

These changes brought about an increasing social concern with health and welfare, exemplified by the introduction of the National Health Service in 1948. This is demonstrated by the growing proportion of government spending which has been taken up by the social services. In parallel with these developments perceptions of illness by the individual, by society and by the medical and nursing professions have changed. The emphasis in health care is now on prevention and patient participation. The informed patient is more likely to change his life-style to enhance his health and this can be demonstrated by the decrease in cigarette smoking amongst the informed and aware members of society. The Report of the Department of Health and Social Security (1980) has demonstrated clearly the relationship between life-style and health status. The clients of the health care professionals are expected increasingly to accept responsibility for their own health. As the client begins to share responsibility for health care, so it is of increasing value and importance to include the client in all aspects of health care delivery. It is therefore reasonable to suggest that the consumer of nursing care should be invited to assess the performance

of learners within the health care facilities.

The past decade has seen an increase in the influence of consumer movements; the Consumers' Association covers a wide field including health care; the Patients' Association represents the interests of dissatisfied patients; special care groups represent patients from a wide range of specialties. Organisations and groups like these grow yearly and provide a valuable service. Patients are no longer passive recipients of nursing care; they are well informed; both they and their families expect the highest standard of care and just as a business evaluates its product from the point of view of the consumer, so must the quality of nursing care be appraised in terms of wants and needs of the patient. In a paper for the Royal Commission on the National Health Service, Farrell (1980) comments that consumers should have a say in the service for which they pay. However, McFarlane (1980), in another paper for the Royal Commission, makes the more important point that the health care team in its fullest sense includes the patient.

It was George Bernard Shaw who wrote in The Doctor's Dilemma, 'all professions are conspiracies against the laity' and there is no doubt that he had the medical profession in mind. Since then a number of people, including Illich (1977), have attempted to deflate medicine by analysing the excessive power and mystique which doctors have created and to question the model of health care they have evolved.

> 'The medical establishment has become a major threat to health. This disabling impact of professional control over medicine has reached the proportions of an epidemic' (Illich 1977, p 11)

With this opening statement and basic contention, Illich (1977) in his book Limits to Medicine, Medical Nemesis: The Exploration of Health, sets out an uncompromising analysis of contemporary medicine. The latest exponent, Kennedy (1980) in giving The Reith Lectures, points out that doctors in the United Kingdom who represent only 7% of the Health Service workforce wield power disproportionate to their numbers. This is perhaps an analysis which deserves scrutiny by the nursing profession.

PATIENT EDUCATION

Research literature on patient education seems to emphasise four areas: the teaching role of the nurse; assessment of patient knowledge; the importance of giving instruction, and evaluating the effectiveness of instruction. Research in this area has been mainly exploratory and experimental in design.

The role of the nurse in teaching health education to patients has been examined by Pohl (1965). This study disclosed confusion among nurses with regard to the teaching function and their concern about inadequate preparation for this aspect of their role. In the clinical situation Palm (1971) showed that 59% of nurses assigned top priority to patient teaching activities in non-emergency situations as opposed to a choice of other nursing activities.

Assessment of patient knowledge has been the focus in a number of exploratory studies for example, Green, Levine and Deeds (1975) surveyed 311 hypertensive outpatients who were selected at random to answer questions regarding hypertension; 70% of the questions were answered correctly. From this the researchers concluded that although patients had sufficient knowledge about hypertension they had insufficient motivation to change their behaviour to follow medical directions. In another survey conducted by Hartley and Brandt (1967), a non-probability sample of 37 post-mastectomy patients was studied to find out if the amount of knowledge they possessed related to post-mastectomy lymphoedema. Of the patients surveyed, 20 had lymphoedema and their knowledge level was similar to the patients without lymphoedema. In contrast, Wynn (1967) demonstrated the patients' need for information in a study that examined 400 male patients with ischemic heart disease. Wynn (1967) believed that the emotional distress caused by fear in 22% of the patients was related to poor doctor-patient communication. However, 38% of patients in the sample had emotional distress due to lack of information.

Two descriptive studies were carried out by Alt (1966) and Benson (1977) to ascertain what patients wanted to know at the time of discharge. Alt (1966) records that 51% had no questions, 49% had unanswered questions. Benson (1977) surveyed women who used or had used intrauterine contraceptive devices for their response to information pamphlets on the subject. Benson (1977) concluded

that this group of women patients wanted comprehensive information regarding their chosen method of contraception.

Studies to ascertain the effect of patient education include those conducted by Hecht (1974), Deberry, Jeffries and Light (1975) and Salzer (1975). Hecht (1974) studied the effect of patient education and medication compliance in tuberculosis patients and concluded that as the number of teaching exposures increased the percentage of error in taking medication decreased. Deberry et al (1975) reported on the effect of a teaching programme for a group of cardiac patients. Following instruction, the patients knew significantly more about their medications. The researchers argue that time of teaching was important, and inclusion of family members in the teaching programme. However, they did not include these variables in the study. Salzer (1975) evaluated the effectiveness of teaching diabetic patients self care by means of a pre-post-test questionnaire. Only 37% of patients returned the questionnaires. Those respondents reported an increase in self care behaviours following group class teaching sessions. Studies have also been conducted to establish the effectiveness of patient education programmes by Conti, Brandzel and Whitehead (1974) and Merkatz, Smith and Seitz (1974). The research instrument used in these studies was a post-treatment questionnaire to what patients felt about the teaching given to them. In all studies, over 80% of patients were satisfied.

One crucial area of patient education that seems to be omitted is patient participation in the assessment of nursing care. This aspect was emphasised at the inaugural session of the Royal College of Nursing Institute of Advanced Nursing Education in London, September 1979 when Professor Baroness McFarlane of Llandaff said she would like to see:-

> 'a greater burgeoning of professional imagination in the role of the nurse. The caring role had been stressed in the treatment of disease, but the relationship with the patient was a person-centred relationship, and the nurse should allow the patient to join in the assessment of care.'
> (Royal College of Nursing, Nursing Standard, p 1)

This is an important statement particularly when one considers that

nursing is an activity which involves an interaction between at least two people, the nurse and the person for whom she is caring. Other social or interactional skills are needed, such as, communication skills, empathy, understanding of language which might be different from common usage and may have been imbued with a more technical meaning. Blondis and Jackson (1977) point out that:-

> 'Patients have the concept of good and bad in nursing care and they perceive good and bad mainly by the nurse's behaviour. Only a small percentage of patients have the background or sophistication to judge the quality of a procedure. Therefore patients who speak of bad nursing care often do not mean that there was no care or that nursing procedures were done incorrectly. They mean they perceive the nurse's behaviour toward them as bad - the nurse appeared indifferent, callous or cold' (p 100)

The patient as recipient of nursing care is at least one judge of the effectiveness of that care. Patient assessment however, has two major disadvantages. First of all for the patient, who may feel at risk by recording subjective responses which will expose his concerns, attitudes, feelings and emotional state which could be detrimental to him, his family and his friends. Secondly, the nurse may feel a personal threat, or a threat to the interpersonal relationship with the patient, or she may even feel that her own perceived authority may be eroded:-

> 'the individual in this case cannot rely on the other's concern for justice' (Heyman and Shaw 1980, p 193)

Nurse learners may also fear that the assessment information may be given to other patients or peers and used to criticise them.

Unless patients and nurses can be made to understand that this assessment method is to help and not to criticise, patient opinion will be of little use to the nurse learner and nurse teacher. Implicit in patient assessment of nursing care are the principles of reciprocal authority:-

> 'the parties to the ... relationship are presumed to be mutually bound by principles of justice and fair play' (Heyman and Shaw 1980, p 190)

The only area in which patient participation has been actively encouraged is in general medical practice. Since 1972 several general practitioners working independently of each other have set up patient participation groups to discuss problems in the provision of primary health care. There has been a spontaneous growth of groups in England and Wales in places widely separated and the purpose of one group is not identical with that of another. All are embraced in the following definition:-

> 'Certain planned and continuing activities between general practitioners and other primary health care staff, on the one hand, and a group of interested patients on the other; this group should be as representative as possible of the population served by the practice' (Horder 1981, p vi)

As a development of patient participation groups the National Association for Patient Participation in General Practice founded in 1978, was set up to link together all existing patient participation groups and to spread the idea by encouraging and helping new groups to form. Dakin (1980) describes the purpose of the Association:-

> 'The Association believes that patient participation offers new methods which will be essential for further development of health care, by providing feedback to doctors; by improving communication so that patients have a voice in the way the practice is run (through collaboration not confrontation); by educating patients in healthy living and self care, and by improving mutual trust as a move towards more 'open' medicine' (p 35)

The concept underlying patient participation is that health is as much a responsibility of the individual as it is of the doctor.

PATIENT ASSESSMENT OF NURSING CARE

The purpose of assessment in nursing is to motivate the learner to achieve the course objectives, to judge the level of achievement, to evaluate teaching effectiveness and includes the measurement of skills, knowledge and attitudes for certification of professional competence; to the learner assessments are a stimulus and a goal and provide feedback on progress; to staff assessments provide

information about the effectiveness of teaching. There is another crucial aspect of assessment, that is, to help the nurse achieve a consistently realistic capacity for self appraisal. In other words, to cultivate in the nurse the ability to be a realistic judge of the care she gives.

> 'Self assessment is undoubtedly a valuable life skill' (Rowntree 1977, p 144)

This statement provides the most basic reason for self assessment. A nurse with limited skills but with a realistic capacity for appraising them might cope with situations better than a highly skilled nurse who lacks the capacity for self knowledge. Simpson (1976) made this point in the context of medical education.

Self assessment however, is only one device to add to the data about a nurse, and by itself it is insufficient.

In assessment of nursing competence, four questions are worthy of consideration, What to assess? How to assess? Whom to assess? Who should assess? Too often what is being assessed is primarily determined by what can be readily assessed rather than what is relevant. In fact, what happens is that knowledge is assessed as it is the easiest and most frequently measured aspect of learned behaviour. In the case of skills there are a number of behaviours which can be assessed, the most common being:-

> 'speed, accuracy, probability of occurrence, originality, persistence, amount, and correctiveness' (Webb 1970, p 58)

In choosing a method of assessment the question of objective assessment versus subjective assessment must be considered. Frequently, objective assessments run into the problems of validity and subjective assessments become the necessary recourse. When the assessment takes place will depend upon the length of time necessary to acquire the particular skill and knowledge to be assessed.

Nurses undertaking basic or post basic courses are expected to achieve a safe standard of nursing practice. Nurse learners are therefore assessed to ensure that they have reached the required level of competence.

The majority of assessments of nursing competence are carried out by teaching and clinical staff. There are occasions when self assessment and peer assessment may be incorporated into the course assessment strategy. Patient assessment of nursing care as defined in this study (Chapter I, page 11) may be viewed as 'experiential learning', in that it begins with experience and is followed by reflection, discussion, analysis and evaluation of the experience.

> 'The assumption which is made in experiential learning is that we are unlikely to learn from experience unless we assess ambitions and expectations. Another point in relation to experiential learning is that experience is not something already existing and there for the taking; it is what is created by the functioning of cognitive processes' (Sheahan 1980, p 505)

In the example of patient assessment of nursing care which is essentially a diagnostic appraisal, three people, the patient, the nurse learner and the nurse teacher will view the stated objectives differently even though the experience is a common one. The patient will assess the nursing care received, the nurse learner will assess the nursing care given and the nurse teacher will assess the activity of nursing care observed. Judgment by each will depend on the functioning of each assessor's cognitive and affective processes, matched with the objectives for the aspect of care being assessed.

Nurses cannot know too much about what patients want and need. Patients cannot have too much knowledge about health, self care, or the use of the health services. Perhaps the current preoccupation of the nursing profession should be to examine ways in which nurses could be helped to look at their own performance; about this, their patients always have views.

The following conflicts would seem to surround patient assessment of nursing care:-

> Different perspectives of nursing care assessed by three people; the patient's judgment of the effectiveness of nursing care received, the nurse learner's perception of nursing care given and the nurse teacher's assessment of observed nursing care

The risk of the patient recording subjective responses of nursing care which may affect that care

The threat to the nurse of being assessed by a patient for whom she is caring.

This study will therefore examine ways in which patients can participate satisfactorily in the assessment of nursing care.

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CHAPTER III: LEARNING, TEACHING AND ASSESSMENT OF NURSING PRACTICE

The literature will be reviewed in three sections: Nursing Practice; Learning and Teaching; Assessment of Learning. Nursing practice will be reviewed briefly, as the main focus of the study is on learning, teaching and assessment of learning. In order to lay the foundation on which to build and develop an appropriate framework for the study it is necessary to include both aspects because nurse education and patient care are inextricably linked.

Patient centred nursing studies such as this are difficult and problematic to undertake because of the large range of uncontrolled variables such as patients' state of health, coping ability, therapy, and the effect of interventions by other health care providers. This is perhaps one of the reasons why so few studies have been conducted. In Britain the field has been pioneered by such people as Altschul (1968) and Macilwaine (1980) both of whom were concerned with nursing research in the psychiatric field; Hayward (1975) demonstrated that informed post-operative patients requested and received less analgesia than others; Boore (1977) studied pre-operative care of patients and Wilson-Barnett (1978) studied patients' emotional responses to a particular diagnostic procedure. It is hoped that this study may also contribute to patient care as well as nurse education.

SECTION I: NURSING PRACTICE

Nursing encompasses many different activities. Among nurses the perceptions of what nursing is and the understanding and meaning of nursing varies.

Attitudes to nursing and the practice of nursing by the profession are conflicting. On one hand nursing is viewed as basic physical care which is involved with caring for the cleanliness and meeting the intimate needs of another person, while on the other hand, nursing is associated with sophisticated medical and technical care. The latter often becomes the main focus. To confuse the issue further, public perception of nursing is often viewed as an extension of medical practice controlled by the medical profession.

The researcher believes that the concept of nursing is not readily understood by the medical profession, perhaps because of the interdependence of the two professions. The doctor tends to focus on those activities of nursing concerned with the curing function of the doctor's role, which is mainly prescribed treatments and the administration of drugs. It is not viewed as a caring process and is not necessarily associated with assisting the patient in performing activities of daily living (Anderson 1973).

The majority of research-related nursing projects in the past were designed to encourage the development of nurse researchers. Nurses studied role and role preparation, for example, Anderson (1973). The study of both the phenomena with which nursing is concerned and the specifics of nursing care have only recently become a more central focus of research (Boore 1977 and Wilson-Barnett 1978).

Existing definitions of nursing from the literature appear to agree that the major domain of nursing functions and objectives is in assisting the patient in restoration, maintenance and promotion of health. Nursing research has not as yet provided conclusive documentation for the justification of these selected functions. The functions require validation and need more definitive methods for identifying the effect of nursing care on patients' status and recovery.

Descriptions of nursing and the role of the nurse are numerous and yet none suits all facets of nursing. This in itself is indicative of the broad spectrum of situations in which nurses practice. Henderson's (1966) description of the unique function contains the essence of nursing:-

> 'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.' (p 15)

The values in nursing are intrinsic in Henderson's (1966) description and encompass such values as respect and dignity for the individual as a person. Most of all it values the quality of

life. It also implies the intimate nature of nursing; the close relationship between nurse and patient; the empathy and understanding required in assisting the individual with the activities of daily living which are a person's intimate, private needs, whether that person be conscious or unconscious. The purpose is twofold. Firstly, to assist the individual to become independent. This in itself implies patient participation in setting achievable objectives and making decisions about nursing care. Secondly, contributing to health or recovery will include patient education about ways and means of achieving the best possible health.

While Orlando's (1961) concept of nursing is similar to the one stated by Henderson (1966), her insistence that the nurse gets the patient to confirm or validate the impression on which the nurse bases an assumption of the patient's need, is an important contribution to the concept of nursing. Orlando (1961) suggests a further dimension by stating that the process culminating in nursing, is the interaction arising from the behaviour of the patient, the reaction of the nurse, and the action designed for the patient's benefit. This acknowledges the nurse's presence as a therapeutic agent when the interactive process is deliberative using cognitive, affective and psychomotor skills. These aspects would require further planning of the learning process within a given curriculum.

Orem (1971) has analysed nursing practice and listed categories of self caring activities, methods of assisting, systems which delineate variations in the role of the patient and the role of the nurse and the categories of nursing activities. Both Orem (1971) and Henderson (1966) refer to self care categories or daily living activities which are common to all human beings in general. Self care categories can be extended further by turning to the theory of human need by Maslow (1968), that man has innate fundamental requirements which emerge in a hierarchy, from (i) physiological (food, shelter, avoidance of pain, survival); (ii) safety (protection and security); (iii) belongingness (affection and love from family, community and friendship); (iv) esteem (respect, approval, dignity); to (v) self-actualisation (freedom for the fullest development of one's capabilities and to fulfil one's potential). These human needs are both essential in health and during illness, irrespective of

the type of illness, the length of stay in hospital or of individual differences. The distinction is that in health, individuals meet these needs for themselves, whereas in illness they are dependent upon others to meet most of them and therefore for the individual the need becomes a problem.

In general the fundamental requirements at the lower end of Maslow's (1968) hierarchical scale, physiological, safety and belonging, are stimulated through deficiency and determine behaviour when needs are not fulfilled, whilst at the higher end of the scale, requirements for esteem and self-actualisation subsequently occur when other needs have been met. Using this method of analysing needs emphasises the division between task oriented actions at the base of the hierarchy and emotion oriented actions towards the apex.

The principal way in which nursing has developed in recent years is through the approach known as the nursing process. This approach to nursing is based on humanistic theories such as those of Maslow (1968). The main feature of the humanistic approach is concern for the individual. Nursing management in the clinical setting involves management of the environment in which the patient is being nursed and the organisation, management and delivery of the nursing care being given to the patient in that environment. These two aspects are inextricably linked because one has profound implications for the other. The nursing process is the term used to describe the principles of clinical nursing management, drawn from a study of a patient's individual needs, and has been defined in different ways. Orlando (1961) sees the nursing process as based on an assessment of the patient's needs and how he is affected by them; Zimmerman and Gohrke (1970) described it as a systematic appraisal of a patient's needs for nursing care; Little and Carnevali (1971) perceived it as steps taken in planning care and as a problem-identifying exercise and Mayers (1972) saw it as a goal directed, problem-solving exercise. According to Ashworth, Castledine and McFarlane (1978), the nursing process is described as a move towards personalised nursing care which is problem-based and includes assessment of patient's needs as a nursing responsibility. The emphasis here is on patient involvement in the assessment of his nursing needs by discussing and agreeing his problems with the nurse. This new approach requires something totally different from the nurse in terms of patient care and attitudes.

The nursing process involves four main stages. The first stage begins with assessment of the patient's needs, consideration being given to deficiency of self care brought about by disease and its treatment; the patient's reaction to it; the sociological, physiological and emotional needs of the patient since disease cannot be considered as an isolated physical entity. The second stage is to devise an individualised nursing plan that will offer help and assistance to the patient according to need. The objective of individualised care is to promote independence subsequent to self care by the patient. Where self care cannot be achieved the aim should be maximum independence. The third stage in the process is to implement the individualised nursing care plan and the fourth stage is to evaluate the nursing care given.

The nursing process introduced the systematic assessment of patients' needs for nursing care; before this, nursing care was seen as an auxiliary feature of medical treatment. The medical model begins with diagnosis based on symptoms and investigation and progresses to treatment in an attempt to achieve cure and where cure is not possible the remission of symptoms and the alleviation of distress. The nurse acted as the physician's auxiliary and carried out his orders. This led to the development of routine care procedures. Consequently many patients received routine and inappropriate nursing care which did not meet their individual needs. Furthermore, the organisation and management of nursing care by task allocation, supplies physical care to meet physical needs. The patients are seen as eyes, mouths, bowels and their individual psychological and sociological needs may never be considered. Nursing solutions are not synonomous with medical solutions as nursing care is required at all stages during a patient's illness and is not dependent upon cure for a successful outcome. In many instances, for example, colostomy, it may be after cure has been achieved that the real process of caring begins. It is however, important to point out that the profession has taken positive steps in recent years to bridge the gap between the medical model and the nursing process model, and much work has been done to modify nurses' approach to meeting the needs of patients through patient allocation, team nursing and total patient care.

The nursing process approach of assessing patients' individual needs, planning individualised programmes, implementing nursing care plans and evaluating nursing care given, has been criticised by Rogers (1981). The idea of 'wholeness' of existence is central to the concept of unitary man and is the foundation stone of Rogers' (1981) concept of nursing which she calls holistic nursing. Holistic nursing is based on the fact that the whole is greater than the sum of its parts and that nursing must be able to take the parts (of the patient) and unite them together. Rogers (1981) argues that the nursing process is an analytical science which reduces the whole to parts and then deals separately with these parts.

The patient must be approached not as ill but as well, seen as a total harmony. The information required is what kind of person has the disease, not what kind of disease a person has. What Rogers (1981) implies is that nursing must abandon the medical model for one which nursing now calls the nursing model for practice, based on a nursing perspective not on a second-hand medical one.

The concept of holistic nursing will, says Rogers (1981) bring to fruition the art and science of care. It is both a science and an art; the science is the organised body of abstract knowledge reached through research and analysis, while the art is the creative use of that knowledge for peoples' well being. Furthermore, Rogers (1981) contends that nursing is a learned profession and is:-

> 'an organised body of abstract knowledge arrived at by scientific research and logical analysis, not a body of technical skills. This is not to be interpreted that technical skills are not important. Rather it is to point out that technical skills are not those things which identify nursing as a science. Nursing as a body of knowledge then becomes a noun, not a verb as formally' (tape)

She further points out that the tools of nursing can easily be confused with nursing itself, and this has been something of a stumbling block in using the nursing process. Rogers' (1981) view, perhaps for some, strikes at the core of nursing: the importance of new thinking promoting a health concept that is optimistic and moves along a continuum of maximum well being.

It may be suggested that nursing is not a unitary activity for which only a single word needs to be used and to do so displays a primitive understanding of the concept. It destroys the richness and diversity encompassed in nursing.

So far the discussion of nursing has been mainly concerned with concepts of nursing. Henderson (1966) talks about a personal concept, Orlando (1961) has a similar concept, Orem (1971), concepts of nursing practice and Rogers (1981) a holistic concept. Such a large number of theories may be a reflection of lack of consensus about the nature of nursing, but it may also indicate the complexity of nursing and the numerous concepts involved. It is also an indication that a unitary theory of nursing is less likely to emerge than a range of theories.

Among the many theories of nursing Rines and Montag (1976) believe that nursing does not exist nor does it change without the use of principles, theories and concepts. They say that a principle is a fundamental, primary or general law from which others are obtained; theory is a proposed explanation and its standing is still conjectural in contrast to well established propositions that are regarded as reporting facts and because they are partly proved and partly unproved they are always questionable and subject to change; concept is an idea of something formed by mentally combining all the characteristics or particulars. Concepts are therefore projections of ideas, they are not laws or rules like principles or established statements like theories. Ellis (1970) and Foley (1971) have said that theory is not a substitute for reality. Argyris and Schön (1974) support the view that theory is not the opposite of practice and refer to practical common sense theories as well as academic or scientific theories. McFarlane (1977) points out that theories in a practice discipline such as nursing must grow out of practice and be intimately related to that practice. She also emphasises the need for more detailed recording of nursing practice in order to classify and categorise nursing practice. Thus theory and practice interact and can be viewed as two related components in a unified nursing discipline. This is best considered in parallel to the nursing process. Bevis (1973) suggests there are in any process three characteristics: purpose, internal organisation and innovation. Bevis (1973) suggests that if nursing practice is seen as a process,

there are six sub-processes within that process: (i) the stress adaptation process, (ii) the decision making process, (iii) the communication process, (iv) the learning process, (v) the human development process and (vi) the change process. She suggests that the activity of nursing is composed of these sub-processes hence the innovation as they unite to form the whole. The conclusion that may be drawn is that there is an immense range of principles, concepts and theories to be learned in an activity as complex as the practice of nursing;

> 'the cognitive skills and content can only be acquired by repeated analysis of nursing situations using, for example, the nursing process. The skills and knowledge required to carry out the nursing process need repeated practice until they become part of the nurse's approach and repertoire ... This kind of learned behaviour cannot be acquired by rote, only by a careful analysis of real situations and the application of relevant knowledge' (McFarlane 1977, p 267)

Education for the practice discipline of nursing calls for learning to take place in the clinical area but theoretical aspects should be constantly reinforced. In this ideal learning situation there is a triad of spectators, the patient, the nurse learner and the nurse teacher. Collectively, these different perspectives of nursing could be utilised to facilitate learning by stimulating new lines of discussion, analysis and evaluation of the learning experience.

SECTION II: LEARNING AND TEACHING

CONTEMPORARY LEARNING THEORIES

It is important to make the distinction between learning theory and teaching theory. Learning is a complex concept which relies both on the encountering of experience and receptiveness to that experience. However, the word learning is often viewed in a simplistic way, not perceived as being problematic, and is used on a much wider scale than can be implied in any single definition. The Shorter Oxford

English Dictionary defines learning as:-

> 'to get knowledge of (a subject) or skill in (an art, etc.) by study, experience, or teaching.'

Teaching may also be viewed as an elementary process of telling. Referring again to the Shorter Oxford English Dictionary, teaching is defined as follows:-

> 'to impart or convey the knowledge of; to give instruction or lessons in (a subject).'

In the following pages the major contemporary learning theories will be discussed, but because there are often no clearly defined lines of demarcation between each theory, the following classification has been adopted: behaviourist theories; cognitive theories and humanistic theories.

Bigge (1976) makes the distinction between behaviourist and cognitive theories in the following way:-

> 'Whereas a behaviourist teacher desires to change the behaviours of his students in a significant way, a Gestalt (cognitive) field oriented teacher aspires to help students change their understanding of significant problems and situations.' (pp 11-12)

In behaviourist theories, learning is considered to be the linking of stimuli with responses to form settled tendencies or practice. Behaviourists deal with learning as a matter of stimulus and response (frequently abridged to S-R). The individual develops responses to stimuli and the behaviourist is concerned with observing those S-R bonds and the manner in which experience with other stimuli can affect and alter individuals. Change in behaviour is in the learning and conclusions from premisses either by induction or deduction which are made from the direct observation of the effects of input and output variables when applied to particular situations. Behaviourists claim that they are concerned with objective methods of studying learning.

It was Ivan P. Pavlov (1849-1936) a psychologist who, in the course of his experiments on digestive secretions, observed phenomena which are fundamental to stimulus-response theory. For example, the dog in Pavlov's experiments made a conditioned response of salivation

when the animal caught sight of food, that is, before food had actually entered its mouth. Pavlov concluded that this salivation was a learned response as opposed to an innate reflex, and referrred to it as 'conditioning'. Pavlovian conditioning has since been termed 'classical conditioning' to distinguish it from 'operant conditioning' referred to by Skinner (1954).

Skinner (1954) a contemporary psychologist, has made an important contribution to the study of learning by his work on 'operant conditioning'. Skinner's (1954) view of operant conditioning is clearly different from classical conditioning in that it is not a sequence of stimulus response connections, but rather that behaviour is spontaneously sent out by the organism; Skinner (1954) tends to disregard the role of stimuli. There are four principles used in operant conditioning:

positive reinforcement which consists of reward following a particular response

negative reinforcement occurs when a particular response is made to an unpleasant stimulus

the principle of punishment differs from negative reinforcement in that the unpleasant stimulus occurs after the response

omission of reinforcement is when there is no reinforcement to the response and absence of reinforcement will lead to extinction of the response.

The central focus of Skinner's (1954) theory is the concept of reinforcement, which he considers to be the main factor in learning.

Classical conditioning has little relevance for the kinds of learning with which education is concerned. This is because the conditioned response can have no effect on the environment, whereas, operant conditioning operates on the environment and the learned behaviour is instrumental in controlling events.

The work of Gagné (1977) is difficult to classify and will therefore be referred to in discussions covering both behaviourist and cognitive theories. Skinner (1954) and Gagné (1977) have had a great influence on vocational training including nursing. Two

nurse educationalists, Bendall (1977) and Marson (1981) have emphasised the importance of Gagné's work to the practice of nursing. Gagné (1977) has defined learning as:-

> 'a change in human disposition or capability which can be retained and which is simply not ascribable to growth. The kind of change called learning exhibits itself as a behaviour, and the inference of learning is made by comparing what behaviour was possible before the individual was placed in a "learning situation" and what behaviour can be exhibited after such treatment. The change may be, and often is, an increased capability for some type of performance. It may also be an altered disposition of the sort called "attitude", or "interest", or "value". The change must have more than momentary permanence; it must be capable of being retained over some period of time. Finally, it must be distinguishable from the kind of change that is attributable to growth.' (p 3)

Gagné's emphasis is on the end product of learning.

In contrast to behaviourists, the cognitivists have been influenced by the Gestalt field psychologists who describe learning in different terms. Bigge (1976) writes of Gestalt field theories:-

> 'They regard learning as a process of developing new insights or modifying old ones. Insights occur when an individual in pursuing his purposes sees new ways of utilising elements of his environment including his own bodily structure. The noun 'learning' denotes the new insights or meanings that one acquired.' (p 95)

In other words the cognitive theorists developed a concern for cognitions (perceptions, attitudes, beliefs) that the individual has about his environment, and claim that these cognitions determine behaviour. They view learning as a process as well as a product in which cognitions are modified by experience.

Bruner and Anglin (1973) put emphasis on the learner achieving insight and understanding of the whole conceptual pattern of what is being learned:-

> 'Subjects do not mechanically associate specific responses with specific stimuli but rather tend to infer principles or rules underlying the

> patterns which allow them to transfer their learning to a different problem.' (pp 421-422)

A different and more practical insight into learning has emerged under the influence of a humanistic psychologist Carl Rogers (1969) which focuses on the whole person rather than on the mechanistic process sought by behaviourists and the purely intellectual understanding of the cognitivists. This is referred to as significant or experiential learning which Rogers (1969) defines in the following way:-

> 'It has a quality of personal involvement, the whole person in both his feeling and cognitive aspects being in the learning event. It is self-initiated. Even when the impetus or stimulus comes from outside, the sense of discovery, or reaching out of grasping comprehending comes from within, it is pervasive. It makes a difference in the behaviours, the attitudes perhaps even the personality of the learner. It is evaluated by the learner. He knows whether it is meeting his need, whether it leads towards what he wants to know, whether it illuminates the dark area of ignorance he is experiencing. The focus of evaluation we might say, resides definitely in the learner. Its essence is meaning. When such learning takes place, the element of meaning to the learner is built into the whole experience.' (p 5)

Experiential learning is learning from experience rather than being taught. It begins with experience and is followed by reflection, discussion, analysis and evaluation of experience. It has a particular value to the learning and teaching of nursing. As previously emphasised in Section I, page 28 of this chapter, the nursing process approach to nursing is based on humanistic theories such as those of Maslow (1968) where the main distinctive or characteristic part of the humanistic approach is concern for the individual. Experiential learning derived from the humanistic theories shares many similarities with the nursing process. It could therefore be argued, that if there is an individualised approach in the provision of nursing care, individualised learning, teaching and assessing strategies in nurse education should also be developed.

It is suggested that no one learning theory in itself is sufficient. The application of behaviourist, cognitive and humanistic theories would seem necessary in nurse education and to adhere to one

theoretical approach is to deny the diverse nature of human learning.

THE LEARNING PROCESS

While it is true to say that the behaviourist and cognitive schools of learning theory describe the learning process differently there are in fact many similarities. Elam (1964), Ford and Pugno (1964) believe that the structure of a subject is synonymous with the structure of the learning process. This is not the view of Bloom, Hastings and Madaus (1971). They have no argument with the view that the learning in a subject field should have a structure which helps connect different aspects of the learning; provides greater meaning to what otherwise might be a large number of unconnected specifics and that parts of learning are more easily grasped and remembered in relationship to each other than in isolation. Bloom, Hastings and Madaus (1971) go on to say that one advantage of a structure for learning may be for the learner who sees it as a way of arranging learning. When alternative structures are available a disadvantage may be that of overlearning one structure to the detriment of other structures later. In contrast, they favour the structuring of the learning process for the following reasons: the learner can move successfully from one phase of learning to another; is able to participate actively in the learning process; is continually rewarded because the learner is able to see his own progress and is able to move on to more complex tasks. The end result of learning will be a structure of the subject which is meaningful and useful.

BEHAVIOURIST VIEW OF LEARNING

The structure of the learning process has been described by Bloom, Hastings and Madaus (1971) as having three distinguished parts:-

> 'a model of outcomes, the diagnosis of the learner at the beginning of the learning unit, and the instructional process.' (p 13)

To elaborate further on these three parts: first of all 'a model of outcomes' or objectives of instruction can be conveyed in a number of ways. One way is by including a large amount of content

and subject matter that the learner should have learned by the end of the course. However, this does not specify in what way the learner has learned the subject. In most instances of contemporary curriculum development there is an attempt to define in behavioural terms what a learner should attain. Behavioural objectives specify learner behaviour and include ways in which learners should be able to think, act or feel about the subject matter. The behavioural objectives can be made more detailed by specifying the behaviours the learner should possess or exhibit if the objectives have been met. This particular approach has been selected by the Joint Board as being an appropriate one for Joint Board curricula where the emphasis is on the development of clinical skills. However, the results of this study suggest that there is a place for the humanistic approach to learning in the clinical field of nursing and perhaps this point is worthy of consideration by the Joint Board. Secondly, 'the diagnosis of the learner at the beginning of the learning unit' emphasises the need to determine individual learning needs and to identify those aspects which the learner has brought to the learning situation which are beneficial. Inherent in this statement is the teacher's knowledge of the learner, in terms of readiness for learning tasks, appropriate learning sequence for individual learners and preparation for a sequence of learning tasks. Thirdly, the 'instructional process' is dependent upon the interaction among the learner or learners, teacher and the learning environment and all that it contains. It is this interaction that is the crucial factor in a teaching strategy and is an important aspect of curriculum.

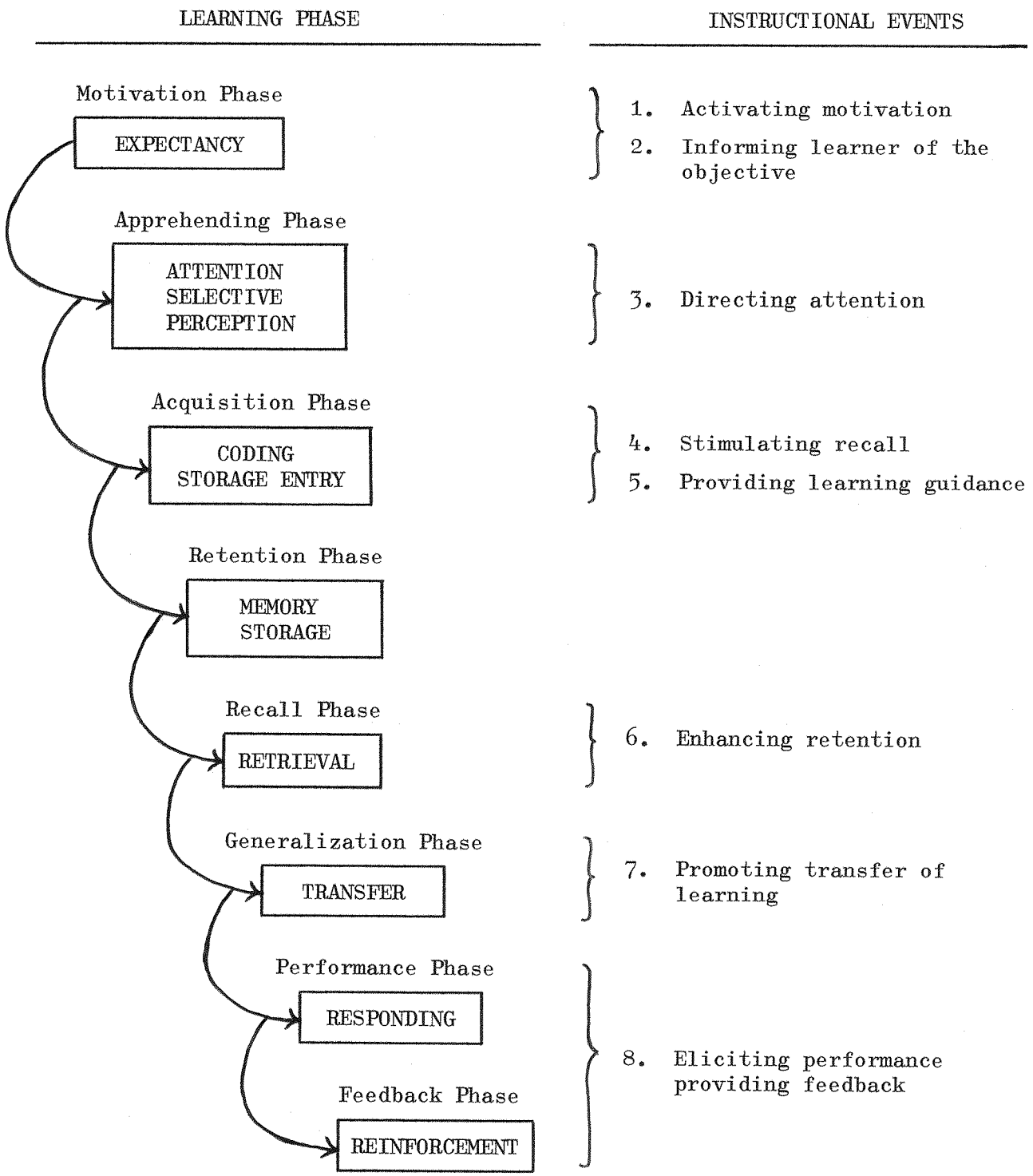
Gagné (1977) identifies a hierarchy of eight types of learning. Each type of learning results in different kinds of behaviour and each needs different conditions to bring it about. Commencing with the lower order categories progressing to the higher order categories they are: signal learning (conditioned behaviour); stimulus-response learning (selective responses to stimuli); motor chain learning (a succession of physical acts performed in a set order); verbal association and sequencing; discrimination (responding differently to different stimuli); concept learning (responding to new stimuli according to their relationship with previously encountered stimuli); principle learning (abstract stage, ideas); and problem solving (recalling learned principles).

Most of nurse education aspires to the categories at the top of the hierarchy. Gagné (1977) emphasises the link between each, the one above depends on the one below. Gagné's (1977) hierarchy of types of learning implies that learning is not all of the same type, and suggests that at the higher end of a hierarchy of learning objectives, the more complex does the type of learning become. The first three stages are simple and fundamental, whilst the categories of discrimination, concepts, principles and problem solving are areas of complex learning. In discrimination learning, the learner must be able to discriminate between things, before being able to place them in categories and conceptualise. Concept learning means concrete concepts (directly observable) and is the stage of learning which every nurse learner should reach to be a safe practitioner. At this level in the hierarchy of learning the nurse learner can generalise as she is not dependent on a specific stimulus to generate a specific response. Once the nurse learner can discriminate and the concept is understood the nurse learner will be able to adapt the learning to meet different situations. Principle learning involves abstract learning and explores the sphere of ideas whereas problem solving is recalling learned principles and where necessary, devising new higher order principles to achieve some objective. What is important in learning is the link between each category, the one above depends on the one below. The level of discrimination must be reached before concept learning can be achieved; concept learning must be reached before principle learning can be achieved; and principle learning must be reached before problem solving can be achieved. Cognitive, psychomotor and affective domains combine when higher levels of learning are attained.

Gagné (1977) also distinguishes eight phases in the act of learning, the processes associated with them and the relationship to instructional events (Figure 1, page 40). To behaviourists the feedback phase is the essence of the learning process and is known as reinforcement. To recall the behaviourists' view, learning is seen in terms of the stimulus-response bond and the accent is on the events external to the learner. When the required response has occurred, the application of a reinforcer will increase the probability of that response being repeated. Restraining reinforcement will reduce the chances of it being repeated and eventually lead to the

Figure 1: Relations between phases of learning and events of instruction

Gagné (1977) Conditions of Learning (p 285)



destruction of that particular response. Skinner (1967) emphasises this point:-

> 'A common generalised conditioned reinforcer is approval. It is often difficult to specify its dimensions. It may be little more than a nod or a smile on the part of someone who characteristically supplies a variety of reinforcements ... because signs of approval frequently precede specific reinforcements appropriate to many states of deprivation. The behaviour they reinforce is likely to be in strength most of the time.' (p 54)

Gagné (1975) emphasises the effect that the environment has on the learner and he further elaborates on this point which critically influences learning:-

> 'Even though the processes of learning are not directly observable they nevertheless can be subjected to influences from the learner's environment. This is what a 'learner' situation amounts to in practice; the 'teacher' brings to bear certain external factors which influence the processes of learning. Thus events may be made to occur which affect motivation of the learner, his attention or any of the other processes.' (p 29)

From the behaviourist viewpoint there seems to emerge four principal ways of influencing the learning process: by direct presentation of stimuli; by activating response to stimuli; by stimulating recall; and by providing reinforcement.

A theme which recurs in the nursing literature is the lack of correlation between theory and practice in nurse education. Bendall (1975), reported that 81% of tutors in her survey thought that they should teach principles rather than details, and 41% of learners thought they gained most from other learners. Hunt (1974), studied the teaching and practice of surgical dressings in three hospitals. She reported discrepancies between what was taught in the classroom and what was practised on the wards where nurse learners gained experience. Dodd (1973) found that nurse learners valued the ward situations as the real learning environment and regarded schools of nursing and nurse tutors as irrelevancies in the practice of nursing. In Bendall's (1977) view this situation could be improved by using

Gagné's approach to learning:-

> 'Gagne's theories are totally applicable for teaching the large part of the nursing syllabus. It means that the learner starts in reality, discovers and discriminates; is helped to categorise, and in discussion with a teacher, builds categories into rules or principles, with the teacher feeding in extra essential knowledge at this stage. If a teacher of nursing follows this theory he or she will automatically reactivate his own skills as a practitioner, will help to turn a syllabus into a curriculum and will rediscover the real.' (p 180)

The importance of reinforcement has already been emphasised and can be used as feedback on a nurse learner's performance. Knowledge of success can reinforce behaviour, so it is particularly important to give immediate feedback on performance, in both clinical and theoretical situations. Extinction can be applied to unwanted behaviour, for example, a nurse learner may dominate a particular teaching session; if the nurse teacher ignores this behaviour it may undergo extinction. Discrimination can be shaped by providing selective reinforcement for nurse learners who have a tendency to use the same format for all written assessments. Selective reinforcement of specific points may shape the learners' responses to the desired form.

COGNITIVE VIEW OF LEARNING

The cognitive view is in direct contrast to behaviourist theories. It is concerned with the thinking, perception and other intellectual functioning of an organism.

