

Mind Shift: Creating Change Through Narrative Learning Cycles

A qualitative interpretive study of
clinical conversation as an appraisal process for
sexual and reproductive health nurses

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: _____

Dated: _____

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ABSTRACT

This thesis explores the process of an annual appraisal strategy, 'clinical conversation', from the perspective of seven nurses who were assessed using this technique. The findings demonstrate that clinical conversation is a strategy which facilitates reflection, both as a solitary exercise and with others, to ensure that learning from experience is optimized.

The research used a qualitative interpretive approach informed by the model of Grounded Theory espoused by Strauss and Corbin. All eight nurses who were assessed using the clinical conversation strategy were advanced practitioners working within the scope of sexual and reproductive health. Two of the actual appraisals were observed and seven of the nurses were interviewed within eight weeks of being assessed.

The outcome of the clinical conversation was primarily one of learning; the acquisition of new insights into self as practitioner. The learning was facilitated through the process of narration; telling the story of clinical practice. Three distinct narrative cycles were identified, each an experiential learning episode. The experience of undertaking a variety of assessment activities created a narrative with self and triggered an internal reflective thinking process; the experience of working with a peer created an additional narrative, a mutual dialogue reflecting back on practice; the experience of sharing practice with an assessor created a further and final narrative, a learning conversation. Each narrative can be seen as a catalyst for change. Primarily, the nurses felt differently about themselves in practice, the way they saw themselves had shifted. Such a change can be described as an alteration in perspective. These alterations in perspective led all nurses to identify ways in which they would change their actual clinical practice. In this way the nurses attempted to align their espoused beliefs about practice with their actual practice.

My study shows that each nurse responded differently to each narrative learning cycle: for some the conversation with the assessor was more of a catalyst for change than for others. In this way clinical conversation may be flexible enough to respond to a variety of differing learning styles. Learning was person specific which is an imperative for the continued professional development of already highly skilled clinicians.

The implication of the research is that whilst clinical conversation was designed as a tool for appraising clinical competence, its intrinsic value lies in supporting the professional development of nurses.

PREFACE

A Rationale For The Format Of This Thesis

Over the past six years I have been involved in the training and assessment of primary health care nurses working in the field of sexual and reproductive health. One of my responsibilities within the Family Planning Association of New Zealand (FPA) was the reorientation of a traditionally skills-based training programme in contraception and sexual health into a New Zealand Qualifications Authority (NZQA) competency based national certificate course. It was during this project that I first became intrigued by the complex debates concerning competency based assessment. Straight away I could see the benefits to nurses, within FPA, of using these assessment strategies to move away from the theoretical examination approach which had limited resonance with clinical practice. As I learnt more about this form of assessment not only was I able to introduce it into the training programmes that FPA offered primary health care workers but I was also able to utilise such methods of assessment within the clinical pathway of FPA nurses.

Competency based assessment can operate at a variety of levels as will be discussed later in the background chapter of this thesis. The most integrated of these levels involves a technique called 'professional conversation' where an array of pertinent evidence of work practice is shared with an assessor (Bowen-Clewley, 1998). In addition the assessor seeks verification from a range of colleagues. This approach has been used within a number of public sector organisations such as the Police and other state services. Professional conversation as an assessment strategy particularly interested me and I wondered what its relevance to nursing practice might be.

Initially I introduced a case study assessment approach for new nurses within FPA. Here they shared consultations with two assessors and answered specific questions pertaining to clinical competence. Whilst this went some way towards

integrated assessment it did not fully meet the requirements of professional conversation. When FPA needed to change their annual appraisal process to align itself with the New Zealand Nursing Council requirements for accreditation I saw an opportunity to mirror professional conversation in a clinical context and so this piece of research came into being. I designed an appraisal format called 'clinical conversation' the root of which lay in the concept of 'professional conversation'.

In order to situate my research the background chapter of this thesis includes a brief history of competency based education both internationally and in New Zealand. The broad principles of assessment are outlined as a way of introducing the more specific form of assessment inherent in clinical conversation. The role of competency based assessment is discussed within the New Zealand nursing context, specifically, in relation to the requirement by the Nursing Council for annual accreditation against a set of predetermined competency statements. This requirement has left nurses who work for small, non District Health Board providers with a challenge; how to meet the needs of both the Nursing Council and their own organisation in terms of an annual appraisal process. Here, clinical conversation is offered as a possible strategy to address this issue. The background chapter continues by discussing 'professional conversation': its origins and principles. The design and development of 'clinical conversation' is explained. To complete the introduction to my thesis I critique the 'clinical conversation' approach in light of assessment design and decision making issues.