The cognitive learning approaches have been influenced by Gestalt psychology which was originally developed from the German philosopher/psychologist's view, first stated in 1912, that an 'organised whole is greater than the sum of its parts' (Marson 1981). The Gestalt psychologists formulated laws of perception:-

Law of similarity:

Similar stimuli tend to be grouped together in one's perception

Law of proximity:

Stimuli in close relationship to each other tend to be grouped together

Law of closure:

Areas which enclose space tend to form a unified whole

Quinn (1982) in discussing these laws of perception says:-

> 'The kind of learning described by Gestalt psychology is called learning by insight, or insightful learning, in which the learner's perception of a situation or problem undergoes a restructuring, and he sees the aspects of the situation in a new relationship to one another. This new relationship forms a unified whole, ... which is meaningful to the learner, who is then said to have insight into the problem or situation.' (p 25)

This sudden insight into a problem applies to human learning. It happens when the 'pieces' come together and there is sudden comprehension and an awareness of how the problem can be solved. The cognitive restructuring which has occurred is 'insightful learning'.

The three principles of similarity, proximity and closure can be applied to nurse education. The main application to the teaching situation is to ensure that the material being taught is the central focus and the environment is viewed as being secondary. The nurse learner should be frequently stimulated by new stimuli which attract attention and keep the nurse learner's concentration on the material being taught; similarities can be introduced to the material being taught so that the nurse learner sees the lesson as a whole, not just in parts; closure can be employed by planning the lesson so that the nurse learner can perceive the completeness of the material being taught.

Another cognitive approach to learning has as its central focus the 'assimilation theory' which, according to Ausubel (1978), is a theory whereby most significant cognitive learning occurs as a result of interaction between new information which an individual acquires, and the specifically relevant cognitive structures he already possesses. The correlation of 'new' and 'old' information results in a more detailed cognitive structure. For Ausubel (1978) all classroom cognitive learning can be categorised into two unrelated dimensions,

namely, meaningful/rote learning and reception/discovery learning.

Ausubel (1978) describes three main types of meaningful learning; first of all 'representational or vocabulary learning' which consists of the learning of single words or what is represented by them; secondly, 'concept learning' which is seen by Ausubel (1978) as, 'objects, events, situations or properties that possess common criterial attributes and are designated by some sign or symbol'; and thirdly, 'propositional learning' in which it is not just the meaning of a single word which is learned but the meaning of complex sentences which contain a multiplicity of ideas.

In reception/discovery learning, the learner is presented with material to be learned in reception learning whereas in discovery learning the learner must discover the material to be learned before it can be assimilated. It is often assumed therefore that reception learning is identical with rote learning, and discovery with meaningful learning. Ausubel (1978), however, contends that both reception and discovery learning may be either meaningful or rote, because the two dimensions are unrelated. Meaningful reception learning can also be considered to be active when the learner is actively assimilating information, whereas discovery learning can be passive in nature if the learner is merely collecting facts without assimilating them.

Ausubel (1978) considers that only cognitive learning as described above has any relevance to the classroom situation and other types of learning such as 'classical conditioning' or 'operant conditioning' should be excluded.

The application of this learning theory in nurse education requires that new information is presented in such a way that it will be related to the information that the nurse learner has already acquired from past experience. The application of this learning theory needs a well planned teaching strategy in which there is a logical sequencing of new information built upon existing information.

A new impetus was given to the field of education by a psychologist Jerome S. Bruner whose name is associated with discovery learning. A strong line of development has stemmed from his clear crystallisation of the issues involved:-

> ' ... The curriculum of a subject should be determined by the most fundamental understanding that can be

> achieved of the underlying principles that give structure to the subject. Teaching specific topics or skills without making clearer their context in the broader fundamental structure of a field of knowledge is uneconomical in several deep senses. In the first place, such teaching makes it exceedingly difficult for the student to generalise from what he has learned to what he will encounter later. In the second place, learning that has fallen short of a grasp of general principles has little reward in terms of intellectual excitement. The best way to create interest in a subject is to render it worth knowing, which means to make the knowledge gained usable in one's thinking beyond the situation in which the learning has occurred. Third, knowledge one has acquired without sufficient structure to tie it together is knowledge that is likely to be forgotten. An unconnected set of facts has a pitiably short half-life in memory. Organising facts in terms of principles and ideas from which they may be inferred is the only known way of reducing the quick rate of loss of human memory.' (Bruner 1960, pp 31-32)

Bruner (1960) argues in terms of transfer of learning, of motivation and of retention. He perceives learning as a process of connected subjects, each with its own structure and method, that have relevance and significance for the learner. He views it as an active process of construction rather than a passive one of reception. The concept of structure is explained by Bruner (1960) as follows:-

> 'Grasping the structure of a subject is understanding it in a way which permits many other things to be related to it meaningfully. To learn structure, in short, is to learn how things are related.' (p 7)

The learning of more complex material is explained by Bruner (1960) in terms of coding systems. It is the way in which the learner groups information together into a set of general categories which are arranged in a hierarchical form. The more specific information is contained in the lowest categories. Ascending the hierarchy, each category becomes more general and less specific than the one below. To recall a specific item it is necessary to recall the coding system of which it is a member. The general principles of a subject are within the upper end of the hierarchy category, and in transfer of learning these previously learned coding systems are applied to new events. Acquisition of such a coding system can be influenced by a number of different learning situations, and in particular discovery learning situations.

Discovery learning involves the learner discovering principles which underlie a specific instance rather than being informed by the teacher. The application of this learning theory in nurse education is to the acquisition of knowledge. The nurse learner must first of all learn the specific aspects of a subject before he can learn the principles which underlie these specifics.

Information processing is a contemporary cognitive theory which has been developed since the advent of computers. This theory focuses on human performance by viewing the individual as a processor of information. Gagné (1977) summarises information processing as follows:-

> 'Stimulation from the learner's environment activates receptors to produce patterns of neural impulses. These patterns persist in the sensory register for a brief interval (some hundredths of a second), from which they may be processed by selective perception into perceived objects and object-qualities, or features. This 'information' may then be stored in short-term memory as auditory, articulatory, or visual images, which are subject to rehearsal. As input to the long-term memory, the information is semantically (or meaningfully) encoded, and then stored in this form. Processes of search may be instituted, followed by the process of retrieval. At this point, the information may be returned to the short-term memory, which is conceived as a 'working' or 'conscious' memory. From this structure, or directly from long-term memory, the response generator is brought into play to generate a suitable response organization. The signal flow from this structure activates effectors which exhibit the human performance. Feedback is provided via the learner's observations of this performance, and the phenomenon of reinforcement establishes the learned entities as capabilities available for future recall, exercise, and use.' (pp 57-59)

Figure 1, page 40 , may be used as an information processing model. This approach can be applied to a number of aspects of learning nursing, for example, the acquisition of skills. It is, however, important to emphasise that the information-processing system has a limited capacity to deal with information, and inputs above this capacity will lead to overload, resulting in inability to perform. This has implications for learning, in that the amount of information must be carefully balanced to avoid overload.

Feedback is a major focus in this theory. The nurse teacher can provide feedback in the form of verbal guidance during the learning of skills and written feedback on theoretical aspects of nursing.

HUMANISTIC APPROACH TO LEARNING

The humanistic approach to learning involves the study of man as a human being with his thoughts, feelings and experiences. It is in direct opposition to the behaviourist viewpoint which looks at man's overt behaviours and disregards feelings and experiences. Humanistic theories differ from cognitive theories, in that the latter emphasises the thinking aspect of man's behaviour to the detriment of the affective component. The humanistic view is summarised by Hamachek (1977):-

> 'It is a psychological stance that focuses not so much in persons' biological drives, but on their goals; not so much on stimuli impinging on them, but on their desires to be or do something; not so much on their past experiences, but on their current circumstances; not so much on life conditions per se, but on the subjective qualities of human experience, the personal meaning of an experience to persons, rather than on their objective, observable responses.' (p 37)

Humanistic theories are therefore concerned with human growth, individual fulfilment and self-actualisation. They emphasise the affective domain as being of equal importance to the cognitive and psychomotor domains.

The humanistic approach to learning and teaching comprises two main principles, namely, teacher-learner relationships and the environment of the classroom.

The two major contributors to the humanistic approach are Abraham H. Maslow and Carl Rogers. Maslow's (1968) theory of a hierarchy of human needs has already been discussed in Section I, page 28 of this chapter in connection with the nursing process.

One of the key concepts to the humanistic approach which Maslow (1971) defined was that of 'self-actualisation'. He stated eight ways in which an individual self-actualises. These include:-

> 'experiencing fully, vividly, selflessly, with full concentration and total absorbtion.' (p 44)

The essence of the humanistic approach is to assist the individual to achieve self actualisation, or as Maslow (1971) states:-

> 'to help the person to become the best that he is able to become.' (p 163)

Rogers (1969) describes two kinds of learning, that which involves the mind only and that which involves the whole person or <u>significant learning</u> or as it is frequently termed, <u>experiential learning</u>. Rogers (1969) feels that teachers:-

> 'fail to recognise that much of the material presented to students in the classroom has, for the student, the same perplexing meaningless quality that learning a list of nonsense syllables has for us.' (p 13)

For the learner this information has no relevance. Rogers (1969) contrasts this with experiential learning:-

> 'The child who has memorised two plus two equals four may one day in his play with blocks or marbles suddenly realise that two and two does make four.' (p 4)

Rogers (1969) has formulated a learner-centred approach to learning which is illustrated in his ten principles of learning:-

1) 'Human beings have a natural potentiality for learning.' (p 157)

Nurse learners enter nursing with a natural enthusiasm to learn which is often destroyed by a rigid, traditional educational system. However, many retain their commitment to nursing and frequently go on to be innovators in the profession. For example, Mrs Ethel Bedford Fenwick, who dominated the nursing scene and nursing politics from 1887-1947 (Hector 1973).

2) 'Significant learning takes place when the subject matter is perceived by the student as having relevance for his own purpose.' (p 158)

This principle emphasises the relevance of the subject matter and is particularly important for the nurse learner in the clinical setting.

3) 'Learning which involves a change in self-organisation - in the perception of oneself - is threatening and tends to be resisted.' (p 159)

With increased medical technology nurse learners' values, attitudes and beliefs are challenged and it is necessary to constantly re-examine these and adapt to meet conflicting issues. Nurse learners require help with the moral and clinical issues with which they are confronted, for example, working in an operating theatre where abortions are performed.

4) 'Those learnings which are threatening to the self are more easily perceived and assimilated when external threats are at a minimum.' (p 159)

Nurse learners in new unfamiliar situations need support and understanding from clinical and teaching staff.

5) 'When threat to self is low, experience can be perceived in a differentiated fashion and learning can proceed.' (p 161)

Self expression has not always been encouraged in nursing. To some extent expression of positive and negative feelings about peers and patients by nurses working in the psychiatric field does take place and through this they learn from their work experience. An example of this is in a therapeutic community. The general field of nursing, however, is not so liberal in its approach.

6) 'Much significant learning is acquired through doing.' (p 162)

Nurse learners could be helped and guided by patient assessment of nursing care, in which there would be patient and teacher involvement and self assessment in the absence of sensure.

7) 'Learning is facilitated when the student participates responsibly in the learning process.' (p 162)

The nursing process approach to nursing care allows the nurse learner to participate actively in the provision of nursing which, if combined with patient assessment of nursing care would provide a tool that would allow the nurse to participate in her own learning.

8) 'Self initiated learning which involves the whole person of the learner - feelings as well as intellect - is the most lasting and pervasive.' (p 162)

This principle emphasises the involvement of the whole person, his thoughts, his feelings, his experiences. Assessment of nursing care therefore should be equally exclusive.

9) 'Independence, creativity and self-reliance are all facilitated when self-criticism and self-evaluation are basic, and evaluation by others is of secondary importance.' (p 163)

The outcome of experiential learning is a self-actualised person. The assessment that matters most is self assessment. This principle is of great importance for nurse learners in encouraging them to critically assess their own performance.

10) 'The most socially useful learning in the modern world is the learning of the process of learning, a continuing openness to experience and incorporation into oneself of the process of change.' (p 163)

This principle emphasises openness to change and is very relevant in learning, teaching and assessing the practice of nursing since medical technology changes constantly and nurses must be prepared to accept and adapt to such changes of nursing care.

Rogers' (1969) approach to learning is contained in these ten principles of learning which emphasise relevance, learner participation and involvement and self evaluation. Rogers (1969) prefers to use the term 'facilitating learning' instead of the more traditional one of teaching. He sees the teacher as a facilitator of learning, a provider of resources for learning and an adviser who shares the learner's feelings as well as his knowledge.

For the particular learning situation, 'patient assessment of nursing care', the ten principles of learning put forward by Rogers (1969) seem most appropriate. To reiterate, the definition of patient assessment of nursing care is:-

> a learning experience in which different perspectives are obtained to help the nurse gain insight into her own reactions, how patients feel about their conditions, what kind of nursing care they receive and how it could be improved.

It is an assessment carried out by the patient, the nurse learner and the nurse teacher. It therefore involves self assessment by the nurse learner; is relevant because it is an assessment of care given by the nurse learner and it involves the patient's perception of care received which may differ from that of the nurse learner. It may be threatening to the nurse learner if free discussion is not encouraged, therefore self expression is an important element in this form of assessment; it is significant learning because the nurse learner is 'doing', and in this way nurse learner participation and involvement facilitates learning, and it involves the nurse learner as a whole person, thoughts, feelings and experiences. The assessment, followed by reflection, discussion, analysis and evaluation of the experience should encourage openness to change.

The nursing process is based on humanistic theories such as those of Maslow (1968). The main feature of the humanistic approach is concern for the individual. The needs of the individual patient provide the basis for the nursing process approach to the delivery of nursing care. The humanistic approach to education focuses on the relationship between the learner and the teacher. Each learner is considered as an individual.

It is important to remain aware that nurse learners are individuals even though they have taken the same course of training. All nurse learners are different with their own set of values, attitudes and standards which will affect the way they individually approach professional moral and ethical issues and in the way they care for patients and their relatives, and work with other members of staff. They should be encouraged to maintain their individuality with their own unique values. The aim should always be to produce a self-actualised nurse. To do this there must be a move away from the traditional methods of learning and teaching towards a more flexible approach to meet the individual nurse learner's needs in the variety of situations in which she works.

The clinical environment is of major importance in learning the practice of nursing and should be a place where psychological safety is apparent and where nurse learners feel at ease. Some of the barriers between nurse learner and nurse teacher may be lessened if free discussion of feelings, attitudes, moral and critical issues

were encouraged more in the clinical setting. This aspect is considered crucial to the humanistic approach to learning.

Conclusion

It is suggested that because of the diversity and complexity of the nature of nursing, no one learning theory in itself is sufficient. It would seem from the learning theories and the processes and conditions of learning discussed, that there is no conclusive evidence as to which instructional process would be best for nurse education. Both behaviourist and cognitive theories are necessary and to adhere to one theoretical approach is to negate the pluralistic nature of human learning. In a way the behaviourist and cognitive views complement each other. Behaviourist theories emphasise the end product of learning, how this can be achieved in the best possible way, and the main application is to the acquisition of clinical nursing skills. Cognitive theories concentrate on the process of learning and the main application is to the acquisition of nursing knowledge. Experiential learning, based on the humanistic theories, seems highly appropriate to the clinical setting where the practice of nursing is learned, taught and assessed. It is perhaps better to select those parts of the theories which are adaptable, appropriate and reliable for the particular learning situation than to rely on one theory.

TEACHING STRATEGIES

As a starting point for analysis the definition of teaching given in the Shorter Oxford English Dictionary is:-

> 'to impart or convey knowledge of; to give instruction or lessons in (a subject).'

Teaching is not simply instruction, but the systematic promotion of learning by whatever means (Stenhouse 1975). The term 'teaching strategies' is used in preference to 'teaching methods' by Stenhouse (1975) as the former implies that the planning of teaching and learning is based on principles, it also emphasises teacher judgment and involves formulating a policy and implementing that policy in practice.

There are, however, differing views about what teaching is. Stenhouse (1975) believes that in devising the teaching strategy aspect of the curriculum, sources of information such as the psychology of learning, developmental psychology, the social psychology and sociology of learning should be utilised. In looking at each of these aspects in turn, Stenhouse (1975) has this to say:-

> 'Motivation and interest are closely and usefully bound into psychologists work on learning, and the curricular atrocities sometimes committed under the sanction of these words are attributable to ignoring the work of psychologists, rather than paying too much attention to it. The distinctions made between blind or rote learning and insightful learning also derive from psychological work. Psychologists' exploration of the role of structure and meaning in learning are an underpinning of, if not the foundation of, a curriculum based on disciplines rather than on the encyclopaedic view of knowledge reflected in the typical nineteenth-century school reader. The conceptual schemes of social learning and the study of emotion in learning are also of clear relevance to work in a curriculum. And transfer of learning is a fundamental and perpetual concern of curriculum developers.' (p 26)

From this statement it can be seen that the work of the psychologists can be used as the tool of the teacher. This is not to say that teachers should be dominated by the work of the psychologists, rather that they should experiment with their findings in a teaching strategy and refute or confirm them.

Stenhouse (1975) points out that developmental psychology has been applied in two main ways in curriculum development; first of all to set limits to readiness, and secondly to provide an understanding of the developmental process as a means of overtaking present developmental norms by means of education. Bruner (1960) can be associated with this aspect in his hypothesis:-

> 'that any subject can be taught effectively in some intellectually honest form to any child at any stage of development.' (p 33)

For Stenhouse (1975), social psychology and sociology have important significance for the development of teaching strategies. The first aspect he views in the context of social psychology and small groups, and comments that the underlying model in most teaching is individual

tuition and that teachers tend to break up the groups they teach and deal with individual learners. To Stenhouse (1975) this could be viewed as generating a sub-culture in the group resulting in the setting up of a cross-group communication system. He further points out that in the past comparatively little attention has been given to making the classroom group a fully interacting sub-culture with educational values.

Commenting on the aspect of sociological work on the relationship of social class to education, Stenhouse (1975) says that these are familiar to all; individuals from working-class backgrounds are disadvantaged as compared to middle-class children. The reason put forward for this is that they are handicapped by what Bernstein (1971) calls the 'restricted code' of their language. Bernstein (1971), however, clarifies this by stating that the spread in habitual linguistic code is an indication of a deeper cultural dissension of values and understandings, in fact, of perception of reality.

Other educationalists concentrate on other aspects. Hirst (1971) feels that there is a great deal of misunderstanding about what teaching is. This seems to be a very important point because how teachers view and understand teaching will affect what they do in the instructional setting. For Hirst (1971) the concept of teaching is dependent upon the concept of learning. What is implied here is that the activity of teaching is the intention to bring about learning. Joyce and Weil (1972) emphasise the values and beliefs of individuals and the environment in which teaching takes place:-

> 'We think of teaching as a process by which teacher and student create a shared environment including a set of values, beliefs (agreement about what is important) which in turn colour their view of reality.' (p 3)

Rogers (1969) thinks that it is a mistake to focus on teaching when the real issue is that of facilitating learning:-

> 'it is most unfortunate that educators and the public think about, and focus on, <u>teaching</u>. It leads them on to a host of questions which are either irrelevant or absurd so far as real education is concerned ... if we focused on the facilitation of <u>learning</u> - how, why, and when the student learns, and how the learning seems and feels from the inside - we might be on a much more profitable track.' (p 125)

Rogers (1969), Joyce and Weil (1972) emphasise the importance of creating a supportive understanding atmosphere in which learning can take place rather than emphasising the activity of teaching.

THEORETICAL APPROACHES TO TEACHING

The instructional teaching model based on the behaviourist view of learning, discussed above, page 37, is a way of sequencing learning and modifying behaviour by manipulating reinforcement whereas, teaching strategies based on information processing models such as those discussed in the section on the cognitive view of the process of learning, page 42, aim to improve the learner's ability to handle and process incoming information. The information processing teaching model requires that, in order to teach effectively, the teacher must have a thorough knowledge of the subject, an understanding of the concepts within that body of knowledge as well as an accurate profile of the learner's progress and difficulties. In contrast, the humanistic approach to learning discussed above, page 47, focuses on the personal sources of the learner, his personal development, his feelings, beliefs and standards. Central to educational objectives and ways of achieving them in this model is emphasis on self as a way of approach to other objectives. The focus of this teaching model is the interpersonal relationship between learner and teacher.

The personal sources teaching model founded in the philosophy of human needs seems contrary to the instructional teaching model advocated by the behaviourist group. In fact it may conflict with preconceived notions of what is reasonable or possible in facilitating learning and in the assessment of learning. If the learner takes the responsibility for directing his own learning how far can the teacher impose conflicting views? How can such learning be planned? What is the role of the teacher in the personal sources model? To answer these questions, it is perhaps appropriate to look at the qualities and attitudes which Rogers (1969) sees as facilitating learning. For Rogers (1969) a teacher is a facilitator of learning, and the most basic essential attitude is 'realness' or 'genuineness'. When the facilitator is real he enters into a relationship with the learner without presenting a façade; his feelings are available to him and he can communicate them if appropriate and he encounters

the learner on a person-to-person basis. Rogers (1969) points out a second important attitude of caring for the learner in a non-possessive way. Such a facilitator who displays this attitude can get satisfaction in the learner's achievement but can also understand and accept the occasional apathy, the learner's erratic unlogical approach to seek knowledge as well as his disciplined efforts to achieve objectives. A further element which establishes a climate for significant learning for Rogers (1969) is empathetic understanding of the facilitator; this is the ability to comprehend the learner's situation and the sensitive awareness of what the learning process means to the learner.

Rogers (1969) feels that the interpersonal relationship in the facilitation of learning is important in creating an atmosphere which encourages significant, self-reliant personal learning. The reputable facilitator is interested in developing learner potential rather than highlighting learner deficiencies.

Conclusion

It is clear that teaching is a complex interaction of many skills and the use of valued strategies. Three main dimensions have emerged: the ability of the teacher to manipulate reinforcement (Skinner 1967 and Gagné 1977); the cognitive ability of the teacher to understand the subject in depth from generalities to specifics; principles and concepts of the subject matter to be taught (Bruner 1960 and Ausubel 1978); the personal qualities of the teacher, such as, values, attitudes, standards, the ability to form relationships with learners and to create a climate of learning (Rogers 1969, Joyce and Weil 1972).

SECTION III: ASSESSMENT OF LEARNING

ASSESSMENT

Assessment and evaluation are synonomous for some educationalists, however, it will be argued here that it is necessary to distinguish between these two concepts. Rowntree (1974) has defined each in the following way:-

> 'Assessment is perhaps the central activity here. By assessment I mean student assessment - finding out what the student's abilities and attitudes are and how they have changed since last assessed. This will not necessarily involve testing him or measuring his performance in any formal way. It may be enough to ask his opinions or unobtrusively observe him in action, and note that same personal trait or ability appears to be present in greater or lesser degree than hitherto.' (p 131)

> 'Evaluation is an attempt to identify and explain the effects (and effectiveness) of the teaching. Assessment reveals to us the most important class of 'effects' - the changes wrought by new learning in the abilities and attitudes of our students. In so far as effects on other people (e.g. teachers, parents, employers, etc.,) are important, evaluation will also need data additional to that provided by student assessment.' (p 132)

In the statement on assessment Rowntree (1974) sees the learner as the central focus; the assessment is clearly not confused with 'grading' or 'marking'. To 'grade' a learner is to ascribe worth to the learner and this cannot take place without it being followed by a grade. Grading usually attempts to categorise each learner in terms of his amount or level of learning in relation to other learners. Assigned grades are represented by letters or numbers. Both numerical and literal marks are always points on a mark scale and are always defined in terms of the number on them. There are different reasons for using mark scales. First of all, it may be used for evaluation purposes. The use of marks indicates progress to the learner and teacher. It shows the learner the level of attainment reached; it demonstrates to the teacher how effectively the learner has been assessed and it shows the teacher how effective the teaching has been for each learner. It may also be used to evaluate individuals, groups, classes and schools. Secondly, mark scales may be used for rank-order placing. Using this technique, the assessor assesses each learner, not against himself, but against the other learners in the group. Thirdly, mark scales may be used to prognosticate future performance. When used in this way, present performance of the learner is used as a criterion for predicting future performance. Fourthly, for diagnostic appraisal. In this respect, the teacher uses marks diagnostically, by looking at the marks and diagnosing the area of performance where the learner needs

guidance. Last of all a mark scale evaluates the progress of learners in a given population on some criterion. There is, however, some evidence that learners are better motivated and study more widely when grades are abolished. Jessee and Simon (1971) compared learners' assessments and study routine at a university where a traditional grading system existed and at another university which introduced the simple pass/fail system with no compulsory in-course assessments. The researchers found that a similar amount of time was spent on study and leisure activities at the two universities, but they concluded that the pass/fail system with no formal assessments produced greater learner motivation and better distribution of study time. Similarly, Reiner and Jung (1972) reported that a pass/fail system produced lower average marks, but concluded that this system encouraged learners to inquire more widely around the subject. Hales and Rand (1973) agreed that the average mark of learners in the pass/fail system was less. Contrary to the findings of other researchers they interpreted this finding as implying a diminution in motivation.

Rowntree (1974) points out that when assessment is confused with grading there is a tendency to only concentrate on the learner's present educational attainment, giving no consideration to learner development, and that assessment is also a necessary pre-condition for 'diagnostic appraisal' of the learner's developing strengths and apparent weaknesses and identifying his emerging needs. Rowntree (1974) defines diagnostic appraisal in the following way:-

> 'Diagnostic appraisal does not involve grading (even though it may use test measurements or observations provided by assessment), but depends upon pedagogic judgment as to what learning sequences are possible and value judgments (both the teacher's and the student's) as to which are desirable.' (p 132)

Rowntree (1974) further states that it is necessary to assess before one can evaluate and that the important aspects of evaluation are: the effectiveness of teaching for the learner and additional information other than that provided by the learner, to evaluate the effect on others.

In learning, teaching and assessing the practice of nursing, evaluating the effect on others seems to be particularly relevant,

since the assessment of clinical practice involves patients, without whom such assessments could not take place.

Assessment of learning can be 'formative' or 'summative'. Bloom, Hastings and Madaus (1971) suggest that the main purpose of summative assessment is to provide measures of the learning outcomes of the entire educational programme or a large section of the course for the purposes of information and decision making. Formative assessments, however, aim to provide feedback on the learner's progress during the course. The purpose of formative assessment is not to grade or mark the learner but to help both the learner and the teacher focus upon the learning that is necessary to progress forward. Diagnostic appraisal, such as 'patient assessment of nursing care' falls into this category. The value of feedback as a source of learning emphasised by Bloom, Hastings and Madaus (1971) has also been demonstrated by Bigge (1976).

Other key factors involved in assessment of learning are 'subjectivity' and 'objectivity'. Subjective assessment according to Schofield (1977) means:-

> 'coloured by personal preference, preconceived ideas, or bias.' (p 35)

In other words what is subjective cannot be proved scientifically. An example of this in nursing, is the nurse learner's progress report which is written by the ward sister at the end of the learner's clinical experience in a particular setting. In this report one person is asked to express an opinion about another. The opinion is usually based on the impression which the nurse learner makes on the ward sister. Thus, if the ward sister is asked to report on the suitability of the nurse learner for work on her ward, she can use two criteria, both of which are subjective. The first is the ward sister's impression of the learner, the second is the ward sister's opinion about the qualities that a nurse must have to work on her ward. The ward sister's opinion of the learner may be influenced by the unfavourable impression which one mistake by the learner, made on the sister. This colours her impression of the learner in every area, whatever quality is under discussion. This is known as the 'Global' or 'Halo' effect - all qualities are enveloped by the

impression made in one particular area; prejudice spreads to cover all areas. In an attempt to guide the ward sister in reporting a nurse learner's ability a standard form is used which has a number of headings or criteria, which are relevant to that particular situation. This does not lessen the subjectivity of the ward sister but it may reduce comment on irrelevant points.

Objectivity according to Schofield (1977) is when:-

> 'we attempt to eliminate subjectivity. We attempt to be more scientific in our approach to whatever we undertake. We attempt to rid the situation of personal prejudices and preferences and to justify actions on rational grounds.' (pp 36-37)

Regardless of the type of assessment used to assess achievement one way of attempting to reduce subjectivity is to base each on relevant criteria. There are three basic criteria which must be met:-

Validity

This is the most important aspect of assessment, and is the extent to which the assessment measures what it is designed to measure. Validity is therefore the relevance of an assessment to its objectives (Quinn 1982). Another important use of the term is in the expression 'predictive validity'. Some assessments are used to predict future performance. Bearing in mind the basic definition of validity, the 'eleven plus' assessment would not be a good predictor of, for example, success as a nurse. If it were, it would probably be invalid as a predictor of grammar school success. Similarly, an assessment carried out to select a person suitable for nursing, would have predictive validity, only if it selected those who subsequently proved to be competent nurses. To determine the predictive validity of the 'eleven plus' it would be necessary to perform what psychologists term a 'follow-up assessment'. This procedure would take years before any justifiable statements could be made about the 'eleven plus'. In industry and the professions it would be unthinkable to wait for such a long time and in these circumstances a technique called concurrent validation can be used as a guide to the effectiveness of the assessment as a predictor. Quinn (1982) defines concurrent validity as the extent to which the results of an assessment correlate with those of other

assessments administered at the same time. Another aspect of validity is that of construct validity. A construct is a quality of human behaviour which cannot be observed, for example, attitudes, values, standards, reasoning, intellectual skills and personal adjustments. Construct validity is the extent to which the results of an assessment are related to the information gathered from the observed behaviour of the individual with regard to the construct in question (Quinn 1982).

Reliability

The term is used to indicate the consistency with which an assessment measures what it is designed to measure. In other words reliability can be affirmed when similar results are obtained from assessments used on two separate occasions in identical circumstances provided that the other intervening variables remain the same (Quinn 1982). Several tests can be employed to test the reliability of assessments. One method of testing is a 'test-retest'. A test is administered to a group of nurses, and after a period of time it is administered again. If the test is reliable and the main feature being measured is stable, the results will be consistent and essentially the same on both occasions. A second test for reliability is the 'equivalent test'. If a group of nurses is given a different test in the re-test phase, but one which measures the same thing, then a high correlation indicates parallel-form reliability. The third type of reliable test, the 'split-half' method, is carried out at the time of scoring results. The assessment items are divided into two halves and the correlation calculated between the two sets of scores. If the two halves of the assessment produce approximately equal scores, this suggests that the test is reliable.

Discrimination

Each assessment should discriminate in such a manner that it will pick out the nurse who is high in achievement from one who is low in achievement. A discriminating assessment should include items at all levels of difficulty. It can be expected that knowledgeable nurse learners will be able to answer the more difficult questions, whereas the least knowledgeable nurse learners will be unable to answer them. The items that are least difficult should be answered

by practically all the nurses. If items discriminate well, the test is considered reliable.

THE PURPOSES OF ASSESSMENT IN NURSE EDUCATION

Assessment in nursing fulfils a variety of purposes. Many of these can be classified into the following three groups:-

To Motivate the Nurse Learner to Achieve the Course Objectives

Intermittent assessments may be used to monitor nurse learners' progress. If standardised assessments are developed through a course using the mean scores, their range, and measures of their power of discriminating between knowledgeable nurse learners and the least knowledgeable nurse learners, they can be used to monitor learners' progress. Sullivan (1971) has used computer marking of multiple choice tests as a diagnostic instrument to remedy learners' weaknesses before the final assessment. Sullivan (1971) claims that more varied objectives may be assessed and less stress put on memory; that multiple choice tests were better for monitoring learners' progress because unlike the assessment of essays, the objective marking did not obscure learners' weaknesses.

Assessments can also be used to motivate learners to work and that the motivation increases as the time of assessment approaches. There is evidence that learners work longer hours in those years in which they have important examinations than those in which they do not, and that the activity increases as the year proceeds (Thoday 1957).

To Judge the Level of Achievement

It is necessary to assess learners' levels of achievement throughout the course. The assessment may be formative, which is an assessment during the course of study and provides feedback to the learner, or summative, which is an assessment carried out at the end of a course. These assessments may be divided into two groups, namely, 'survey assessments' or 'mastery assessments'. In the survey type of assessment there is a distribution of ability, and grades at a number of different levels are awarded to signify these. In mastery assessment a simple pass/fail decision has to be made, and is common

in nursing where assessors have to decide whether a nurse learner is acceptable to the profession. Achievement assessments may also be divided into 'norm-referenced' assessments and criterion-referenced' assessments. Norm-referenced assessments are designed to assess the learner's achievement in comparison with other individuals who have taken the same assessment. For example, written assessments in nursing are norm-referenced. Criterion-referenced assessments are designed to assess the learner's achievement with respect to some criterion or standard performance. Assessment of skills in nursing is criterion-referenced, as the result is either pass or refer. It does not matter whether the last nurse learner on the ward was passed or referred; this has no effect on the present result of the present assessment. There is a tendency for norm-referenced assessments and survey assessments to be linked together in examinations which are in effect competitive. Criterion-referenced and mastery assessments also tend to be linked together, because the assessor is not comparing one learner with another but judging the level of performance. However, these assessments need not always be associated in this way.

To Evaluate Teaching Effectiveness

Nurse learners may be assessed to evaluate the effectiveness of teaching as assessments are part of the total teaching in a school of nursing, not just a method of awarding grades.

ASSESSMENT METHODS USED IN NURSE EDUCATION

It may be argued that assessments presume a way in which knowledge should be arranged and that the selection of subjects by assessors pre-supposes a value system and imposes it on the learner. Nevertheless, nurse learners enter nursing to obtain a qualification, knowing that they will be assessed throughout the course. In a survey conducted by Siann and Pilliner (1974), 60% of university learners wanted assessment for the award of a degree eliminated. The problem is that frequently the assessment methods used are irrelevant. The Joint Board has attempted to overcome this difficulty by issuing guidance to staff involved in Joint Board courses. The course tutor in consultation with members of the teaching and clinical staff is advised to look critically at the overall pattern of assessments

which they set up for post basic learners. The group is also advised to discuss the sequence and timing of assessments, methods of assessment, selection and preparation of assessors, the objectives to be assessed formally and criteria for success in each assessment. Furthermore this group of teaching and clinical staff is asked to judge whether a course member should or should not be awarded a Joint Board certificate. The guidance given to staff is contained in Occasional Publication 4, Assessment Strategy - Guidance for staff involved in Joint Board Courses. By this method a joint conclusion is reached which is at least more defensible and is likely to be acceptable. In this way all aspects of professional competency are judged, cognitive, psychomotor and affective domains, by those directly involved in planning, teaching, assessing and evaluating the course.

The researcher believes that the starting point for a sound assessment scheme is some overall plan or strategy of what to test, when, how, where and to what level. In an unpublished survey of Joint Board courses by Bridge and Clamp (1979) they reported that about two thirds of the courses surveyed had some such strategy. The remaining one third had a variety of ways of arranging assessments. However, in a recent survey of assessment methods used by Joint Board certificate centres, Scott (1982 unpublished) demonstrated the lack of a clearly defined pattern of assessments. In designing an assessment strategy consideration must be given to assessment methods. There is a wide range of assessment methods and different types measure different qualities. To obtain a complete profile of each learner's achievements it is necessary to use a combination of methods. The following traditional methods are used in nursing:-

Essays

Essays are used extensively in nurse education and require the nurse learner to present an answer which is organised in the nurse learner's own words, style and handwriting. However, there are a number of weaknesses in this form of assessment which limit its usefulness. In a study designed to observe two divergent qualities of handwriting, and two qualities of spelling, and presence or absence of checklist to guide assessors, Chase (1968) reported that quality of handwriting significantly influences grades and the influence of

of this factor appears to increase as successive essays are marked; spelling as applied in the study was not significantly related to grades; and assessors were more generous in the marking of essays when they had a checklist.

Bligh, Ebrahim, Jacques and Piper (1975) suggest two analytical approaches to marking essays, the points method and the rating method but their broad stages are similar:-

> 'First, at the time the essay topic is devised, and not later, the major points or characteristics of the expected answers should be set out in writing. This could consist of a model answer, but it need not do so. In the points method a long list of facts may be listed together with the characteristics of the answers required. In the ratings method the characteristics are usually more important than the facts and a series of rating scales of the characteristics should be devised.
>
> The second stage is for all examiners to agree upon the weighting to be given to each of these factors ...
>
> The third stage after the examination is to mark the essays either by the points method in which grades may be allocated for points raised, or by the ratings method in which grades may be allocated on a number of different scales. It is usually advisable not to have many more than five points on any one rating scale. The rating method is suitable for the profile system of grading. It is also better than the points method when the essays are longer.' (p 39)

There is also some evidence to suggest that assessor reliability can be improved if short notes are used. Mowbray and Davies (1967) believe that short notes demand more focus from the assessor. This could explain their greater reliability but it is probable that the assessors have well defined objectives when assessing short answers.

Essay questions are useful in that they give learners the opportunity to present a reasoned argument or to offer for consideration an original idea; for assessing higher levels of cognitive functioning, such as application, analysis and evaluation, and for indirectly assessing the affective domain of attitudes, values and beliefs. These are all important aspects of nursing. However, there may be little correlation between what the learner writes and what she does in practice (Bendall 1975).

Objective Tests

Limitations of the essay assessment have led to the development of objective tests and other written forms of assessment. The term 'objective test' refers to the marking of the test, which is not influenced by the subjective opinion of the assessor. In comparison with essay assessments, objective tests have greater assessor reliability because the answer is predetermined. However, scores obtained by any method of assessment to a certain extent are adulterated by the learners' skills and strategies in taking that particular kind of assessment. In objective tests, these tactics are more positive and measureable than in many other types of assessment. It does not mean, however, that they do not exist in those assessment methods where they are not so readily exposed. Lennox (1967) studies the possible responses to various ways in which objective tests can be written. He concluded that a learner can improve his score by exploiting the rules in the following way: perusal of earlier question papers will disclose a pattern of questions and the idiosyncrasies of individual assessors; advantage can be gained from studying the marking strategy and if guessing is heavily penalised, no random guesses should be attempted.

There are different types of objective tests, for example, the 'practical objective test' to assess psychomotor skills, but the disadvantage of this type is that a written paper rather than practical work is assessed. Another type, 'simulated tasks', where the objective is to assess personal interaction and application of knowledge. One advantage may be that it closely approximates to some nursing situations that are otherwise difficult to assess. In this case a carefully prepared assessor's checklist is necessary. 'Viva-voce' and group discussions may also be of the objective test variety where personal interaction and reasoning behind personal thought is a possible assessment objective. The advantage of this type of session is that it is flexible, and useful to confirm other assessment scores. The disadvantage, however, is that it is a very subjective, 'halo effect' assessment.

Projects

Project teaching in nursing is particularly popular for a number of reasons, namely, it helps to develop attitudes of critical enquiry,

research techniques and thought. Participation in a project is an invaluable part of nurse education for these reasons particularly when followed up by seminars and discussion groups which re-examine questions already posed in the project. This helps to make the latter more meaningful by sharpening its focus. Group projects have the added value of encouraging learners to work as a team.

Nurse teachers and nurse learners work together on projects; for this reason the roles of each can be confused and it can be difficult for the nurse teacher to carry out an objective assessment. The issue is further confused by the fact that nurse learners or a group of nurse learners usually choose different topics for project work and the question of incomparability arises. The Nuffield Group for Research into Higher Education (1973, 1974) has suggested that the teacher enters into a contract with the learner at the beginning of the project and that they discuss and agree on the various stages of the project and the criteria which will be used to assess these stages. The Nuffield Group further suggested that other factors such as personal qualities, resourcefulness, creative thinking, initiative, and in some cases of group work, ability to work in a team should be considered. Teacher involvement in project work therefore makes assessment problematic. This can be overcome by inviting a group of assessors who are detached in their judgments to assess projects. Using criteria such as design, planning of time, use of resources, data collected, analysis and presentation of material, the group of assessors should be able to compare one project with another. If the overall assessment strategy does not require the quantification of grades for project work, a profile assessment may be suitable.

Films

The advantages of films are many but perhaps the most important one is that they depict real situations when the same situation is not available. Perhaps the best example of this is a major disaster. This type of emergency does not always occur when nurse learners are due to have their accident and emergency nursing experience. Films can also be useful educational instruments particularly when they are used to assess the responses of nurse learners to filmed patient situations. This can be done by asking nurse learners to record their

observations, the actions they would take and the reason for those actions. Briggs, Campeau, Gagné and May (1967) used films in a number of learning situations and investigated their use. The investigators concluded that films are very effective in presenting information related to action.

Videotapes

The use of television for teaching purposes in nurse education is increasing. In a continuing education programme for staff nurses clinical simulations have been videotaped and used to teach the nursing process (Smyth and McMahon 1976). Videotapes of the nurse learner's performance have been used as feedback to help them improve their observation and psychomotor skills and to share experiences (Smith Holland 1977). Videotape recordings for the purpose of assessment have developed in parallel with their teaching purposes. Griffin, Kinsinger, Pitman and Kessler (1966) reported the use of closed-circuit television as an assessment instrument used by nurse teachers to observe the performance of nurse learners. By this method one nurse teacher could monitor several nurse learners giving care in different wards of the hospital.

The advantages of videotape recordings in nurse education seem to be that of instant feedback; they can be replayed as necessary; the closed-circuit feature makes it especially useful for restricted viewings, for example, in the operating theatre; it eliminates repetitive teaching; and videotapes are erasable. Among the disadvantages are, when viewing the performance of a nurse learner on videotape there is no saving of time; criticism by the viewers of their peers in the videotape recording; the teaching pace may be too rapid and nurse teachers may not be familiar with the videotape equipment.

Viva-voce

It is the researcher's experience that oral assessments at post basic level in nursing are frequently employed. Little is known about the validity and reliability of this method because there have been few investigations carried out in this area. Bendall (1975) demonstrated a lack of correlation between verbal descriptions of nursing behaviour and observed nursing behaviour. Holloway, Hardwick, Morris and Start

(1967) reported that although there was a high degree of agreement between assessors, results of viva-voce assessments did not compare with any factor except emotional constancy.

Learners' personalities and visual appearances are factors which frequently influence assessors' opinions at viva-voce assessments. Easton (1968) found that this appears to be supported by differences between viva-voce assessment grades awarded by nurses and doctors who assess in pairs. The nurses' assessments were not significantly different from the results of objective tests but the opinions by doctors were. This could be explained first of all by the fact that nurses and doctors have different conceptual backgrounds and secondly the reason may be that all the nurse assessors and nurse learners were female and the doctors were male.

Bligh, Ebrahim, Jacques and Piper (1975) conclude that explanation of empirical evidence on viva-voce assessments is about as subjective as the assessments themselves. Bligh et al (1975) said that they perhaps have a limited place in an overall assessment strategy but they require careful preparation.

Assessment in the Clinical Setting

Nursing is essentially a practical activity involving the cognitive, psychomotor and affective domains. Quinn (1982) lists the characteristics of skilled performance as, precision, smoothness, timing, efficiency and ease. Connolly (1974) lists the component parts of the performance of a motor skill as follows:-

> output mechanism, or effectors, which perform the action, for example, limbs;
>
> plan, and instruction, which control the effectors;
>
> mechanism for comparing plan with actual actions performed;
>
> receptors, which monitor the actions, and signal to the mechanism for comparing the plan;
>
> regulatory signals, which modify the action of the effectors to conform to the original plan

It can be seen from these component parts that learning a motor skill involves feedback, a factor which has been emphasised above on page 47

by Gagne (1977). The larger areas of human performance are referred to by Gagne (1977) as 'procedures' which consist of cognitive and motor skills and are subjected to the influence of the affective domain. The cognitive components are: a sequential rule which determines the order in which the action will be performed and intellectual skills such as appraising the situation and being aware of variables. The motor skills are necessary to accomplish the procedure. In nursing the term psychomotor skill is often used in preference to motor skill to emphasise the cognitive elements involved.

Practice in nursing is essential for learning the practical skills which are acquired through repetition. Repetition in itself is insufficient and in order to be effective must be accompanied by feedback as knowledge of results. Feedback is vital to skills learning and can be augmented by comment from the patients and the teacher. The two maxims of assessment that are essential are firstly, learners must have the opportunity to learn before they are assessed, and secondly, the purpose of assessing the nurse learner's performance needs to be identified. Is the reason for assessing performance to help the learner to master the task or material (formative assessment) or is it for the purpose of a grade or a mark (summative assessment)? The marking of observational assessments, indicate the standard of performance being observed. The use of precise checklists where possible normally improves objectivity, validity and reliability of observational assessments. Where this is not possible rating scales may be used. The rating scale may be of the numerical type, where an aspect of nursing care is rated on a scale from one to five, or alternatively a graph type scale from excellent to poor. The choice will depend on the type of criteria used for the assessment.

Assessment can be intermittent or progressive. Like many other educational organisations the Joint Board recommends progressive assessment of learners. There seems to be a considerable variation in interpretations of what continuous assessment means (Bridge and Clamp 1979 unpublished). This was supported by Scott (1982 unpublished). The Joint Board suggest that assessments should comprise:-

> 'a planned series of formal and informal assessments based upon detailed objectives for the theoretical and clinical aspects of the course.' (Assessment Strategy 1982)

Assessing clinical performance in nursing has been problematic for a long time. The problems inherent in the assessment of nursing practice are, inconsistency between raters, low reliability of results obtained, defects in assessment validity, application of standards derived from mere opinions and weighting of some aspects of nursing practice when such action may not be warranted. Although there has been a number of meaningful contributions made to the area of assessment of nursing practice, none has provided complete solutions to these problems.

In the United States the assessment of nursing practice has been investigated by a number of individuals and groups. Urey (1968) adapted a method of task analysis before proceeding to analyse the total range of nursing practice. Only six nursing procedures were analysed, and it was concluded from this investigation that factors such as, space, facilities, time and stress, did not alter performance. Dunn (1970) used the same method of task analysis to develop checklists for five nursing procedures. Each stage in each checklist specified the relationship to the scientific principle involved as well as indicating the weighting for each behaviour according to its significance to the procedure. This emphasised the fact that each step in a procedure may not be equally important. Evidence is given relating to content validity, reliability and inter-rater reliability. Each procedure was carried out four times by each nurse, and was watched on each occasion by two nurse observers simultaneously and separately. High correlation of inter-rater reliability was obtained only when the observations were simultaneous.

Klaus, Goswell, Jacobs, Reilly and Taylor (1966) carried out a research project in three stages to look at ways of improving nursing proficiency. The first stage reported in 1966, established the rationale of the investigation; the second stage report in 1968, identified 84 nursing tasks that a staff nurse working on a medical or surgical unit does during the course of her work. These 84 nursing tasks were grouped into 15 categories. The third stage report in 1968 suggested a method of analysing these tasks and described a number of ways that nursing proficiency could be judged. However, the method used was extremely detailed and time consuming and therefore only one task was analysed.

A 'walk around' practical assessment of basic clinical nursing skills was conducted by Simpson (1967). Equipment was displayed and nurse learners were directed to each situation by means of instructions on a card. Nurse learners were also informed about the type of information they were to record on their answer form. Patients were not used in this assessment. This method seems most inappropriate for the more complex nursing skills and for assessing desired behaviours.

In Britain, past research in the area of assessment of nursing practice has been dominated by the work of Bendall (1975). In a study which showed a lack of correlation between verbal descriptions of nursing behaviours and real observed nursing behaviours there existed incompatibility between what was taught in the school of nursing and what was practised in the ward situation. There was conflict between 'ideal theory' and 'real practice'. Hunt (1974) and Hend (1975) also report this conflict.

Boreham (1978) attempted to develop a taxonomy of clinical skills for the analysis of the skills which are involved in nursing practice. As a progression from this theoretical standpoint, Boreham (1978) carried out a task analysis of the nursing assignment of caring for a patient receiving peritoneal dialysis and this revealed a diverse range of sub-tasks. He concluded that in the practice of nursing four assessment methods are commonly used, namely, self-report, simulation tests, ward based assessments and continuous assessment. Each assessment method is relatively sensitive to some of these sub-tasks, and relatively insensitive to others. In the nursing task investigated by Boreham (1978) no one assessment method sampled adequately all aspects of performance and he suggested that a range of assessment methods should be employed. Individual assessments should be interpreted as necessary but are not sufficient evidence of mastery.

A sample survey of the assessment methods employed on Joint Board courses was carried out by Bridge and Clamp (1979 unpublished). The sample they employed represented 30% of all Joint Board courses which were available in 1977. They report that the psychomotor and affective domains are less frequently and less comprehensively assessed than the cognitive domain. This is despite the fact that

these courses are intended to be oriented towards clinical practice. In general, cognitive assessments predominated because factual (and particularly written) testing is relatively easy to plan, administer and record, and also the detailed objectives devised by planning teams at centres were largely in the cognitive domain. In contrast, the psychomotor domain tests were generally less carefully planned and tailored to fit the particular clinical specialty covered by the course.

The most recent research in the area of nurse assessment conducted by Scott (1982 unpublished) lists the most frequently used assessment methods in the clinical field of nursing as being, schedule of experience, formal set-piece skills assessment, self assessment of skills and attitudes, peer assessment of skills and attitudes and patient care plans. The analysis in the survey, however, only describes the range of assessment methods and not the weight given to each method by respondents.

The research carried out in the area of assessment of clinical nursing practice seems to emphasise the need for a variety of methods to obtain information about a nurse learner. In the researcher's opinion if assessment of clinical practice is to have any measure of validity and justice, there is also a need for further development of appropriate objective assessments and procedures. Equally important, the nurse learner who is being assessed is entitled to a fair assessment by the most appropriate assessor or assessors. The most appropriate assessor would depend on the objective of the assessment in question.

Assessment of clinical competence in nursing is in the form of two main methods, namely, by observation and reports of the opinions of other clinical staff, for example the nurse's progress reports. The nurse's progress report is a very traditional assessment method in nursing based on the opinions of clinical staff and provides important evidence of a learner's progress in the clinical environment. The subjectivity of progress reports has already been discussed on page 59.

Assessment of performance by observational techniques can be accomplished in a number of ways, for example, by the nurse teacher, by the clinical staff, self assessment by the nurse learner, by the learner's peers and by the patient. It is essential that the assessor

is aware of the criteria by which the performance will be assessed, otherwise, the assessment will be subjective. However, there are factors which influence the assessment, for example, the assessor may be biased in her perception of the nurse learner's performance and influenced by the general characteristics of the nurse learner. In this case the nurse learner is likely to be rated high if the assessor has a good impression of the nurse learner, and similarly if the impression is unfavourable the nurse learner will be rated low. Another common factor is the central tendency error in which the assessor gives a higher score than warranted. In addition, assessors may be influenced by their own past experience, motivation and personality. These factors apply to any assessor, nurse teacher, clinical staff, nurse learner, peer or patient. From the nurse learner's viewpoint the presence of any assessor may cause anxiety which could have some effect on their decision-making ability if this is required during the assessment and on their overall performance. It is the researcher's opinion that it is highly desirable to give the performance assessment instrument to the nurse learner before the assessment. Nurse learners have a right to know the criteria by which they are assessed and they have the right to be assessed objectively, specifically and constructively.

Assessment by Teacher and Clinical Staff

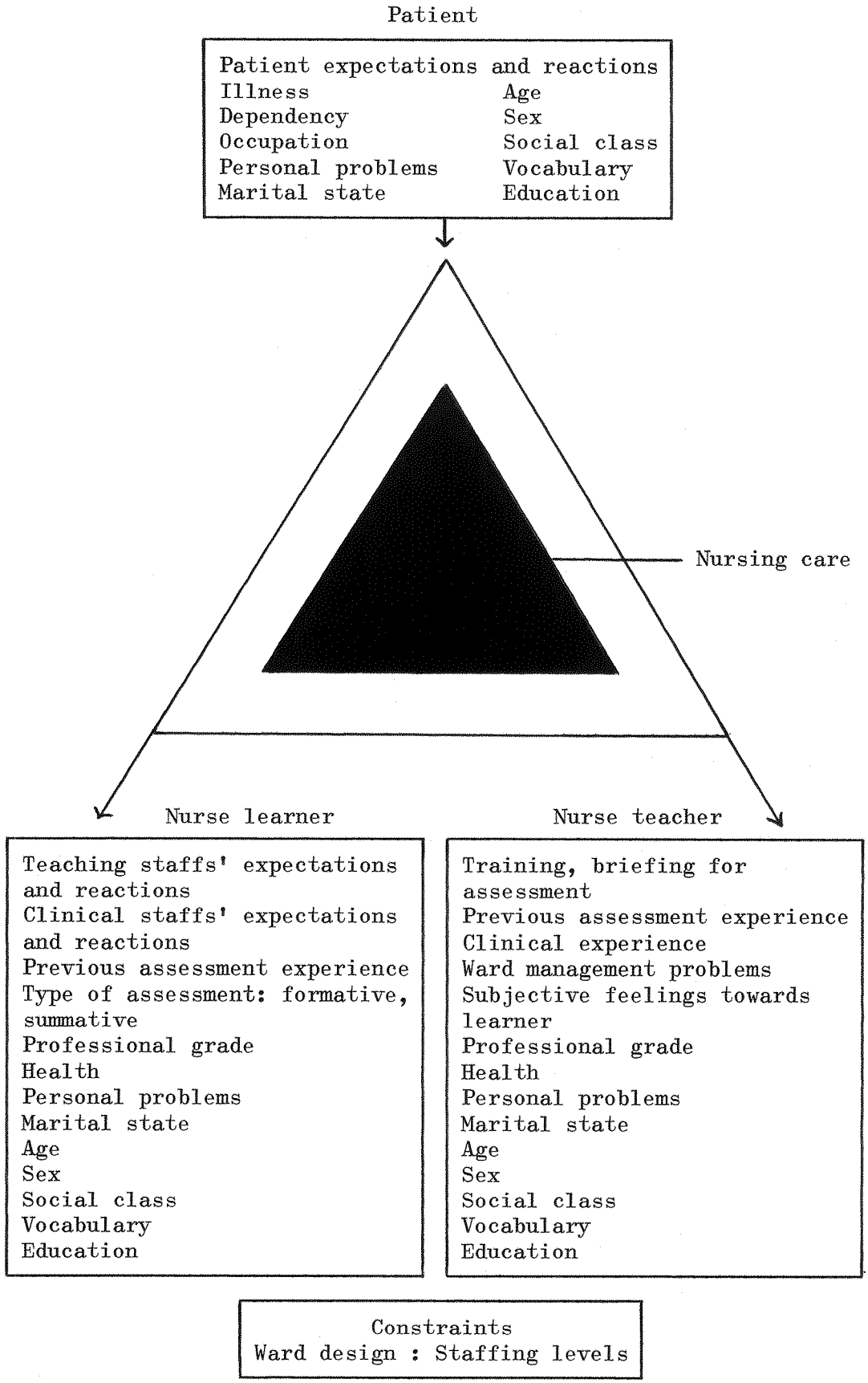
Assessment of a nurse learner's clinical competence is of key importance. The assessor should ask what competencies are being assessed and how these can best be assessed; whether, for example, it can be done by using an objective structured clinical assessment, progress reports, project work, films, or by videotape recordings. The assessor should consider the functions of the clinical assessment, in particular its role in providing feedback to the nurse learner and nurse teacher. Sequence and timing are of great importance; nurse learners should have the appropriate theory and practice before the assessment; with regard to timing there is a place for both in-course and end-of-course assessment of clinical competence. In considering who should undertake the assessment, the role of the nurse learner in assessing her own competence should not be overlooked.

The appropriate setting for assessment of nursing practice is in the clinical situation and not in the classroom which is far

removed from the reality of clinical nursing. Assessment in the clinical situation, however, has its difficulties; the ward design may create problems; staffing levels fluctuate, emergency situations occur; and there may be frequent interruptions from other personnel such as doctors, physiotherapists, occupational therapists and social workers. Many other factors affect the clinical situation and are of intrinsic value but at the same time of potential danger to the assessment. These factors are known as the dependent and independent variables. The dependent variable is essentially the question being asked or the subject areas being assessed. In clinical assessment they are genuine and significant questions which address concerns, attitudes, responses, awareness, feelings and concepts. They do not exist independently, but are resultant and dependent on a given situation or condition as an anticipated, ongoing or consequent subjective experience.

Independent variables are characteristics, such as, age, sex, social class, occupation, etc. of the people in the setting supplying the behaviours. The clinical situation is a source of an enormous number of independent variables each having some influence on the effectiveness of care (King 1971). This is undoubtedly increased in an assessment of nursing care which involves the patient, the nurse learner and the nurse teacher, each with a different background, motivation and personality (Figure 2, page 76). Furthermore, there are many nurse teacher variables and it may be suggested that in the assessment situation several are of great importance, for example, training for assessment, previous experience of assessment, clinical experience and subjective feelings towards the nurse learner. Other variables may influence the nurse teacher but they are probably of less importance, such as, social class and personal maturity. Similarly, the nurse learner brings expectations and previous experiences to the assessment situation, for example, her beliefs about the expectations and reactions of the teaching and clinical staff. The patient's perspective is also complex and involves aspects such as his illness and his expectations of nurses. All three are constrained by the setting in which the assessment takes place, by factors such as ward design and staffing levels. Some of these variables will be considered with the impressionistic data in Chapter VI.

Figure 2: A schematic view of some of the patient, nurse learner and nurse teacher variables affecting assessment of learning



The obvious incentive for conducting observational assessments in the clinical situation is that the assessor will be able to observe nursing care as it is carried out. The potential danger is of the assessor's subjective feelings which arise from involvement through social interaction with those participating in the assessment. These subjective feelings may influence the way in which nursing actions are interpreted and could contribute to a poor assessment (Kehoe and Harker 1977).

In view of the significance attached to the assessment of nursing skills and of the important consequences of failure, assessment of the nurse learner by assessors should be valid, reliable and discriminating. Other factors such as objectivity, subjectivity, grading and criteria are of the utmost importance and assessors must be aware and familiar with these before carrying out the assessment. These factors have already been discussed on pages 57, 59 and 60.

Knowledge of what is to be assessed is a pre-requisite for any assessment, and many of the problems in relation to assessment arise because of inadequate attention to this question (Harden 1979). It is therefore essential that the objectives of what is to be assessed are clearly documented for each assessor.

In general, the purpose of assessment of nursing skills does not differ from other assessments in nurse education previously discussed in this section. These are: to motivate the nurse learner, to judge the level of achievement, to provide feedback to the nurse learner and nurse teacher and to assess certain basic competencies to allow a nurse to practise clinically.

Assessment of nursing skills provide the important function of feedback to the nurse learner, the nurse teacher and other staff. Continued practice is not in itself a guarantee of improved performance and assessments should emphasise to the learner ways in which improvements are possible. In the same way, good practice can be reinforced.

Responsibility for the assessment of clinical competence of a nurse learner should be shared by clinical staff and teaching staff. This may be the ward sister or the clinical teacher. This assumes, however, both an impartiality on the part of the assessor and

appropriate training and briefing. In addition to this, the nurse learner should be encouraged to accept responsibility for assessing his own clinical assessment by means of self assessment.

Peer Assessment

Rousseau, Côté and Quenville (1981) point out the fact that peer assessment has received little attention from nurse educators. They put forward reasons for retaining peer assessment in a community health nursing course which they had examined over a period of three years. The reasons fell into two categories, practical and educational. First of all it was impossible for the nurse teacher to supervise directly each nurse learner most of the time because of the nurse teacher's work load. Peer assessment appeared to be one solution to this practical problem. In addition to these practical problems, peer assessment was seen as a means of giving nurse learners an opportunity to give an objective appraisal about their peers' performance. In this way it was hoped to develop professional maturity among nurse learners. The authors concluded that nurse learner peer assessment is more influenced by personality than is the nurse teacher's assessment. It is interesting to note that the authors used the nurse teacher's assessment as a point of reference to determine whether or not nurse learners are competent to assess. This same basis is suggested by Lutkus (1978) who has used a Peerate Programme which is a computerised system to grade learners' term papers.

In a project to assess learning and teaching carried out by Turner (1978), criteria were developed and used as guidelines in assessing self and peers. The findings indicated that assessment posed a threat, especially in assessing one's peers, but this threat tended to decrease through involvement in the process, which included group discussions and talking and sharing feelings both in formally devised and spontaneous informal encounters. In fact the conferences which brought peer partners together before and after the observation of performance, proved to be a positive experience.

It has been suggested by Burk (1969) that peer assessments in awarding university course grades are more reliable than self assessments by learners. The investigation revealed that there was consistent agreement in the marks awarded by teachers and peers whereas learners tended to be generous in their assessment of themselves.

Self Assessment

This type of assessment has not been used to any great extent in nursing even although it is a method of providing nurse learners with additional feedback about their learning. Unlike formal assessments, self assessment is non-threatening in that assessment results do not contribute to a learner's final grade. Rowntree (1977) perhaps gives the most basic reason for this method:-

> 'self assessment is undoubtedly a valuable life skill.' (p 144)

In other words when the skill is developed it can be utilised by the individual in his work situation and in his personal life.

Walbek and Gordon (1980) reported on three self-report measures of assertiveness in nurse learners. The study was evaluated by correlating the self assessment scores obtained from a sample of 88 nurse learners with peer and teacher ratings of assertiveness. Self-reported assertiveness failed to predict the amount of participation in class within a sub-sample of 48 nurse learners. It would appear, however, that the within-subject variable of setting (lectures, seminars, clinical) had a consistently significant effect on class participation. More questions were asked in a group seminar than in the other two settings.

Details of a self assessment case study are reported by Lublin (1980). The study investigated the self assessment abilities of a group of engineering learners and showed the majority to be satisfactorily competent. Lublin (1980) argues for the importance of assisting learners to be realistic judges of their own performance and advocates an increase in the informal type of self assessment and a decrease in the formal type of grading assessments. It can be argued by those who combine these two functions that the award of a grade provides a diagnostic feedback and without a grade the learner will not be aware of his progress. Miller (1976) showed the fallacy of this by indicating that the grade assessment penalised the learner for revealing ignorance whereas the diagnostic appraisal rewarded a learner for revealing ignorance.

Rogers (1969), in discussing self assessment following his experience with a graduate course on 'Values in Human Behaviour',

indicates that there is a type of learning which has to do with the different criteria which individuals utilise in assessing their work and themselves. For Rogers (1969), the usual 'iron mold' assessment into which teachers try to fit and grade all learners is absurd. Learners undertaking the above course were allowed to set their own criteria for self assessment. The following example illustrates some of the criteria and some of the thinking which entered into this matter of self assessment:-

> 'A. Criteria that are personally most meaningful:
>
> 1) amount of satisfaction I found in the work, what I get from it;
> 2) whether or not I grew, intellectually and personally;
> 3) how much of myself I put into the course;
> 4) am I inspired to pursue some things that come from the course?
>
> B. Criteria imposed from outside, or taken on in the past:
>
> 1) amount or depth of recording;
> 2) effort put into all phases, meetings, readings, papers;
> 3) effort relative to my effort in other courses for a particular grade;
> 4) effort relative to others in the class.' (p 92)

For Rogers (1969) all aspects of learning should involve feelings or personal meanings so that it has relevance for the whole person. This includes assessment of learning.

Patient Assessment

After an extensive review of the literature it was found that patients have not apparently been involved in the educational assessment of individual nurse learners as defined in this study. Patient assessment of nursing care is defined by the researcher as:-

> a learning experience in which different perspectives are obtained to help the nurse gain insight into her own reactions, how patients feel about their conditions, what kind of nursing care they receive and how it could be improved.

It is an assessment carried out by three people, the patient, the nurse learner and the nurse teacher. The role of the patient becomes one of assessor of nursing care received, the role of the nurse learner becomes one of assessor of nursing care given (self assessment) and the role of the nurse teacher becomes one of assessor of observed nursing activity, in addition to one of facilitator, adviser and provider of resources.

Patient assessment of nursing care relates to significant or experiential learning as defined by Rogers (1969):-

> 'It has a quality of personal involvement - the whole person in both his feeling and cognitive aspects being in the learning event. It is self-initiated. Even when the impetus or stimulus comes from outside, the sense of discovery, or reaching out of grasping comprehending comes from within, it is pervasive. It makes a difference in the behaviours, the attitudes perhaps even the personality of the learner. It is evaluated by the learner. He knows whether it is meeting his need, whether it leads towards what he wants to know, whether it illuminates the dark area of ignorance he is experiencing. The focus of evaluation we might say, resides definitely in the learner. Its essence is meaning. When such learning takes place, the element of meaning to the learner is built into the whole experience.' (p 5)

This emphasises the meaningfulness and significance to the learner of this type of learning.

One responsibility facing every profession is the need to adapt to a changing society. Consumers hold every profession accountable for providing services which satisfy current needs and demands. The public holds the nursing profession accountable for the competence of its practitioners. The corporate responsibility of that profession must therefore be: to establish certain standards by which the quality of nursing practice, service and education can be judged; to modify and expand the scope of its education and practice in the light of new demands from the health services and medical and scientific technology. Consequently nurses have a responsibility for initiating innovative ways of learning, teaching and assessing the practice of nursing.

George Bernard Shaw at the age of eighty eight was still a lively

critic of the health establishment of his time. In 1944 he wrote in an essay called The Medical Man:-

> 'But always we need more knowledge; and this means controversial instead of dogmatic education.'

It may be argued that schools of nursing locked into a traditional and conventional approach make significant, meaningful learning improbable if not impossible.

CONCLUSION

In view of the lack of assessment instruments which enhance the nurse learners' learning and which ensure that learning becomes a meaningful experience, it was decided to design a 'Patient Assessment of Nursing Care' assessment instrument. The key to this development was seen to lie in the inclusion of all parties in the assessment situation, the patient, the nurse learner and the nurse teacher.

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CHAPTER IV: DESIGN OF THE STUDY

INTRODUCTION

The overall aim of the study was to investigate the feasibility of patients, as recipients of nursing care, assessing that care. The researcher was also concerned with the nurse learner's perception of her performance as a care giver and how both patient's and nurse learner's perceptions would compare with that of the nurse teacher's assessment of the nursing care given.

This broad aim incorporated the following research objectives as already stated on page 11 above:-

> To identify aspects of nursing care which are important to patients, nurse learners and nurse teachers and which can be assessed by them
>
> To design a 'Patient Assessment of Nursing Care' assessment instrument
>
> To explore the suitability of this method of assessment for use in formative assessment
>
> To furnish information on which to base guidelines for future research.

If education in nursing is to be a dynamic and continuing process, then each individual nurse must develop self awareness in order to acquire not just appropriate care-giving behaviours but the capacity to accept professional change. The rigidity which has been apparent in nurse education (for example, the teaching of specific skills rather than principles) will become a greater barrier to the development of high professional standards in nursing as the pace of technological change increases. Each nurse learner must acquire a thorough knowledge of the principles of caring and see herself as a dynamic open-system ever willing to learn the new skills required for an advanced technological society.

The nurse has to achieve competence in three domains, the affective, the cognitive and the psychomotor, as nursing is a process which includes the application of knowledge to care-giving activities

performed with sensitivity towards the needs of the recipient of care. The complexity of assessing the performance of the nurse learner as a care giver is very great, for example Figure 2 (page 76) shows some of the variables involved. Assessment in the clinical situation should include the perspectives of three participants - the patient, nurse learner and nurse teacher. Each party to the assessment has a differing perspective, influenced by previous experiences of and expectations about the performance of care-giving activities. If each is allowed to contribute to the assessment of care then a more complete picture of the nurse learner's abilities is likely to emerge than could be expected from just the traditional type of assessment by the nurse teacher. Herein lies the crux of this study; would it be possible to utilise the patient as an active participant in the assessment of nurse learners, thus using the patient as a learning resource? Similarly, would it be possible to ask nurse learners to assess themselves and so develop a critical appreciation of their own performance? It was decided therefore to conduct a study to examine the possibility of developing an educational assessment tool to be used by patients, nurse learners and nurse teachers.

The researcher began the study by assuming that it would be possible to develop an effective pen and paper assessment instrument which would measure the nurse's performance in the three domains of nursing skills: cognitive, affective and psychomotor. In fact, this apparently straightforward measurement task proved to be extremely complex and had to be modified in the light of experience. The preliminary data generated from an open-ended questionnaire sent to patients and nurses, in themselves provided some interesting information, for, instead of reflecting the three domains, items in the affective domain were preponderant. So the purpose of the study was modified at its outset before the test instrument could be constructed. Indeed, the complexity of the study made it impossible for one researcher to produce a fully developed assessment instrument.

Thus the instrument which has been developed as a result of this study is offered as a tentative prototype and a basis for further study by a research team. It is believed however, that there are important implications for nurse education in developing such an instrument. If it is possible to involve patients as active participants

in nurse education and assessment, then nurses should become more sensitive to and aware of the patients' views of their care. This should encourage the nurse to develop as a practitioner of patient centred care, to perceive the needs of each individual with greater clarity, and to maintain her own capacity to accept change.

Current policy in nursing practice is to base practice on individual plans of care for each client. It is suggested that the development of assessment tools which involve patients as active participants in nurse education, during which nurse learners assess their own performance will be of value in the new approach to nurse education. The dynamic nurse should then evolve, aware of her patients' perception of care and willing to adapt her practice to the demands of our rapidly changing society.

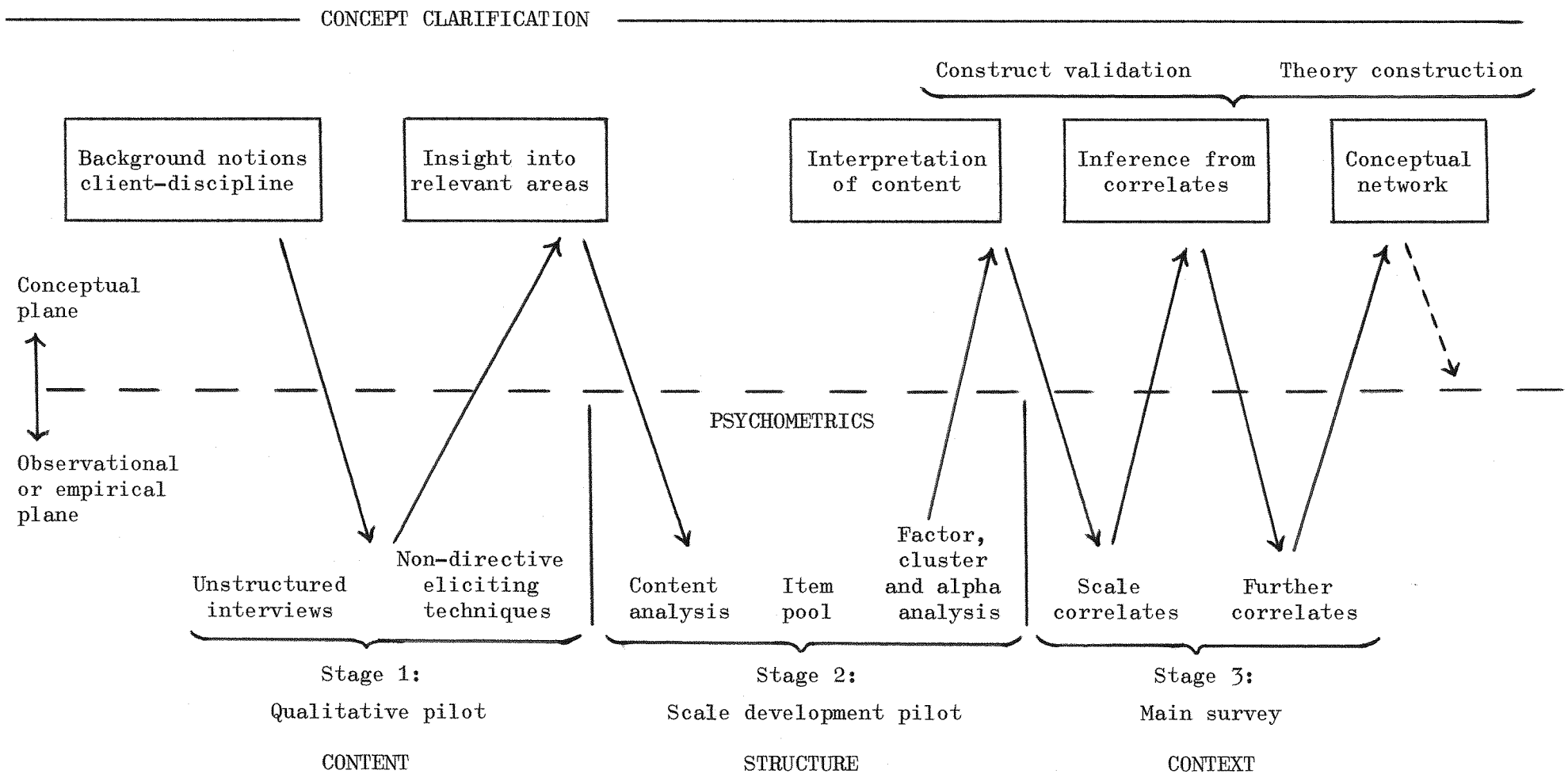
DEVELOPMENT OF THE STUDY

The study design was formulated with an open empirical approach to the problem being investigated, in that, there were no set hypotheses to be tested, no pre-design instruments and procedures to be used. The research was based on data obtained from patients' and nurses' responses for the purpose of developing a conceptual framework for understanding and explaining what takes place in giving and receiving nursing care in an assessment situation. Research such as this has value in two ways for nursing practice. Firstly, because nursing practice takes place within a social context, involves interaction with others and is a dynamic rather than a static activity, it can provide the nurse learner with a tool for judging her own performance. Secondly, it can serve as a base from which more rigorous and refined research can evolve, for example, as a means of developing substantive theory, as demonstrated in social research by Glaser and Strauss (1967) and in nursing by Quint (1967).

The method used in this study is based on McKennell's (1974) approach to exploratory surveys illustrated in Figure 3 (page 92). This study follows Stage 1: qualitative pilot and Stage 2: scale development pilot. The complexity of the study made it impossible for one researcher to produce a fully developed assessment instrument and for this reason this study does not include McKennell's Stage 3: the main survey. It must be emphasised again that the 'Patient

Figure 3: Attitude measurement in exploratory surveys

McKennell (1974) Surveying Attitude Structures (p 10)



Assessment of Nursing Care' instrument which has been developed as a result of this investigation is offered as a basis for further study by a research team.

The Preliminary Study

A qualitative study was carried out as a preliminary to developing the assessment instrument in order to find out what aspects of nursing care were important to patients and nurses and what could be assessed by them. This was done by open-ended questionnaires and discussion which took place in 8 centres. The preliminary qualitative data are discussed in Chapter V.

Development of the Assessment Instrument

The goal of the assessment instrument is to provide one method of assessing the learner on the general aspects of nursing care which apply across all general nursing situations.

McKennell (1974) points out there are three phases of measurement in the construction of measuring instruments: content, structure and context.

> Content includes 'what is achieved in the process of forming a concept of some domain of variables and the selection of a set of indicators to represent it'
>
> Structure refers 'to the conceptualisation of the domain'
>
> Context includes 'the process of using the scores to explicate the meaning of the measurements by relating them to other variables' (p 9)

McKennell (1974) suggests that the practice of attitude assessment would be enhanced if these three aspects are recognised as distinct phases to be followed in sequence. The assessment instrument was derived from an item pool generated by the groups who were due to use it. It follows the recommendations of McKennell (Figure 3, page 92).

The Venues of the Study

Eight Joint Board approved training centres were chosen for the study, based in hospitals situated in three Regional Health Authorities and included 2 teaching hospitals, 2 large district general hospitals in urban areas, 1 large district hospital situated in a rural area and 2 other smaller hospitals in urban areas. The centres in these hospitals are within the area of responsibility of the researcher where there is a secure permanent acceptance of the working relationship, with a captive group, known for their interest and enthusiasm in the study, and the agreed support of nurse managers and nurse educators to participate in the study.

The clinical nursing specialties covered in the study are representative of the types of courses set up by the Joint Board. They cover the principles from medical and surgical nursing, outpatients, to the type of nursing care which requires a non-directive approach. One specialty was chosen because of the unique contribution of parents, where they were the assessors of nursing care given to their babies. The specialties involved in the study are listed in Table 1 (page 98) and Appendix 2 (page 180). The range of care in the chosen specialties spans the spectrum from maximum patient dependency to self care (Table 2, page 100 and Appendix 3, page 181), in all social classes (Table 3, page 101 and Appendix 4, page 183) and in all age groups, from newborn babies to elderly patients. The patients in the study included those who were experienced in hospital routine because of their frequent admissions to hospital, and those who were inexperienced first time patients.

Initial Approach to Staff

Most important to the study was the preliminary planning for it, and the understanding both nursing and medical staff had of the objectives. It was felt that co-operation would be forthcoming most readily if all staff knew why the study was being done, who in the centre was taking part, what kind of information the study could provide and how the findings would be reported. To achieve this co-operation and support it was necessary to meet and discuss the study with nursing and medical staffs to obtain their agreement.

Some Initial Reactions to the Study

Overall reaction in all centres:-

'we do not want patients upset.'
'is it possible for patients to be objective?'

Nurse educationalists:-

'it might provide the specialties with useful information.'
'try it out and see what happens.'

Nurse managers:-

'see what everyone else thinks - I am happy if they are.'
'go ahead if it doesn't upset the patients.'
'proceed but I am concerned that patients may be upset.'
'good idea, it might provide useful information.'

Ward sisters:-

'not convinced of the value.'
'start it and see what happens.'
'it might provide constructive practical ideas.'

Consultants:-

'take it to the ethical committee.'
'cannot allow it until it has been agreed by the ethical committee.'
'seems a good idea.'
'if sister agrees, then I agree.'
'keep us informed.'

Approval was sought from two ethical committees before the study commenced.

Study Co-ordinators

Two study co-ordinators were appointed from each centre. The study co-ordinators were nurse tutors and clinical teachers who afforded the link between researcher and centre, they attended briefing

meetings at the Joint Board prior to the commencement of each stage of the study and were responsible for preparing patients, nurse learners and staff for the assessments. They also participated in the assessments.

The Initial Item Pool

An average of about 5 patients and 5 nurses at each centre were asked to list in writing:

> aspects of nursing care that they felt most important for a nurse to acquire
>
> aspects of nursing care that they felt patients were able to assess.

Selection was done purely on availability and patients and nurses carried out this exercise individually, except for elderly patients where this was done by group discussion with the study co-ordinators. The response from these groups provided the information for the initial item pool.

THE CORE STUDY

The core study follows as far as feasible the recommendations of McKennell (1974), Figure 3 (page 92), Stage 2: scale development pilot.

The goal of the assessment procedure is to test the suitability of this assessment method for use in formative assessment. The data collected are both qualitative and quantitative.

Preparation of Study Co-ordinators for the Assessments

Preparation of study co-ordinators for the assessments was considered necessary to provide the same information to those involved in preparing staff, selecting patients and nurse learners and for the purpose of conducting the assessments in a similar manner, irrespective of the specialty and the setting. The preparation was carried out in two ways:

1) Initial preparation as a group: The researcher arranged a one day meeting of all study co-ordinators to discuss

all aspects of the assessment procedure. This was an informal meeting where views presented by each co-ordinator were considered and discussed before the researcher prepared detailed written guidelines for the assessment procedure. This was an important meeting because constraints, such as, ward design, staffing levels, study days for nurse learners and nurse learners on night duty were discussed and solutions reached prior to the assessments taking place

2) Individual preparation at centre: The researcher spent a day at each centre with the study co-ordinators to train them in the use of the assessment instrument, to discuss the guidance documents and the selection of patient assessors, nurse learner and nurse teacher assessors.

Guidance to Patients and Staff Involved in the Assessments

Detailed guidelines were produced by the researcher for study co-ordinators at each centre. Co-ordinators were responsible for preparing patients, nurse learners and staff as well as participating in the assessment procedure. The guidelines included such information as pre-assessment preparation, preparation of the patient, preparation of the nurse learner and self preparation. The guidance is given in Appendix 10 (page 229).

Participants Involved in the Assessments

Table 1 (page 98) shows the different types of clinical nursing specialties involved in the study together with the number of patients, nurse learners and nurse teachers.

Selection of Patient Assessors

Following the instructions given by the researcher, the nurse teacher discussed with the ward sister which patients would be able to take part in the assessments. Selection was based on the researcher's

Table 1: Participants and nursing specialties involved in the assessments

Centre Number	Number of Patients	Number of Nurse Learners	Number of Nurse Teachers	Nursing Specialty
1	6	6	1	Family planning nursing
2	4	4	1	Burns and plastic surgery nursing
3	3	3	1	Accident and emergency nursing
4	0	0	0	General intensive care nursing
5	6	6	1	Special and intensive care of the newborn
6	4	4	1	Care of the elderly and geriatric nursing
7	4	4	1	Neuromedical and neurosurgical nursing
8	6	6	1	Renal and urological nursing

guidelines and patients were excluded from the study if they were unwilling to take part, were due for diagnostic investigations or operation, or were classified as intensive care patients using the nursing dependency categories (Table 2, page 100 and Appendix 3, page 181). Patients who agreed to take part were given a letter from the researcher (Appendix 11, page 231) which explained their part in the assessment. No patient refused to take part in the assessments.

Nursing Dependency Categories of Patient Participants

Patients require different amounts and degrees of nursing care. The assessment of that care is usually based on such factors as whether the patient is conscious, continent, ambulant etc. For the purposes of this study the nursing dependency categories developed by the Oxford Regional Hospital Board Operational Research Unit (1967) have been used (Table 2, page 100).

Social Class by Occupation of Patient Participants

In this study Hockey's (1976) definition of social class was used so that patients were classified according to occupational criteria. Hockey (1976) in considering the definition of social class says:-

> 'Occupational status tends to correlate with most other indicators of social status; income, wealth, education or place of residence. The usefulness of the variable in analysing data is generally and officially recognised' (p 208)

The classification of social class (Table 3, page 101) is the eight-fold classification used by Hockey (1976) and shows the number of patient participants in each category.

Selection of Nurse Learners

All learners were undertaking a Joint Board course in the specialty and all readily agreed to take part. There was no selection as such, the nurse learner on duty during the assessment period

Table 2: Nursing dependency categories of patient participants (n = 33)

Oxford Regional Hospital Board Operational Research Unit (1967) No 9 Measurement of Nursing Care (pp 15-17)

Category		Number of Patients
1	Self care	9
2	Intermediate care - ambulatory	6
3	Intermediate care - others	6
4	Intermediate care - bedfast	9
5	Intensive care	3

Table 3: Social class by occupation of patient participants (n = 33)
Hockey L., (1976) Women in Nursing (pp 208-214)

Class Number	Category	Number of Patients
1	Professionally qualified and high administrative	2
2	Managerial and executive with some responsibility for directing and initiating policy	7
3	Inspectional, supervisory and other non-manual higher grade	7
4	Inspectional, supervisory and other non-manual lower grade	2
5	Routine grades of non-manual work	5
6	Skilled manual workers	7
7	Semi-skilled manual workers	1
8	Routine manual workers	0
	Occupation not recorded	2

(page 103) agreed to take part. Nurse learners were also provided with written information in the form of a letter from the researcher (Appendix 12, page 232). The nurse teacher prepared learners prior to the assessments, following the written instructions for the learner.

Selection of Nurse Teachers

The clinical teacher study co-ordinator at each centre was selected as the nurse teacher to participate in the study. Six of the nurse teachers were experienced in their own specialty and had undergone training for their teaching and assessing role; the two unqualified nurse teachers were experienced sisters in their own specialty. All held the post of clinical teacher to the approved Joint Board course at the centres involved in the study. Each nurse teacher was trained by the researcher for the assessment.

Number of Assessments and Assessment Venues

The study was conducted in seven of the eight centres involved in the preliminary study. The nursing specialty and the number of assessments carried out at each centre are listed below:

Family planning nursing	6 assessments
Burns and plastic surgery nursing	4 assessments
Accident and emergency nursing	3 assessments
General intensive care nursing	Nil
Special and intensive care of the newborn	6 assessments
Care of the elderly and geriatric nursing	4 assessments
Neuromedical and neurosurgical nursing	4 assessments
Renal and urological nursing	6 assessments

Centre 4 (General intensive care nursing) was excluded from the study as all patients were in group 5 (intensive care) of the nursing

dependency categories and were unable to participate.

The Assessment Situation

The assessments took place between 9am. and 1pm. during normal work on the ward. This was done so that each centre would have the same pressures during the assessment procedure, such as, ward cleaning, medical staff ward rounds, other health personnel visiting the ward to give treatment such as physiotherapy and occupational therapy. Although these activities continue during the day, the main concentration is usually during the morning (Rhys-Hearn, 1973). In the outpatients department the assessment procedure was not restricted to the morning but the total length of the assessment period was the same (i.e. 4 hours).

Post Assessment Evaluation

The final aspect of the study method was to evaluate the assessment procedure. This was done in two ways:-

1) Post assessment meeting: This meeting, arranged by the researcher included all study co-ordinators. The purpose of the meeting was to elicit reactions of staff to the assessment procedure. These data will be considered in Chapter VI.

2) Post assessment evaluation forms: The patient, nurse learner and nurse teacher involved in each assessment were invited to evaluate the procedure by means of a written evaluation. The forms used are shown in Appendices 13 (page 233), 14 (page 234) and 15 (page 235). The responders were requested to express an opinion about patient assessment of nursing care based on their experience of the delivery of care. These data, shown in Appendices 16 (page 236), 17 (page 247) and 18 (page 260) will also be considered in Chapter VI.

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CHAPTER V: PRELIMINARY STUDY

THE PRELIMINARY DATA

The qualitative preliminary study was carried out prior to developing the 'Patient Assessment of Nursing Care' assessment instrument in order to find out what aspects of nursing care were important to patients and nurses and what could be assessed by them.

The 680 initial items gathered from the open-ended questionnaire were divided into 269 from patients and 411 from nurses and are shown in Appendices 5 (page 184) and 6 (page 198). An initial examination of these items by the researcher revealed that the patients' and nurses' responses were remarkably similar. The nurses did not use a more sophisticated vocabulary than the patients; indeeed it was difficult to distinguish between professional and patient.