Whilst much can be inferred about clinical conversation as an assessment strategy little is known about what the process is like for those being assessed using this technique. In an attempt to determine the process, from the perspective of those being assessed, I undertook the qualitative interpretive study reported in this thesis.

For this study eight advanced FPA nurses were appraised using the clinical conversation assessment technique. I observed two of the conversations and interviewed seven nurses approximately two weeks after they had had their appraisals. From my initial interpretation of the data it seemed that the process of

clinical conversation was both reflective and supervisory in nature and that the role of the assessor appeared pivotal. The process seemed to facilitate change in some way. I sought the literature pertaining to nursing supervision and the use of reflection within supervision. This introduced new concepts with which to challenge the data. These included the specific role of reflection within the process, the nature of the change or learning that took place and the outcomes of 'clinical conversation' in terms of personal development, professional practice and support.

Following the literature review I returned to the data again and again as the process of abstract conceptualisation developed. I finally concluded that, from the point of view of the nurses being assessed, the core process involved in 'clinical conversation' was in fact one of perspective alteration due to reflecting back on practice. Change occurred during three distinct yet interlinked dialogues which I have called narrative learning cycles: the narrative discussion with self which was triggered by undertaking the assessment activities; the discussion with a peer during the chart audit and clinical observation; and finally, through the discussion with the assessor where clinical experience was further narrated and shared.

Having unravelled the process of clinical conversation from the nurses' perspective as I saw it, I returned to the literature to situate it within the theoretical framework of learning in an attempt to add greater clarity and substance to my findings. Theories of learning are many and varied, yet in line with my personal constructionist approach to knowledge acquisition I felt 'clinical conversation' fitted within the fields of experiential and reflective learning. The discussion chapter explores the relationship between these paradigms and establishes the way clinical conversation is positioned within them. It concludes by exploring each narrative learning cycle further and suggests how each facilitates learning.

To summarise, Chapter 1 provides the context for this thesis in terms of situating clinical conversation within a competency based assessment framework. Chapter 2 focuses on the literature pertaining to clinical supervision and its reflective practice component which initially seemed to relate to the process of clinical

conversation more closely than any other. Chapter 3 discusses the qualitative interpretive methodology and methods used to conduct this research. Chapter 4 describes and interprets the results of the data analysis. Chapter 5 discusses my research findings within the context of learning theories, specifically experiential and reflective learning. Chapter 6 concludes the thesis.

CHAPTER 1: BACKGROUND

Competency Based Education

Origins

Competency based education has its origins in teacher training in America. In the early 1960's many student teachers felt disillusioned with what they were being taught and consequently were exiting the educational institutions prior to completing their qualification (Harris, Guthrie, Hobart, & Lundberg, 1995). This teaching crisis created both the political and economic demand that drove the development of a competency based training programme for primary school teachers. The programme was required to not only detail the precise specifications of competences or behaviours to be learned but also the modularization of instruction, the mechanisms of evaluation and feedback and the aims and objectives of field experience (Burke, 1989). Such requirements provided a framework for the emerging notion of competency based education. This was further reinforced in the 1970s and 1980s by the demands of industry which requested the training of a skilled, adaptable workforce to meet the challenge of globally integrated markets (Usher & Edwards, 1994). Governments throughout the world supported such moves as they believed they would ensure an education system that was directly related to workforce requirements, which in turn would lead to economic growth and financial security (Grundy, 2001).

Fundamental Principles

Competency based education has been described in many ways. It can be seen as a process that changes the focus of education from what academics believe graduates need to know (teacher-focused), to what students actually need both to know and to be able to do in varying and complex situations (student and/or workplace focused) (Gonczi, Hager & Athanasou, 1993). However, it can also be considered an instrument of government and industry to promote economic viability rather than a mechanism to meet students' needs pertaining to knowledge and learning (Chapman, 1999). Many purists feel that higher education should be

about excellence and not just competence (Hyland, 1994).

In general terms, competency based education focuses on outcomes or competencies that are linked to workforce needs as decided by the employers and the professionals within the specialized field. Tuxworth's (1989) understanding of competency specifications can be summarized as follows:

- Competencies are based on an analysis of the professional role(s) and/or a theoretical formulation of professional responsibilities.
- Competency statements describe outcomes expected from the performance of professionally related functions or those knowledge, skills and attitudes thought to be essential to the performance of those functions.
- Competency statements facilitate criterion referenced assessment.
- Competences are treated as tentative predictors of professional effectiveness and are subjected to continual validation procedures.
- Learners completing competency based education programmes demonstrate a wide range of competency profiles.