Examples:

Patients and nurses when asked about the nursing care they felt most important for this group included items such as,

Centre 8: Renal and urological nursing:-

'complete knowledge of the kidney machine and its function' (patient)

'knowledge of problems of transplant and haemodialysis patients' (nurse)

Centre 6: Care of the elderly and geriatric nursing:-

'nurses should not talk between themselves and ignore the patient' (patient)

'do not talk over patient' (nurse)

The patients and nurses however, were clearly writing from different viewpoints. The patients saw themselves as individuals usually immobile and dependent, relating to a limited number of nurses.

Examples:

Centre 4: General intensive care nursing:-

'not having to wait for bedpans or toilet when you need to go badly' (patient)

Centre 7: Neuromedical and neurosurgical nursing:-

'ability to complete tasks and not to rush off before they are finished' (patient)

The nurses saw themselves as professionals relating to a never ending stream of patients.

Example:

Centre 2: Burns and plastic surgery nursing:-

'good manners with the ability to have discretion i.e. never discussing patients outside the ward circle so that the patient knows she can trust you' (nurse)

The patients focused on the need for 'tender loving care' - which includes patience, understanding, intuition, empathy, respect and appreciation of anxieties. Emphasis was placed by parents on nurses showing <u>love</u> for small babies (a word not used by nurses); of showing respect for the elderly, treating them as individuals and allowing sufficient time for them.

Some nurses seemed to understand this, but there was a tendency to hide behind their practical skills.

Example:

Centre 5: Special and intensive care of the newborn:-

'the ability to help with breast feeding and understanding the problems of this situation' (nurse)

The nurses' priorities seemed to be to show efficiency, professionalism, ability, unflappability - but perhaps some of this is used as a shield against the unknown, the unexpected and the difficult to manage. The patients' priorities were to be treated as individuals, kindly,

gently, even affectionately, but with competence.

It may be suggested that both parties are in threatening situations. The patient is ill and dependent on the professional, whilst the nurse is a professional who cannot afford to become too involved with those in her care.

Many of the items focused upon the affective domain rather than the psychomotor or cognitive domain. The data which substantiate this finding are in Figures 4 (page 111) and 5 (page 112) and are listed below:-

Items from cognitive domain:-

Category A	Knowledge of nursing care	- 18 patient items
		- 19 nurse items

Items from psychomotor domain:-

Category B	Ability and skill in performing nursing care	- 45 patient items
		- 93 nurse items

Items from affective domain:-

Category D	Ability in developing relationships with patients	- 49 patient items
		- 89 nurse items
Category F	Attitudes	- 103 patient items
		- 106 nurse items

Clearly the items from the affective domain dominated the data. This suggests that if there is such a thing as an overall standard of nursing care which can be assessed it may lie in the nurse's approach to her work, her ability to communicate and develop good relationships with those in her care. This was a most important finding since it transformed the whole direction of the study. It had been assumed from the outset that an instrument for the assessment of nursing care would draw equally upon the three domains. Clearly, the data were guiding the researcher in a different direction. In retrospect perhaps this result should not have been surprising in view of previously reported findings related to patients' opinions of nursing

care. For example, Anderson (1973) found that patients valued nurses for their personal qualities, and in data collected from nurses and patients in a sentence completion task, patients frequently mentioned 'civility', 'courtesy' or 'politeness' whereas nurses emphasised 'confidence' and 'reassurance'.

Nevertheless this preliminary finding led to a very early re-appraisal of the way in which the research had to be approached and its importance in the context of this study cannot be over estimated. Clearly it would have been impossible to construct a pen and paper assessment instrument which focused on psychomotor and cognitive items equally with affective items. It was also the case that the psychomotor and cognitive items were of more importance to the nurses than to the patients, whose overwhelming concern was the nurse's ability to deal with the emotional state accompanying their illnesses. One patient wrote that nurses should be:-

> 'aware of patient's embarrassment and helpful'

Yet another asked that a nurse should be:-

> 'friendly and open, yet knows what she is talking about to her patients'

There was a longing for personal attention and one patient wrote:-

> 'treat patient as an individual rather than a number'

Before the final quantification of the data was attempted, it became clear that the major theme of the patients in their comments about nursing care was that above all else the nurse should be kind, polite, helpful and should approach each patient as an individual. This was summarised by the patient who wrote that nurses should:-

> 'strive in all ways possible to be the one that a patient will point out to his visitors saying 'that's my nurse and she is wonderful''

The patients clearly expected some sort of competence in task performance, particularly the knowledgeable renal dialysis group at Centre 8 (Renal and urological nursing), who laid greater stress

than any other group on these aspects of care. Several patients mentioned such skills. One wrote that the nurse should:-

> 'have the ability to care for shunt and fistula and put in fistula needles'

However, the overwhelming impression of the initial data was of patients' desperate anxiety that nurses should have superior skills in developing human relationships.

QUANTIFICATION OF THE PRELIMINARY DATA

The formalisation and quantification of the initial item set occurred when the data were categorised by judges. At this point the researcher's impressions of the qualitative data were tested against the judges' categorisations.

The Judging Procedure

The number of individuals selected to act as a jury was determined by the researcher. The content validity of the instrument was important. Someone had to judge if the content of the instrument was appropriate and in this case a jury opinion seemed to be better than a single individual. The jury comprised of individuals who were considered by the researcher to be experts in the field under study. The jury of five people, two patients (one male, one female) experienced in hospital routine and two nurse tutors (one male, one female) both experienced educationalists and the researcher who is also an educationalist, examined the initial item pool for content and focus.

From this pool of 680 items the jury identified the following 15 categories:-

Category A	Knowledge of nursing care
Category B	Ability and skill in performing nursing care
Category C	Ability in organising nursing care
Category D	Ability in developing relationships with patients
Category E	Ability in developing relationships with other members of staff

Category F Attitudes

Category G Ability and skill in observing

Category H Ability and skill in reporting

Category I Ability and skill in recording

Category J Ability and skill in making judgments

Category K Acceptance of responsibility

Category L Ability and skill in teaching patients

Category M Ability as a leader

Category N Personal appearance

Category O Ability to be professional

Each of the above categories was defined by the jury (Appendix 7, page 220). Items were then placed in the appropriate category by the jury as shown in the categorisation of items in Figures 4 (page 111) 5 (page 112), 6 (page 113) and 7 (page 114). Figures 4 (page 111) and 5 (page 112) are simple histograms of the patients' and nurses' use of the categories developed from the initial item pool, using raw data. Figures 6 (page 113) and 7 (page 114) are histograms using transformed data. The initial item set in Figure 6 (page 113) is transformed with percentages so that the patients' and nurses' use of the initial categories could be compared. There were unequal numbers of both patients (n = 54) and nurses (n = 52) and items generated by each group (patients generated 269 items and nurses 411 items). Figure 7 (page 114) transforms the initial item set into proportions so that a centre by centre analysis could be carried out. To have transformed the data to percentages would have been unacceptable as the numbers per category were very low. Therefore a histogram has been drawn to demonstrate the distribution of the proportion of items over categories and centres. There is a relatively even spread of items across centres. The main categories are B, D, F and L. A detailed look at Figure 7 (page 114) shows that:

Category B: Ability and skill in performing nursing care:-

> Nurses in Centre 1 (Family planning nursing) and Centre 6 (Care of the elderly and geriatric nursing) did not use this category but all other centres did.

FIGURE 4: CATEGORISATION OF PATIENTS' ($n = 54$) INITIAL ITEMS ($n = 269$)

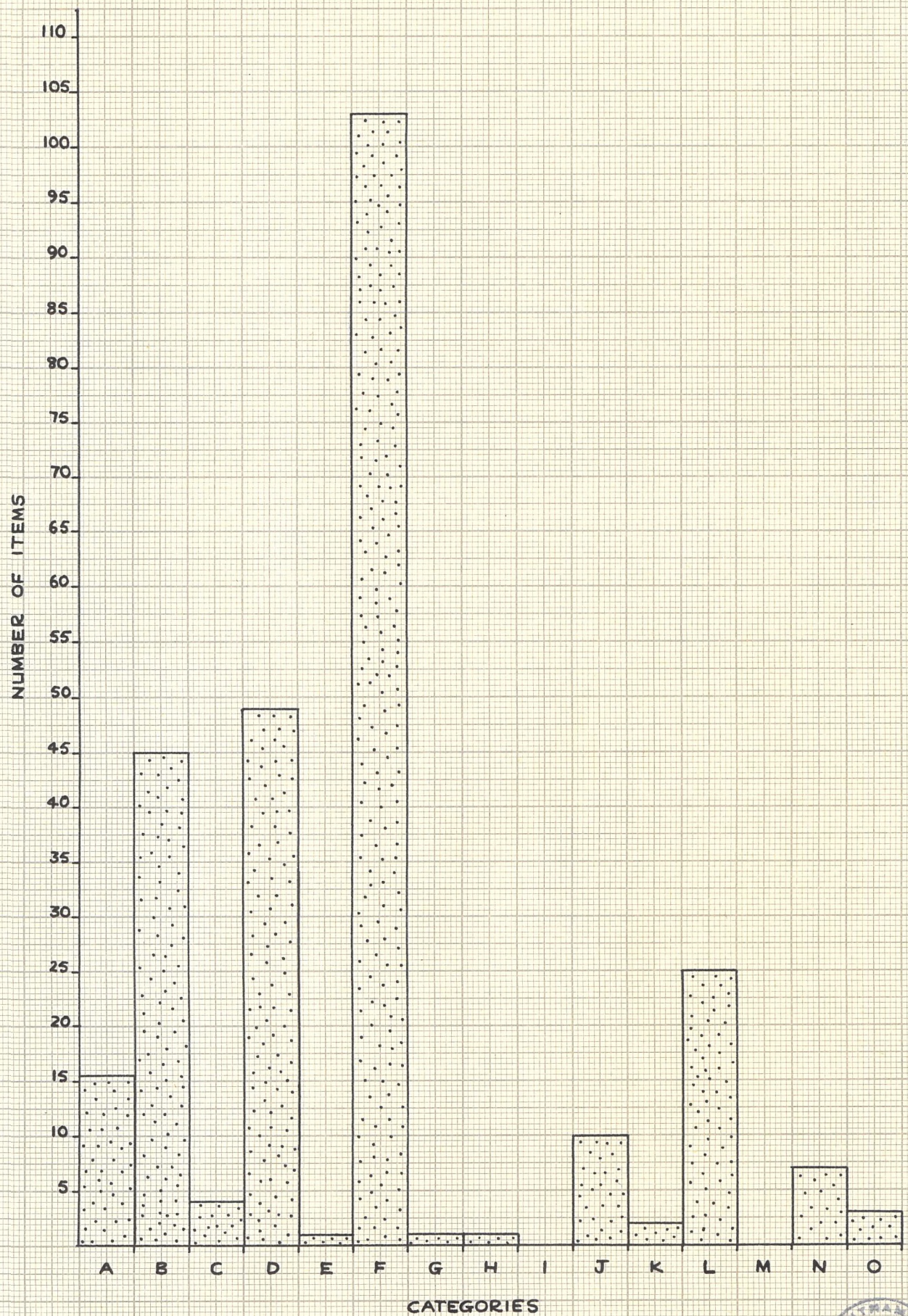


FIGURE 5: CATEGORISATION OF NURSES' (n = 52) INITIAL ITEMS (n = 411)

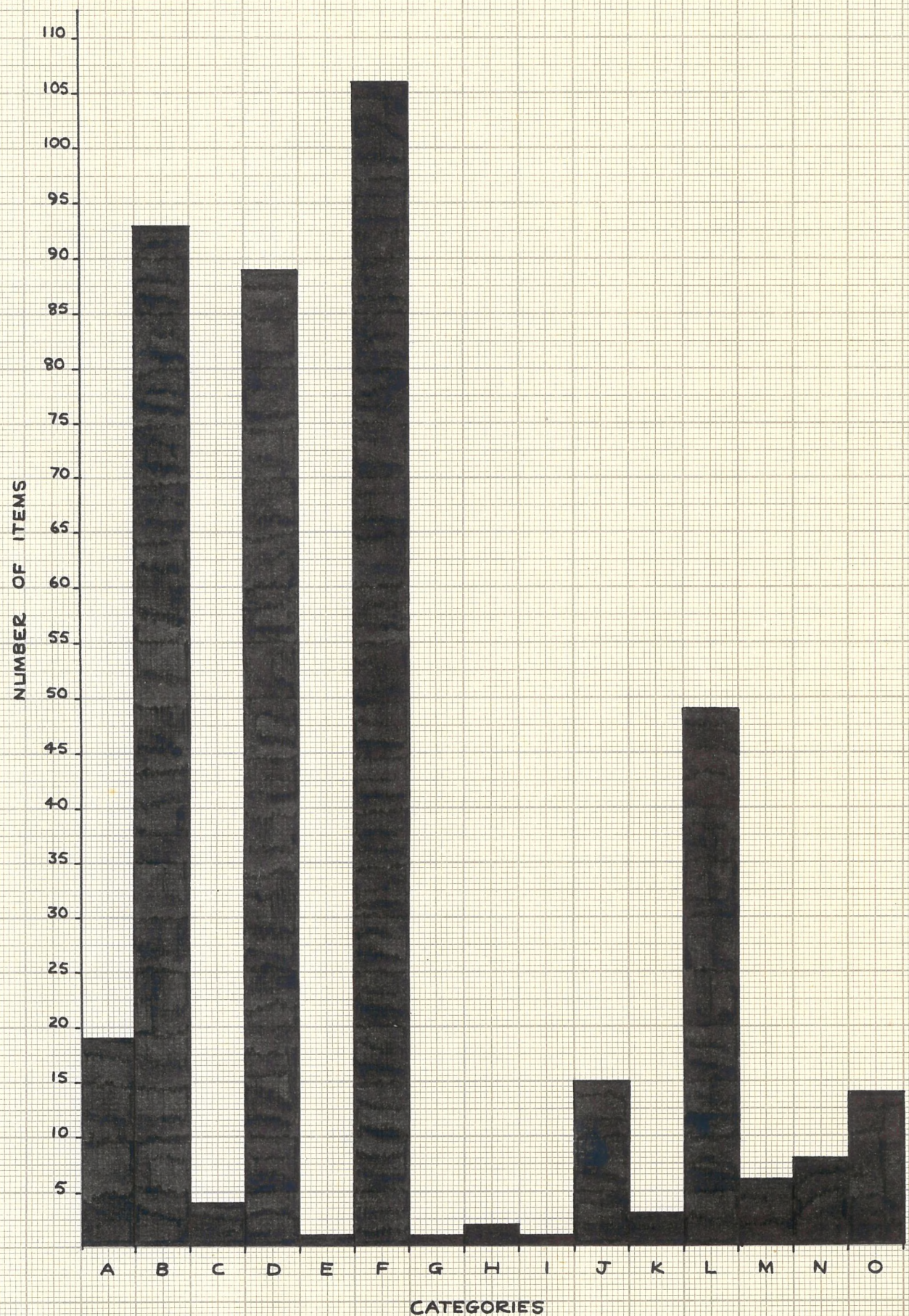


FIGURE 6: COMPARISON OF PATIENTS' AND NURSES' USE OF THE INITIAL CATEGORIES ACCORDING TO PERCENTAGE OF ITEMS PER CATEGORY; PATIENTS (n = 54) NURSES (n = 52)

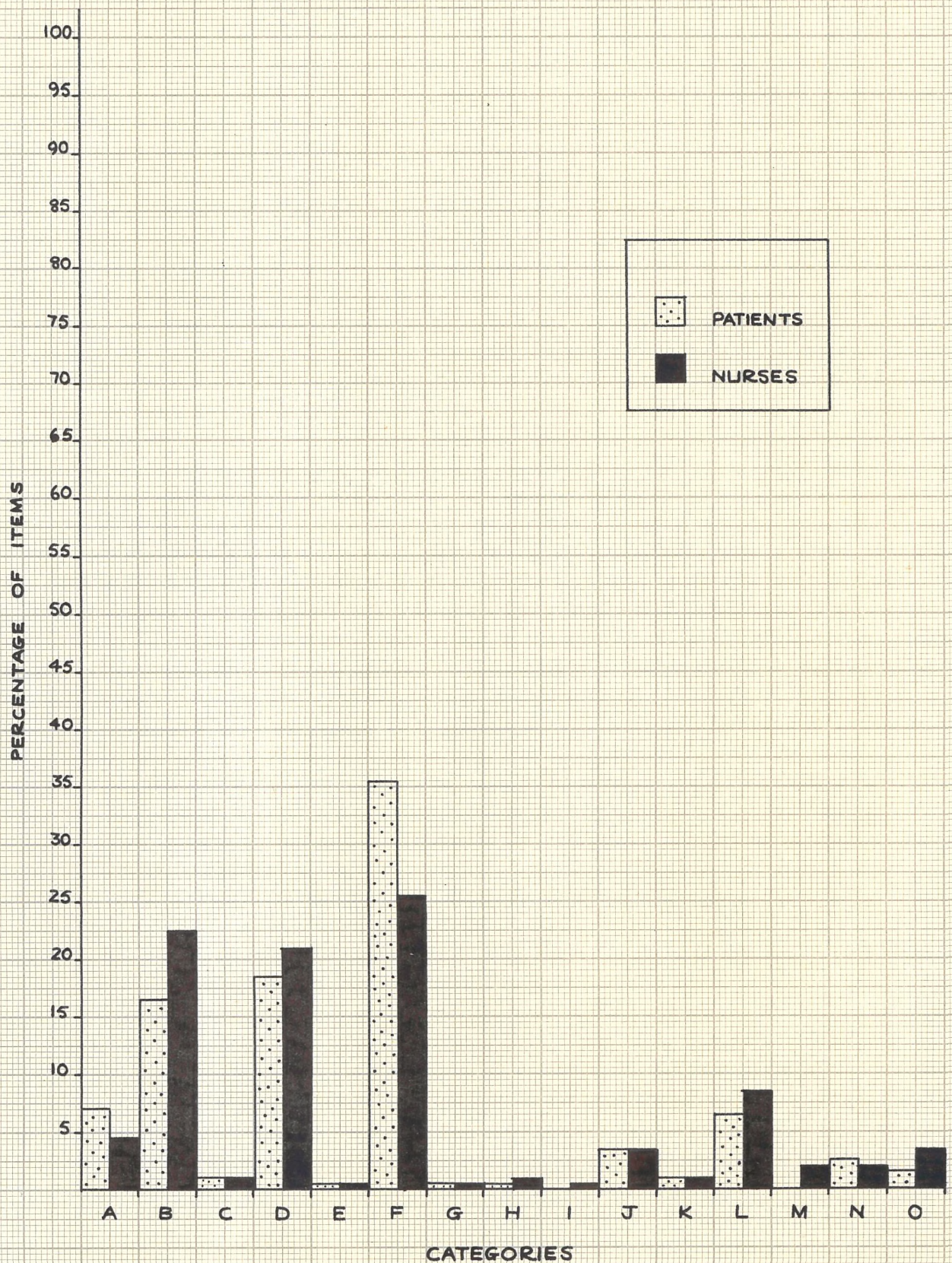


FIGURE 7: COMPARISON OF PATIENTS' AND NURSES' USE OF INITIAL CATEGORIES ACCORDING TO PROPORTION OF ITEMS PER CATEGORY:- CENTRE BY CENTRE ANALYSIS

KEY

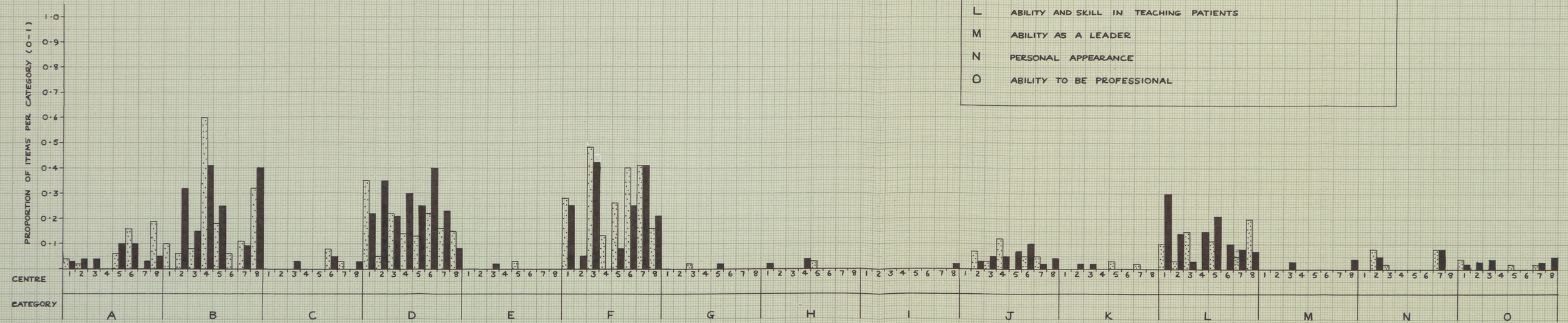
PATIENTS

NURSES

CENTRE	NURSING SPECIALTY
1	FAMILY PLANNING NURSING
2	BURNS AND PLASTIC SURGERY NURSING
3	ACCIDENT AND EMERGENCY NURSING
4	GENERAL INTENSIVE CARE NURSING
5	SPECIAL AND INTENSIVE CARE OF THE NEWBORN
6	CARE OF THE ELDERLY AND GERIATRIC NURSING
7	NEUROMEDICAL AND NEUROSURGICAL NURSING
8	RENAL AND UROLOGICAL NURSING

DEFINITIONS OF CATEGORIES

A	KNOWLEDGE OF NURSING CARE
B	ABILITY AND SKILL IN PERFORMING NURSING CARE
C	ABILITY IN ORGANISING NURSING CARE
D	ABILITY IN DEVELOPING RELATIONSHIPS WITH PATIENTS
E	ABILITY IN DEVELOPING RELATIONSHIPS WITH OTHER MEMBERS OF STAFF
F	ATTITUDES
G	ABILITY AND SKILL IN OBSERVING
H	ABILITY AND SKILL IN REPORTING
I	ABILITY AND SKILL IN RECORDING
J	ABILITY AND SKILL IN MAKING JUDGMENTS
K	ACCEPTANCE OF RESPONSIBILITY
L	ABILITY AND SKILL IN TEACHING PATIENTS
M	ABILITY AS A LEADER
N	PERSONAL APPEARANCE
O	ABILITY TO BE PROFESSIONAL



Patients in all centres used it.

Major differences in the use of the category: Centre 2 (Burns and plastic surgery nursing) and Centre 4 (General intensive care nursing), Centre 1 (Family planning nursing) and Centre 6 (Care of the elderly and geriatric nursing). However, overall there was a fairly good spread.

Category D: Ability in developing relationships with patients:-

All patients and all nurses in all centres used this and only one large discrepancy between patients and nurses occurs in Centre 2 (Burns and plastic surgery nursing).

Category F: Attitudes:-

Centre 2 (Burns and plastic surgery nursing) - no nurses used this but nurses in all other centres used it.

Centre 4 (General intensive care nursing) - no patients used this but patients in all other centres used it.

Centre 5 (Special and intensive care of the newborn) - large differences.

Category L: Ability and skill in teaching patients:-

Centre 4 (General intensive care nursing) - no patients used this but patients in all other centres used it.

Centre 6 (Care of the elderly and geriatric nursing) - no patients used this but patients in all other centres used it.

Centre 1 (Family planning nursing) and Centre 8 (Renal and urological nursing) showed large differences between patients and nurses.

This is an important finding in the context of this study since if each centre had used the categories in a very different way

from all other centres, then a specific measure for each centre would have been necessary. The aspects of care mentioned by each centre are important for assessment and seem, on the evidence of the initial categorisation (Figure 7, page 114) to be common to all centres. The researcher concluded therefore that a measure which incorporated these aspects of nursing care could be used by all centres.

The Categorial Framework

The categories developed from the initial data by the jury reflected the initial impressions of the data. The major categories were B, D, F and L. Category B (Ability and skill in performing nursing care) was the only major category concerned with technical skills. Category D (Ability in developing relationships with patients) and Category F (Attitudes) along with the next most frequently used Category, L (Ability and skill in teaching patients), reflect a concern with interpersonal skills and personal qualities. Category F (Attitudes) was used particularly by patients whilst Category D (Ability in developing relationships with patients) and Category L (Ability and skill in teaching patients) were used rather more by nurses. There was considerable agreement between patients and nurses as to the important aspects of nursing care, suggesting that both groups shared a common perception which lay mainly in the affective domain of nursing skills. This is supported by the data in Figure 6 (page 113) which shows the comparison of patients' and nurses' use of the initial categories according to percentage of items per category; patients (n = 54) and nurses (n = 52).

Category B	Ability and skill in performing nursing care	- patients 17% - nurses 22%
Category D	Ability in developing relationships with patients	- patients 19% - nurses 21%
Category F	Attitudes	- patients 35.5% - nurses 25.5%

Category L	Ability and skill in teaching patients	- patients	7%
		- nurses	9%

This was important in the context of the study since it had to be shown that 'NURSING CARE' is a concept which can be understood by both patients and nurses in a similar way, so that the measures obtained from both groups could be compared. Similarly, it was important that the categories were used over most centres; if each centre had accounted for one individual category, this would have suggested that patients and nurses did not share a common perception of nursing care.

The categorised data provided further evidence of the trend noted in the initial examination of the qualitative data. Nurses' attitudes and human qualities were of over-riding importance. Thus the construction of an instrument to measure nursing skills in the three domains would have been unrealistic. Any instrument would have to reflect the initial data and measure mainly in the affective domain, rather than in the psychomotor or cognitive domains.

Conversion of Items to Statements

The jury re-examined the categorised item pool (Figure 7, page 114) and after some considerable discussion formed 51 statements which reflect the content and focus of the original items. These statements and the category from which they originated are listed in Appendix 8 (page 222).

The Assessment Instrument

The 'Patient Assessment of Nursing Care' instrument shown in Appendix 9 (page 226) was designed in co-operation with the groups who were going to use it. The initial instrument designed by the researcher was presented to 6 patients and 6 nurses for discussion on the format, scoring system and the number of statements to be included.

a) Summary of patient discussion

Patients felt that there should be 5 categories for marking:

Not applicable:	The action stated did not occur	Score 0
Strongly agree:	Nursing care was fulfilled as indicated in the statement in excess of the wording	Score 4
Agree:	Nursing care was fulfilled as indicated in the statement and no more	Score 3
Disagree:	Nursing care as indicated in the statement was not fulfilled	Score 2
Strongly disagree:	Total disregard or indifference to the statement even when the opportunity arose	Score 1

Patients also felt that there should be a column for comments to enable them to clarify any points. They also suggested that the assessment should be carried out by the patient, the nurse learner and an independent third person, preferably a nurse teacher.

b) Summary of nurse discussion

The nurses were a heterogeneous group made up of nurse teachers, clinical nursing staff and nurse learners. The group agreed with the patients scoring system and supported the idea of an independent third assessor. The group suggested that the maximum number of statements on the assessment instrument should be 20. They also felt it necessary to design a form for easy referral, to compare the scores of the three assessors, and all agreed that it should be an educational/self development instrument.

Much has been written about the development of scales to measure the opinions and attitudes of our fellow humans. Although textbooks

suggest that there are three main methods available for use in the construction of scales, in fact only one has been used extensively. Oppenheim (1966) has listed the three with his comments. The Likert procedure, the most commonly used, is recommended for the exploration of attitude patterns. The Guttman method is useful in examining the structure of attitudes and attitude change, whilst Thurstone's method is useful for the study of the differences in attitudes between and amongst groups.

The Likert-type scale suggested by patients and nurses was chosen for the study as it is frequently employed in opinion research. A Likert-type scale has certain features: discriminating statements are submitted to the respondents who are asked to choose one of five responses that best reflect their pattern; each response has a value and when totalled gives a rating to the subject's opinion; the scale is developed from a large pool of items as a starting point for scaling. This follows the recommendation of McKennell (1974), Figure 3 (page 92) Stage 2: scale development pilot.

The 20 statements for the assessment instrument were chosen by the jury following discussion, and include items from all categories except C, E, K and N. The largest number of items selected were from three of the four main categories, B, D and F. Hence the scale was heavily weighted in favour of statements which would assess nurses in the affective domain, since this reflected the emphasis in the initial data. The jury selection is listed below:-

		Statement number on the assessment instrument
Category A	Knowledge of nursing care	12
Category B	Ability and skill in performing nursing care	9 10 13 19
Category C	Ability in organising nursing care	Nil

		Statement number on the assessment instrument
Category D	Ability in developing relationships with patients	1* 2* 3 4
Category E	Ability in developing relationships with other members of staff	Nil
Category F	Attitudes	6 7 8 15
Category G	Ability and skill in observing	11
Category H	Ability and skill in reporting	17
Category I	Ability and skill in recording	5*
Category J	Ability and skill in making judgments	16
Category K	Acceptance of responsibility	Nil
Category L	Ability and skill in teaching patients	14
Category M	Ability as a leader	18
Category N	Personal appearance	Nil
Category O	Ability to be professional	20

The 'Patient Assessment of Nursing Care' instrument (Appendix 9, page 226) shows the three sections of the instrument, for patient, nurse learner and nurse teacher; the 20 statements, personalised for each group and the Likert-type scale used for each statement except Statements 1, 2 and 5 where two grades were used. The five point scale was not applicable to these statements to which agree or disagree was the only possible answer.

The Status of the 'Patient Assessment of Nursing Care' Assessment Instrument

The status of such a measure as the 'Patient Assessment of

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* Two grades used

Nursing Care' instrument should be defined, since there have been many attempts to measure nursing care. For example, Anderson (1973) examined patients', nurses' and doctors' perceptions of the role of the nurse. A questionnaire was developed to elicit patients' opinions of the care they received. Work in the United States has focused on the development of qualitative measures of care, for example Phaneuf (1972). Such attempts to measure the quality of care have been divided by Woody (1976) into measures of process and outcome. Process measures are those which can provide guidance as to the patients' progress whilst under treatment; for example, a patient satisfaction index may record patients' views whilst they are in hospital, but a year later these views may change; a measure taken then may demonstrate more or less satisfaction with hospital treatment. This would then be a measure of patient outcome. Using the process-outcome distinction, the measure which was being developed would be considered a process measure. It is not an attempt to measure the outcome of care as such. It is a means of recording patients', nurse learners' and nurse teachers' perceptions of current care. For the nurse learner 'Patient Assessment of Nursing Care' should provide a learning experience; the purpose being to provide feedback on the nurse learner's progress and help the nurse teacher focus upon learning that is necessary to progress forward. 'Patient Assessment of Nursing Care' falls into the category of formative assessment and in this way the assessment instrument becomes a learning tool.

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CHAPTER VI: CORE STUDY - THE USE OF THE 'PATIENT ASSESSMENT OF NURSING CARE' ASSESSMENT INSTRUMENT

PREAMBLE

Analysing the data generated in the core study proved to be a complex process, since much of it was of a qualitative nature and demanded illuminative and insightful examination such as is recommended by Glaser and Strauss (1967). However, as the initial purpose of the study had been to construct an assessment instrument, another type of analysis had also to be considered to see if the assessment instrument was an effective tool for certain purposes. The one chosen is that recommended by Kerlinger (1973), using formal statistical methods. This chapter will be devoted to the quantification of the data as recommended by psychologists who use the classic scientific method. Illuminative analysis of the data in the preliminary study was carried out in Chapter V. At this point there is an important caveat to add regarding statistical analysis of the preliminary data in this study, in that, it should certainly not be taken as final, enabling conclusions to be made. The use of statistical methods in this chapter rather enables the researcher to organise the data to provide some basis for future work.

Kerlinger (1973) recommends that before any statistical analysis of data is attempted, the measurement level should be identified. There are four levels of measurement:-

a) Nominal

This is the lowest level of measurement and is applied to data which have been placed into categories, such as the preliminary data generated in this study

b) Ordinal

This is a higher level of measurement and occurs when data are not just placed into categories but the judges are asked to decide about order of items in relation to some property. However, assigning scores to these items does not mean that these are the numerical

values although numbers are used. No assumptions about the space between numerical intervals can be made and there is no absolute zero

c) Interval

This is a much higher level of measurement. A property is measured into fixed units but without a true zero. Time is a good example of such a property

d) Ratio

This is the highest level of measurement. A property is not only measured into fixed units but has a true zero. Height and weight are examples of ratio measures.

The data generated in this study were at the two lowest levels of measurement. The categories devised by the judges into which the initial items were placed ensured that measurement was at the nominal level. The 'Patient Assessment of Nursing Care' assessment instrument asked users to perform a ranking task on each statement and therefore the data are at the ordinal level of measurement. Two types of statistical analysis are available:-

Descriptive statistical methods

These are methods of presenting the data in a variety of ways without the use of special tests. Examples are such procedures as histograms and tables of percentages

Inferential statistics

These are methods of analysing data by applying tests to the data which allow the researcher to note differences between groups which could not have occurred by chance. Inferences about the data can then be made. There are two types of inferential statistics:

a) Non-parametric

These are especially suitable for preliminary small scale behavioural science projects since they make few assumptions about the distribution of data and measurement level. Tests are available for data at nominal and ordinal levels of measurement

b) Parametric statistics

These powerful statistical tests are recommended for use with data at the higher measurement levels (interval and ratio) and the researcher should be aware of the problem of distribution of the data.

Clearly only the weaker forms of analyses were suitable for these data. Therefore a variety of descriptive and non-parametric techniques were used to provide some form of preliminary statistical analysis.

In conclusion it should be noted that there were two types of data collected in this study:-

1) Qualitative

   a) the preliminary study survey

   b) the post assessment evaluation survey

2) Quantitative

   a) the categorisation of the preliminary study survey data

   b) the scores from the use of the 'Patient Assessment of Nursing Care' instrument.

CORE STUDY

The quantitative aspects of the 'Patient Assessment of Nursing Care' instrument score data will be considered here using the least rigorous statistical techniques suitable for preliminary data at the lowest levels of measurement.

The data collected in this part of the study were analysed in several ways; a variety of descriptive statistical methods were used and non-parametric inferential statistics.

Descriptive Statistics

a) Histograms

Figures 4 (page 111) and 5 (page 112) are simple histograms of the patients' and nurses' use of the categories developed from the initial item pool. Figures 6 (page 113) and 7 (page 114) are histograms using transformed data. The initial item set in Figure 6 (page 113) is transformed with percentages so that the patients' and nurses' use of the initial categories could be compared. Figure 7 (page 114) transformed the initial item set into proportions so that a centre by centre analysis could be carried out. These data have already been discussed in Chapter V.

Figures 8 (page 127) and 9 (page 128) are histograms to demonstrate aspects of the patients', nurse learners' and nurse teachers' scoring patterns on the 'Patient Assessment of Nursing Care' instrument. Figure 8 (page 127) is a statement by statement analysis of the scoring pattern whilst Figure 9 (page 128) looks at the scoring patterns on the statements derived from the three major categories in the initial data.

Figure 8 (page 127) shows the patients', nurse learners' and nurse teachers' score patterns on the assessment instrument. Three main score patterns seem to emerge: pattern one contains statements 8, 9, 10, 12, 15 and 16 which show similar score patterns given by patients, nurse learners and nurse teachers; pattern two contains statements 7, 11, 13 and 18 which show the consistent use of not applicable, strongly agree and agree in these statements and pattern three with only two statements, 14 and 17 shows a low score overall.

Figure 9 (page 128) demonstrates the patients', nurse learners' and nurse teachers' score pattern on the statements relating to the three main categories: B, (Ability and skill in performing nursing care); D, (Ability in developing relationships with patients) and F, (Attitudes). These demonstrate remarkably scattered score patterns; there seems to be no particular relationship between the individual

FIGURE 8: STATEMENT BY STATEMENT ANALYSIS OF PATIENTS' (n = 33) NURSES' (n = 33) AND NURSE TEACHERS' (n = 33) SCORING PATTERNS ON THE 'PATIENT ASSESSMENT OF NURSING CARE' ASSESSMENT INSTRUMENT

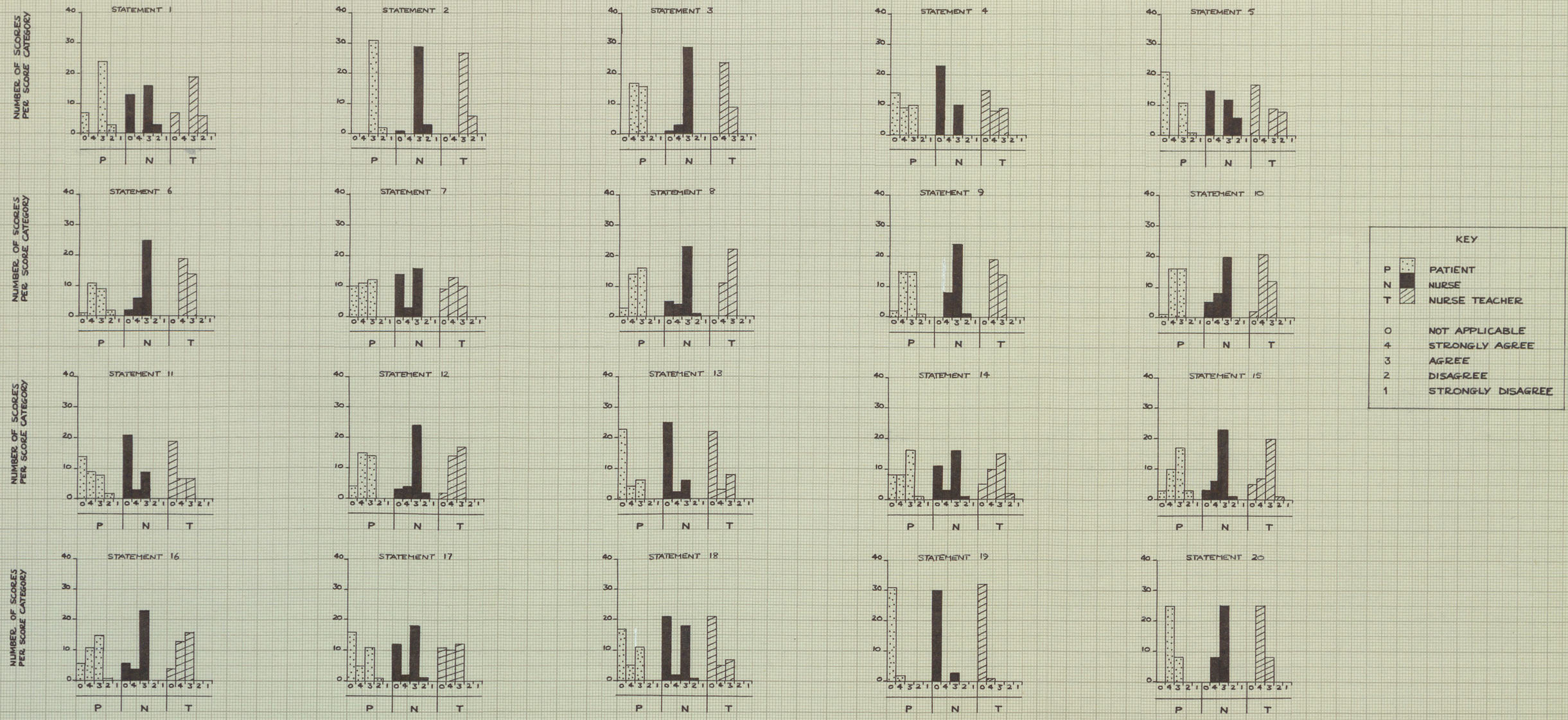
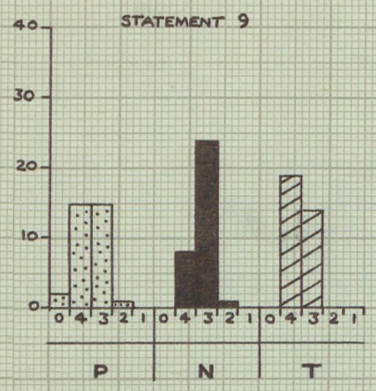
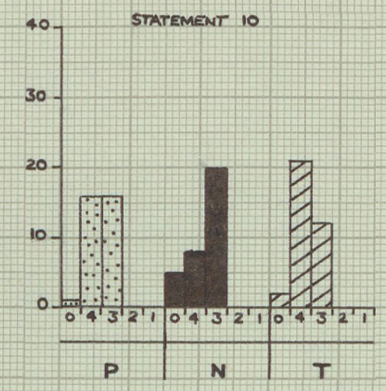
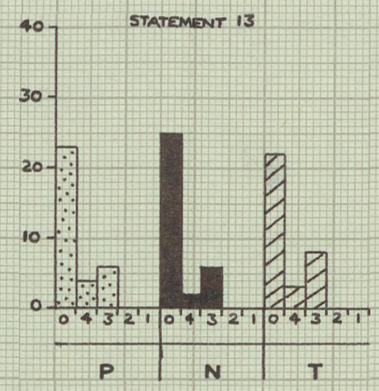


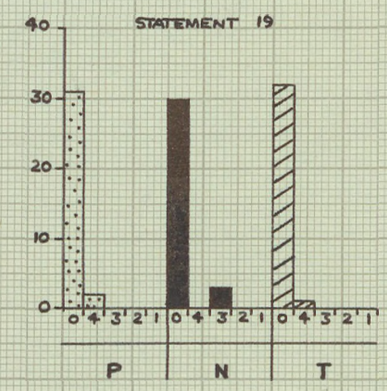
FIGURE 9: DISTRIBUTION OF PATIENTS' ($n = 33$) NURSES' ($n = 33$) AND NURSE TEACHERS' ($n = 33$) SCORES ON THE 'PATIENT ASSESSMENT OF NURSING CARE' ASSESSMENT INSTRUMENT TO SHOW THEIR USE OF THE THREE MAJOR CATEGORIES IN THE INITIAL DATA

CATEGORY B ABILITY AND SKILL IN PERFORMING NURSING CARE

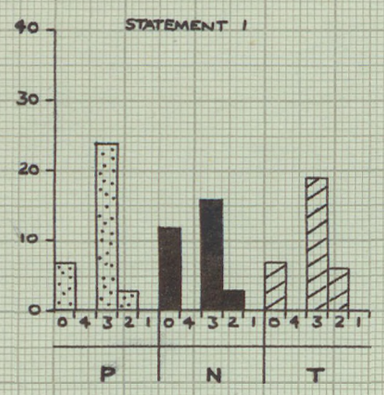


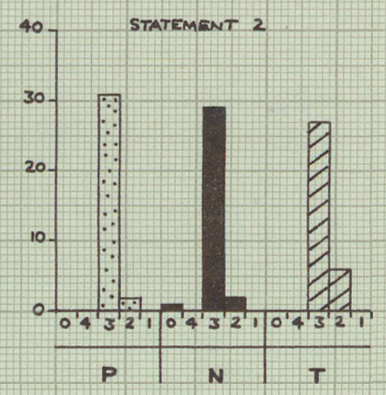


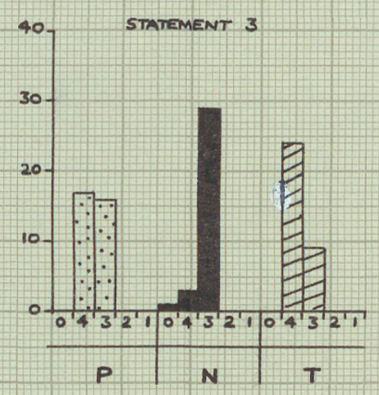


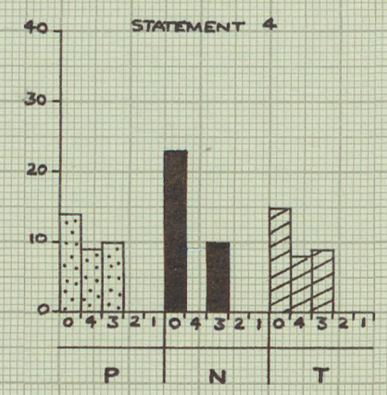


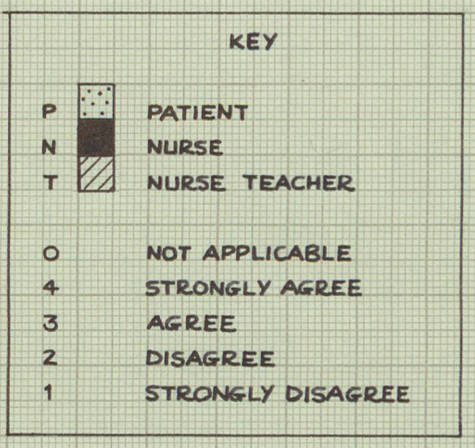
CATEGORY D ABILITY IN DEVELOPING RELATIONSHIPS WITH PATIENTS



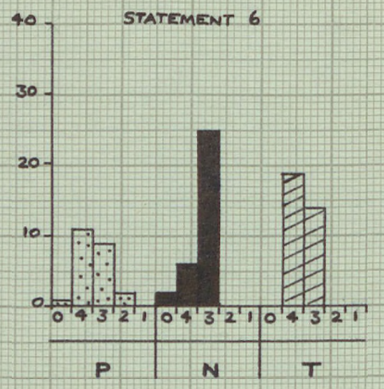


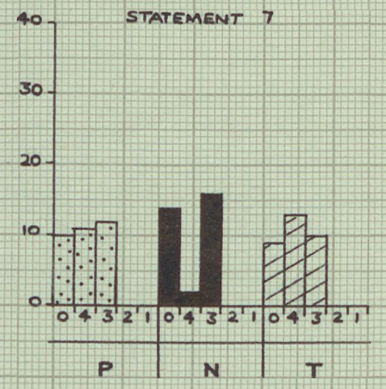


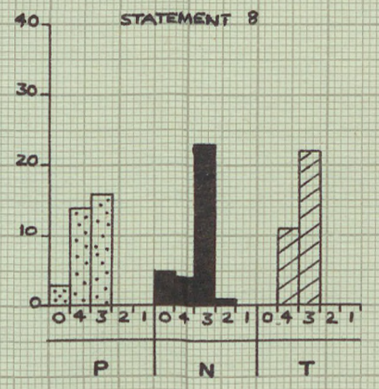


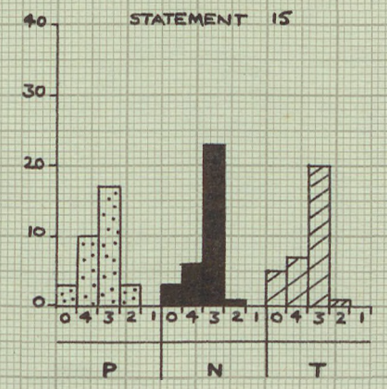


CATEGORY F ATTITUDES









statements and score patterns within categories apart from 9 and 10 (Category B) and 8 and 15 (Category F). This would suggest that the statements chosen to represent the categories are not reflecting pure traits but are themselves heterogeneous collections of statements, each possibly reflecting different aspects of the category.

The Three Main Score Patterns

Score Pattern 1:

Statement 8	The nurse showed a sense of humour at the right time
Statement 9	The nurse understood what I needed and how to make me comfortable
Statement 10	The nurse told me what she was doing to help me and was gentle and tried not to hurt me
Statement 12	The nurse appeared to know about the equipment she used in my care and how to look after me so I felt safe
Statement 15	The nurse was prepared to learn from me about my condition
Statement 16	The nurse was able to make decisions but asked for help when it was needed

The statements which fall into this score pattern seem to demonstrate a relatively high score on grade 3 or 4. The theme of this group of statements is concerned with the nurse's understanding and her ability to make the patient feel safe and secure.

Score Pattern 2:

Statement 7	The nurse was patient and tactful when things were difficult
Statement 11	The nurse noticed changes in my condition and changed her nursing care accordingly
Statement 13	The nurse noticed when it was necessary to change my dressing and did it gently

Statement 18 The nurse made sure the other nurses gave me the care I needed

This pattern of scores again shows considerable use of grades 3 and 4 but also a relatively high proportion of not applicable scores. The theme of this group of statements seems to be the nurse's ability as an observer.

Score Pattern 3:

Statement 14 The nurse taught me about my care so that I was able to understand

Statement 17 The nurse told a senior nurse about me clearly and when necessary asked for help on how best to look after me

This pattern of scores shows a spread over all grades apart from grade 1. The theme of this group seems to be the nurse as a communicator.

General Comments on Score Patterns

It may be noted from Figure 8 (page 127) that grade 1 was never used. This may be due to the reluctance of those involved to score harshly in the context of such an intimate assessment. However, all three groups used grade 2 on several occasions. Patients were prepared to use this grading even when nurse teachers were not, for example, statements 11 and 15.

The not applicable category (0 score) may have been used to avoid the use of grade 1. Nurse learners used it about themselves quite frequently, for example, statements 4 and 11 demonstrate the nurse learners using this whilst the patients and nurse teachers were using other grades more extensively. Statement 11 (The nurse noticed changes in my condition and changed her nursing care accordingly) seems to be a key statement in that nurse learners used the not applicable category more than the patients and nurse teachers and at least one patient was prepared to use grade 2.

In reviewing these data it is interesting to note that the three groups, patients, nurse learners and nurse teachers differed

in their use of the grades; this suggests that each group has a specific contribution to make to the assessment of nursing care. According to Rogers (1969) the most important contribution to the facilitation of learning is the quality of the interpersonal relationship between teacher and learner. Equally important are the attitudes of 'realness', 'genuineness', 'caring' and 'empathy' in the facilitator. The contribution of patients suggests that they had expectations of nursing care which they compared with the nursing care received. Although numbers of patients in the study were small (Table 1, page 98) they did, however, include all nursing dependency categories except category 5 (Table 2, page 100) and all social classes as classified by occupation (Table 3, page 101).

It may now be argued that patients of limited educational achievement would find difficulty in using a written assessment form which required some degree of literacy. Bernstein (1971) attempted to relate social structure to educational achievement via language, out of which he developed his concept of two linguistic codes, namely, the restricted code and the elaborated code. The restricted code is simple; involves a limited range of alternatives; is descriptive and narrative; relies on a common understanding between speaker and listener; its meaning is implicit and the manner and circumstances of speech are important. The elaborated code is more complex; involves a wide range of alternatives; is analytical and abstract; does not rely on common understanding; its meaning is explicit and extra verbal factors are not important. Bernstein's (1971) work, however, contains no clear precise definition of the term social class and therefore has a tendency to describe restricted code users as 'lower working class' and his use of elaborated code users suggests the upper and educated end of the middle class. Thus it can be argued that in using this categorisation, Bernstein (1971) leaves the majority of society outside the class categories of code users and although the study sample contained several patients who might be described as 'lower working class' (n = 15), they were competent in the use of the form. From the evidence gathered in this study it does not appear that 'linguistic code' had any significant effect on the outcomes, even though the social class composition of the group (Table 3, page 101) showed a wide range of occupational categories on Hockey's (1976) classification.

All patients in the study were in all nursing dependency categories except category 5 (Table 2, page 100). This indicates the different amounts and degrees of nursing care required by patients in the study. It is interesting to note that patients in all social classes and at varying levels of nursing dependency had a contribution to make to the assessment. As previously stated in the assessment of learning section, page 75, there are many intervening variables which have some influence on effectiveness of care provided by nurses and in the assessment of learning (Figure 2, page 76). The variables listed under 'nurse learner' in Figure 2 (page 76) could serve as a potential source for predicting nurse behaviour, for example, differences in education and experience can be hypothesised to account partially for differences in nurse effectiveness (King, 1971). All nurse learners in the study were registered nurses undertaking a post basic clinical course in a chosen specialty. It may be assumed that knowledge, communications and interpersonal skills vary in direct proportion to the training of these post basic learners in relation to the time already spent on the course in preparation for their role in that specialty (King, 1971). Although intervening variables influence the patient, nurse learner and nurse teacher (Figure 2, page 76), the data suggested that each group had a specific contribution to make (Figure 8, page 127).

b) Tables

Table 1 (page 98) shows the number of participants in the core study, Table 2 (page 100) shows the nursing dependency categories and Table 3 (page 101) social class by occupation of patient participants. These tables have been discussed in Chapter IV.

Table 4 (page 133) shows the mean score and standard deviation of each statement (n = 20) and each centre (n = 7) for each group of participants in the assessment: patients, nurse learners and nurse teachers. An overall mean has also been calculated. This procedure was adopted as it seemed to be the best way of developing a data base for future assessments. Each statement should be scored separately since this is not a homogeneous scale measuring one pure concept. 'Nursing care' is a general quality made up of many factors, hence

Table 4: Centre 1: Mean scores showing patients' mean, nurses' mean, teachers' mean and the overall mean for each statement

Statement Number	Patients		Nurses		Teachers		Overall	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1	3.00	0.00	3.00	0.00	3.00	0.00	3.00	0.00
2	2.80	0.45	3.00	0.00	2.50	0.50	2.77	0.25
3	3.67	0.52	3.00	0.00	3.80	0.45	3.40	0.56
4	3.00	0.00	3.00	0.00	3.30	0.58	3.10	0.17
5	3.00	0.00	2.67	0.52	2.53	0.92	2.60	0.09
6	3.50	0.55	3.00	0.00	3.67	0.52	3.39	0.35
7	3.20	0.45	3.00	0.00	3.30	0.58	3.15	0.21
8	3.50	0.55	3.00	0.00	3.50	0.55	3.33	0.28
9	3.40	0.55	2.83	0.41	3.50	0.55	3.25	0.35
10	3.20	0.45	3.00	0.00	3.50	0.55	3.25	0.35
11	3.25	0.50	3.00	0.00	3.00	0.00	3.12	0.18
12	3.00	0.00	2.67	0.52	3.00	0.00	2.89	0.19
*13	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
14	3.17	0.41	3.67	0.52	3.20	0.45	3.34	0.28
15	3.17	0.41	3.00	0.00	3.67	0.52	3.28	0.35
16	3.25	0.50	3.00	0.00	3.17	0.41	3.14	0.13
17	3.33	0.58	2.80	0.45	3.00	0.00	3.04	0.27
18	3.33	0.58	3.00	0.00	0.00	0.00	3.16	0.23
*19	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
20	3.67	0.52	3.00	0.00	3.80	0.45	3.40	0.56

* Mean based on 2 groups or less
SD Standard deviation

Patients', nurses' and teachers' scores: raw data

Statements	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Patients	3	3	4	3	3	4	3	3	3	0	4	0	0	4	3	4	3	3	0	4
	3	3	3	3	3	3	3	3	3	3	3	3	0	3	3	0	0	0	0	3
	3	3	4	3	3	4	3	4	3	3	3	3	0	3	3	3	3	3	0	4
	3	3	4	0	3	3	0	4	0	3	0	0	0	3	3	3	0	0	0	4
	3	3	3	3	0	3	3	3	4	3	0	3	0	3	3	0	0	0	0	3
	3	2	4	3	3	4	4	4	4	4	3	3	0	3	4	3	4	4	0	4
Nurses	3	3	3	3	3	3	3	3	3	0	0	3	0	3	3	3	3	3	0	3
	3	3	3	0	2	3	3	3	3	3	3	3	0	4	3	3	3	0	0	3
	3	3	3	3	3	3	3	3	3	3	0	3	0	3	3	3	3	3	0	3
	3	3	3	0	3	3	3	3	3	0	0	3	0	0	3	3	3	0	0	3
	3	3	3	0	3	0	0	3	3	0	0	3	0	3	3	3	3	0	0	3
	3	3	3	0	2	3	3	3	2	3	0	2	0	3	3	3	2	3	0	3
Teachers	3	2	3	3	2	3	3	3	3	0	3	0	0	3	3	3	3	0	0	3
	3	2	4	4	2	3	3	3	3	4	0	3	0	3	3	3	3	0	0	4
	3	2	4	3	2	3	4	4	3	3	0	3	0	3	3	3	3	0	0	4
	3	3	4	0	2	4	0	3	4	0	0	3	0	0	4	4	3	0	0	4
	3	3	4	0	3	4	0	4	4	4	0	3	0	4	3	3	0	0	0	4
	3	3	4	0	2	3	0	4	4	3	0	3	0	3	4	3	0	0	0	4

In statements 1, 2 and 5 only grades 3 and 2 were used

Table 4: Centre 2: Mean scores showing patients' mean, nurses' mean, teachers' mean and the overall mean for each statement

Statement Number	Patients		Nurses		Teachers		Overall	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1	3.00	0.00	3.00	0.00	3.00	0.00	3.00	0.00
2	2.80	0.45	2.80	0.45	3.00	0.00	2.86	0.15
3	3.50	0.58	3.00	0.00	3.75	0.50	3.42	0.38
4	3.33	0.57	3.00	0.00	3.00	0.00	3.11	0.19
*5	0.00	0.00	3.00	0.00	0.00	0.00	*3.00	0.00
6	3.25	0.50	3.25	0.50	3.50	0.58	3.33	0.14
7	3.67	0.57	3.33	0.57	3.50	0.58	3.42	0.12
8	3.25	0.50	3.50	0.58	3.00	0.00	3.25	0.35
9	3.50	0.58	3.50	0.58	3.50	0.58	3.50	0.00
10	3.50	0.58	3.25	0.50	4.00	0.00	3.62	0.53
11	3.50	0.71	3.33	0.57	3.50	0.71	3.52	0.21
12	3.50	0.58	3.00	0.00	3.25	0.50	3.25	0.35
13	3.50	0.71	3.00	0.00	3.50	0.71	3.33	0.28
14	3.33	0.57	3.00	0.00	3.33	0.57	3.16	0.23
15	3.67	0.57	3.25	0.50	3.33	0.57	3.41	0.22
16	3.25	0.50	3.00	0.00	3.50	0.58	3.25	0.35
17	3.33	0.57	3.00	0.00	3.50	0.71	3.42	0.12
*18	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
*19	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
20	3.50	0.58	3.75	0.50	3.50	0.58	3.62	0.18

* Mean based on 2 groups or less
SD Standard deviation

Patients', nurses' and teachers' scores: raw data

Statements	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Patients	0	2	3	0	0	3	0	3	3	3	0	3	0	3	3	3	0	0	0	3
	3	3	3	3	0	3	3	3	3	3	3	3	3	3	0	3	3	0	0	3
	0	3	4	3	0	3	4	3	4	4	0	4	0	0	4	3	3	0	0	4
	3	3	4	4	0	4	4	4	4	4	4	4	4	4	4	4	4	0	0	4
Nurses	0	2	3	0	0	3	3	4	4	3	3	0	0	3	4	3	3	0	0	4
	0	3	3	0	0	4	3	3	4	4	4	0	0	3	3	3	0	0	0	4
	0	3	3	0	0	3	0	3	3	3	0	3	3	0	3	3	0	0	0	3
	3	3	3	3	3	3	4	4	3	3	3	3	3	3	3	3	3	0	0	4
Teachers	0	3	3	0	0	3	3	3	3	4	0	3	3	3	0	3	3	0	0	3
	0	3	4	3	0	3	4	3	3	4	3	3	0	4	3	3	0	0	0	3
	0	3	4	0	0	4	3	3	4	4	0	4	4	0	4	4	0	0	0	4
	3	3	4	3	0	4	4	3	4	4	4	3	0	3	3	4	4	0	0	4

In statements 1, 2 and 5 only grades 3 and 2 were used

Table 4: Centre 3: Mean scores showing patients' mean, nurses' mean, teachers' mean and the overall mean for each statement

Statement Number	Patients		Nurses		Teachers		Overall	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1	3.00	0.00	2.66	0.57	2.66	0.57	2.77	0.19
2	2.66	0.57	3.00	0.00	2.66	0.57	2.77	0.19
3	3.33	0.57	3.33	0.57	3.00	0.00	3.16	0.23
4	3.50	0.71	3.00	0.00	3.50	0.71	3.33	0.28
5	3.00	0.00	2.50	0.71	2.00	0.00	2.50	0.50
6	3.33	1.15	3.33	0.57	3.00	0.00	3.16	0.23
7	3.66	0.57	3.00	0.00	3.33	0.57	3.16	0.23
8	3.66	0.57	3.00	0.00	3.00	0.00	3.11	0.19
9	3.33	0.57	3.33	0.57	3.00	0.00	3.16	0.23
10	3.66	0.57	3.50	0.71	3.33	0.57	3.42	0.12
11	3.00	1.40	0.00	0.00	0.00	0.00	3.00	1.40
12	3.66	0.57	3.33	0.57	3.00	0.00	3.16	0.23
*13	0.00	0.00	0.00	0.00	3.00	0.00	*3.00	0.00
14	3.50	0.71	2.66	0.57	3.00	0.00	3.08	0.59
15	3.50	0.71	3.00	0.00	3.50	0.71	3.33	0.28
16	3.33	0.57	4.00	0.00	3.00	0.00	3.50	0.71
*17	3.33	1.15	0.00	0.00	0.00	0.00	*3.33	1.15
*18	3.33	0.57	0.00	0.00	0.00	0.00	*3.33	0.57
*19	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
20	3.66	0.57	3.33	0.57	3.66	0.57	3.49	0.23

* Mean based on 2 groups or less
SD Standard deviation

Patients', nurses' and teachers' scores: raw data

Statements	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Patients	3	2	3	4	3	4	4	4	3	4	4	4	0	0	3	3	4	4	0	4
	3	3	3	3	3	2	3	3	3	3	2	3	0	3	0	3	2	3	0	3
	3	3	4	0	3	4	4	4	4	4	0	4	0	4	4	4	4	3	0	4
Nurses	3	3	3	3	2	3	3	3	3	3	0	3	0	3	3	0	0	0	0	3
	3	3	3	0	3	3	0	3	3	0	0	3	0	3	3	0	0	0	0	4
	2	3	4	0	0	4	0	3	4	4	0	4	0	2	3	4	0	0	0	3
Teachers	3	2	3	4	0	3	3	3	3	3	0	3	0	3	4	0	0	0	0	4
	2	3	3	0	2	3	3	3	3	4	0	3	0	3	0	0	0	0	0	3
	3	2	3	3	2	3	4	3	3	3	0	3	3	3	3	3	0	0	0	4

In statements 1, 2 and 5 only grades 3 and 2 were used

Table 4: Centre 5: Mean scores showing patients' mean, nurses' mean, teachers' mean and the overall mean for each statement

Statement Number	Patients		Nurses		Teachers		Overall	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1	3.00	0.00	3.00	0.00	3.00	0.00	3.00	0.00
2	3.00	0.00	3.00	0.00	3.00	0.00	3.00	0.00
3	3.50	0.55	3.00	0.00	4.00	0.00	3.50	0.71
*4	3.50	0.70	0.00	0.00	4.00	0.00	*3.75	0.35
5	3.00	0.00	2.75	0.50	3.00	0.00	2.91	0.14
6	3.50	0.55	3.00	0.00	4.00	0.00	3.50	0.71
7	3.00	0.00	3.00	0.00	4.00	0.00	3.33	0.57
8	3.40	0.55	3.00	0.00	3.67	0.52	3.34	0.47
9	3.33	0.82	3.16	0.41	4.00	0.00	3.58	0.59
10	3.67	0.52	3.16	0.41	4.00	0.00	3.61	0.43
11	3.80	0.45	3.33	0.57	4.00	0.00	3.71	0.34
12	3.67	0.52	3.16	0.41	4.00	0.00	3.61	0.43
13	3.67	0.57	3.50	0.71	4.00	0.00	3.72	0.25
14	3.67	0.52	3.00	0.00	3.83	0.41	3.41	0.58
15	3.20	0.84	2.75	0.50	3.33	0.57	3.09	0.30
16	3.20	0.84	3.00	0.00	3.83	0.41	3.41	0.58
17	3.33	0.57	3.00	0.00	3.83	0.41	3.39	0.42
18	3.50	0.70	3.00	0.00	4.00	0.00	3.50	0.70
19	4.00	0.00	3.00	0.00	4.00	0.00	3.66	0.57
20	3.83	0.41	3.00	0.00	3.83	0.41	3.41	0.58

* Mean based on 2 groups or less
SD Standard deviation

Patients', nurses' and teachers' scores: raw data

Statements	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Patients	3	3	4	0	3	3	0	0	4	4	4	4	0	3	3	3	3	0	0	4
	3	3	3	0	0	3	3	3	4	4	4	4	4	4	0	0	0	4	4	4
	3	3	3	0	0	4	3	4	3	4	4	4	0	3	4	4	4	0	0	4
	3	3	3	0	0	3	3	3	3	3	3	3	3	3	3	3	0	3	0	3
	3	3	4	4	0	4	0	4	4	4	4	4	0	4	4	4	0	0	0	4
	0	3	4	3	0	4	3	3	2	3	0	3	4	3	2	2	3	0	0	4
Nurses	0	3	3	0	3	3	0	0	3	3	0	3	0	3	0	0	3	0	0	3
	3	3	3	0	0	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	3	3	3	0	3	3	0	3	3	3	3	3	0	3	3	3	3	0	0	3
	3	3	3	0	2	3	3	3	3	3	0	3	0	3	3	0	0	0	0	3
	3	3	3	0	3	0	0	0	3	3	0	3	0	0	0	3	3	0	3	3
	0	3	3	0	0	3	3	0	4	4	4	4	4	3	2	3	3	3	3	3
Teachers	3	3	4	0	3	4	0	3	4	4	4	4	0	3	3	3	4	0	0	3
	3	3	4	4	3	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
	3	3	4	0	3	4	0	4	4	4	4	4	0	4	0	4	4	0	0	4
	3	3	4	0	3	4	4	3	4	4	0	4	0	4	0	4	4	0	0	4
	3	3	4	0	3	4	0	4	4	4	4	4	0	4	3	4	3	0	0	4
	3	3	4	0	0	4	4	4	4	4	0	4	4	4	0	4	4	0	0	4

In statements 1, 2 and 5 only grades 3 and 2 were used

Table 4: Centre 6: Mean scores showing patients' mean, nurses' mean, teachers' mean and the overall mean for each statement

Statement Number	Patients		Nurses		Teachers		Overall	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1	2.25	0.50	2.33	0.57	2.25	0.50	2.28	0.13
2	3.00	0.00	3.00	0.00	3.00	0.00	3.00	0.00
3	3.80	0.45	3.00	0.00	3.80	0.45	3.40	0.46
4	3.50	0.71	3.00	0.00	3.33	0.57	3.27	0.25
*5	0.00	0.00	2.89	1.44	0.00	0.00	*2.89	1.44
6	3.00	0.82	3.25	0.50	3.25	0.50	3.16	0.14
7	3.50	0.71	3.50	0.71	4.00	0.00	3.66	0.29
8	3.00	0.00	3.00	0.00	3.00	0.00	3.00	0.00
9	3.25	0.50	3.25	0.50	3.80	0.45	3.52	0.39
10	3.25	0.50	3.50	0.58	3.50	0.58	3.37	0.17
11	2.50	0.71	3.00	0.00	3.33	0.57	3.17	0.23
12	3.50	0.58	3.00	0.00	3.80	0.45	3.40	0.56
*13	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
14	3.00	1.00	3.50	0.71	3.67	0.57	3.39	0.35
15	2.50	0.57	3.00	0.00	3.00	0.00	2.83	0.29
16	3.00	0.00	3.00	0.00	3.00	0.00	3.00	0.00
17	3.00	0.00	3.33	0.57	3.00	0.00	3.11	0.19
18	3.00	0.00	3.50	0.71	3.00	0.00	3.16	0.29
*19	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
20	3.80	0.45	3.50	0.58	4.00	0.00	3.76	0.25

* Mean based on 2 groups or less
SD Standard deviation

Patients', nurses' and teachers' scores: raw data

Statements	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Patients	3	3	3	4	0	3	3	3	4	3	0	3	0	3	2	3	3	3	0	4
	2	3	3	3	0	4	4	3	3	3	3	4	0	4	3	3	0	3	0	4
	2	3	4	0	0	3	0	3	3	4	0	4	0	0	3	0	0	0	0	4
	2	3	3	0	0	2	0	0	3	3	2	3	0	2	2	0	0	0	0	3
Nurses	3	3	3	3	0	3	0	3	3	4	0	3	0	0	3	3	3	0	0	3
	2	3	3	3	2	3	3	3	3	3	0	3	0	3	3	3	3	3	0	3
	2	3	3	0	0	3	0	3	3	3	3	3	0	0	3	0	0	0	0	4
	0	3	3	3	3	4	4	3	4	4	0	3	0	4	3	0	4	4	0	4
Teachers	3	3	4	4	0	3	4	3	4	3	0	3	0	3	3	3	3	3	0	4
	2	3	4	3	0	3	4	3	3	3	4	4	0	4	3	3	3	3	0	4
	2	3	4	0	0	3	0	3	4	4	3	4	0	0	3	0	0	0	0	4
	2	3	3	3	0	4	4	3	4	3	3	4	0	4	3	0	3	3	0	4

In statements 1, 2 and 5 only grades 3 and 2 were used

Table 4: Centre 7: Mean scores showing patients' mean, nurses' mean, teachers' mean and the overall mean for each statement

Statement Number	Patients		Nurses		Teachers		Overall	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1	3.00	0.00	3.00	0.00	2.50	0.71	2.83	0.28
2	2.75	0.50	2.75	0.50	2.75	0.50	2.75	0.50
3	4.00	0.00	3.25	0.50	4.00	0.00	3.75	0.43
4	4.00	0.00	3.00	0.00	3.50	0.71	3.50	0.50
*5	0.00	0.00	3.00	0.00	0.00	0.00	*3.00	0.00
6	4.00	0.00	3.25	0.50	4.00	0.00	3.75	0.43
7	4.00	0.00	3.00	0.00	3.67	0.57	3.41	0.50
8	4.00	0.00	3.33	0.58	3.50	0.57	3.61	0.35
9	4.00	0.00	3.25	0.50	3.75	0.50	3.66	0.38
10	3.75	0.50	3.25	0.50	3.75	0.50	3.50	0.35
*11	4.00	0.00	3.00	0.00	0.00	0.00	*3.50	0.71
12	3.75	0.50	3.00	0.00	3.75	0.50	3.37	0.53
*13	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
14	4.00	0.00	2.00	0.00	2.75	0.50	2.92	1.01
15	3.75	0.50	3.50	0.57	3.25	0.50	3.37	0.17
16	4.00	0.00	3.25	0.50	3.50	0.57	3.58	0.38
*17	0.00	0.00	3.00	0.00	3.00	0.00	*3.00	0.00
18	3.50	0.71	2.50	0.71	3.50	0.71	3.00	0.70
*19	0.00	0.00	0.00	0.00	0.00	0.00	*0.00	0.00
20	4.00	0.00	3.25	0.50	3.50	0.57	3.58	0.38

* Mean based on 2 groups or less
SD Standard deviation

Patients', nurses' and teachers' scores: raw data

Statements	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Patients	0	3	4	4	0	4	0	4	4	4	0	4	0	0	4	4	0	0	0	4
	3	3	4	4	0	4	4	4	4	4	4	4	0	4	3	4	0	3	0	4
	3	3	4	0	0	4	4	4	4	4	0	4	0	4	4	4	0	4	0	4
	3	2	4	4	0	4	4	4	4	3	0	3	0	0	4	4	0	0	0	4
Nurses	0	3	3	3	0	3	0	3	3	3	0	3	0	0	3	3	0	3	0	3
	0	3	3	0	0	3	0	0	3	3	3	3	0	0	3	3	3	0	0	3
	0	3	4	0	0	4	0	4	4	4	0	3	0	0	4	4	0	0	0	4
	3	2	3	0	3	3	3	3	3	3	0	0	0	2	4	3	3	2	0	3
Teachers	0	3	4	4	0	4	0	4	4	3	0	4	0	0	3	3	0	0	0	4
	2	3	4	0	0	4	3	3	3	4	0	3	0	3	3	4	3	3	0	3
	0	3	4	0	0	4	4	4	4	4	0	4	0	3	3	4	0	4	0	4
	3	2	4	3	0	4	4	3	4	4	0	4	0	2	4	3	0	0	0	3

In statements 1, 2 and 5 only grades 3 and 2 were used

Table 4: Centre 8: Mean scores showing patients' mean, nurses' mean, teachers' mean and the overall mean for each statement

Statement Number	Patients		Nurses		Teachers		Overall	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1	3.00	0.00	3.00	0.00	2.67	0.57	2.89	0.19
2	3.00	0.00	2.80	0.45	3.00	0.00	2.93	0.12
3	3.33	0.52	3.20	0.45	3.50	0.55	3.35	0.21
4	4.00	0.00	3.00	0.00	3.66	0.51	3.55	0.50
5	2.67	0.57	2.50	0.71	3.00	0.00	2.75	0.35
6	3.40	0.55	3.33	0.52	3.71	0.48	3.48	0.20
7	3.67	0.57	3.25	0.50	3.20	0.45	3.22	0.03
8	3.40	0.55	3.00	0.71	3.33	0.52	3.17	0.23
9	3.40	0.55	3.33	0.52	3.33	0.52	3.35	0.04
10	3.50	0.55	3.40	0.55	3.16	0.41	3.35	0.17
11	3.33	0.57	3.33	0.57	3.25	0.50	3.30	0.05
12	3.50	0.57	3.16	0.75	3.20	0.45	3.18	0.03
13	3.20	0.45	3.25	0.50	3.00	0.00	3.15	0.13
14	3.00	0.00	3.00	1.00	3.00	0.82	3.00	0.00
15	3.16	0.41	3.60	0.55	3.00	0.63	3.25	0.31
16	3.40	0.55	3.33	0.52	3.50	0.55	3.41	0.08
17	3.00	0.00	3.33	0.58	3.71	0.48	3.35	0.35
18	3.33	0.58	3.33	0.57	3.71	0.48	3.45	0.22
*19	3.50	0.71	0.00	0.00	0.00	0.00	*3.50	0.71
20	3.83	0.41	3.16	0.41	3.83	0.41	3.50	0.47

* Mean based on 2 groups or less
SD Standard deviation

Patients', nurses' and teachers' scores: raw data

Statements	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Patients	0	3	4	4	0	4	4	4	4	4	4	4	3	3	3	4	3	3	0	4
	0	3	3	0	3	0	0	3	0	3	0	3	3	0	3	0	3	0	0	4
	0	3	3	0	2	3	0	0	3	3	3	3	3	0	3	3	0	0	3	3
	3	3	4	4	3	3	4	3	3	4	3	4	3	3	3	3	3	3	4	4
	3	3	3	0	0	3	0	4	4	4	0	0	0	0	4	4	3	4	0	4
	3	3	3	0	0	4	3	3	3	3	0	0	4	3	3	3	0	3	0	4
Nurses	0	2	3	0	0	4	3	2	3	0	3	3	0	2	3	3	3	3	0	3
	0	3	3	0	2	3	0	0	4	4	0	4	3	0	4	3	0	0	0	3
	0	3	3	3	3	3	3	3	3	3	3	3	3	0	0	3	3	0	0	3
	0	3	4	0	0	4	4	4	4	4	4	4	4	4	4	4	4	4	0	4
	0	0	0	3	0	3	0	3	3	3	0	2	0	0	4	4	0	0	0	3
	3	3	3	0	0	3	3	3	3	3	0	3	3	3	3	3	0	3	0	3
Teachers	0	3	3	3	0	4	3	3	3	3	3	3	3	3	2	4	4	4	0	4
	0	3	4	0	3	3	0	4	3	3	0	3	3	0	3	3	3	3	0	4
	0	3	3	4	3	4	3	3	4	3	4	4	3	0	3	3	4	3	0	4
	3	3	4	4	3	4	3	3	4	3	3	3	3	4	3	4	4	4	0	4
	2	3	3	3	0	3	3	3	3	4	3	3	3	2	4	3	3	3	0	3
	3	3	4	4	0	4	4	4	3	3	0	0	3	3	3	4	4	4	0	4

In statements 1, 2 and 5 only grades 3 and 2 were used

Table 5: Comparison of overall means and standard deviations in each centre on the 'Patient Assessment of Nursing Care' assessment instrument

Statement Number	Centre 1		Centre 2		Centre 3		Centre 5		Centre 6		Centre 7		Centre 8	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1	3.00	0.00	3.00	0.00	2.77	0.19	3.00	0.00	2.28	0.13	2.83	0.28	2.89	0.19
2	2.86	0.15	2.86	0.15	2.77	0.19	3.00	0.00	3.00	0.00	2.75	0.50	2.93	0.12
3	3.42	0.38	3.42	0.38	3.16	0.23	3.50	0.71	3.40	0.46	3.75	0.43	3.35	0.21
4	3.11	0.19	3.11	0.19	3.33	0.28	3.75	0.35	3.00	0.25	3.50	0.50	3.55	0.50
5	3.00	0.00	3.00	0.00	2.50	0.50	2.91	0.14	2.89	1.44	3.00	0.00	2.75	0.35
6	3.39	0.35	3.33	0.14	3.16	0.23	3.50	0.71	3.16	0.14	3.75	0.43	3.48	0.20
7	3.15	0.21	3.42	0.12	3.16	0.23	3.33	0.57	3.66	0.29	3.41	0.50	3.23	0.03
8	3.33	0.28	3.25	0.35	3.11	0.19	3.34	0.47	3.00	0.00	3.16	0.35	3.17	0.23
9	3.25	0.35	3.50	0.00	3.16	0.23	3.58	0.59	3.52	0.39	3.66	0.38	3.35	0.04
10	3.25	0.35	3.62	0.53	3.42	0.12	3.61	0.43	3.37	0.18	3.50	0.35	3.35	0.17
11	3.52	0.21	3.52	0.21	3.00	1.40	3.71	0.34	3.17	0.23	3.50	0.71	3.30	0.05
12	3.25	0.25	3.25	0.25	3.16	0.23	3.61	0.43	3.40	0.56	3.37	0.53	3.18	0.03
13	3.33	0.28	3.33	0.28	3.00	0.00	3.72	0.25	0.00	0.00	0.00	0.00	3.15	0.13
14	3.16	0.23	3.16	0.23	3.08	0.59	3.41	0.58	3.39	0.35	2.92	1.01	3.00	0.00
15	3.41	0.22	3.41	0.22	3.33	0.28	3.09	0.30	2.83	0.29	3.37	0.17	3.25	0.31
16	3.25	0.35	3.25	0.35	3.50	0.71	3.41	0.58	3.00	0.00	3.58	0.38	3.41	0.08
17	3.25	0.35	3.45	0.12	3.33	1.15	3.39	0.42	3.11	0.19	3.00	0.00	3.35	0.35
18	0.00	0.00	0.00	0.00	3.33	0.57	3.50	0.70	3.16	0.29	3.00	0.70	3.45	0.22
19	0.00	0.00	0.00	0.00	0.00	0.00	3.66	0.57	0.00	0.00	0.00	0.00	3.50	0.71
20	3.62	0.18	3.62	0.18	3.49	0.23	3.41	0.58	3.76	0.25	3.58	0.38	3.50	0.47

In statements 1, 2 and 5 only grades 3 and 2 were used

the scale is heterogeneous and no global score can be allocated. The calculation of the mean and standard deviation for each statement in each centre provides a way of comparing centres; it also has potential as a scoring guide for subsequent use of the instrument (this will be discussed in the conclusions and recommendations section). Inspection of Table 4 (page 133) demonstrates only small differences between groups of participants within centres on statements.

Table 5 (page 140) presents the overall centre means to allow them to be more easily compared. However, the overall norms in Table 5 (page 140) do not show dramatic differences. There is a tendency for centres to agree that some statements are not applicable (Statements 18 and 19) but there is no unanimity about any one statement as completely inapplicable.

Centre by Centre Comparison

The mean and standard deviations of the scores on each statement were calculated for each group in each centre and an overall centre mean was estimated. Although the numbers were small in each case, this was done to explore the possibility of developing a scoring system which would provide the nurse learner with criteria against which she could assess her performance. An examination of each centre's score patterns in Tables 4 (page 133) and 5 (page 140) demonstrated some differences amongst them. The highest and lowest scoring statement for each group in each centre, excluding statements 1, 2 and 5 were sought. These are listed below:-

Centre 1: Family planning nursing

	Statement Number	Score	Standard Deviation
Patients' lowest score	12	3.00	0.00
	4	3.00	0.00
Patients' highest score	3	3.67	0.52
	20	3.67	0.52
Nurse learners' lowest score	12	2.67	0.52
Nurse learners' highest score	14	3.67	0.52

	Statement Number	Score	Standard Deviation
Nurse teachers' lowest score	11	3.00	0.00
	12	3.00	0.00
Nurse teachers' highest score	3	3.80	0.45
	20	3.80	0.45

Exclude statement 1, 2 and 5

Centre 2: Burns and plastic surgery nursing

	Statement Number	Score	Standard Deviation
Patients' lowest score	4	3.11	0.19
Patients' highest score	20	3.62	0.18
Nurse learners' lowest score	3	3.00	0.00
	4	3.00	0.00
	12	3.00	0.00
	13	3.00	0.00
	14	3.00	0.00
	16	3.00	0.00
	17	3.00	0.00
Nurse learners' highest score	20	3.75	0.05
Nurse teachers' lowest score	4	3.00	0.00
	8	3.00	0.00
Nurse teachers' highest score	10	4.00	0.00

Exclude statement 1, 2 and 5

Centre 3: Accident and emergency nursing

	Statement Number	Score	Standard Deviation
Patients' lowest score	11	3.00	1.40
Patients' highest score	7	3.66	0.57
	8	3.66	0.57
	12	3.66	0.57
	20	3.66	0.57
Nurse learners' lowest score	14	2.66	0.57
Nurse learners' highest score	16	4.00	0.00
Nurse teachers' lowest score	3	3.00	0.00
	6	3.00	0.00
	8	3.00	0.00
	9	3.00	0.00

	Statement Number	Score	Standard Deviation
	12	3.00	0.00
	13	3.00	0.00
	14	3.00	0.00
	16	3.00	0.00
Nurse teachers' highest score	20	3.66	0.57

Exclude statement 1, 2 and 5

Centre 5: Special and intensive care of the newborn

	Statement Number	Score	Standard Deviation
Patients' lowest score	7	3.00	0.00
Patients' highest score	20	3.83	0.41
Nurse learners' lowest score	15	2.75	0.50
Nurse learners' highest score	13	3.50	0.71
Nurse teachers' lowest score	15	3.33	0.57
Nurse teachers' highest score	3	4.00	0.00
	4	4.00	0.00
	6	4.00	0.00
	7	4.00	0.00
	9	4.00	0.00
	10	4.00	0.00
	11	4.00	0.00
	12	4.00	0.00
	13	4.00	0.00
	19	4.00	0.00

Exclude statement 1, 2 and 5

Centre 6: Care of the elderly and geriatric nursing

	Statement Number	Score	Standard Deviation
Patients' lowest score	11	2.50	0.71
Patients' highest score	20	3.80	0.45
Nurse learners' lowest score	3	3.00	0.00
	4	3.00	0.00
	8	3.00	0.00
	11	3.00	0.00
	12	3.00	0.00
	15	3.00	0.00
	16	3.00	0.00

	Statement Number	Score	Standard Deviation
Nurse learners' highest score	7	3.50	0.71
	10	3.50	0.58
	14	3.50	0.71
	20	3.50	0.71
Nurse teachers' lowest score	8	3.00	0.00
	15	3.00	0.00
	16	3.00	0.00
	17	3.00	0.00
	18	3.00	0.00
Nurse teachers' highest score	7	4.00	0.00
	20	4.00	0.00

Exclude statement 1, 2 and 5

Centre 7: Neuromedical and neurosurgical nursing

	Statement Number	Score	Standard Deviation
Patients' lowest score	18	3.50	0.71
Patients' highest score	3	4.00	0.00
	4	4.00	0.00
	6	4.00	0.00
	7	4.00	0.00
	8	4.00	0.00
	9	4.00	0.00
	11	4.00	0.00
	14	4.00	0.00
	16	4.00	0.00
	20	4.00	0.00
Nurse learners' lowest score	14	2.00	0.00
Nurse learners' highest score	15	3.50	0.57
Nurse teachers' lowest score	14	2.75	0.50
Nurse teachers' highest score	6	4.00	0.00

Exclude statement 1, 2 and 5

Centre 8: Renal and urological nursing

	Statement Number	Score	Standard Deviation
Patients' lowest score	14	3.00	0.00
Patients' highest score	20	3.83	0.41

	Statement Number	Score	Standard Deviation
Nurse learners' lowest score	8	3.00	0.71
	14	3.00	1.00
Nurse learners' highest score	15	3.60	0.55
Nurse teachers' lowest score	13	3.00	0.00
	14	3.00	0.82
	15	3.00	0.63
Nurse teachers' highest score	17	3.71	0.48
	18	3.71	0.48

Exclude statement 1, 2 and 5

OVERALL LOWEST AND HIGHEST SCORES - CENTRE BY CENTRE

Centre 1: Family planning nursing

	Statement Number	Score	Standard Deviation
Lowest score	4	3.11	0.19
Highest score	10	3.62	0.53
	20	3.62	0.18

Centre 2: Burns and plastic surgery nursing

	Statement Number	Score	Standard Deviation
Lowest score	4	3.11	0.19
Highest score	10	3.62	0.53
	20	3.62	0.18

Centre 3: Accident and emergency nursing

	Statement Number	Score	Standard Deviation
Lowest score	8	3.11	0.19
Highest score	16	3.50	0.71

Centre 5: Special and intensive care of the newborn

	Statement Number	Score	Standard Deviation
Lowest score	15	3.09	0.30

	Statement Number	Score	Standard Deviation
Highest score	13	3.72	0.25

Centre 6: Care of the elderly and geriatric nursing

	Statement Number	Score	Standard Deviation
Lowest score	15	2.83	0.29
Highest score	20	3.76	0.25

Centre 7: Neuromedical and neurosurgical nursing

	Statement Number	Score	Standard Deviation
Lowest score	14	2.92	1.01
Highest score	6	3.75	0.43

Centre 8: Renal and urological nursing

	Statement Number	Score	Standard Deviation
Lowest score	14	3.00	0.00
Highest score	20	3.50	0.47

In the overall lowest and highest scores, statements 1, 2 and 5 were excluded.