In other words, competency statements define the knowledge, skills and attitudes that learners should exhibit to become proficient within the context of their chosen field of practice.

Competency Based Education In New Zealand

Competency based learning has been predominant in the New Zealand education system since the late 1980s. The New Zealand Qualifications Authority (NZQA), which emerged out of the old Education Department, has developed an eight-level National Qualifications Framework (NQF). It is one of the most comprehensive frameworks in the world. Not only does it cover secondary schools, it also covers post-compulsory learning including both academic and vocational training.

Some universities have resisted the attempt to be included on the NQF; their concerns are both pedagogical and administrative (Tuck & Peddie, 1995). Issues raised include the cost of developing, updating and moderating thousands of

standards plus the very real question of how to ensure standards are consistent across a variety of providers. The emphasis on performance and product, fundamental to competency based education, is incongruent with many tertiary institutions' concepts of knowledge, wisdom, understanding and excellence. Additional issues include the concern that competency based qualifications focus so precisely on individual units of learning that they fail to see the significance of the whole in terms of purpose, composition and the overall coherence of a qualification (Harris et al, 1995). Implicit within such reticence is the belief that competency based qualifications wholly dictate curriculum as their detailed descriptive nature can strongly influence content. This can lead to a reductionist, behaviourist approach which can downgrade the value of education (Jones, 1999). Taken one step further the prescriptive nature of competency statements allows students and teachers to predict what is to be assessed; this in turn can have the consequence of further narrowing the curriculum to only that which will be assessed (William, 2001). Critics believe that in this way a spiraling down of holistic education ensues (Hyland, 1994; Usher & Edwards, 1994).

Proponents of competency based education see it as an attempt to upgrade the skills of students to a national standard (Peddie, 1992). It is this strong desire that has driven the increase in competency based education programmes within New Zealand. Education and training are no longer the preserve of tertiary institutions; a range of new providers, in the shape of Industrial Training Organisations (ITO), have emerged within the market place (Bowen-Clewley, 2000). ITOs design and manage the unit standards and qualifications relevant to their profession and liaise closely with Private Training Establishments (PTE) who provide the training. NZQA has an overall quality assurance role to ensure standards are being maintained across and between sectors.

Competency Based Assessment

Educational assessment is used for a variety of reasons: to determine aptitude for a specific job; to establish ongoing educational or training needs; to assist and support learning; to illustrate whether an individual has met the learning outcomes of a particular programme; to assess prior learning and finally, to assess people in the workforce to ensure ongoing competence (performance appraisal). It is recognised that in an ever changing world competence is not static but can in fact “decay” (Harris et al, 1995, p.170). People’s inability to perform in accordance with the latest research can erode competence. In light of this New Zealand has legislated to ensure that all health professionals are assessed on an annual basis. This emphasises the importance of ongoing professional development to maintain currency and provides reassurance to the public that once qualified professions will be monitored to ensure their practice remains up to date.

Although assessment can have many purposes the underlying assumption in all educational assessment is that the individual to be assessed will have a “well defined amount of knowledge, expertise and ability and the purpose of the assessment task is to elicit evidence regarding the amount of knowledge, expertise or ability” (Wiley & Haertel, 1996, p.66).

Once this evidence is collected it is interpreted and inference is used about the overall capabilities of the individual. Such a belief fits within the positivist paradigm where knowledge is seen as objective, measurable and reliable (Okasha, 2002).

There are two significant types of referencing that underpin most assessment principles; these are norm referencing and criterion referencing. Each will be discussed briefly.

Norm Referenced Assessment

Norm referenced assessment uses techniques such as multi-choice questionnaires and written examinations which primarily focus on what a student knows, rather

than the application of knowledge. Norm referencing allows an individual to be ranked against a group of other individuals, however the basis for the rank ordering is not always clear (Hill & Parry, 1994). What is clear is that such testing often requires only a certain percentage of people to pass; this can be a disincentive for those who receive low marks and who may consequently perceive themselves as academic failures. Such a result can negatively affect the chances of long life learning and can be viewed as detrimental not only for the individual but also for society where continuing skill development across the population is seen as economically advantageous (Capper, 2000).

The techniques used within norm referenced assessment assess a small part of the overall learning that has taken place within any given educational programme. Elwood (2001) suggests as little as ten percent of learning is actually assessed using such a system. These results are then taken and statistical inference is used to determine overall achievement. Experts continue to argue about the extent to which statistical inference correlates with broader measures of achievement (Elwood, 2001; Eraut & Cole, 1993; Gonzci, 2000; Harris et al, 1995). Few would agree that such inference can predict how knowledge and skills would be applied in a new situation or adapted to an unpredictable situation.

Norm referenced tests have been criticised for negatively impacting on learning as both students and teachers concentrate on what is likely to be in the assessment rather than aim for a broader approach to learning. It was this limitation that created, in part, the interest in criterion reference assessment. Ironically the same criticism is now being applied to criterion reference assessment strategies which have been accused of narrowing learning by dictating curriculum. Eraut and Cole (1993) observe that assessment, whether norm referenced or otherwise, diverts students and teachers from the process of teaching and learning.

Criterion Referenced Assessment

Criterion referenced assessment aligns itself with the principles of competency based education as individuals are assessed against a transparent standard rather

than against another individual or less specific criteria. It must be noted that the standard has, however, been through a norm referencing type of process during its development (Peddie, 1992). A wide group of stake holders will have been consulted prior to agreeing on the content and context of the standard.

Assessment within such a competency based framework then, is the process of judging competence against pre-established performance standards written as competency statements (Gonczi, 1993). As Wolf states:

The crucial idea underpinning criterion referenced assessment is that one should look at the substance of what someone can do, in effect, compare a candidate's performance with some independent, free-standing definition of what should be achieved, and report on the performance in relation to this criterion (1995, p.5).

Criterion based assessment attempts to define more clearly than norm referenced assessment exactly what the learner is being asked to achieve: to spell out the objectives or outcomes as clearly as possible. To ensure that criterion based assessment is more than just behavioural observation, standards must be written to include not only knowledge and skill but also values and attitudes within a contextual framework. As competency standards themselves are individualised and detailed to make them relevant and situation specific, so too are the criterion based assessment techniques used to assess them (Gonczi, 1993). No longer is assessment concerned primarily with written examination but employs such techniques as direct observation, role play, individual presentations, oral questioning, multiple choice tests, short and long written answers/examinations, reflective logs/journals, diaries and essays (Thomson, 1995). It is the mix of techniques that, taken as a whole, can offer insight into not only observed skill but also the knowledge base, attitudes and values of the person being assessed.

Assessment then, in a competency based system, is the process of collecting evidence and making judgements on the nature and extent of progress towards the learning outcomes captured within the competency statement (Rumsey, 1994). Bowen Clewley (2000) has described three models of competency based

assessment. The behaviourist model focuses on what the assessor can actually see occurring in the workplace or simulated environment. This approach is time consuming, often relies on a reductionist, checklist approach to assessment and seldom relies on inference. The integrated assessment model identifies underpinning knowledge, skills and attitudes across a range of standards and infers competence. The collection of evidence model takes this one step further. It enables the candidate to take a lead role in the assessment process by gathering authenticated evidence which they believe pertains to the standard(s), discussing the evidence with an assessor and seeking verification from a range of people. The assessment technique 'clinical conversation' falls into the collection of evidence model and will be discussed in more detail later. Firstly, I need to return to competency based education within the New Zealand nursing context to illustrate in what way the need for such a process as 'clinical conversation' arose.

Competency Based Education In Nursing

Origins

Nursing education in New Zealand did not escape the ramifications of the competency based approach to generic education. Traditionally nurses were trained in training hospitals and had to pass the State Examination for registration as a nurse. As early as 1971 the Carpenter report considered the prospect of both polytechnic and university education for nurses but it was not until the Nurses Amendment Act of 1990 that experimental nursing programmes in tertiary institutions became legally possible. The Education Amendment Act that same year allowed polytechnics to start preparing degree programmes for nurses (Williams, 1992). In 2007 there are now seventeen undergraduate nursing programmes and four Master of Nursing programmes available throughout New Zealand. Whilst these programmes sit outside the National Qualifications Framework, the individual papers of which they are comprised belie the concept of competency based education. Learning objectives and outcomes are clearly stated in a precise and prescriptive manner. Overall the goal of such programmes is the acquisition of a specified knowledge base, assimilation of clinical information

and the necessary skills to provide competent nursing care (Bechtel, Davidhizar & Bradshaw, 1999).