In view of the differences demonstrated above in grading, it may be argued that each centre should develop its own data base for future assessments. For example, the nurse teacher's mean score ranged from 3.66 (S.D. 0.57) in centre 3 (Accident and emergency nursing) to 4.00 (S.D. 0.00) in centre 2 (Burns and plastic surgery nursing), centre 5 (Special and intensive care of the newborn), centre 6 (Care of the elderly and geriatric nursing) and centre 7 (Neuromedical and neurosurgical nursing).

This would suggest that, although the test assessment instrument 'Patient Assessment of Nursing Care' is designed for use in a wide range of nursing situations, local variations should be taken into account. It is not the purpose of this instrument to grade learner

against learner, rather it exists to facilitate learner learning. The value of this instrument as a learning tool has already been mentioned above, page 121. A further way to facilitate learning apart from the actual assessment itself would be to encourage the learner to compare herself with others who have previously taken the Joint Board course at the centre. For this reason a system of centre data bases is proposed and will be discussed in more detail in Chapter VII.

Inferential Statistics

As the study progressed it became obvious that there would be three sets of scores from patients, nurse learners and nurse teachers on the 'Patient Assessment of Nursing Care' instrument, which could be compared. It was decided therefore to explore the possibility of using inferential statistical techniques to effect this comparison.

Fisher's Exact Probability Test (Siegal, 1956) was used to compare the scores of the patients, nurse learners and nurse teachers on the patient assessment of nursing care. In reviewing the scoring pattern of the three groups on the patient assessment of nursing care, it was noted that there were several categories which contained no score and that adding together the scores was unlikely to provide a meaningful number. The data themselves were at ordinal level, thus making them suitable for non-parametric statistical analysis. In view of the small numbers and the difficulty of analysing such data, several options were considered. The X^2 test of association for independent samples might have been suitable. Each statement could have been compared on each score (4, 3, 2, 1 and 0) for the three groups leading to 20 separate tests. However, the matrices would not have been meaningful.

The X^2 test cannot be carried out if any cell has an expected frequency of less than 1 or where more than 20% of the cells have an expected frequency of less than 5 (Siegal, 1956). These data could not have fulfilled these conditions.

In view of these problems and reviewing the data collected it was decided to dichotomise the data in two ways:-

1) Applicable (all scores except 0) versus not applicable (scores of 0)

2) Agree (scores of 4 and 3) versus disagree and not applicable (scores of 2, 1 and 0).

Fisher's Exact Probability Test (Siegal, 1956), is used for analysing discrete data at the nominal or ordinal levels of measurement when the two independent samples are small in size. It is used when the scores from two independent random samples all fall into one or the other of two mutually exclusive classes. These data were at the ordinal level of measurement and fulfilled the criteria for Fisher's Exact Probability Test. The results are presented in Table 6 (page 151).

Table 6 (page 151) shows the comparison of patients, nurse learners and nurse teachers on the patient assessment of nursing care. Each group is compared with each other using Fisher's Exact Probability Test in the two ways mentioned above on page 147, applicable versus not applicable and agree versus disagree. Six statistical hypotheses were therefore generated:-

Hypothesis 1

a) That there is no difference between the patients and nurse teachers as to their scores on the 20 patient assessment of nursing care statements when their levels of agreement are compared with their levels of disagreement and non-applicability (H_o)

b) That there are differences between the patients and nurse teachers as to their scores on the 20 patient assessment of nursing care statements when their levels of agreement are compared with their levels of disagreement and non-applicability (H_1)

Hypothesis 2

a) That there is no difference between nurse learners and nurse teachers as to their scores on the 20 patient assessment of nursing care statements when their levels of agreement are compared with their levels of disagreement and non-applicability (H_o)

b) That there are differences between nurse learners and nurse teachers as to their scores on the 20 patient assessment of nursing care statements when their levels of agreement are compared with their levels of disagreement and non-applicability (H_1)

Hypothesis 3

a) That there is no difference between nurse learners and patients as to their scores on the 20 patient assessment of nursing care statements when their levels of agreement are compared with their levels of disagreement and non-applicability (H_o)

b) That there are differences between nurse learners and patients as to their scores on the 20 patient assessment of nursing care statements when their levels of agreement are compared with their levels of disagreement and non-applicability (H_1)

Hypothesis 4

a) That there is no difference between patients and nurse teachers as to their scores on the 20 patient assessment of nursing care statements comparing the applicable with the non-applicable score levels (H_o)

b) That there are differences between patients and nurse teachers as to their scores on the 20 patient assessment of nursing care statements comparing the applicable with the non-applicable score levels (H_1)

Hypothesis 5

a) That there is no difference between nurse learners and nurse teachers as to their scores on the 20 patient assessment of nursing care statements comparing the applicable with the non-applicable score levels (H_o)

b) That there are differences between nurse learners and nurse teachers as to their scores on the 20 patient assessment of nursing care statements comparing the applicable with the non-applicable score levels (H_1)

Hypothesis 6

a) That there is no difference between nurse learners and patients as to their scores on the 20 patient assessment of nursing care statements comparing the applicable with the non-applicable score levels (H_0)

b) That there are differences between nurse learners and patients as to their scores on the 20 patient assessment of nursing care statements comparing the applicable with the non-applicable score levels (H_1)

A significant difference was said to have occurred when a difference at the 5% level of probability on a two-tailed test was found.

In reviewing Table 6 (page 151) in the light of the above hypotheses, it should be noted that the overwhelming result tends to support the null hypothesis. However, it should also be noted that there is at least one significant difference between each group in three comparisons which would tend to support the alternate hypothesis in the cases of 2b, 5b and 6b.

A more detailed analysis of the differences in the perceptions of the three groups shown in Table 6 (page 151) suggests that out of the total of six comparisons made: nurse learners versus patients, patients versus nurse teachers, nurse teachers versus nurse learners, when the data were dichotomised in two ways there were several points to note:-

'Agree' versus 'disagree' and 'not applicable'

This compares the extent to which the three groups were in agreement i.e. used grade 3 and 4 on the 'Patient Assessment of Nursing Care' instrument

Table 6: Comparison of patients (n = 33), nurses (n = 33) and teachers (n = 33) by statement. Each group is compared with both of the others, using Fisher's Exact Probability Test

a) Comparison of levels of agreement versus disagreement and non-applicability

Statement Number	PvT	NvT	NvP
1	NSD	NSD	NSD
2	NSD	NSD	NSD
3	NSD	NSD	NSD
4	NSD	NSD	*
5	NSD	NSD	NSD
6	NSD	NSD	NSD
7	NSD	NSD	NSD
8	NSD	*	NSD
9	NSD	NSD	NSD
10	NSD	NSD	NSD
11	NSD	NSD	NSD
12	NSD	NSD	NSD
13	NSD	NSD	NSD
14	NSD	NSD	NSD
15	ND	NSD	NSD
16	NSD	NSD	NSD
17	NSD	NSD	NSD
18	NSD	NSD	NSD
19	NSD	NSD	NSD
20	ND	ND	ND

b) Comparison of levels of applicability versus non-applicability

Statement Number	PvT	NvT	NvP
1	NSD	NSD	NSD
2	ND	NSD	NSD
3	NSD	NSD	NSD
4	NSD	NSD	*
5	NSD	NSD	NSD
6	NSD	NSD	NSD
7	NSD	NSD	NSD
8	NSD	*	NSD
9	NSD	ND	NSD
10	NSD	NSD	NSD
11	NSD	NSD	NSD
12	NSD	NSD	NSD
13	NSD	NSD	NSD
14	NSD	NSD	NSD
15	NSD	NSD	ND
16	NSD	NSD	NSD
17	NSD	NSD	NSD
18	NSD	ND	NSD
19	NSD	NSD	NSD
20	ND	ND	ND

Key

* $p = < 0.05$ (two tailed test)

NSD No significant difference

ND No difference

P Patient

N Nurse

T Teacher

v versus

Nurse learners versus nurse teachers, statement 8 (The nurse showed a sense of humour at the right time): Hypothesis 2: this demonstrated slight differences between the nurse learners and the nurse teachers on the nurse's sense of humour. Five nurse learners seemed to find this statement inapplicable or disagreed whereas nurse teachers graded all nurse learners as either 3 or 4. Nurse learners and nurse teachers showed some level of disagreement as to the importance of humour in giving nursing care.

Nurse learners versus patients, statement 4 (The nurse was patient when I couldn't explain what I meant): Hypothesis 3: twenty three nurse learners saw this as an inapplicable statement, however, patients did not agree as 19 of them clearly saw it as a meaningful statement.

Applicability versus non-applicability

This examines the way in which the three groups used all scores except zero scores. In statement 8 (nurse learners versus nurse teachers) and statement 4 (nurse learners versus patients) both the differences noted above were significant.

In general it should be emphasised that the differences amongst the three groups were not large and occurred on statements 4 and 8:-

Statement 4 - 'The nurse was patient when I couldn't explain what I meant'

Statement 8 - 'The nurse showed a sense of humour at the right time'

It may be suggested that these statements are areas where discrepancies in perception amongst the three groups may lie. Further comparisons should perhaps be made amongst the three groups as the 'Patient Assessment of Nursing Care' instrument is developed to test the idea that there are real differences rather than minor statistically significant differences amongst the three groups in the assessments of nursing care.

The qualitative aspects of the core study will now be considered using the post assessment evaluation data provided by study participants.

Illuminative Analysis of the Evaluation of the Study by Participants

This was carried out in two ways:-

1) Questionnaire

The participants in the study were asked to evaluate the study by means of an open-ended questionnaire shown in Appendices 13 (page 233), 14 (page 234) and 15 (page 235). Each group was asked the following questions (personalised to suit the case):-

1. Do you agree that patients should be asked to assess the nursing care they receive?
2. Do you agree that nurses should be asked to assess the care they give to patients?
3. Do you agree that during a patient-nurse assessment an independent nurse assessor should be present?
4. Did you feel able to assess nursing care under the categories that were given?
5. Are there any other categories of nursing care that you consider should have been included?
6. Do you consider that the nursing care you received was affected by you being an assessor?
7. How long have you known the nurse? (Patients and nurse teachers only)
8. Any other comments

The data collected from the evaluation questionnaire were considered as qualitative data and will be reviewed here impressionistically. The data provided interesting insights into the participants' perceptions of the assessment procedure.

Patients

There was general agreement that involvement in assessing nurses was likely to be of benefit and value for all concerned.

One parent in centre 5 (Special and intensive care of the newborn) was quite emphatic about this:-

> 'Definitely - this should be a matter of course for nurses anyway'

A patient in centre 7 (Neuromedical and neurosurgical nursing) concurred:-

> 'Yes, most definitely. Because each patient is an individual even though he has the same condition as other patients he needs individual care'

A patient in centre 1 (Family planning nursing) remarked:-

> 'Yes, feedback from patients must surely help both nurse and patient in the long run'

One patient in centre 3 (Accident and emergency nursing) answered negatively but gave no explanation of his distaste for the assessment procedure. Six patients gave qualified support to the idea. For example, a parent in centre 5 (Special and intensive care of the newborn) said:-

> 'I agree that it's a good idea but shouldn't be forced onto patients - the option to refuse should be made clear'

Only two patients felt unable to assess their care within the categories given and there were few suggestions as to other categories which should be included. Participants in centre 7 (Neuromedical and neurosurgical nursing) were particularly concerned about procedures, for example, they suggested extra categories for:-

> 'Specific skills e.g. shaving and feeding'
>
> 'Lifting ability'
>
> 'Lifting'

Only three patients felt their care had been affected by their position as an assessor. Most patients would have agreed with the opinion of a patient in centre 8 (Renal and urological nursing) who said:-

> 'No, the nurse was treating me the same way as any other patient as she always does'

The data would suggest that patients are willing to participate in the nurses' learning experiences in a responsible and informed way. Their capacity to act as assessors of nursing care was not affected by social class or nursing dependency category. Macilwaine (1980) notes a similar phenomenom in her study of nurse-patient communication in psychiatric units. Women in the lower socio-economic groups were as keen to participate in a study which involved them wearing a radio microphone so that their nurse-patient interactions could be recorded. It may be argued that interest in health care and its evaluation is not related to socio-economic class. The 'Patient Assessment of Nursing Care' assessment instrument can therefore be used in many situations.

Nurse Learners

Nurse learners were in general, enthusiastic supporters of the concept of patient involvement in their assessment. A nurse learner's comment in centre 1 (Family planning nursing) summarises the general feeling:-

> 'Yes! Self assessment is very difficult - always good to know how one can improve or where one is lacking'

The only doubts were voiced by nurse learners in centre 5 (Special and intensive care of the newborn). One nurse learner said:-

> 'This seems very unfair to the parents as they cannot be really objective where their baby is concerned. Also many parents are unaware of nursing procedures and cannot tell if they are being done correctly'

It may be interesting to speculate about centre 5 (Special and intensive care of the newborn) and its participants at this point. The nurses working there were in a highly charged atmosphere, stressful for all participants, caring for very ill babies. The nurse learners' view of their role as technical experts is reflected in the comment above.

Many nurse learners felt that the nurse teacher had a useful role to play although they had some doubts about assessment procedures in general. A nurse learner in centre 3 (Accident and emergency

nursing) said:-

> '... an 'assessed situation' is always slightly false'

Whilst a nurse learner in centre 2 (Burns and plastic surgery nursing) said:-

> '... a third person present as an observer creates an artificial situation and lessens the direct interaction between nurse and patient. On the other hand, only an outside observer can give an objective opinion on care given'

Only one nurse learner in centre 5 (Special and intensive care of the newborn) found the 'Patient Assessment of Nursing Care' instrument irrelevant; she suggested that:-

> '... many of the categories were very ambiguous and seemed hardly relevant'

However, a nurse learner in centre 7 (Neuromedical and neurosurgical nursing) said:-

> '... the categories are very basic and involved physical care of the patient. I think psychological care, particularly with this patient is very important and understanding is required'

A nurse learner in centre 3 (Accident and emergency nursing) suggested that whilst the form was general rather than specific it might be helpful in the learning process:-

> '... the form as it is can produce discussion between the nurse and the assessor on points of nursing care which can be clarified under the different aspects raised on the assessment form'

Nurse learners were divided almost equally as to whether or not the care they had given was affected by the assessment. Those who felt their performance had been affected made comments such as the one made by a nurse learner in centre 3 (Accident and emergency nursing):-

> 'Being assessed in any way is an anxiety producing situation no matter how competent the individual nurse is'

Others thought it made no difference; for example, a nurse learner in centre 5 (Special and intensive care of the newborn) remarked:-

> 'It should not be so. As a nurse, I shall do my very best to help my patient. It is not affected by any assessment'

Nurse learners made helpful comments about the 'Patient Assessment of Nursing Care' instrument. A nurse learner in centre 3 (Accident and emergency nursing) said:-

> 'This continues the crusade to make a nurse 'patient orientated' rather than 'task orientated''

However, a nurse learner in centre 5 (Special and intensive care of the newborn) commented:-

> 'My own feelings were that neither I nor the mother assessing me really gained anything by it, it seemed a total waste of time'

No other nurse learner concurred with this sentiment.

Nurse Teachers

All nurse teachers except the nurse teacher in centre 5 (Special and intensive care of the newborn) agreed wholeheartedly with the concept of patient involvement in the assessment of nursing care. The nurse teacher in centre 7 (Neuromedical and neurosurgical nursing) was particularly concerned to develop collaborative care, for, not only did she believe that patients should participate in assessments, she added that:-

> 'I also believe that patients should be asked to participate in planning their own care'

All agreed that nurses should assess the care given to patients. The comment of the nurse teacher in centre 1 (Family planning nursing) summarises this:-

> 'This is a valuable exercise and again all nurses should do this, not just course members'

The categories chosen for the assessment were considered adequate for the purpose, however, the nurse teacher in centre 6 (Care of the elderly and geriatric nursing) suggested that statement 13 (dressing technique) should be widened to include any special procedure.

Other categories were suggested by the nurse teacher in centre 6 (Care of the elderly and geriatric nursing) who seemed to feel that a more detailed schedule of specific statements for each centre should be included. This is an idea which could be developed within each centre.

The nurse teachers in general, apart from centre 8 (Renal and urological nursing) felt their presence did not affect the assessment.

The nurse teachers' general opinions may be summarised by the remark of the nurse teacher in centre 7 (Neuromedical and neurosurgical nursing):-

> 'The whole venture turned out to be much easier
> and more enjoyable than I had first anticipated.
> The patients seemed glad to be asked their opinion'

2) Nurse Teachers' Meeting

The nurse teachers were invited to a meeting to discuss their experiences of using the 'Patient Assessment of Nursing Care' instrument. In the context of this study it seemed to be important to allow the nurse teachers' group the opportunity to ventilate their feelings about an experience which had been a source of some anxiety and to provide them with a learning experience.

The Assessments as a Learning Experience

The assessments were a learning experience for all concerned: the researcher, patients, nurse learners and nurse teachers. The nurse teachers varied in the extent to which they had accepted the project initially - some had grave doubts, whilst others were enthusiastic. At the end of the assessments, all were more enthusiastic than they had been. One nurse teacher said that initially she had thought the assessments were quite a good idea but she really had questioned in her own mind whether they would work as a testing instrument. Having

actually done the assessments she thought that it was a useful teaching tool. The researcher and the nurse teachers had learned that it was possible to include the patients in the assessment of nursing care.

The nurse teachers also felt that the nurse learners had benefited from the experience. One commented that the 'Patient Assessment of Nursing Care' instrument was valuable as a learning tool in that nurse learners would learn to relate care to patients' feelings as well as their needs. The nurse learners in centre 5 (Special and intensive care of the newborn), where there was a tendency to continue the nurses' role in terms of technical procedures had also changed somewhat. The nurse teacher commented that the nurse learners said that the 'Patient Assessment of Nursing Care' instrument had made them aware of the importance of talking to mothers. Although, because of the mothers' emotional involvement and their gratitude to the nurse learners, the nurse teacher in centre 5 (Special and intensive care of the newborn) felt that the parent as an assessor would always tend towards high assessment grades because they would not wish to criticise a nurse who was caring for their baby; this impression was not reflected by the data collected in the study (Table 4, page 133).

The 'Patient Assessment of Nursing Care' Instrument and What it Assesses

The comments of the nurse teachers would suggest that the 'Patient Assessment of Nursing Care' instrument is useful in encouraging them to consider the affective domain in the delivery of nursing care. A nurse teacher noted that these particular assessment forms were completely different from the ones that were usually used for the course members in that they were much more attitude orientated and she found that she had to stand back and focus on this aspect. She had had to alter her baseline for these assessments. She also felt that the 'Patient Assessment of Nursing Care' assessments had taught her a great deal more about herself and that it would influence her in future assessments.

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CHAPTER VII: CONCLUSIONS AND RECOMMENDATIONS

The four research objectives will be reviewed individually; an overall review of the study will then be attempted.

RESEARCH OBJECTIVES

Research Objective 1: To identify aspects of nursing care which are important to patients and nurses and which can be assessed by them.

Initial Interview Data

Initial interview data collected in the preliminary study would seem to support the view that patients and nurses were able to express their ideas about those aspects of nursing care that were important to them and that could be assessed by them. Each group responded enthusiastically and produced a total item pool of 680 items (Figure 7, page 114). The items when examined fell into 15 categories (Appendix 7, page 220) which emerged from the data base and covered cognitive, psychomotor and affective domains. The main emphasis, however, lay in the affective domain. A jury of two patients, two nurse tutors and the researcher converted the categorised items into 51 simple statements (Appendix 8, page 222) which reflected a general quality of nursing care. The jury then selected 20 statements for the assessment.

Assessments

Thirty three assessments were carried out in 7 of the original centres selected for the study. Centre 4 (General intensive care nursing) was omitted due to the unsuitability of patients during the period when assessments were being conducted. This group, however, contributed to the initial item pool. The data suggests that patients, nurse learners and nurse teachers each had a specific contribution to make to the assessment of nursing care (Figure 8, page 127).

Post Assessment Evaluation

The data collected in the core study following the assessments suggests that patients, nurse learners and nurse teachers support the concept of patient participation. However, nurse learners and nurse teachers in Centre 5 (Special and intensive care of the newborn) felt that parents may not always be prepared to assess nursing care in view of their circumstances. This was not the opinion of the parents in the study who on the whole, supported the notion of patient participation.

At the post assessment evaluation meeting of nurse teachers it was reported that patients enjoyed the experience and thought that they should be involved in assessing the nursing care they received. Nurse learners felt they too had learned from self assessment. The nurse teachers felt that the assessment procedure was far more natural than other forms of assessment in the clinical setting and that they themselves had learned from the experience.

Research Objective 2: To design a 'Patient Assessment of Nursing Care' assessment instrument.

Validity

The development of the assessment instrument followed stages 1 and 2 of the McKennell (1974) model (Figure 3, page 92). Unstructured interviews and non-directive eliciting techniques were used to collect the initial item pool from patients and nurses (Figure 7, page 114). This was followed by the scale development pilot, by content analysis of the item pool, categorisation of items and forming statements for use in the assessment procedure. It may be suggested that the 'Patient Assessment of Nursing Care' instrument is a valid instrument since it has been developed from items generated by the group who are to use it. This is, however, only the beginning of construct validation of the instrument. This would require further development and refinement in stage 3. This exploratory study does not cover the final stage in the McKennell (1974) model. Recommendations for further developments will be made below.

Another consideration is the validity of the study. An attempt has been made to make the instrument valid in that the initial item pool was generated by the groups who were involved in the assessment procedure; they were also involved in the jury decisions with regard to categories, construction of statements and choice of statements for the assessment as well as being involved with the design of the instrument and grades used. The concurrent construct validity of the instrument will of necessity be a further development of this exploratory study. The reliability of the instrument must also be considered and this will be examined in the recommendations.

'Patient Assessment of Nursing Care' Assessment Instrument - A Learning Tool

The goal of the study was to provide a method of assessing the nurse learner on the general aspects of nursing care which apply across all general nursing situations. The data collected from the 33 assessments and the evaluation procedure would seem to support the use of patient assessment of nursing care which relates to significant or experiential learning as defined by Rogers (1969):

> 'It <u>has a quality of personal involvement</u> - the whole person in both his feeling and cognitive aspects being in the learning event. It <u>is self-initiated</u>. Even when the impetus or stimulus comes from outside, the sense of discovery, or reaching out of grasping comprehending comes from within, it is <u>pervasive</u>. It makes a difference in the behaviours, the attitudes perhaps even the personality of the learner. It is <u>evaluated by the learner</u>. He knows whether it is meeting his need, whether it leads towards what he <u>wants</u> to know, whether it illuminates the dark area of ignorance he is experiencing. The focus of evaluation we might say, resides definitely in the learner. <u>Its essence is meaning</u>. When such learning takes place, the element of meaning to the learner is built into the whole experience.' (p 5)

Patient assessment of nursing care was defined at the beginning of the study as:-

> a learning experience in which different perspectives are obtained to help the nurse gain insight into her

> own reactions, how patients feel about their reactions, what kind of nursing care they receive and how it could be improved.

Assessments were carried out by three people, the patient, the nurse learner and the nurse teacher. This type of assessment was designed to facilitate learning; be used alongside other assessment tools; was intended to be a diagnostic appraisal and not a marking assessment even though it used test measures provided by assessment. The post assessment evaluation data in the core study suggests that it is a means of diagnostic appraisal for the nurse learner. In this respect, the teacher uses marks diagnostically, by looking at the mark of each assessor and diagnosing the area of performance where the learner needs guidance. It may therefore be viewed as a learning tool. The post assessment evaluation data would seem to suggest that what is important is the creation of an atmosphere in which learning can take place rather than emphasising the activity of teaching. A nurse learner from Centre 3 (Accident and emergency nursing) when asked, 'Do you agree that nurses should be asked to assess the care they give to patients?' seemed to sum up the feeling of others in her reply:-

> 'Yes, because on reflection, the nurse will see how she actually appears as a nurse to others, and may detect any faults she has. On detection she may be able to correct these faults and therefore give her patients a better standard of care'

Rogers (1969) thinks it is a mistake to focus on teaching when the real issue is that of facilitating learning:-

> 'It is most unfortunate that educators and the public think about, and focus on, teaching. It leads them on to a host of questions which are either irrelevant or absurd so far as real education is concerned ... if we focused on the facilitation of learning - how, why and when the student learns, and how the learning seems and feels from the inside - we might be on a much more profitable track' (p 125)

It may be suggested therefore that the 'Patient Assessment of Nursing Care' assessment instrument is a learning tool. It seems to be one way of recording patients', nurse learners' and nurse teachers' feelings about nursing care; provides feedback on the nurse learner's

progress and helps the nurse teacher to focus upon learning that is necessary to progress forward. This aspect is discussed further in the overall review of the study on page 165 below.

Limitations

There were a number of limiting factors in this exploratory study. Firstly, the small sample size (n = 33) was restricting from the point of view of comparing the opinions of all three groups of assessors. At the outset of the study it was anticipated that a large number of assessments would be conducted but this was not possible because of the limiting factor of time. It was necessary to devote more time than had originally been allocated for staff meetings at each centre in order to gain the co-operation of those who would be involved. In addition, the agreement of two ethical committees was necessary before the study commenced.

Research Objective 3: To explore the suitability of this method of assessment for use in formative assessment.

The post assessment evaluation data of this exploratory study suggests that it is a means of diagnostic appraisal for the nurse learner in her attitude to the general aspects of nursing care in the clinical situation. The fact that 33 assessments were carried out in 7 nursing specialties by patients in different social groups and at varying levels of nursing dependency suggests that it is a feasible proposition to involve patients in this type of formative assessment.

Research Objective 4: To furnish information on which to base guidelines for future research.

There are indications for an extension to this study which are discussed in the recommendations below, page 168.

OVERALL REVIEW OF THE STUDY

The overall aim of the study was to investigate the feasibility of patients as recipients of nursing care, assessing nursing care;

how this compares with the nurse learner's perception of nursing care given and with a nurse teacher's observation of nursing care.

It has been recognised by both patients and nurses that problems in nursing care do exist. It is difficult to ensure that nursing care given is of a high standard. Since nursing care is the provision of a human service, a range of variables must be considered in giving nursing care, not least of which are human values and knowledge levels of both provider and consumer. Since nursing care represents a major portion of 24 hour-a-day health care services, it is essential to examine new ways of judging that care.

This small scale study of patient assessment of nursing care demonstrates that in this situation there is never a 'doer' and 'done to'. Each participant, patient, nurse learner and nurse teacher assumed the role of assessor during the assessment procedure and had a specific contribution to make (Figure 8, page 127).

Patients assess nurses already and make up their own minds what, to them, constitutes a good nurse (Blondis and Jackson 1977). The majority of patients do not have the background to judge the quality of a procedure correctly. What they are judging is the nurse's behaviour towards them (Blondis and Jackson 1977). This was a point of note throughout the study.

The 'Patient Assessment of Nursing Care' instrument was constructed by the jury with the purpose of providing a statement-set to assess a general quality of 'nursing care'. The nurse learner may then experience meaningful learning about her professional practice by self assessment, patient assessment and nurse teacher assessment.

The aim of the 'Patient Assessment of Nursing Care' instrument was to provide a meaningful learning experience by allowing the nurse to compare her own grading of her performance with the grading of the patient she has been nursing and the nurse teacher's assessment. If there were differences in the three groups' assessments, then this should be of value to the nurse learner since her learning should be enhanced by this knowledge. The assessment, followed by reflection, discussion, analysis and evaluation of the experience should encourage openness to change. The evidence from this study suggests that the 'Patient Assessment of Nursing Care' instrument did achieve some

success in encouraging this approach to learning. The post assessment evaluation data suggests that nurse learners did indeed benefit from the experience.

This type of assessment may be compared with Rogers (1969) learner-centred approach to learning in that it involves self assessment by the nurse learner, involves the patient's perception of care received and the nurse teacher's assessment of observed nursing care and both may be different from the learner's appraisal of her own performance. It may be threatening for the learner if free discussion is not encouraged, therefore self expression is an important aspect of this type of assessment. Rogers (1969) takes the view that much learning is acquired by 'doing'; in this way every learner participation and involvement facilitates learning, and it involves the learner as a whole person, thoughts, feelings and experiences. The 'Patient Assessment of Nursing Care' instrument seems to be one way in which the affective component of nursing care, that is, the patients' and nurses' feelings about the care given can be expressed.

Patient assessment of nursing care may also be compared with 'diagnostic appraisal' put forward by Rowntree (1974). It involves appraisal of the learner's developing strengths, apparent weaknesses and identifying the learner's emerging needs. The purpose of the assessment is not to grade, even though it may use test measurements, but to help both the learner and the teacher focus upon the learning that is necessary to progress forward.

Patient assessment of nursing care if used in association with other assessment methods may help to develop the nurse's sensitivity which will make any nursing performance more complete especially from the patient's point of view. It will also help the learner to realise that the patient's needs include those that are not so apparent as well as those which are immediately apparent. The nurse teacher has the responsibility of ensuring that she includes in her assessment the less tangible aspects of care. It is also important that she tries to develop an insight into herself and to view situations from alternative viewpoints. In this way the nurse teacher will be able to guide the nurse learner to accept the things that the patient finds important in both skills and knowledge and above all in her attitudes. She will also be able to help the nurse learner to analyse her response

to these aspects and adjust to concepts which might be new to her.

Patient assessment of nursing care encompasses Rogers' (1969) approach to learning. The teacher is a facilitator of learning, a provider of resources for learning and an adviser who shares the learner's feelings as well as her knowledge.

It may therefore be suggested that the significance of this study lies in the preliminary development of an assessment instrument which is essentially a learning tool but which will certainly require further refinement before it can be used in isolation as a fully developed assessment instrument. However, the 'Patient Assessment of Nursing Care' instrument:-

> demonstrates that patients' views about nursing care may be of considerable value in assessing nurses in the affective domain of nursing skills
>
> encourages the development of learners' social and personal skills
>
> provides a meaningful learning experience
>
> helps identify learners' strengths, weaknesses and emerging needs
>
> may be used alongside other assessment methods to provide additional information about learners' progress
>
> puts the teacher in the role of facilitator of learning.

The assessment instrument which has been developed as a result of this exploratory study is offered as a tentative prototype and a basis for further study by a research team.

RECOMMENDATIONS

This study was initiated in the hope that the results would have practical applications of value to nursing. The following recommendations are made with this aim in view:-

1. Technical Improvements to the 'Patient Assessment of Nursing Care' Assessment Instrument

   1.1 To test the reliability of the assessment instrument a test-retest should be carried out omitting statements

18 (The nurse made sure the other nurses gave me the care I needed) and 19 (In an emergency, the nurse acted quickly and worked well with other nurses). As indicated in this study these statements did not seem to be applicable. This could be done during a further study using the revised 'Patient Assessment of Nursing Care' assessment instrument to conduct a 24 hour test-retest reliability. The participants would be asked to complete the 'Patient Assessment of Nursing Care' assessment instrument (revised version) at the end of the assessment as usual. They would then be asked to complete the instrument the following day. The test-retest reliability could then be computed.

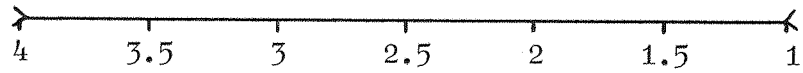
1.2 The validity of the test instrument could then be further assessed in several ways. Clearly the instrument has high content validity since the statements were derived from an appropriate universe of content and were selected by suitable judges. As the test instrument is used and further developed criterion-related validity will become of greater importance. Since nursing is essentially the application of theory in a practice discipline, then external criteria of the nurse's ability to perform satisfactorily should be sought. Perhaps it would be possible to develop a prospective study of nurse learners who are assessed on the 'Patient Assessment of Nursing Care' assessment instrument and then followed up over one or two years in practice. Their 'Patient Assessment of Nursing Care' scores could then be compared with some external measure such as staff appraisal. The construct validity of the test would be another area of interest. Since so many of the test statements are in the affective domain, it should be possible to compare 'Patient Assessment of Nursing Care' scores with scores on personality assessment instruments. This should help to clarify the issue of exactly what property the 'Patient Assessment of Nursing Care' instrument measures.

1.3 An issue related to that of validity is discrimination. The extent to which any test can discriminate between individuals and groups is of some importance. A test which cannot discriminate is an inadequate instrument, for example, a thermometer which failed to distinguish between hot and cold temperatures would be quite useless. However, this issue demonstrates the complexity of subjective assessments such as the 'Patient Assessment of Nursing Care' instrument, since, although it has been developed using traditional scientific methods, its purpose is rather different from most comparable tests. It has been categorically stated above (page 146) that it is not the purpose of the 'Patient Assessment of Nursing Care' instrument to set one learner against another. Rather it is the purpose of the 'Patient Assessment of Nursing Care' instrument to encourage the learner to develop a critical awareness of her own performance. It may be suggested that discrimination is a concept applicable mainly to summative assessments and that the 'Patient Assessment of Nursing Care' instrument, as an instrument of formative assessment, should not develop formal scores for discrimination between learners, rather it should encourage a dialogue between teacher and learner based on the learner's scores from the three participants in the assessment.

2. Use of the 'Patient Assessment of Nursing Care' Assessment Instrument

2.1 The assessment instrument, omitting statements 18 (The nurse made sure the other nurses gave me the care I needed) and 19 (In an emergency, the nurse acted quickly and worked well with other nurses), could be used by centres to assess the nurse learner on a general quality of nursing care related to the nurse's behaviour and attitudes towards the patient based on the level of expectancy of each individual patient.

2.2 It is suggested that score profiles should be developed within each centre. These would consist of a clear plastic film with the centre's over means for each statement marked on a scale e.g.



An example for Centre 1 (Family planning nursing) is given in Appendix 19 (page 268). A mark sheet would be designed for each learner and the grades given by patients, nurse learners and nurse teachers would be averaged. By placing the clear plastic film over the mark sheet, the learner would see immediately the relationship between her score and the general average within her centre.

Centres should be encouraged to record all assessment scores and use them to provide the individual with a point of comparison. In this way the nurse learner would be able to learn about herself in relation to other learners.

2.3 Post assessment follow up discussion with the nurse learner, analysis and evaluation is also recommended to enhance her learning experience and encourage self expression. This is an important aspect of significant learning (Rogers 1969). It may be suggested therefore that the 'Patient Assessment of Nursing Care' assessment instrument is a learning tool; it provides feedback on the nurse learner's progress and helps the nurse teacher to focus on learning that is necessary to progress forward.

2.4 It may also be suggested that any nurse teacher using the 'Patient Assessment of Nursing Care' instrument should routinely discuss with the patient assessor her feelings about being involved in the assessment both before and after this takes place. This will allow the nurse teacher an opportunity to ensure that the assessment

is not too stressful for the patient. It is obvious that the nurse teacher should not use these discussions to influence the patient assessor in her judgment, rather they should be seen as opportunities for the counselling of patients since they may be anxious about their new role as assessors.

3. General Implications of Study for Nurse Education

3.1 Attention should be given to developing diagnostic assessment instruments alongside other assessment instruments to estimate the progress of the nurse learner. This could be in the form of patient assessment of nursing care which incorporates different perspectives of nursing care assessed by three people: the patient's judgment of the effectiveness of nursing care received, the nurse learner's perception of nursing care given (self assessment) and the nurse teacher's assessment of observed nursing care. A fourth dimension (that of previous learners' experiences) can be added by using the grading system referred to in 2.2 above. In this respect the nurse learner would then have feedback on her performance from four viewpoints. The principle of feedback is of great importance for learners in encouraging them critically to assess their own performance.

3.2 The nursing process approach to nursing care allows the nurse learner to participate actively in the provision of individualised nursing care which, if combined with patient assessment of nursing care would provide an instrument that would allow the nurse learner to participate in her own learning in the way that Rogers' (1969) thought was important:-

> 'Learning is facilitated when the student participates responsibly in the learning process.' (p 162)

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APPENDIX 1

ASSESSMENT STRATEGY FOR A COURSE IN ACCIDENT AND EMERGENCY NURSING

Entry requirements

The course is for nurses registered on the general part of the Register for England and Wales, or Scotland or the Northern Ireland Council for Nurses and Midwives. It is recommended that each nurse should have had a minimum of six months general hospital experience as a staff nurse before taking the course.

Length of the course

The period of training is 39 weeks exclusive of any holiday during the course.

Teaching Time

Not less than one-third of the total length of the course is devoted to the planned teaching programme commencing with an introductory period of at least three days, during which time nurses are given details of all aspects of the course, are orientated to the hospital, have preparatory induction into the work of the accident and emergency department and gradual introduction into the department team.

Clinical experience

Clinical experience with accident and emergency patients is gained in the following areas of the department: reception and resuscitation areas for stretcher and ambulant patients, treatment areas, observation and recovery area or ward, operating theatre, and fracture clinic. In addition, visits are made to other departments of the hospital and places outside the hospital relevant to the course.

Assessment of course members

The policy is progressive assessment of skills, knowledge and attitudes throughout the course rather than one final examination. The most important skills are tested formally and in detail at the end of the clinical experience in each specified area within the department, whereas others may be recorded after supervised practice. Knowledge is also tested at the end of each period of experience. Attitudes are assessed by appraisal of behaviour towards patients, relatives and colleagues which is appropriate to the attitude outlined in the curriculum.

Pre-testing of course members

This is based on progressive assessment throughout the introductory period and includes the following:

Written objective type list

Practical assessment of skills commencing during the first week but continuing when course members are established in the working field

Group discussions and personal interview and discussions. Careful note is taken of the course member's past experience, expected potential and individual comments on the proposed course plan. This helps in programming the needs of individual course members.

Assessment of skills

This is based on progressive assessment throughout the course using a schedule of clinical experience which is completed at intervals during the course, a structured appraisal form

completed at intervals during the course and assessment of clinical skills in definite procedures which are listed below:

Application of traction

Application of Plaster of Paris

Assessment in two patient-centred situations in the accident and emergency department e.g. trauma and emergency area

Assessment in nursing management of the accident and emergency department

Assessment of a patient-centred situation in the intensive therapy unit or admission ward

Assessment of knowledge

Regular tests (objective type, structured question or essay question)

Two nursing care studies

Project or dissertation

Assessment of the course member's knowledge of the units of learning are made before, during and on completion of the unit

Assessment of attitudes

Objective appraisals using an appraisal form which is completed for each of the clinical allocations

When assessing attitudes, group discussions, individual interviews and discussions, practical work and written assessments are all taken into consideration.

DETAILED PLANNING OF ONE UNIT OF LEARNING IN A GERIATRIC NURSING COURSE

The unit of learning is community nursing care and supportive services:

Behavioural Objectives - Skills

At the end of the course the nurse is able to:

1. Assess and accurately describe in writing the home conditions of patients and their needs and list ways of mobilising services

2. Demonstrate safety and competence in nursing techniques and procedures and apply this skill to the home situation

3. Detect health hazards in the home and describe in writing the precautions which can be taken to prevent home accidents

4. Demonstrate rapport and effective communication with all concerned

5. Demonstrate the ability to effectively teach both patients and their relatives

Pre-test

Interview each course member to ascertain knowledge

Practical simulation test

Post-test

a) Progressive assessment

b) Practical test on the organisation of CARE for an individual patient for a period of time

c) Structured written test based on objective 1 and 3

Behavioural Objectives - Knowledge

At the end of the course the nurse is able to:

1. Define and discuss correctly the role of each member of the primary care team

2. Recall and list correctly in writing the services and equipment available to care for the elderly at home

3. Detect and discuss the common signs of emotional stress in the patient and his family

4. Describe and define in writing the agreed criteria for hospital admission, part 3 accommodation and day care centre

5. Discuss the factors contributing to prevention of disease and the promotion of health in the elderly

6. Discuss means of overcoming the greatest problems of the elderly in our society today - viz: isolation and poverty, and recall ways of solving these problems

Pre-test

Interview

Objective test

Post-test

a) Objective type test based on objectives 1, 2 and 4

b) Project on one of the aspects of community care

c) Viva-voce

Behavioural Objectives - Attitudes

At the end of the course the nurse is able to:

1. Discuss the different relationship and approach of community nursing and compare this with nursing in hospital

Pre-test

Interview

2. Demonstrate an appreciation of the importance of constant reassurance and encouragement to the patient and his family by demonstrating a caring and interested attitude towards the welfare of the elderly at home

3. Demonstrate positively her acceptance of the need regularly to evaluate the quality of care she is giving.

Post-test

a) Progressive assessment

b) Viva-voce

APPENDIX 2

NURSING SPECIALTIES IN THE STUDY

Centre 1	Family planning nursing
Centre 2	Burns and plastic surgery nursing
Centre 3	Accident and emergency nursing
Centre 4	General intensive care nursing
Centre 5	Special and intensive care of the newborn
Centre 6	Care of the elderly and geriatric nursing
Centre 7	Neuromedical and neurosurgical nursing
Centre 8	Renal and urological nursing

APPENDIX 3

NURSING DEPENDENCY CATEGORIES

Oxford Regional Hospital Board Operational Research Unit (1967)
No. 9 Measurement of Nursing Care (pp 15-17)

Care Group 1 (Self Care)

I Patients aged 12-75 years of age, up at least six hours daily and recorded as:

(a) Ambulatory - Self
(b) Bathroom - Self
(c) Toilet - Self
(d) Feeding - Self

and with no other nursing indications recorded

II Patients aged 12-60 years, up at least six hours daily and recorded as:

(a) Chair - Self
(b) Bathroom - Self
(c) Toilet - Self
(d) Feeding - Self

(Patients under 12 years or over 75 years and chairfast patients over 60 years are considered as being in care group 2, 3, 4 or 5)

Care Group 2 (Intermediate Care - Ambulatory)

Walks without help and up for more than 3 hours, but with nursing indications which would exclude from care group 1

(Patients under 12 years or over 75 years or chairfast patients over 60 years if otherwise fulfilling the criteria of care group 1)

Care Group 3 (Intermediate Care - Others)

All other patients not classified as care group 1, 2, 4 or 5

Care Group 4 (Intermediate Care - Bedfast)

Bedfast but with insufficient nursing requirements for care group 5

Care Group 5 (Intensive Care)

Patients recorded as:

(a) Unconscious, or

(b) Requiring special nursing, or

(c) Undergoing (any three of the following five treatments, or
(any two if combined with marked confusion, or
(any two if the patient is over 70 years of age

(i) Intravenous therapy

(ii) Suction

(iii) Oxygen administration

(iv) Blood transfusion

(v) Drainage

A P P E N D I X 4

CLASSIFICATION OF SOCIAL CLASS BY OCCUPATION

Hockey L., (1976) Women In Nursing (pp 208-214)

1. Professionally qualified and high administrative

2. Managerial and executive with some responsibility for directing and initiating policy

3. Inspectional, supervisory and other non-manual higher grade

4. Inspectional, supervisory and other non-manual lower grade

5. Routine grades of non-manual work

6. Skilled manual workers

7. Semi-skilled manual workers

8. Routine manual workers

APPENDIX 5

ITEMS LISTED BY PATIENTS

(Patients' Own Words)

Patients were asked to:

(i) write down the nursing care that they felt most necessary for a nurse to acquire

(ii) list the nursing care that they felt most able as patients to assess

Category A - Knowledge of nursing care

Centre 1	A thorough knowledge of her job
Centre 2	Knowledge of what the patient has been through and what their capabilities are
Centre 5	Specialist knowledge of paediatrics Thorough knowledge of the subject
Centre 6	Know what's wrong with us Know how to help us "They can't tell us what to do if they don't know what's wrong with us" Know what she is doing with equipment and furniture Knowledge of what's wrong or the nurse might damage us Know person and illness
Centre 7	Have knowledge of possible side effects following investigations e.g. mylography
Centre 8	Have knowledge of dialysis - how good dialysis is achieved Know how the kidney machine and equipment works A knowledge of home difficulties

Keep informed of new developments and how they might improve the quality of life for the patient - pass such encouraging news on

Complete knowledge of the kidney machine and its functions

Have knowledge of drugs in renal nursing

Awareness of patient's home circumstances

Category B - Ability and skill in performing nursing care

Centre 1

Patience on behalf of the patient is sometimes required

Warm hands!