Initially competency based education within nursing was welcomed as it was believed it would enable the profession to be better articulated and therefore understood. It was hoped that this in turn would not only allow for self evaluation to take place but also increase accountability to a range of stakeholders (Sutton & Arbon, 1994). Many feel that these high expectations have not come to fruition and that the use of standards has fragmented nursing into a series of tasks rather than a sophisticated relationship with individuals, groups and communities (Watkins, 2000).

Dreyfus and Dreyfus (1982) consider competence to be based on intuition and tacit knowledge, neither of which is susceptible to objective methods of testing. Likewise, Chapman (1999) blames competency based education for denying the art of nursing, in particular the humanistic and psychosocial aspects of nursing care. Whilst these criticisms may have some validity it does not mean that assessors cannot work with these types of knowing, within these different dimensions of nursing. The assessor is often an expert in the field when assessing empirical/analytical or technical knowledge. When discussing meaning they become the partner in the process and when exploring critique they become the listener and learner and the nurse becomes the one in control (Lovat, 2004). Such an approach could significantly change the power imbalance that currently exists within most assessment frameworks (Massey & Osbourne, 2004). A fascinating piece of research would be to identify the way clinical conversation assessors utilise these potential roles.

From an educational perspective concern has been expressed regarding the disparity between the philosophy of adult education and that of competency based education. Adult education has been perceived as that involving self directed learning and discovery. This seems in direct conflict with competences which are prescriptive in nature (Bradshaw, 2000; Knowles, 1984). The results of this study may shed light on whether self assessment against broad ranging competencies

can start the process of self-directed learning by highlighting areas for change.

Registration And Annual Accreditation Of Nursing Practice

In the United Kingdom (UK) competency statements not only reflect the outcomes of pre-registration nurse training programmes but also the requirements of entry onto the nursing register (Grundy, 2001). In the UK registration competencies fall under the four categories: professional/ethical issues; care delivery; care management and personal/professional development (UKCC, 1999c).

In New Zealand this has been taken one step further with the introduction of the Health Practitioners Competence Assurance Act 2003. All health professionals are now required to state competence to practice on an annual basis to remain on the register. The main purpose of the Act is to protect the health and safety of members of the public by ensuring that health practitioners are competent and fit to practice their professions. To this end each health discipline has attempted to establish mechanisms to measure ongoing competence.

Nursing Council Competencies

In the light of the Health Practitioner Competence Assurance Act the Nursing Council of New Zealand has now become the regulatory body for post registration maintenance of competency (Nursing Council of New Zealand, 2001a). To meet this challenge they have, after considerable consultation with the profession and other stakeholders, developed the process of competency based practicing certificates which incorporate standards pertaining to clinical competence, cultural competence and ethical conduct (Nursing Council of New Zealand, 2001b). Together these define the scope of practice for each level of registration. Nurses are required to show evidence of continuing competence on an annual basis. As Bowen-Clewley (1998) suggested, the acquisition of a qualification is no longer enough to infer ongoing competence; other processes by professional bodies have been put in place to assure this. With the advent of competency based education in nursing the concept of competence is not new to the profession but its use as an indicator of fitness for ongoing registration is. This begs the question: how is

competence going to be assessed on an annual basis?

The Nursing Council has established four domains of competence for the registered nurse scope of practice (Nursing Council of New Zealand, 2005). The domains are:

- professional responsibility
- management of nursing care
- interpersonal relationships
- inter-professional health care and quality management.

For each domain they have developed competency statements (Appendix A, p.167). For example, in the domain of professional responsibility the competency statements are as follows:

- 1.1 accepts responsibility for ensuring that nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements
- 1.2 demonstrates the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice
- 1.3 demonstrates accountability for directing, monitoring and evaluating care that is provided by nurse assistants, enrolled nurses or others
- 1.4 promotes an environment that enables client safety, independence, quality of life and health
- 1.5 practices nursing in a manner that the client determines as being culturally safe.

It is these competency statements against which a nurse's practice will be judged on an annual basis.

Assessing Against Nursing Council Competencies

Audit

All registered nurses are required by the Nursing Council to maintain and collate evidence of their competence to practise. When applying for an annual practising

certificate, they are asked to declare that they can meet the Council's competencies within their scope of practice, have completed sixty hours of professional development over three years, and have undertaken sixty days of practice within the last three years. Up to five percent of nurses are randomly selected for audit each year. If audited, nurses are required to provide the following evidence:

- verified practice hours: a minimum of 450 hours in the last three years
- verified professional development hours
- two verified types of assessment against all the Nursing Council competencies either by self assessment, senior nurse assessment or peer assessment.