Doing all that is necessary, no fussing

Centre 2

Gentle when dressings are done

Confident when doing dressings etc. (fidgeting makes me nervous)

Centre 3

Carry out procedures quietly and competently

Carry out doctors orders punctually - especially giving drugs for relief of pain

Remain composed when giving care

Centre 4

Give bedbath every day and provide with clean linen

Make you feel at home

Not having to wait for bedpans or toilet when you need to go badly

To be left alone early morning if you are asleep

Pillows to be made comfortable

Cleaning of eyes - mouth

Shaving

Haircut

	Continuous attention to very ill patient
Centre 5	Competence in all general nursing skills
	Specialist knowledge of maternity procedures
	Specialist knowledge of special care equipment and procedures
	Not to have any qualms about holding the mother's breast firmly and putting it into the baby's mouth
	Dexterity
Centre 6	Should not be rough
	Should physically help patients
Centre 7	Ability to use equipment
	Gentleness of handling when turning the patient in bed
	Needs to be thorough in everything she does
	Individual needs - turning, lifting, placing furniture
	Ability to complete tasks and not to rush off before they are finished
Centre 8	To be able to handle problems and emergencies efficiently and without panic
	However hard pressed try not to hustle patient
	Ability to care for shunt and fistula and put in fistula needles
	Ability to attach and discontinue dialysis
	Ability to act well and quickly in an emergency
	Ability to wash, give mouth care and help patient to walk
	Care for the patient and patient's needs
	To be able to recognise and deal with reasons for the alarm on the kidney machine going off
	To be able to insert dialysis needles and connect patient

to machine and be able to reverse the procedure

Ability to cope with any problem whether medical or technical at least until a doctor or technician is available

Ability to operate the kidney machine

Ability to put dialysis needles into arm

Ability to be gentle when removing dialysis needles

Ability to handle all emergencies

Know fistula and shunt (including operation itself) and other means of vascular access

Encourage patients to join in ward activities

Category C - Ability in organising nursing care

Centre 6 I wish they wouldn't say 'hang-on, I'll get it' - then forget you

Nurses should finish what they are doing, NOT leave you and say they'll come back later

Nurses should ask someone else if they haven't time to finish what they are doing

Centre 7 Complete tasks

Category D - Ability in developing relationships with patients

Centre 1 Be prepared to listen to their fears and apprehensions - sometimes entirely superficial

Ability to communicate with the patient

Ability to make the patient feel at ease and unembarrassed

A good listener

Ability to communicate so that she can pass on information to us and gather what our problems are

	Very helpful
	Aware of patient's embarrassment and helpful
	Being able to talk to the patient and make her feel comfortable and at ease
	Friendly and open yet knows what she is talking about to her patients
Centre 2	Reassuring and one who will stop and listen to anything worrying the patient
	Treat every patient the same
Centre 3	Be aware that relatives (husband/wife/parents) can give information when patient is experiencing severe pain
	Appreciate the anxiety of patient and particularly relatives
	Helpful towards patient's relatives
	Talk to the patient to relieve tension
	Puts patient at ease
	Treat patient as an individual rather than a number
	Treat patient as an individual
Centre 4	To be able to talk to the nurses about your worries
	Help and assurance given to relatives
Centre 5	Ability to help forge baby/mother bond
	The ability to communicate to parents what is being done for their baby and why
	Ability to mind read! i.e. to know when the mother wants the nurse to stay and help and give encouragement, and later when the mother gains confidence and experience not to 'hang over'
	Reassurance

Centre 6	Know our feelings
	Talk straight to me - NOT shout
	Don't shout even when speaking to deaf patients
	Noise is very upsetting
	Keep voices quiet
	They should be quiet - very rude to shout
	Nurses should not talk between themselves and ignore the patient
	Should watch the way she speaks - not shout
Centre 7	Talk to the patient and keep them up to date with what is going to happen to them
	Appreciation of the fact that the patient may be slow
	Able to get to know the patient and get to know their needs
	Good listener
	Needs to be able to talk to the patients
	Keep the patient in the picture about what is happening
	Time to talk and listen
	Pronounce patients' names correctly
	Help the patient retain their independence as far as possible and give praise
Centre 8	Have an awareness of patient's fears and seek to reassure
	Recognise and accept that patients have different ways of doing things which are not necessarily wrong
	Strive in all ways possible to be the one that a patient will point out to his visitors saying 'that's my nurse and she is wonderful'
	Talk to relatives
	Treat patient as an individual

Help with difficulties and anxiety

Deal with requests from patients as soon as possible

Category E - Ability in developing relationships with other members of staff

Centre 5 Ability to work as part of a team

Category F - Attitudes

Centre 1 Respect for patient

Understand and listen to patient's wishes

Do not force your own attitudes or preferences on patients

A sense of humour

Understanding

Patience - if we, as patients seem stupid or slow

Sympathy and a warm manner to overcome any embarrassment new patients may feel

Kindness

Understanding

Friendly attitude to put patient at ease coupled with attitude of efficiency and understanding

Kindness

Centre 2 A cheerful disposition

One that keeps cool and calm

Kind and gentle

Patience

Considerate

Consider the patient's feelings

	Have time to be friendly
	Not to be made to feel that the patient is a nuisance
	Gentleness
	Politeness
	Confident manner
	Friendly and warm towards the patient and each other
	Jolly, keep a smile on their face
	Gentle, yet firm when necessary
	Sympathetic - without 'spoiling' the patient
	Casual, but disciplined in manner
	Patient, especially with older or troublesome patients
	Willing in the way they carry out their work
	Have a good sense of humour
Centre 3	Friendly, sympathetic caring attitude
	Calm confident manner
	Sympathetic
	Considerate
	Sense of humour
	Patience
	Kind attitude towards patient
	Kind and caring
	Cheerful
	Pleasant
	Should not dictate to patient
	Good humoured
	Friendly
	Someone "human" rather than "super efficient"
	Patient

	Sense of humour within limitations
	Sympathetic
	Pleasant attitude
	Approachable
Centre 4	Kind and friendly nurses
	Cheerfulness by all in attendance
Centre 5	Ability to lovingly relate to the baby
	Friendly, approachable manner towards parents
	A sympathetic, reassuring and realistic approach to parents
	A loving attitude towards the babies in their care
	Plenty of determination and perseverance
	Love of children
	Patience
	Patience
	Stamina
	Imperturbability
	Love of babies
Centre 6	Should be mentally with us
	Be kind and gentle and any amount of love
	Be kind
	Give us encouragement when we have done something that we think is important
	Appreciate our trying
	They shouldn't rush patients
	They should have patience during the night
	They should think of self last
	Be friendly

Needs a little sense of humour - should not be too frivolous

Should be coaxing

Should not bully

Should have a sense of fun

Understanding

Remember to have patience at night - brain not so alert as when waking up

Centre 7

Sense of humour

Steady unflappability

Patience

Gentleness but more importantly firmness and strength

Friendly

Friendly and cheerful

Confident

Common sense

Pleasant personality

Confident

Even temperament

Confident approach

Showing respect, being polite

Cheerful and kind

Patience to communicate (this patient has to spell out words with a pointer fixed between his teeth and alphabet board)

Gentleness but firmness of handling

Common sense

Cheerful, kind and pleasant

Centre 8 Give patient confidence

Administer to the needs of the patient with kindness, understanding and tolerance

Friendliness - sense of humour, confidence

Gentleness

To be warm and human and especially good humoured

To be of a controlled nature and not to panic

To be caring in attitude and not to be off-handed

To understand the situation the patient finds him/herself in

Category G - Ability and skill in observing

Centre 3 Continual observations on patients in a cubicle (five minutes can seem like fifty!)

Category H - Ability and skill in reporting

Centre 5 Report information concerning the baby accurately and concisely

Category I - Ability and skill in recording

Category J - Ability and skill in making judgments

Centre 2 Able to distinguish between the apprehensive and the confident patient

Able to distinguish between a patient needing sympathy and a patient needing a firm guide and being able to act in an appropriate manner

Centre 3 Assess patient's character

Assess degree of pain

Centre 4 — To be given pain relief as soon as possible when one is in pain

Knowing pain by expression

Centre 6 — Read our character

Realise we're slower at night

Centre 7 — Appreciation and anticipation of the need for pain relief

Appreciation of patient's need for pain relief both pre and post operatively. Anticipation of the need arising

Category K - Acceptance of responsibility

Centre 5 — Responsible for patients

Centre 6 — They should be reliable and responsible for patients

Category L - Ability and skill in teaching patients

Centre 1 — Teach the most natural methods of family planning first

Discuss and teach problems about the "pill"

Explain things really clearly - how the "pill" works or what other contraceptives are available

Centre 2 — Explain nursing procedure adequately

Centre 3 — Give accurate instructions to patient and relatives

Inform patient as to what is happening or about to happen

Explain the reason for any long delays before admission to the ward and give advice to relatives

	Give an explanation of treatment simply without being condescending
	Allow patients to participate in care
	Explain to the patient what is being done - however if patient is 'squeamish' the nurse may need to modify what she says
Centre 5	Readiness to involve and teach parents in baby's day-to-day care whenever possible
	Not to teach unless really sure of subject
	Ability to communicate with parents in a positive and informative way
Centre 7	Tell the patient what is happening
	Able to explain things that are going to happen
Centre 8	Highlight the 'pluses' of dialysis - play down the 'minuses'
	Explain renal diets and what deviation from this can do to harm the patient
	Ability to teach patients and listen to patients' advice re dressings
	To be able to instruct and reassure new patients coming up to dialysis
	To be conversant with various types of kidney machines
	To be able to teach the patient
	Explain transplant procedure and what a successful transplant means (or indeed failure)
	Explain the difference between home dialysis and hospital
	Explain diet and restrictions
	Explain dietary requirements - potassium/protein/sodium fluid balance

Category M - Ability as a leader

Category N - Personal appearance

Centre 2	Tidy appearance with little or no make-up
	Cleanliness and tidiness of the nurse
	Neat and tidy in appearance
Centre 3	Professional appearance
Centre 7	Neat and tidy
	Neat, tidy and cheerful
	Neat appearance

Category O - Ability to be professional

Centre 1	Interest in her work
Centre 5	Dedication to duty with an efficient manner
Centre 7	Dedication to duty (professional)

APPENDIX 6

ITEMS LISTED BY NURSES

(Nurses' Own Words)

Nurses were asked to: (i) write down the nursing care that they felt most necessary for a patient

(ii) list the nursing care that they felt patients could assess

Category A - Knowledge of nursing care

Centre 1

Show knowledge of nursing care

Centre 2

Show interest and have some knowledge about the patient's case history

Have knowledge of patient's complaint so that the patient is not informed that she is making great progress only to be told later by doctors that another operation is necessary

Centre 3

Have a good knowledge of nursing

Good standard of work/knowledge

Good memory

Show knowledge of nursing care

Centre 5

Ability to recognise any social problem

Theoretical knowledge to answer parents questions coherently

Have knowledge of the basic concepts of special care work and she must be conversant with techniques and therapy in current use within the unit in order to have confidence in her own ability and thus impart that confidence to a parent whose ability to comprehend the situation may be marred by the exceptional circumstances in which they find themselves

Understanding drugs and intravenous fluids

Theoretical competence - sound understanding of problems encountered in nursing neonates undergoing special and intensive care

Centre 6 Know more about the patient's situation as a whole, family, home set-up, interests

Knowledge of the patient's condition

Centre 8 Interpret blood and urine investigation results

Knowledge of blood chemistry results and cardiac monitors

Knowledge of patients' problems

Knowledge of problems of transplant and haemodialysis patients

Knowledge of chronic and acute renal failure and the nursing care of patients in these conditions

Category B - Ability and skill in performing nursing care

Centre 2 Skill in giving nursing care under stress in an emergency

Servant to the patient

Serve meals when still hot, within easy reach, and if necessary help in cutting the meat etc.

Give wash bowl after bedpan

Urine bottle emptied when used

Gentleness in doing dressing, and including the patient in general conversation

Put the tray in front of the patient and cut the meat into bite sized pieces

Pass on a friendly wish expressed by a friend on the telephone; receiving meals on time; having flowers put in a vase

Someone who cares for the patient as an individual respecting their colour and creed. Making them feel they are being nursed by people who care for them as a complete human being, not just a name and diagnosis

Do the more menial duties such as bedbaths, attending to pressure areas and giving out bedpans as efficiently as she would do a more interesting task such as a dressing or administering medications

Be able to anticipate the patient's needs, such as giving you an extra blanket when it is cold, placing your bed table near enough to your bedside, makes you feel less of a nuisance

Make sure patient is comfortable and warm

Pays attention to small details i.e. emptying bottles, ashtrays, offering bedpans etc.

Prepares herself and has all the equipment she needs for the dressing she is to do

Performs dressings quickly and as painlessly as possible

Makes sure patient is comfortable when the task has been performed

Be careful to ensure that the least possible pain was inflicted and apply the maxim of 'Do unto others as you would be done by'

To keep the patient as comfortable as possible e.g. daily bedbath, cleaning of teeth, oral hygiene, pressure areas, regularly changing patient's position in bed, coaxing me with food and drink and maintaining the patient's body functions

Centre 3 Remain calm in a situation of emergency when giving care

Be able to cope with violent patients or others under the influence of alcohol or drugs

Be prepared for a variety of cases (e.g. from tiny laceration to suspended breathing)

Work quickly and efficiently thus avoiding congestion in waiting rooms

Avoid cross infection by cleaning equipment and washing hands properly following each dressing

Never attempt to tackle a dressing that is alien to you. Ask your senior if unsure

Win the patient's confidence in your ability and reassure her/him throughout procedures

Ability to carry out nursing procedures with confidence

Ability to carry out nursing procedures with gentleness

Ability to carry out nursing procedures with skill and dexterity

Ability to carry out nursing procedures with safety

Competence

Ability to cope with stress situations

Centre 4

Provide physical needs e.g. blanket bath, mouth/eye care, pressure area care, toilet facilities and privacy

Maintenance of vital functions i.e. maintenance of airway

Monitor vital functions - observations

Visitors (i.e. relatives) to participate in care if possible

Don't expose your patient

Try and make your patient look and feel presentable e.g. shave your man, maybe a lady might want a bit of make-up on, even to do their hair might make her/him feel a bit better

Wash or make sure patient is properly clean after being to toilet

Attend to patient's pressure area care, mouth care and eye care

Never leave your patient longer than need be

Centre 5	Willing help with any problem of bonding, feeding etc.
	Dexterity - the nurse should have the ability to handle the baby competently
	Patience and tolerance to cope with the most difficult situations
	Overall competence in care of ill and premature babies
	Ability to demonstrate skills e.g. feeding and bathing and to support parents in their efforts to acquire confidence
	Confident and experienced with child and baby care
	To be skilled in the care of the baby from birth and be able to give the necessary support and advice to the parents
	The ability to help with breast feeding and understanding the problems of this situation
	The ability to make unwilling babies feed
	To be competent in looking after machines
	Constant observation of all babies
	Technical competence - thorough understanding of all equipment used and ability to use it effectively
	Practical competence - the ability to put theoretical and technical knowledge into effective use
Centre 7	Skill and dexterity
	Efficiency in performing manual skills including gentle handling of the patient
	Skill in the basic nursing procedures
	Ability to cope with the very 'dirty' tasks with a grin and reassurance to the patient that he still has the nurse's respect
	Skill
	Remember all the little things that sometimes get forgotten e.g. cleaning my reading spectacles, finding

me a paper or book to read or even reading to me or writing a letter for me if she had time

Centre 8

Give total body care

Provide neat and tidy area round bed - ward tidy

Acquire skill with all renal procedures

Give drugs at the right time

Order correct diet for patients with renal disease

Practise meticulous aseptic dressing technique

Practise meticulous post-transplant care procedures

Use and store specialised equipment correctly

Ability to make comfortable

Confidence in dressing techniques

Give tablets and other medication and diet

Ability to act quickly in emergency situations

Act swiftly and calmly in an emergency

Confidence in carrying out procedures

Willingness to carry out instructions quickly in an emergency

Act swiftly in an emergency

Good aseptic techniques

Care of the access sites - shunts, fistulas, Tenckhoff catheters, subclavian lines

Care of equipment e.g. Tekmar, Gambro, Sage pump - resuscitation equipment

Clinic work

Confident and capable in an emergency situation

Care of all or most aspects of peritoneal dialysis (insertion of Tenckhoff catheters, Line change, dressing, exchanges)

Shunt care (dressing, observations etc.)

Fistula care observations

Care of post transplant patient

Setting up Teckmar and Gambro machine - and looking after it

Taking blood

Collection of 24 hour urine specimens

Reading E.C.G. and care of patient on monitors

Preparation of patient for special tests - renal biopsy, I.V.P. etc.

Adept in all common renal procedures (e.g. care of fistulas, shunts, peritoneal dialysis, care of transplants, diets, biopsies etc.)

Skill to perform procedures such as shunt dressing and be meticulous in doing this

Give general nursing care and attention to detail and the patient's comfort

Category C - Ability in organising nursing care

Centre 6 Awareness of workload

Centre 8 Ability to be aware of all the patients in the unit when attending to a particular patient

Category D - Ability in developing relationships with patients

Centre 1 The patient should go away with the feeling that no problem will be considered too trivial in the future

Inspiring trust and confidence

Ability to listen

Relaxed friendly manner

Ability to put patient at ease

Ability to listen

	Ability to respect privacy and avoid embarrassment
	The ability to listen to the patient and to relate professionally in all aspects of the work
Centre 2	To be happy and cheerful with a sense of humour and the ability to converse with people from all levels of society. Take an interest in the patient as a person noticing improvement in their illness or disability
	As an individual not bed so and so, or the lacerated hand etc. By a name - Mr or Mrs so and so
	Sympathetic and intelligent and most of all considerate to relatives especially in times of stress
	Privacy and respect for patients i.e. using name and not bed number so and so
	Nurses must not tell patients about the status of other nurses, because when that nurse comes to do a dressing the patient may not have any confidence in a junior nurse
	Nurses must not discuss their own affairs or discuss other patients' treatment while doing dressings
	To be able to confide in the nurse - sometimes the doctors may seem too busy with more important matters
	Be able to treat patients in the way nurses themselves would like to be treated - with care and consideration in a friendly professional manner
	Easy to approach
	Talks to patient whilst doing dressing etc.
	Considerate, kind and to treat me as a reasonably intelligent person
	Be able to forgive outbursts of frustration and anger, maybe rudeness which nurses are subjected to as illness and dependency sometimes get the better of patients
Centre 3	Support bereaved relatives/friends

	Be as helpful as possible when answering calls to Accident and Emergency. Bear in mind the caller will be very anxious
	Have a good sense of humour but at no time be flippant
	Manner of receiving the patient appears friendly but not flippant
	Ability to listen to patients and their relatives as well as being able to talk to them
	Talk to patients in a language they understand
	Talk to patients honestly and sincerely
	Talk to patients tactfully and truthfully
	Talk to patients on appropriate occasions with a sense of humour
	Have the ability to treat patients as individuals
	Have the ability to provide emotional support
	Be friendly without being too casual
	Understanding the need for quietness in speech and manner
	Having time to listen
Centre 4	Important that staff identify themselves i.e. nurses doctors etc.
	Reassure patient that everything possible is being done
	Gain patient's confidence
	Praise patient to boost confidence
	Remeber even though a patient is unconscious he/she may still be able to hear you
	Reassuring patients - talking to them, encouraging them to gain your confidence
Centre 5	Awareness of maternal anxieties and needs
	The ability to listen

Obvious specialised skill and knowledge - thus giving confidence to the patient

Visiting mothers who are too ill, making sure that they can see their baby or at least a photograph

The ability to reassure patient and relatives

Ability to relate to parents and anticipate their anxieties

Approachability and friendliness in relationships with parents

To be able to nurse babies with congenital abnormalities, being able to recognise and discuss emotional problems that may arise, giving advice and support when needed

Understanding patients' problems of depression

Friendly disposition towards parents so that they feel able to talk about any problems

To be able to talk to parents of desperately ill children

The willingness and ability to listen

The willingness and ability to talk (to let parents talk out their own problems by talking to you)

Centre 6

Taking time to stop and listen - not half listening

Do not talk over patient

More aware about patient's interests

Make patients feel they are individuals

Treat patients as individuals (could be our mothers or grandparents)

Interest in the patients

Ability to communicate with relatives

Praise goes a long way

Centre 7

An ability to communicate with the patient

Ability to communicate with patient's relatives

It is important for the nurse to project an image to the patient that she cares for that person as an individual and that she has time to stop and discuss his problems and worries

Give the patient credit for his intelligence and remember he is an individual not just another name on the list and treat him accordingly regardless of any defects he may have

Treat patients as fellow human beings, whether or not they have physical/neurological deficits, with kindness, compassion and a sense of humour

Reassurance that he will make a good and full recovery or at least that he is making good progress

Communicative - if tests are delayed tell the patient and say what time it was likely to be and what was involved etc.

Be there when I want her

Talk to me sometimes

Ability to have a smile ready and be able to listen to the patients

Understanding of physical deficits and patience with patient who is trying hard to do things himself properly, even if there is little success or the ward routine has to be put back a little

Ability to spot the smallest of improvements and to give due praise and admiration to the patient without gushing!

A nurse who gives a patient encouragement with associated reassurance, which in turn gives the patient some confidence

Make a patient feel at his/her ease and able to confide with her if necessary

Listen and help solve any problem no matter how small or large

Give constant reassurance

Always listen to my worries, fears, problems etc. and really listen to me as an individual

Talk to the patient as she is, a normal person, not down to her as if she is of low intelligence

Centre 8 Perception of emotional problems

Ability to meet all types of patients, to give reassurance and help put them at their ease in the unit, whether chronic or acute patients aim at a good relationship

To be interested in the patient as a person but especially in the particular problems he or she may be having in coping with a restricted life style and any resulting problems in family relationships/work situations

The ability to care about the patient as an individual

Maintenance of morale in patients

To be able to communicate verbally and non-verbally

To give praise when necessary and to encourage

Show awareness of patients' long-term problems and show sympathy, support and understanding

Category E - Ability in developing relationships with other members of staff

Centre 3 Have a good relationship with colleagues

Category F - Attitudes

Centre 1 To have calm, non-condescending manner

Sympathetic and welcoming

Initial attitude towards patient

Empathy

	Approachability
	Understanding
	Sympathetic
	Sympathy
	Understanding
	Approachability on all matters relating to sexual problems
	Empathy
	Tact
Centre 2	Courtesy and kindness
	Appearance of confidence in what she does and says
	To realise that patients have human failings such as weaknesses, likes and dislikes
Centre 3	Welcome all patients with a friendly smile
	Be kind and understanding to parents when their child is the patient
	Be friendly
	Be approachable at all times
	Be patient with children (and obnoxious adults)
	Be tactful always
	Politeness at all times
	Use gentle persuasion when patient refuses (or is reluctant) to allow you to treat them
	Never assume that your patient is over re-acting
	Is kind and gentle but firm if necessary
	Inspires confidence through a friendly approach
	Is patient and understanding to all types of people i.e. children, adults and elderly alike
	Be courteous to patients and relatives

	Be sympathetic and understanding
	Have poise and good manners
	Provide tender loving care
	Helpfulness
	Reassurance and sympathy
	Understanding
	Calmness
	Pleasantness
	Kindness
	Confidence with kindness
	Attitude and temperament - politeness, patience, tact, gentleness and friendliness
	Approachability
	Efficiency with kindness
	Common sense approach
	Empathy
	Calmness
	Patience
	Sense of humour
	Understanding
	Reassuring manner
	Air of confidence and calmness
	Understanding
Centre 5	Friendly, competent and welcoming attitude at all times
	Ability to show interest in baby without assuming a possessive air towards it
	Competent and kind handling of child
	Kind
	The willingness and ability to help

Centre 6

Patience

Have the ability to be firm, without giving the impression of being unkind or soft

Should be someone with a happy disposition

Forget their age

Patience

Centre 7

Confident approach to work

Gentleness

Kind attitude to relatives

Tactful and discreet regarding patient's condition

Manner in which the nurse addresses the patient

Patience

It is distressing for a patient to see a nurse that is disorganised, continually in a hurry and flap

Show understanding and make allowance of mental state e.g. patient may be frightened or depressed as a result of his illness

Patience

Gentleness

A confident approach

Sense of humour

Patience and understanding

A gentle and understanding nature

Friendly

Patience

Inspire confidence

Unflappable

Sense of humour

Sympathetic ear

	Treat patients as adults and with respect - including the aged and mentally handicapped patients
	Unflappability and sympathy
	To have a broad shoulder handy when needed
	Happy and cheerful and wears a smile
	Think of the 'little things' e.g. everything being in reach for a hemiplegic patient
	Patience, especially with patients who take longer to complete simple tasks
	Smile and give sympathy if needed
	Confident, safe and kind
Centre 8	Confident and kind
	Kindness, flexibility and tolerance in long term care
	Adaptability
	Acquire high tolerance to stress
	Patience with all aspects of care
	Understanding of psychological problems
	Show willingness to learn from patients
	Willing attitude when called by the patient
	Empathy
	Willing to learn from experienced patients
	Patience
	Understanding
	Confidence in his/her work
	Politeness - respectfulness to patient's dignity and independence
	Friendliness
	Psychological care - supportive attitude, being flexible, approachable
	Attitudes to patients (e.g. sympathetic, friendly)

Attitudes to other staff (e.g. co-operative, friendly, respectful)

Category G - Ability and skill in observing

Centre 5 The ability to notice changes in a baby's condition and act accordingly

Category H - Ability and skill in reporting

Centre 1 Ability to pass on information verbally in a clear manner

Centre 4 Report abnormalities as soon as possible

Category I - Ability and skill in recording

Centre 8 Attention to detail in recording observations on charts

Category J - Ability and skill in making judgments

Centre 2 Judge the needs of patients

Patient's well-being should be uppermost in a nurse's thoughts and she should act accordingly

Centre 3 Have the sense to give priority to patients e.g. one who is bleeding profusely etc.

Ability to set priorities and function effectively in situations of stress

Centre 4 If a patient is in need of analgesia never hold back and wait a while

Centre 5 Recognising the need for reassurance if necessary by a doctor of the unit

Perceptiveness - be able to anticipate what the parent requires

To know when it is time to call the doctor and be able to work with him/her

Perceptibility - awareness of visible needs and the invisible needs and the ability to act accordingly

Centre 6 Judge each patient individually

Know when to stop 'pushing' patients. Not only in the long-term but short-term as well

Centre 7 Judge the patient's needs

Centre 8 Assess the level of anxiety

Knowing one's limitations

Category K - Acceptance of responsibility

Centre 2 Caring - so that the patient will have the confidence in you as a person and also in your sense of responsibility and efficiency

Centre 3 Accountable for actions

Centre 7 Acknowledges responsibility for actions

Category L - Ability and skill in teaching patients

Centre 1 Able to gather relevant facts for teaching purposes

To teach the chosen contraceptive method clearly

Explain methods of family planning available, clearly, and in an unbiased manner

Teach the chosen method of contraception clearly without trying to 'blind the patient with science'!

	Ability to explain all methods of family planning concisely without influencing choice
	Clarity when explaining and teaching and repeat if necessary
	Give instructions with regard to future visits
	Give guidance
	Ability to give clear concise instructions
	Ability to instruct clearly
	Clarity and precision of expression when counselling or teaching
Centre 2	Teach and advise with social problems when necessary especially the elderly on discharge
	Explain in layman's language. Not too many big words, it's confusing and frightening
	Give information about treatment
	Tells the patient what she is going to do and why
	Answers any questions as best she can - finds out if she doesn't know
	To respect confidences, listen and reassure. Explain any procedures and treatment
	Explain anything that may be of concern to the patient or arrange for the appropriate person to give advice
Centre 3	Advise patients re future appointments and dressings they have to do themselves at home
	Ensure (especially with the elderly) that patients understand instructions before they leave the department
	Advisory help
Centre 4	Explain the reason for being admitted to the unit in simple terms so that the patient understands
	Explain treatment that is to be carried out

	Explain procedure beforehand and also while doing the procedure
Centre 5	Willingness to explain the technical apparatus in use
	Teach the mother to help care for her baby
	Ability to explain equipment in use in detail
	To be confident with specialised procedures and equipment to be able to explain these to the parents so that they can understand
	The ability to discuss and teach parents about their child's condition
	Instructional competence - the ability to be able to impart one's knowledge to enable others to become more effective in their care
	The willingness and ability to explain
	The willingness and ability to demonstrate nursing care
	The willingness and ability to reiterate what has been said yet again
	The willingness and ability to confirm medical statements and to explain them further
	The willingness and ability to reinforce mother/baby relationships as much as possible
Centre 6	Use practical situations to instruct patients
	Explain the treatment thoroughly to the patient then they will know why things are being done for them
Centre 7	Explain procedures and situations
	Ability to explain about patient's condition and answer any questions he may have
	Explain the procedure in layman's language (not childish) terms
	Explain to me any procedure that she was about to undertake concerning me

Repeat instructions given by the doctor to the patient which have not been understood

Centre 8 — Ability to be able to teach the principles of dialysis

Ability to be very patient and very repetitive to those experiencing difficulty in learning

Ability to help and teach the patient to achieve good standards

Capabilities of teaching

Teaching of patients, relatives and other staff

Teach patients effectively (e.g. peritoneal dialysis, transplant drugs, diets) and explain difficulties clearly to them (e.g. relation of weight and B.P., aseptic techniques)

Category M - Ability as a leader

Centre 8 — Supportive to learners but not over-officious

Manage the ward

Manage the patients in the ward

Category N - Personal appearance

Centre 2 — Fairly smart appearance

Appearance should be neat as this inspires confidence

Neat and tidy

Centre 3 — Neat in appearance

Be neat and well groomed in appearance

Centre 7 — Good appearance

Nurses' general appearance - tidy

Tidy appearance

Be clean, tidy and cheerful in carrying out tasks

Neat, clean and tidy appearance - first impressions often linger a long time

Category 0 - Ability to be professional

Centre 1 Good manners

Centre 2 Good manners with the ability to have discretion i.e. never discussing patients outside the ward circle so that the patient knows she can trust you

Professional behaviour from all concerned

Centre 3 Professional manner

Avoid any behaviour that will make your patient wish he'd never come to Accident and Emergency

Professional behaviour with high standard of care

Professional manner and care

Centre 7 Professional yet caring

Professionalism - an outward appearance that she is confident in her tasks (emergency or otherwise) even when perhaps she is not

Centre 8 Work quickly, quietly, confidently and professionally

Interest in patient as a person and development of warm relationship combined with professionalism

Nurse's personality and attitude to work - professional

Enthusiasm for work, efficient and caring

Attitudes to work (conscientious, careful)

APPENDIX 7

DEFINITION OF CATEGORIES

Category A - Knowledge of nursing care

Theoretical and or practical understanding required of the nurse when giving nursing care

Category B - Ability and skill in performing nursing care

Capacity and expertise required of the nurse when giving nursing care

Category C - Ability in organising nursing care

Capacity of the nurse to arrange nursing care for patients in an orderly way

Category D - Ability in developing relationships with patients

Capacity of the nurse to realise and augment all that is potentially contained in associating with patients

Category E - Ability in developing relationships with other members of staff

Capacity of the nurse to realise and augment all that is potentially contained in associating with other members of staff

Category F - Attitudes

The nurse's behaviour or manner of acting, as representative of feeling or opinion

Category G - Ability and skill in observing

Capacity and expertise of the nurse to notice changes in the patient's condition

Category H - Ability and skill in reporting

Capacity and expertise of the nurse to give an accurate account

Category I - Ability and skill in recording

Capacity and skill of the nurse to put information down in writing

Category J - Ability and skill in making judgments

Capacity and expertise of the nurse to give an informed opinion

Category K - Acceptance of responsibility

The nurse acknowledges and is accountable for her actions

Category L - Ability and skill in teaching patients

Capacity and expertise of the nurse to give information to patients

Category M - Ability as a leader

Capacity of the nurse to assert her personal influence over others

Category N - Personal appearance

Visual impression of the nurse

Category O - Ability to be professional

Capacity of the nurse to conduct herself in an efficient manner

APPENDIX 8

STATEMENTS

Category A - Knowledge of nursing care

1. The nurse was aware of new developments in nursing care and was able to tell the patient of these
2. The nurse was familiar with the patient's home circumstances
3. The nurse understood the patient's needs and was able to select, and give nursing care to meet these needs
4. The nurse appeared to know about the equipment she used and how to look after the patient so that he felt safe

Category B - Ability and skill in performing nursing care

5. The nurse told the patient what she was doing to help him and was gentle and tried not to hurt him
6. The nurse gave an explanation to the patient when the order of nursing care was interrupted
7. In an emergency the nurse acted quickly and worked well with other nurses
8. The nurse used equipment and ward furnishings correctly when carrying out nursing care
9. The nurse encouraged the patient to join in ward activities within his capabilities
10. The nurse understood what the patient needed and how to make him comfortable
11. The nurse noticed when it was necessary to change the patient's dressing and did it gently
12. The nurse created a 'home-like' feeling about the ward and paid special attention to cleanliness and tidiness particularly in the area around the patient's bed
13. The nurse gave medicines at the correct time

Category C - Ability in organising nursing care

14. The nurse identified the nursing care which was essential to the patient and made sure it was completed before leaving the patient

15. The nurse was aware of the needs of other patients in the ward when attending to one particular patient

Category D - Ability in developing relationships with patients

16. The nurse listened and acted on what was said by the patient without betraying the patient's trust

17. The nurse helped the patient to express and come to terms with his feelings

18. The nurse spoke to the patient kindly and with confidence

19. The nurse dealt with the patient's requests as soon as possible

20. The nurse introduced herself and said who she was

21. The nurse used the patient's name

22. The nurse assessed the patient's degree of independence and allowed him to do things within his capability and encouraged by praise any achievement

23. The nurse refrained from talking about her own personal affairs with other members of staff in front of the patient

24. The nurse talked to the patient and answered his questions truthfully

25. The nurse talked clearly and directly to the patient without shouting

26. The nurse was patient when the patient couldn't explain what he meant

Category E - Ability in developing relationships with other members of staff

27. The nurse worked together with other members of staff when carrying out duties in the ward

Category F - Attitudes

28. The nurse showed a sense of humour at the right time

29. The nurse was sensitive to the patient's problems

30. The nurse had a sincere and friendly manner with the patient

31. The nurse was patient and tactful when things were difficult

32. The nurse was prepared to learn from the patient about his condition

33. The nurse showed confidence when carrying out nursing care

34. The nurse was firm without giving the impression of being unkind

35. The nurse was sympathetic with patients

36. The nurse refrained from influencing the patient by telling him of her own preferences

Category G - Ability and skill in observing

37. The nurse noticed changes in the patient's condition and changed her nursing care accordingly

38. The nurse was aware that time can become distorted to the patient when nursed on their own

Category H - Ability and skill in reporting

39. The nurse told a senior nurse about the patient clearly and when necessary asked for help on how best to look after him

Category I - Ability and skill in recording

40. The nurse checked with the patient that she had written down his details correctly

Category J - Ability and skill in making judgments

41. The nurse gave nursing care to meet the patient's needs and adjusted the speed to match the patient's ability

42. The nurse knew when the patient needed sympathy or when firmness was required

43. The nurse was able to make decisions but asked for help when it was needed

Category K - Acceptance of responsibility

44. The nurse accepted responsibility for nursing care within her capability

Category L - Ability and skill in teaching patients

45. The nurse taught the patient about his care so that he was able to understand

46. The nurse gave clear information of nursing care to the patient so that he could understand

47. The nurse knew when the patient was able to join in nursing care and gave help and encouragement

Category M - Ability as a leader

48. The nurse made sure the other nurses gave the patient the care he needed

49. The nurse taught students in a friendly way

Category N - Personal appearance

50. The nurse was neat and tidy

Category O - Ability to be professional

51. The nurse appeared to have a caring enthusiastic attitude to nursing

APPENDIX 9

'PATIENT ASSESSMENT OF NURSING CARE' ASSESSMENT INSTRUMENT

PATIENT ASSESSMENT FORM

Centre:

Name of patient:

Name of nurse:

	Do you agree with the following statements:	Not applicable	Strongly agree	Agree	Disagree	Strongly disagree	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable	Strongly agree	Agree	Disagree	Strongly disagree
1	The nurse introduced herself and said who she was														
2	The nurse used my name when looking after me														
3	The nurse spoke to me kindly and with confidence														
4	The nurse was patient when I couldn't explain what I meant														
5	The nurse checked with me that she had written down my details correctly														
6	The nurse was sensitive to my problems														
7	The nurse was patient and tactful when things were difficult														
8	The nurse showed a sense of humour at the right time														
9	The nurse understood what I needed and how to make me comfortable														
10	The nurse told me what she was doing to help me and was gentle and tried not to hurt me														
11	The nurse noticed changes in my condition and changed her nursing care accordingly														
12	The nurse appeared to know about the equipment she used in my care and how to look after me so I felt safe														
13	The nurse noticed when it was necessary to change my dressing and did it gently														
14	The nurse taught me about my care so that I was able to understand														
15	The nurse was prepared to learn from me about my condition														
16	The nurse was able to make decisions but asked for help when it was needed														
17	The nurse told a senior nurse about me clearly and when necessary asked for help on how best to look after me														
18	The nurse made sure the other nurses gave me the care I needed														
19	In an emergency, the nurse acted quickly and worked well with other nurses														
20	The nurse appears to have a caring enthusiastic attitude to nursing														

'PATIENT ASSESSMENT OF NURSING CARE' ASSESSMENT INSTRUMENT

PATIENT ASSESSMENT FORM

Centre:

Name of patient:

Name of nurse:

	Do you agree with the following statements:	Not applicable	Strongly agree	Agree	Disagree	Strongly disagree	Comments
1	The nurse introduced herself and said who she was						
2	The nurse used my name when looking after me						
3	The nurse spoke to me kindly and with confidence						
4	The nurse was patient when I couldn't explain what I meant						
5	The nurse checked with me that she had written down my details correctly						
6	The nurse was sensitive to my problems						
7	The nurse was patient and tactful when things were difficult						
8	The nurse showed a sense of humour at the right time						
9	The nurse understood what I needed and how to make me comfortable						
10	The nurse told me what she was doing to help me and was gentle and tried not to hurt me						
11	The nurse noticed changes in my condition and changed her nursing care accordingly						
12	The nurse appeared to know about the equipment she used in my care and how to look after me so I felt safe						
13	The nurse noticed when it was necessary to change my dressing and did it gently						
14	The nurse taught me about my care so that I was able to understand						
15	The nurse was prepared to learn from me about my condition						
16	The nurse was able to make decisions but asked for help when it was needed						
17	The nurse told a senior nurse about me clearly and when necessary asked for help on how best to look after me						
18	The nurse made sure the other nurses gave me the care I needed						
19	In an emergency, the nurse acted quickly and worked well with other nurses						
20	The nurse appears to have a caring enthusiastic attitude to nursing						

'PATIENT ASSESSMENT OF NURSING CARE' ASSESSMENT INSTRUMENT

NURSE SELF ASSESSMENT FORM

Centre:

Name of nurse:

Name of patient:

	Do you agree with the following statements:	Not applicable	Strongly agree	Agree	Disagree	Strongly disagree	Comments
1	I introduced myself to the patient and said who I was						
2	I used the patient's name when looking after him						
3	I spoke to the patient kindly and with confidence						
4	I was patient when the patient couldn't explain what he meant						
5	I checked with the patient that the details I had written down were correct						
6	I was sensitive to the patient's problems						
7	I was patient and tactful when things were difficult						
8	I showed a sense of humour at the right time						
9	I understood what the patient needed and knew how to make him comfortable						
10	I told the patient what I was doing to help him and I was gentle and tried not to hurt him						
11	I noticed changes in the patient's condition and changed my nursing care accordingly						
12	I knew about the equipment I used in the patients care and how to look after him safely						
13	I noticed when it was necessary to change the patient's dressing and did it gently						
14	I taught the patient about his care so that he was able to understand						
15	I was prepared to learn from the patient about his condition						
16	I was able to make decisions and asked for help when it was needed						
17	I told a senior nurse about the patient clearly and when necessary asked for help on how best to look after him						
18	I made sure the other nurses gave him the care he needed						
19	In an emergency, I acted quickly and worked well with other nurses						
20	I feel that I have a caring enthusiastic attitude to nursing						

'PATIENT ASSESSMENT OF NURSING CARE' ASSESSMENT INSTRUMENT

ASSESSOR ASSESSMENT FORM

Centre:

Name of assessor:

Name of patient:

Name of nurse:

	Do you agree with the following statements:	Comments	Not applicable	Strongly agree	Agree	Disagree	Strongly disagree
1	The nurse introduced herself to the patient and said who she was						
2	The nurse used the patient's name when looking after him						
3	The nurse spoke to the patient kindly and with confidence						
4	The nurse was patient when the patient couldn't explain what he meant						
5	The nurse checked with the patient that the details she had written down were correct						
6	The nurse was sensitive to the patient's problems						
7	The nurse was patient and tactful when things were difficult						
8	The nurse showed a sense of humour at the right time						
9	The nurse understood what the patient needed and knew how to make him comfortable						
10	The nurse told the patient what she was doing to help him and was gentle and tried not to hurt him						
11	The nurse noticed changes in the patient's condition and changed her nursing care accordingly						
12	The nurse appeared to know about the equipment she used in the patient's care and how to look after him safely						
13	The nurse noticed when it was necessary to change the patient's dressing and did it gently						
14	The nurse taught the patient about his care so that he was able to understand						
15	The nurse was prepared to learn from the patient about his condition						
16	The nurse was able to make decisions and asked for help when it was needed						
17	The nurse told a senior nurse about the patient clearly and when necessary asked for help on how best to look after him						
18	The nurse made sure the other nurses gave him the care he needed						
19	In an emergency, the nurse acted quickly and worked well with other nurses						
20	The nurse appears to have a caring enthusiastic attitude to nursing						

PATIENT ASSESSMENT OF NURSING CARE

ASSESSMENT

Date:

Overall Assessment Time:

From: To:

Ward:

Grading:	Not applicable:	The action stated did not occur
	Strongly agree:	Nursing care was fulfilled as indicated in the statement in excess of the wording of the statement
	Agree:	Nursing care was fulfilled as indicated in the statement and no more
	Disagree:	Nursing care as indicated in the statement was not fulfilled
	Strongly disagree:	Total disregard or indifference to the statement even when the opportunity arose

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DETAILS OF PATIENT

Name:

Age:

Sex:

Occupation:

Number of visits/admissions to hospital excluding the present one: ☐

Patient Dependency Code: ☐

Outline of Nursing Care:

DETAILS OF NURSE BEING ASSESSED

Name:

Age:

Sex:

Grade:

DETAILS OF ASSESSOR

Name:

Age:

Sex:

Grade:

A P P E N D I X 1 0

GUIDANCE FOR NURSE TEACHERS

These guidelines are for the nurse teachers of the eight centres involved in the study so that assessments may be conducted in a similar manner and provide the same information to patients and nurse learners.

In preparation for the assessments, co-operation, agreement and support will be necessary from the ward sister and other staff members. This will be forthcoming most readily if all staff know when the assessments are to take place and who will be involved. Discussions should take place with ward staff prior to the date of the actual assessments.

ALL ASSESSMENTS SHOULD TAKE PLACE BETWEEN 9am. AND 1pm.

1. Pre-assessment Preparation

Discuss with the ward sister which patients are able to take part. Many will be excluded because they may be going for operation, X-ray or other tests during the period of assessment. Intensive care patients, classified in the nursing dependency categories (Appendix 3, page 181), should also be excluded.

In choosing patients for the study it is important to try and include patients ranging from self care to intermediate care.

Complete the information requested on the reverse side of the nurse teacher's assessment form before the assessment begins.

2. Preparation of the Patient

Give the patient the attached letter and patient assessment form (Appendix 11, page 231) to read.

Go over the details in the letter with the patient.

Read the patient assessment form with the patient and repeat the information contained in the letter.

Tell the patient that there will be three people involved in the assessment, the patient, the nurse learner and the nurse teacher.

Explain to the patient that this assessment will be a learning situation for the nurse learner and that the nurse learner's agreement will be obtained prior to the assessment taking place.

After discussing the assessment procedure ask for the patient's agreement to take part.

Ask the patient to tick the statements on the form at the end of the assessment period and not to discuss the assessment form with other patients.

At the end of the assessment period collect the assessment form from the patient and thank the patient.

Ask the patient to complete the evaluation form (Appendix 13, page 233).

3. Preparation of the Nurse Learner

The nurse learner should be prepared in exactly the same way as the patient. The instructions given to the patient in paragraph 2 of the guidance should be repeated to the nurse learner altering the word 'patient' for 'nurse learner' and the word 'nurse learner' for 'patient'.

4. Preparation of the Nurse Teacher

Having discussed the assessment procedure with ward staff and the assessment form with the patient and nurse learner, the nurse teacher will be familiar with the content and design of the form.

Guidance given in the patient letter (Appendix 11, page 231), nurse learner letter (Appendix 12, page 232) and in this paper also applies to the nurse teacher.

APPENDIX 11

LETTER TO PATIENT

Dear Patient,

I am interested in finding out what you feel about the nursing care given to you this morning. In order to do this I have listed a number of statements on the attached form.

A nurse will be allocated to look after you between 9am. and 1pm. The nurse may or may not be known to you. Please only consider the nursing care that your nurse gives to you this morning.

I would be grateful if you would read each of the statements on the form. At the end of the morning mark each statement with a tick (✓) in the space provided to indicate which comes closest to saying how you feel about each statement. If the action expressed in the statement does not occur between 9am. and 1pm., please put a cross (X) in the space marked 'not applicable'.

Your answers will not be discussed with anyone so please be frank.

Thank you for your help and co-operation

APPENDIX 12

LETTER TO NURSE LEARNER

Dear Nurse,

I am interested in finding out what you feel about the nursing care that you will give this morning. In order to do this I have listed a number of statements on the attached form.

A patient will be allocated for you to look after between 9am. and 1pm. The patient may or may not be known to you. Please only consider the nursing care that you give the patient this morning.

I would be grateful if you would read each of the statements on the form. At the end of the morning mark each statement with a tick (✓) in the space provided to indicate which comes closest to saying how you feel about each statement. If the action expressed in the statement does not occur between 9am. and 1pm., please put a cross (X) in the space marked 'not applicable'.

Your answers will not be discussed with anyone so please be frank.

Thank you for your help and co-operation

APPENDIX 13

PATIENT EVALUATION FORM

1. Do you agree that patients should be asked to assess the nursing care they receive?

   Comments:

2. Do you agree that nurses should be asked to assess the care they give to patients?

   Comments:

3. Do you agree that during a patient - nurse assessment an independent nurse teacher assessor should be present?

   Comments:

4. Did you feel able to assess nursing care under the categories that were given?

   Comments:

Yes	No

Please tick

5. Are there any other categories of nursing care that you consider should have been included?

   Please list below:

   1.
   2.
   3.

6. Do you consider that the nursing care you received was affected by your being an assessor?

   Comments:

7. How long have you known the nurse? .....

8. Any other comments:

A P P E N D I X 1 4

NURSE LEARNER EVALUATION FORM

1. Do you agree that patients should be asked to assess the nursing care they receive?

   Comments:

2. Do you agree that nurses should be asked to assess the care they give to patients?

   Comments:

3. Do you agree that during a patient - nurse assessment an independent nurse teacher assessor should be present?

   Comments:

4. Did you feel able to assess nursing care under the categories that were given?

   Comments:

Yes	No

Please tick

5. Are there any other categories of nursing care that you consider should have been included?

   Please list below:

   1.

   2.

   3.

6. Do you consider that the nursing care you gave was affected by your being assessed by a patient?

   Comments:

7. Any other comments:

A P P E N D I X 1 5

NURSE TEACHER EVALUATION FORM

1. Do you agree that patients should be asked to assess the nursing care they receive?

   Comments:

2. Do you agree that nurses should be asked to assess the care they give to patients?

   Comments:

3. Do you agree that during a patient - nurse assessment an independent nurse teacher assessor should be present?

   Comments:

4. Did you feel able to assess nursing care under the categories that were given?

   Comments:

   Yes No

   ☐ ☐

   Please tick

5. Are there any other categories of nursing care that you consider should have been included?

   Please list below:

   1.
   2.
   3.

6. Do you consider that the nursing care given was affected by your presence as an independent nurse teacher assessor?

   Comments:

7. How long have you known Nurse 1: ..... Nurse 4: .....
   Nurse 2: ..... Nurse 5: .....
   Nurse 3: ..... Nurse 6: .....

8. Any other comments:

APPENDIX 16

ASSESSMENT EVALUATION BY PATIENTS

1. Do you agree that patients should be asked to assess the nursing care they receive?

Comments:

Centre 1

"Yes if they seem willing/able to do so and have the confidence to express an opinion. The last thing one would wish to do is to make a patient nervous with forms to fill in etc."

"Yes. The only way to evaluate how good your nursing care is"

"Yes, feedback from patients must surely help both nurse and patient in the long run"

"Yes. I think it is a good way to help patients feel involved"

Centre 2

"Yes, I think this would be a great asset for the nurses"

"Yes so that the nurses can get to know the patients"

Centre 3

"Yes to compare it"

"No"

Centre 5

"I agree that <u>some</u> parental assessment of the nursing care that a baby receives could be of benefit, especially during a long-term period of care"

"This is very difficult to comment on as I am so pleased with the care that my baby has received. If there were any areas that parents did not understand or disagreed with then I feel their views should be seriously considered as part of the baby's progress - depends upon the peace of mind of the parent"

"This does have a small part to play in assessing a nurse's performance"

"I agree to a certain extent that parents should be asked to assess the nursing care as they themselves, long-term could learn from this. However, on the other hand parents are usually learning themselves and rely on the nurse's skills and experience to show them and to gain confidence as new parents"

"I agree that it's a good idea but shouldn't be forced onto patients - the option to refuse should be made clear"

Centre 6

"Yes, but I think it could be very biased as some people are hard to please"

"Yes. The care was good - I feel I want to say when I have good care"

"I don't think it is necessary"

Centre 7

"Yes most definitely. Because each patient is an individual and even though he has the same condition as other patients he needs individual care"

"Yes to a certain extent. But the patient needs to make a fair assessment of what is happening and not be biased either in favour or against the nurses"

"Yes. Especially if it helps the nurses and other patients in the future"

"Yes I do agree. If the nurses ask the patients their opinions about their difficulties it helps them to learn. Helps to relieve the patient's mind too, as then they know that the nurse knows about them"

Centre 8

"Yes - good to ask for patients' ideas"

"Yes the patient can put their points of view forward if they are not happy with the treatment"

"Yes provided allowance is made for the fact that some patients are unjustifiably critical"

"Yes. Very difficult question - can only answer on after care and their knowledge and experience"

"Yes - we both learn from each other"

"Yes this could be a valuable exercise"

Seven said "yes"

2. Do you agree that nurses should be asked to assess the care they give to patients?

Comments:

Centre 1

"Yes, although I can imagine it being a problem for them whether they are being over modest"

"Yes, as this will encourage them to evaluate for themselves the personal care they are giving their patients"

"Yes it seems a little more personal, especially to the patient"

Centre 2

"Yes, it is very important especially with older folk"

"Yes. Personal analysis would lead to improved care"

"Yes so that they can get to know the patient they are caring for"

Centre 3

"Yes to compare it"

"No"

Centre 5

"I agree that nurses should evaluate their own performances - as a self-critical assessment of ones work usually modifies future performances"

"Yes they should, but then so should any doctor, teacher etc. assess the value of their work"

"Definitely - this should be a matter of course for nurses anyway"

"I think that nurses should have the choice and sometimes through questioning their own care could find their own mistakes, if any, by this method instead of forming their own habits"

Centre 6

"I suppose so. I am in two minds about this question"

"Yes I should say so"

"No, I don't think they should be. They may be biased one way or the other"

Centre 7

"Yes. They should assess it with the needs of the patient uppermost in their minds"

"Yes, certainly. They should find out if the patients are satisfied with the methods they use"

Centre 8

"Yes to make sure they are treating the patients as they should"

"Yes - self assessment is a very good thing"

Fourteen said "yes"

3. Do you agree that during a patient - nurse assessment an independent nurse teacher assessor should be present?

Comments:

Centre 1

"Yes, they can then definitely assess the nurse's attitude"

"With me it didn't matter but I must agree in some cases it could really throw a lot of people into a sense of insecurity"

"Yes, if this can be of help to the nurse in adding an independent observation of what has taken place"

"It perhaps builds up the patient's confidence a little more"

Centre 2

"No, depending on the nurse"

Centre 5

"I do not think that an independent nurse assessor is an absolute necessity, but perhaps they would be helpful if used in random cases"

"Perhaps"

"I do not necessarily agree to this as probably the nurse would not be quite so relaxed than if she was in the company of just the parent whom she would probably know much better"

"Yes, this is a good idea and should cancel out prejudices on both sides - parents and nurse as long as the independent nurse manages to be present discreetly without making everyone concerned"

Centre 6

"yes - good"

"I don't really think it makes much difference"

"Personally I don't think it was necessary"

Centre 7

"Yes, to represent an unbiased view. To prevent favouritism"

"Yes. But the assessor should possibly be totally independent of the situation e.g. from another hospital. Certainly not involved with the tutoring of the nurse being assessed"

"Yes there should be an independent person, but they should be well in the background"

Centre 8

"Not really necessary"

"Probably a desirable check"

"No, not really"

"Not really necessary"

Nine said "yes"

Two said "no"

Two did not answer the question

4. Did you feel able to assess nursing care under the categories that were given?

Comments:

Centre 1

"Question unclear" (did not answer)

Centre 2

"Yes, but only on certain things"

"Yes but more time required"

Centre 5

"Yes, I feel I was able to assess although some categories were not applicable"

"No. Occasionally 'disagree' is too strong - I'd like a chance to qualify it e.g. sometimes, occasionally"

Centre 6

"Yes, categories quite sufficient"

"No. Conditions vary from day to day. I don't think so"

Centre 7

"Yes. I have to have everything done to me, so I know what should be done"

"Yes, extremely competent"

"Yes, they were simple to assess"

Twenty one said "yes"

Two said "no"

5. Are there any other categories of nursing care that you consider should have been included?

Centre 2

"I am not qualified enough to answer"

"Humour by the nurse must be at a level tolerated by the individual patient"

"Important that the nurse can hold an intelligent conversation and is prepared to talk to the patient who is isolated from the rest of the ward"

Centre 5

"Instead of including babies' nursing care as a whole, I do think attention should have been paid to the fact that some babies are in the ordinary nursery, some in the hot nursery and others in special care which makes the nursing care more specialised and so parents need more reassurance etc."

"Sometimes"

Centre 6

"I don't think so"

"No. Good enough"

"At the moment I can't"

Centre 7

"Ability to concentrate on the job in hand"

"Specific skills e.g. shaving and feeding"

"Lifting ability"

"Lifting"

Ten said "no"

Thirteen did not answer the question

6. Do you consider that the nursing care you received was affected by your being an assessor?

Comments:

Centre 1

"Yes. Perhaps the nursing care might have been just a bit more thorough"

"Undoubtedly"

"Possibly"

"No, but the fact that the nurse was being assessed may well have affected her performance in that she was aware of the presence of an independent assessor"

"The general care of nurses to patients is good but when it is carried out in this way, it seems to help them relax and be more interested in what's happening"

Centre 2

"No not in any way at all"

"No she just carried on with her job"

Centre 5

"I do not feel that the nursing care was affected by my being an assessor as care shown right throughout the baby's treatment by other nurses was as exemplary as the nurse I assessed"

"I do not consider the nursing care given to my baby was affected in any way with me being an assessor because the atmosphere was relaxed and the nurse was extremely confident in everything she did"

"Absolutely not. The nurses I have seen have all been highly competent"

Centre 6

"Not affected in this case"

"It did not occur to me"

"No, I don't think it was"

Centre 7

"No, but you feel it could possibly do"

"No, because there was a good patient/nurse relationship and I know her well"

"No. Exactly the same as every other day"

"No. You do not think it makes any difference"

Centre 8

"No difference"

"No, the nurse was treating me the same way as any other patient as she always does"

"I think it inevitably was to some extent"

"Yes"

Eleven said "no"

7. How long have you known the nurse?

"Not known before today"

"My first treatment today - ten minutes"

"An hour"

"First time I have met her"

"One week two days"

"Three years"

"Seven months"

"Unknown"

"Approximately four months"

"I met and spoke to her a few times over a week ago - I don't know her very well"

"Seven weeks"

"About five minutes before 9am."

"I get confused one with another"

"Four weeks"

"Two years"

"Two months"

"Recently"

Three said "half an hour"

Three said "one day"

Two said "Two days"

Two said "four days"

Two said "approximately one week"

Two said "fourteen days"

Two said "Three weeks"

8. Any other comments:

Centre 1

"She generally made me feel relaxed and I found her easy to talk to"

"It's comforting to see someone who is cheerful and helpful"

Centre 2

"I am very grateful for all the attention I receive"

Centre 5

"My baby was born 16 days ago and was 12 weeks premature. During these 16 days I have been very impressed by the standard of nursing care that he and I have received. It has not just been by the book, much common sense has been shown and observational knowledge acted upon. Machines do not run the special care unit - people do"

Centre 6

"The nurse is always very gentle and always greets me with a smile"

"Very good nurse - I felt alright with her"

"No, not at the moment"

Centre 7

"I felt that I was in the care of a very competent and caring nurse"

"I felt able to assess the situation because I am used to assessing apprentices at work"

Centre 8

"A lot of these questions were not applicable because I am a self-caring patient but when I wanted her she was willing to help"

Two said "no"

Twenty one had no comments to make

A P P E N D I X 1 7

ASSESSMENT EVALUATION BY NURSE LEARNERS

1. Do you agree that patients should be asked to assess the nursing care they receive?

Comments:

Centre 1

"Yes - nurses can assume that the care they give is correct, only the patient, the one receiving care can say if it hurt or if they were cold when blanket bathed"

"Yes! Self-evaluation is very difficult - always good to know how one can improve or where one is lacking"!

"Yes, I think they are the most important people to ask about nursing care"

"Yes, since the service is designed for their care and comfort"

Centre 2

"Yes, I think that patients should be asked to assess their nursing care"

"Yes, because the patient is the 'consumer' of our care and it is their satisfaction and comfort we should seek in our work"

"Yes, I agree because I feel patients should have a say in how they are being treated and cared for"

Centre 3

"Yes as this would emphasise the need for the nurse to assess the patient as an individual with individual needs. However, the possibility that the patient would see the nurse as a pseudo parent (child-parent) would affect the validity of such assessments"

"Yes I do agree with some reservations. Communication problems and personality clashes may arise with the best of nurses who thus may be unjustly penalised in the course of their assessment. However, some nurses may perhaps be shocked when they learn how

patients really felt about the nursing care they receive and hopefully the nurse (and patients she deals with thereafter) would benefit from the experience"

"In certain cases I agree that patients should be asked to assess the nursing care they receive. Some patients may be too frightened of being critical, and others may just complain about everything if given the chance. I therefore think that one would not always have a fair assessment"

Centre 5

"No. Most parents have more than enough to cope with when their baby is in a special care baby unit"

"Disagree/agree. A verbal assessment is valuable, a written assessment is time consuming and confusing to some. This depends on a number of factors - (a) the mother's capabilities and (b) how ill the baby is and how the parent is coping with it"

"This seems very unfair to the parents as they cannot be really objective where their baby is concerned. Also many parents are unaware of nursing procedures and cannot tell if they are being done correctly"

"No. I do not think that parents can objectively assess a nurse in this clinical situation"

"It all depends on how much they do know about the nursing care and what sort of mood they have"

Centre 6

"As they are the ones it affects, it is essential that their opinion be asked. Yes"

"Yes it is very important to learn what patients think of the nursing care we give them"

"I think it is a good idea. As nurses we tend to assume that a patient will not object to any of our nursing procedures purely because they are under our care. Also it is good to have the person on the receiving end of the treatment describing what they thought of it"

"Yes, I think it is important to have the patient's opinion"

Centre 7

"Yes, as sometimes they may be too intimidated to make comments on their care"

"Not sure. It would depend on the patient's condition. If a patient claims that his care is inadequate will the nurses treat him as a 'problem patient'"?

"Yes. By assessing patient needs and a nurse's knowledge - the incorporation of both equals a high standard of care of the patient. Each patient is a person and all people are different"

"Yes. Surely it's the best way to know what care to give. I think that the patient should not only be told when something is going to happen but why as well. The only problem is that patients may not want to be hard (honest!?) on the nurse giving the care"

Centre 8

"It seems a reasonable thing to try and do but very open to bias"

"Yes, because it may pinpoint areas of care which you might not otherwise be aware of"

"Yes. It could expose problems or worries that had not been recognised before"

"Yes, sometimes things do not appear as they are meant. It is important to learn which methods are most successful"

"Yes - I think it's important that nurses should know which points are the most important to the patient"

"Yes. I agree. It would be interesting to find out the patient's nursing care assessment, if any improvements can be made in the nursing care of the patients"

One said "no"

Three said "yes"

2. Do you agree that nurses should be asked to assess the care they give to patients?

Comments:

Centre 1

"Yes, but I feel that you cannot be generous in praise even if necessary because you are biased and many of the questions seemed unfair"

"Yes. Nurses know what sort of care should be given. Assessing themselves may remind them what they havn't done and make sure they are better next time"

"Yes! Makes them more conscious of covering all things"

"Yes, it is always useful to stand back and look at yourself and what you are doing from time to time; self criticism is a valuable exercise"

"Yes. It is important to have a critical look at the care offered in order to maintain standards"

Centre 2

"Yes - so that any mistakes in care can be noted and rectified and any problems sorted out whilst the patients are in hospital"

"Self assessment can lead to improved standards - people seldom consciously observe themselves at work"

"Yes, because it makes them more aware of the care they give and more aware of the care that is being forgotten"

Centre 3

"Yes, this should happen continuously as it helps the nurse to realise the individual needs of different patients - also to improve his/her own standards of care"

"Yes, so that they can view the care they give to patients objectively, and adjust so as to improve the quality of their care accordingly"

"Yes, because on reflection, the nurse will see how she actually

appears as a nurse to others, and may detect any faults she has. On detection she may be able to correct these faults and therefore give her patients a better standard of nursing care"

Centre 5

"Yes, self assessment can't do nurses any harm and might do some good"

"Agree"

"No, because any competent nurse is doing this every day she works"

"I think we assess the care of babies all the time"

"I agree that nurses should be assessed only by professional people who know about neonatal nursing"

Centre 6

"Yes, as it makes them more aware of their effect on the patients"

"Yes, because it makes them think more about what they are doing"

"Again I think it is good for nursing care to be assessed by the nurse, because it makes her think about the care she is giving - the reasons why and how it can be improved"

"Yes, it makes them think about the care they give to patients"

Centre 7

"Yes, to reflect on the care you are giving for self-appraisal"

"Yes, definitely"

"Yes as it would make them AWARE of their care as opposed to routine care which may not be applicable"

"Nurses should be continually assessing the care they give to individuals"

Centre 8

"I think it is something nurses do all the time - and usually feel that nursing care could always be better. Lack of time and staff are great curtailers of good nursing care"

"Yes, it helps them to give a better standard of care and is useful when teaching junior members of staff"

"Yes, self evaluation is often useful to determine a nurse's attitude towards the care she gives"

"No - I think it is extremely difficult to assess yourself"

Five said "yes"

One said"no"

3. Do you agree that during a patient - nurse assessment an independent nurse teacher assessor should be present?

Comments:

Centre 1

"Yes, but maybe only for periods during the assessment"

"It can make it difficult to behave naturally. The patient must be friendly and easy to teach"

"Yes! Third person evaluation of the situation as an 'outsider' often presents a different point of view"

"Yes, as well as a friendly manner, one needs to be accurate in ones advice"

"Yes, in order to give support to both parties"

Centre 2

"No, because you are conscious that someone is watching you so you can't be more relaxed"

"Sometimes, mostly yes. A third person present as an observer creates an artificial situation and lessens the direct interaction between nurse and patient. On the other hand, only an outside observer can give an objective opinion on care given"

"Yes, because they can see independently where care is being neglected and can advise the nurse on what they are neglecting to do"

Centre 3

"The assessor/independent nurse should be aware of the patient's needs both psychologically and physically and ideally have nursed the patient. On this, fair assessment can be made. If the assessor/independent nurse is unaware of the patient's individual 'needs' then only a textbook assessment of the care given can be made"

"Yes, though an 'assessed situation' is always slightly false"

"Yes. In some cases a nurse assessor should be present because some nurses will be more aware of their performance, but others may find that having another person present may make them nervous or shy, when normally they are not. Therefore it is not always possible to have an accurate assessment in this situation"

Centre 5

"Yes - as long as the staffing levels can cope"

"I agree - self-assessment encourages a biased opinion"

"No, because it makes both the parent and nurse feel very self conscious. Watching discreetly from time to time would be preferable to continued observation"

"Yes. I do not think that a nurse can assess herself fairly"

Centre 6

"Yes, because the nurse is probably going to have a biased opinion of herself. The patient may misinterpret what the nurse is doing for her. Elderly patients may not fully understand the questions, or what is expected of them"

"Yes, because nurses tend to be biased about themselves"

Centre 7

"It may be necessary sometimes because of conflict of personalities"

"Yes - but depending upon the reason for the assessment - bit inpractical if on a large scale"

"Would depend on the patient and nurse - possibly an independent nurse is better able to assess the situation as viewed from the outside in"

Centre 8

"I think the best people to assess a nurse's work are those who work with him/her all the time. Ask their colleagues"

"Not necessarily. Especially if the nurse and patient are assessing each other"

"I am not sure that she needs to be present but it should be an independent nurse who talks to the patient in the first instance"

"No, because the presence of an assessor is bound to alter the nurse/patient situation from normal"

"Yes. There may be several points raised by the patient regarding the nursing care given to him which are not on the assessment form"

Six said "yes"

Two said "no"

4. Did you feel able to assess nursing care under the categories that were given?

Comments:

Centre 1

"Not all are applicable but they do give a good broad outline"

Centre 2

"Yes. No 'mass produced' questionnaire such as this one can ever meet every nursing situation"

Centre 3

"Yes. I felt the assessment form puts more emphasis on communication with the patient than any other form I have seen, thus encouraging the nurse to treat the patient as an individual"

Centre 5

"No. Many of the categories are very ambiguous and seemed hardly relevant"

Centre 6

"Yes, but the questions would have to be adapted to fit different wards"

Centre 7

"Yes. Care given, for example, explanation of patient's condition etc. could not be included. Previous knowledge of patient influenced care given. Perhaps this could be avoided if the nurse had not seen the patient before"?

"Yes. The categories are very basic and involve physical care of the patient. I think psychological care particularly with this patient is very important and understanding required"

Centre 8

"Yes, but not all are applicable to all situations"

Twenty two said "yes"

Three said "no"

5. Are there any other categories of nursing care that you consider should have been included?

Centre 1

"Not in this situation. Possibly should cover areas pertaining to home circumstances and family situations"

"Ability to adapt to different sorts of patients"

Centre 3

"The form is too generalised, perhaps forms can be produced according to the particular procedure being assessed. However, the form as it is can produce discussion between the nurse and

assessor on points of nursing care which can be clarified under the different aspects raised on the assessment form"

"The inclusion of relatives and social circumstances"

Centre 6

"Possibly more questions for rehabilitation"

Centre 7

"Was patient's comfort included"?

"Psychological/social status/family"

"Relevant past medical history - knowledge of"

Centre 8

"Home and family"

"Teaching other nurses to give his care"

"The individual needs of the patient"

Eight said "no"

Sixteen did not answer the question

6. Do you consider that the nursing care you gave was affected by you being assessed by a patient?

Comments:

Centre 1

"Yes, in some ways I felt more nervous than in an ordinary nurse/patient relationship"

"The patient I nursed was very easy to teach and responded well to help. With a difficult patient communications may have been broken down under close supervision"

"Not very much, though in part this is inevitable"

"No, I would have probably been more relaxed without her presence but the actual content of the interview would have been no different"

"Slightly nervous"

"Yes, greater awareness of the need for each action"

Centre 2

"I think it is inevitable that all the people involved would be affected by the knowledge of the assessment (i.e. nurse, patient and assessor)"

"Yes, because I had more time for the patient and her individual needs and was able to listen more intently to her worries and problems"

Centre 3

"Yes. Being assessed in any way is an anxiety producing situation no matter how competent the individual nurse is"

"Yes, because it was an assessment situation, and no because I usually aim to treat patients in the way in which I would wish to be treated myself"

Centre 5

"No - I have nursed babies with their mothers present before. This felt no different"

"It should not be so. As a nurse, I shall do my very best to help my patient. It is not affected by any assessment"

Centre 6

"No. The fact that I was being assessed on this occasion did not affect the care given"

"No, the care I gave was very basic and necessary"

Centre 7

"I don't think so, but I do tend to be nervous when watched"

"No, my care during that time was as always. With that particular patient I think the patient was initially slightly nervous but relaxed when things were being done as per normal shift"

"No. I did what I would have done under the same circumstances at any other time"

Centre 8

"No. Patient care should not differ whether you are being assessed or not"

"No, I expected it to but it did not"

"No. I felt confident in that I have had experience in most fields of nursing and in general most patients assess individual nurses"

One said "yes"

Twelve said "no"

7. Any other comments:

Centre 1

"The patient assessing must be chosen carefully"

"The patient may feel he/she cannot be totally honest - especially if he/she is an in-patient and will continue to be so after the assessment"

Centre 2

"This study is limited by taking place over a relatively short period of time - patient care is generally more intermittent and over a longer period of time (e.g. weeks)"

Centre 3

"This continues the crusade to make a nurse patient orientated rather than task orientated. I have only been able to make brief comments on this form. Each point raised could produce a lengthy discussion"

Centre 5

"Though the idea behind this assessment has been explained to me, I still feel its value is doubtful. The actual nursing care

has already been assessed previously on my course and I feel the assessment dropped to allow this one to be done was far more relevant and important. It seems grossly unfair to ask parents of ill babies to assess their care, and as each parents' standards must vary, it is almost impossible to decide on an average. My own feelings were that neither I nor the mother assessing me really gained anything by it, and it seemed a total waste of time"

"In a situation such as a special care unit I don't think it's fair to ask a parent to assess a nurse looking after their baby"

Centre 6

"No. I misread question 6 and the comment I crossed out (naturally I was aware of being watched but trust the nursing care that I gave was the same as usual) was meant to be in reply to the affect of being assessed by an independent assessor"

Six said "none"

Twenty did not answer the question

APPENDIX 18

ASSESSMENT EVALUATION BY NURSE TEACHER

1. Do you agree that patients should be asked to assess the nursing care they receive?

Comments:

Centre 1

"Yes, it is a good idea and enables the nurse to evaluate the care she gives. Perhaps all nurses should do this occasionally, not just course members. However, it should not take precedence over her work"

Centre 2

"Yes"

Centre 5

"No. Some parents obviously find it difficult to assess nursing care as they feel so involved and also appreciative of the nurse's effort. They are often accompanied by their other small children which adds difficulties"

Centre 6

"Yes, but I can also see problems arising from this particularly when a patient has been nursed on a general ward and then transferred to a rehabilitation ward where withdrawal of care is very much part of the programme"

Centre 7

"Most certainly. I also believe that patients should be asked to participate in planning their own care. Obviously, this would only be if patients wanted to assess care - but many of them do it anyway without realising it. But with formal assessing it must be with their consent"

Centre 8

"Yes. But not on a one-to-one basis - patients who have known nurses a long time or not very long can make allowances"

2. Do you agree that nurses should be asked to assess the care they give to patients?

Comments:

Centre 1

"Yes. This is a valuable exercise and again all nurses should do this, not just course members"

Centre 2

"Yes"

Centre 5

"Yes. Some degree of self assessment should be undertaken when working in a constantly changing specialty"

Centre 6

"Yes. I am very much in favour of this as nurses will need to stand back and look at the care they have given and hopefully learn from self appraisal"

Centre 7

"Most certainly. This would always happen if nurses were encouraged to evaluate their nursing care, as with the nursing process"

Centre 8

"Yes. This is a valuable idea. They should also know what patients - in general think of the nursing"

3. Do you agree that during a patient - nurse assessment an independent nurse teacher assessor should be present?

Comments:

Centre 1

"Yes, it may be off putting but when a nurse is learning it is essential - if for instance the patient was hypocritical the independent nurse assessor can put this into proportion for the course member. If trained staff are being assessed I think the independent nurse assessor is not necessary"

Centre 2

"Yes"

Centre 5

"Yes. This is fair to both parent and nurse"

Centre 6

"I feel that if the nurse's attitudes are right, it does not matter to her who looks on at the care she is delivering"

Centre 7

"Yes. It would tend to even things out and stop disputes. If the patient does a more favourable assessment than the independent assessor though, who would be right? It has to be the patient perhaps as they are on the receiving end but would that apply if it was unfavourable"?

Centre 8

"It does not appear to have been necessary and in fact may adversely affect the interaction of patient and nurse. The independent nurse is really only needed to explain the assessment and help with any queries"

4. Did you feel able to assess nursing care under the categories that were given?

Comments:

Centre 1

"Yes"

Centre 2

"Yes. The categories are based on attitudes rather than specific skills. We observe interaction between patient and nurse"

Centre 5

"Yes"

Centre 6

"I am not quite sure why the dressing technique was picked out. I felt No. 13 could be used to apply to any special nursing care being given to a patient"

Centre 7

"Yes. Most of them were applicable most of the time"

Centre 8

"Yes. In a ward situation, some of the items were always non-applicable i.e. introductions as patients and nurses get to know each other very quickly"

5. Are there any other categories of nursing care that you consider should have been included?

Centre 1

"No"

Centre 2

Did not answer the question

Centre 5

"No"

Centre 6

"As this centre was asked to exclude patients in group 1 and 5, patients used were all rehabilitation patients so probably more specific statements relating to that care would make it easier for the patient to assess -

statement pertaining to mobility or exercises

statement pertaining to diversional therapy

statement pertaining to dressing practices"

Centre 7

"As an independent assessor no, but I think patients could have"

Centre 8

"Tact - not what the nurse does so much as how she/he does or says it. Relatives - very important to a patient's peace of mind"

6. Do you consider that the nursing care given was affected by your presence as an independent nurse teacher assessor?

Comments:

Centre 1

"To some extent"

Centre 2

"No"

Centre 5

"No"

Centre 6

"Not in these cases as I have established a good relationship with the nurses"

Centre 7

"No. Mainly because all the nurses know me and are used to working with me"

Centre 8

"Sometimes - nurses and even patients seemed to 'act up' to my presence on occasions"

7. How long have you known the nurse learner?

Centre 1

All nurse learners were known for approximately two months

Centre 2

All nurse learners were known for approximately one year

Centre 5

All nurse learners were known for approximately fourteen weeks

Centre 6

All nurse learners were known for approximately five months

Centre 7

All nurse learners were known for approximately five months

Centre 8

All nurse learners were known for approximately one month

8. Any other comments:

Centre 1

"The assessments went well, but on an 'outpatient' course it does take a long time (average about an hour) in a three hour clinic which means patients may become anxious to get away (to work, children at home, a further appointment etc.) and also the nurse misses other experience she could have gained by seeing other patients in this time. Two or three of these nurses may need an extra practical session as a result of this. However, it has been a valuable experience for them.

The assessments improved as I went along and I think that this was due to the course members having reached a later stage in the course and to my greater confidence as I did them.

A disadvantage of doing these assessments was that I had to arrive at the beginning of clinics in order to find a suitable patient, and therefore left before the end of the clinic (twice in order to arrive at the beginning of my next course member's clinic) and so my usual 'counselling' after the clinic was cut short as I was anxious for the course member to have as much experience with patients as possible"

Centre 2

Did not answer the question

Centre 5

Did not answer the question

Centre 6

"With the four patients chosen, I had to explain to them what 'assessment of nursing care' or 'assess' meant. Although I explained and they said they understood, I am not quite sure if they really did"

Centre 7

"The whole venture turned out to be much easier and more enjoyable

than I had first anticipated. The patients seemed glad to be asked their opinion"

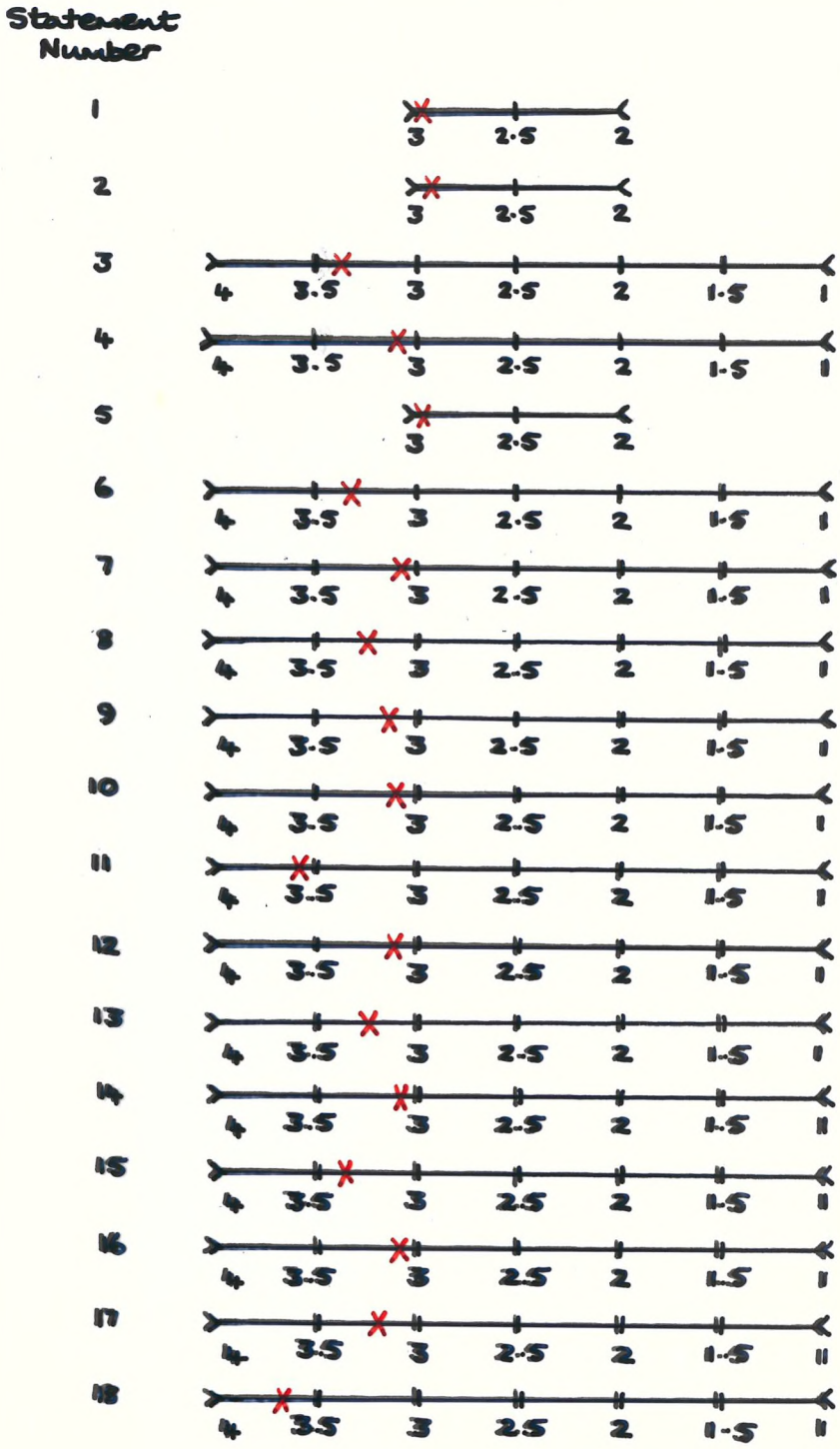
Centre 8

"I think the nurses and patients in a ward situation are frightened and threatened by a one-to-one assessment. I received the impression that it would be easier for them to assess their care on a less personal level. They appreciated the initial anonimity, but this became less important as the assessment progressed; they found it difficult not to discuss, nurses and patients, what was going on. The evaluation sheets show, sometimes, a truer picture of the people involved than the ticks and crosses"

APPENDIX 19

SAMPLE QUESTIONNAIRE SCORE PROFILE FOR CENTRE ONE

Original statement numbers 1 to 17 and 20 are used and re-numbered 1 to 18. The overall centre mean is used and marked with a cross on the grade scale for each statement



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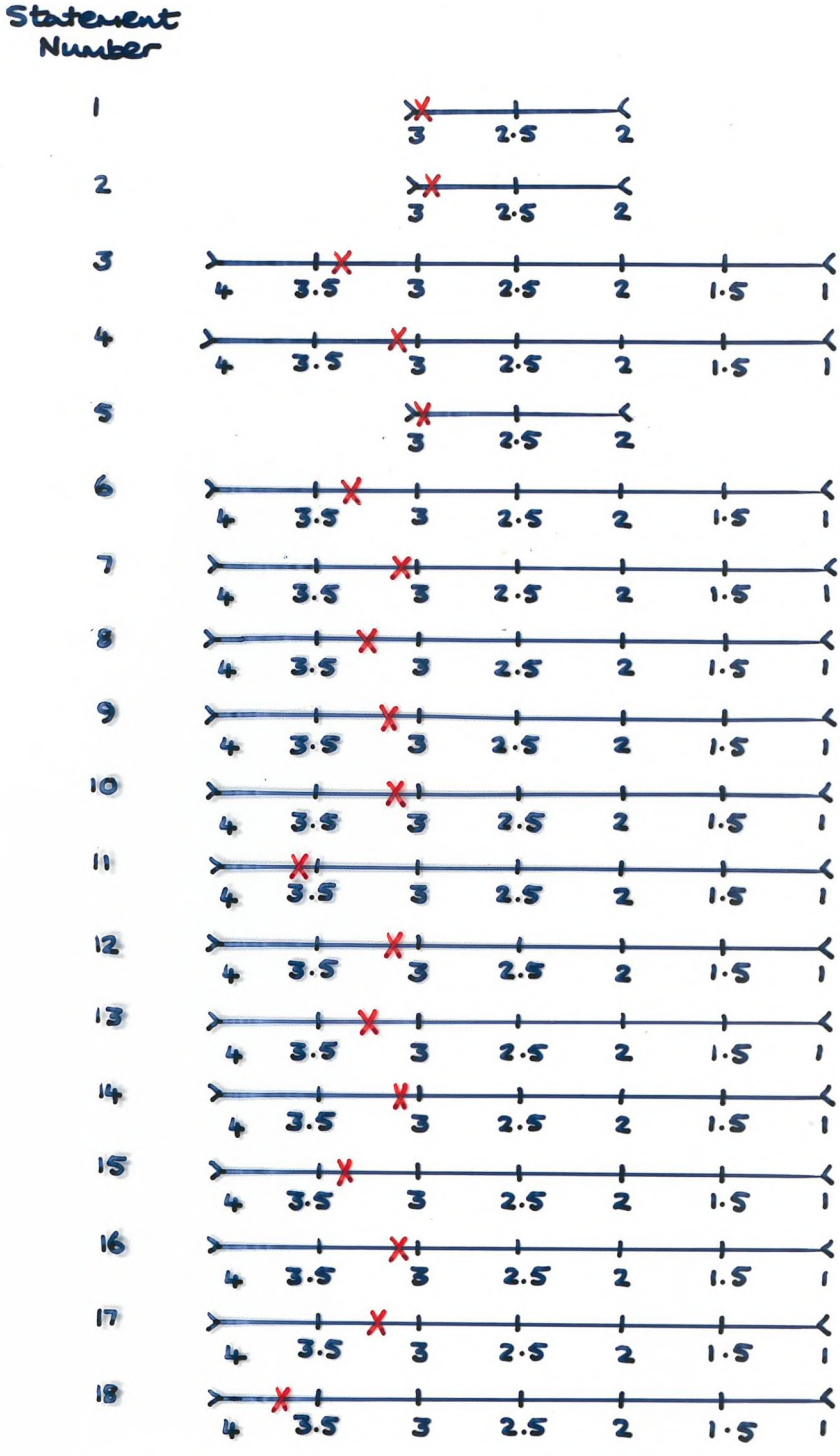

NURSES' PERSONAL SCORE PROFILE