Professional Development and Recognition Programmes

Many District Health Boards are designing professional development and recognition programmes (PDRP), which incorporate Nursing Council competencies. Once such a programme is approved by the Nursing Council, any nurse on the programme is exempt from the audit process as the Council has assurance that practice is being adequately assessed on an ongoing basis.

One of the most common assessment strategies being used within the PDRP is a professional portfolio. Professional portfolios have been defined in a number of ways, ranging from a simple tangible record of what someone has done to a dynamic record illustrating a practitioner's professional growth (Price, 1994).

Portfolios

In simple terms portfolios have been defined as "a collection of evidence, usually in written form, of both the products and processes of learning. It attests to achievement and personal and professional development, by providing critical analysis of its contents" (McMullan et al., 2003).

Such a concise definition belies the fact that portfolios come in all shapes and sizes depending on their purpose and often lack the critical element. Webb et al,

(2003) have identified four different approaches to portfolio development which they have conceptualized into the following models: “shopping trolley, toast rack, spinal column and cake mix” (p. 251). The shopping trolley format allows for inclusion of a range of written evidence gathered together in no particular order, with little structure and for no clear purpose. It is not presented in a way that links it to either learning outcomes or competencies. The toast rack portfolio contains discrete pieces of work which show little relationship to one another “there was no overarching narrative to connect the various sections, different people might participate in the assessment of the various sections and some sections might not be assessed at all” (p.252). The spinal column portfolio is structured around competency statements or learning outcomes. A piece of evidence might relate to more than one competency and likewise several pieces of evidence might relate to just one competency. The cake mix model builds on the spinal column model by truly allowing an integration of evidence to illustrate the assimilation of theory into practice and the critical thinking and reflective skills of the student: “The cake was more than the sum of its individual parts.... Reflectivity, practice and professional development were likely to be features of this model” (p.253).

However, such reflectivity, analytical and critical thinking skills are captured in written format only.

Evaluation of portfolios as an alternative form of assessment has had mixed results. The majority of research pertains to the use of portfolios in undergraduate learning rather than as a form of explicit assessment, however, research undertaken by Gallagher (2001) with pre-registration students found portfolios made a positive contribution to learning and did indeed allow for an accurate assessment of knowledge. On the whole portfolios have been found to be time consuming to construct and initially confusing (Harris, Dolan & Faribairn, 2001). With regard to reflection, a significant finding from the research suggests that academically and professionally, mature students develop through reflection and portfolio writing much more than those with less academic and professional maturity who require more specific guidelines (Scholes et al., 2004). It could be suggested that the group of academic nurses who promote the use of portfolios as

a method of assessment are themselves the ones who most confidently and appropriately use the tool to best effect.

Not only are portfolios looked at in terms of an assessment tool some research identifies the way they are used as part of an assessment process. Often the portfolio is presented at a 'tripartite meeting' which includes the nurse, assessor and mentor or clinical teacher. Such a meeting allows the nurse to demonstrate their communication, reflective and analytical skills whilst allowing the mentor to provide feedback and guidance. Within the teaching profession the use of portfolios in the assessment process is well supported. Portfolios have been defined as "scaffolding for reflective...learning (Lyons, 1998); the key ingredient is the dialogue that goes along with this process. It is the conversation that accompanies the portfolio that allows new knowledge to develop and accurate assessment to occur (Broadfoot, 1987). Within the clinical conversation format of assessment, evidence of competence is gathered together and shared with the assessor. The gathering of evidence may provide an aide to reflection and be an important part of the process; so too may the discussion with the assessor.

Initially the Nursing Council encouraged all nurses to maintain a professional portfolio and submit it as part of the audit process. The guidelines they provided suggested the format followed the 'shopping trolley' approach to the gathering of evidence. I have assumed that the Nursing Council found these portfolios difficult to assess as they are now asking for different types of evidence of ongoing competency; namely, a self assessment and an assessment by one other, both against the competency statements.

Smaller organizations, particularly those that employ a range of health professionals, often do not have professional development and recognition programmes because they are costly to establish and implement. For the nurses within these organizations the thought of being audited is an alarming process, particularly if it is on top of the need to undertake an annual appraisal to meet employer requirements. An alternative assessment method which could meet both requirements would be helpful.

Professional Conversation

Chris Devereux (1997), a UK based workplace assessor initially developed professional conversation in an attempt to find a process which could assess high level, integrated work performance. Bowen-Clewley (1998) refined the technique and used it within New Zealand, the Pacific Nations and South Africa. Professional conversation is based on the principle that assessment should be as close as possible to the outcomes one wants to assess (Wolf, 1995). The assessment method has its origins in both discourse analysis and behavioural interviewing allowing participants to demonstrate their understanding and give examples of their skills and attitudes.

The basis of the conversation centres on the evidence the participant shares with the assessor from previous or current work experience and associated learning. These experiences are assessed against competency standards or a qualification. For this process to work the participant has to understand the requirements of the standards being assessed and has to have undertaken a thorough self-assessment prior to the conversation. The self-assessment allows the participant to decide what evidence they need to present during the conversation in order to show that they can meet the requirements of the standards. Evidence can be in a variety of forms: written assignments, attestations, performance appraisals, case studies, client feedback. The assessment is in the form of a taped conversation where the participant discusses the evidence they have collated to demonstrate their competence. Documentary evidence and validation from authorised personnel must be included; in most instances the assessor speaks directly with colleagues and managers for validation. The technique of professional conversation allows participants not only to discuss what they do but also why and how they do it. The assessor makes a judgment about the evidence provided by linking it to the standards. If the evidence is sufficient the standards can be awarded; if the evidence is insufficient two outcomes may occur. Either the participant will be asked to provide additional material for assessment, or they may be asked to undertake new learning. In the professional conversation context the assessor is making a decision about whole performance within a specific scope, for example business administration. Professional conversation has been used with a

variety of public sector employees including Police, water reticulation engineers, first line managers from a variety of settings and adult education and training facilitators.

As I learnt more about this assessment process and became a registered assessor using this technique, I saw potential for its adaptation into the area of assessing nursing competence. Within the Family Planning Association of New Zealand (FPA) I had been responsible for the reorientation and refinement of the clinical training pathway for new nurses. This involved identifying learning outcomes and translating them into competency statements. Alongside this process I began to think about changing the assessment procedures, which up until that point were focused on written exams and an oral examination with a senior doctor. I introduced the concept of case study discussion based on principles similar to professional conversation where a nurse would collate evidence from a variety of consultations and discuss these with assessors. From this starting point the development of 'clinical conversation' which more closely followed the principles of 'professional conversation' seemed possible. Clinical conversation attempts to assess a range of abilities such as clinical assessment skills, attitude, critical thinking, problem solving, clinical decision-making and safe practice. In essence the whole performance of working as a family planning nurse.

Clinical Conversation As An Appraisal Strategy

In the remainder of this chapter I describe and report on the experience of developing the 'clinical conversation' appraisal format used within FPA for which I was primarily responsible. I developed the process over a period of many months. Two advanced nurses agreed to trial the appraisal and changes were made to the process following this. All parts of the procedure and all supporting documentation were finalized prior to my undertaking this piece of research. I left the Family Planning Association of New Zealand soon after completing the data collection for this study.

Development

With the introduction of competency based annual practicing certificates FPA management needed to consider how best to support their nursing staff through this process. It was decided initially that a professional development and recognition programme (PDRP) was outside the scope of the organization and that another mechanism for supporting staff should be looked at. Clinical conversation was the assessment process suggested to address this issue.

The generic competencies established by the Nursing Council were used as the basis for the appraisal process. For each Nursing Council competency statement FPA developed potential 'performance indicators'; ways in which a nurse could show that she was meeting the competency (Appendix A, p.167). For example, competency statement 1.1 states "[The nurse] accepts responsibility for ensuring that nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements" (Nursing Council, 2005, p.5). The performance indicators are:

- maintain client privacy and confidentiality
- ensure informed consent prior to practice
- practice within the law with regards to sexuality and adolescents
- work within the legal framework of standing orders and repeat medication orders.

In this way the competencies were reorientated to reflect the clinical reality of working as a family planning nurse.

Performance indicators provide context, which is important for the discipline of nursing as it links nursing values such as professional behaviour to the standard (Watkins, 2000; Wooley, Bryan & Davis, 1998). The use of FPA specific performance indicators also allowed the competency statements to become more than just behavioural objectives by describing a variety of skills within a complex environment (Andre, 2000). It must be remembered that the purpose of such assessment is to contribute to the maintenance of professional standards and to

facilitate judgements about a practitioner's qualities, abilities and knowledge against predetermined standards (Milligan, 1998).

Design Of The Assessment Activities Within Clinical Conversation

As with professional conversation, the nurse undertaking the clinical conversation approach to annual appraisal had to collect a variety of evidence to share with a nurse assessor. In order to assist with this process a number of assessment tools were designed. Before relevant tools could be designed however, I undertook a thorough analysis of the role of the advanced FPA nurse. The various skills and attributes of the job were identified and translated into performance indicators. Throughout the development process the Locality Nurse Advisors (LNA) were consulted as experts in clinical sexual and reproductive health nursing. The LNA's reviewed and amended the performance indicators as the draft appraisal format progressed. The final indicators were then categorised into groups and work was undertaken to determine which type of assessment tool would reveal evidence for each group and also across groups. Consultation across the workforce took place to ensure the proposed techniques were realistic, applicable and appropriate.

The assessment tools used within the appraisal process all provided easily occurring evidence that was directly related to the role of an FPA nurse. They attempted to capture a sense of all aspects of performance such as attitude and cultural safety which can be difficult to assess by norm referenced techniques. The tasks were chosen to provide an holistic, comprehensive view of the nurse's professional performance. Dywer & Mosel-Williams (2000) suggest that clinical competence can not be evaluated by a single method: "Nursing practice encompasses behaviours in the cognitive, psychomotor and affective domains requiring a multitude of methods to appraise learner's competence in all three (p.63).

In total seven assessment tools were developed; these included a self assessment checklist, client feedback forms, chart audit forms, case presentation guidelines, peer observation and feedback forms, a professional development record and a

verification record sheet, all of which are discussed below. Nurses could choose to use these tools or to bring other kinds of evidence to share with the appraiser. The nurses were asked to collate all their evidence into a folder which became a portfolio of types. The appraiser sought verification from a range of people including nursing peers, clinic managers and senior colleagues prior to the commencement of the conversation. Verification was sought on issues of team work and collaborative practice.

Case Study

The case study allowed for detailed consideration of the care of a client over a period of time and attempted to reveal the complexity and creativity of many nursing situations (Appendix A, p.162). The following areas were addressed: the assessment of the client including their risk factors, informed consent issues, the joint decision making processes and the consideration of family/whanau perspective. The nurses were asked to reflect on their practice and their values and describe how these impacted on this particular consultation. The case study was written but was also presented orally at the time of the appraisal.

Chart Audit

The chart audit was undertaken with a peer to encourage a close examination of ten clinical consultations (Appendix A, p.173). Each consultation was considered in terms of the clinical assessment process, safe clinical decision making, accurate record keeping and appropriate referral. The use of computer technology was also captured by this assessment tool as templates were examined, task and recall facilities on the computer made explicit and documentation noted. In this instance the audit record sheet provided the initial context of the conversation between the nurse and her peer.

Having completed the chart audit the nurse wrote down what she had discussed with her colleague and also documented any insights into her practice that she had gained from this activity. The ten consultations she reviewed were then printed off and included in the portfolio, along with the chart audit form and written reflections.

This evidence was discussed with the assessor at the time of the clinical conversation.

Peer Observation

Peer observation involved observing two actual consultations which provided a framework for comment and a focal point for discussion (Appendix A, pp.174-176). The format of the observation was designed in line with the mini clinical evaluation exercise (MiniCEX) which was introduced by the American Board of Internal Medicine to assess student doctors' history taking and physical examination skills. It asks the peer reviewer to judge clinical assessment skills, physical examination skills, communication skills, clinical decision making skills, information giving skills, organisational/efficiency skills and finally, overall clinical competence. It has to be recognised that assessment undertaken in the clinical setting is fraught with difficulty. The time available can often be limited as the peer reviewer may be carrying a workload at the same time as observing; also the observed nurse may change her behaviour by the very fact of being observed. It can not be inferred that one appropriate clinical consultation means that all consultations will be appropriate (Watson, 2002). There is also the issue of observer subjectivity, in particular when there is a need for both parties to have a continuing professional relationship (While, 1991). In spite of such legitimate concerns MiniCEX has been found to be a reliable and valid assessment tool for clinical competence in a medical setting (Hatala, Ainslie, Kassen, Mackie, & Roberts, 2006; Holmboe, Huot, Chung, Norani & Hawkins, 2006). Within nursing, peer assessment is being used both in undergraduate and postgraduate programmes as one strategy, among many, to assess competence (Howard & Eaton, 2003).

Client Feedback Form

Nurses were asked to ensure that at least two client feedback sheets were completed (Appendix A, p.172). The client feedback form included questions regarding the level of comfort and safety experienced by the client during the consultation. This is important as culturally safe practice needs to be determined

from the perspective of the receiver of nursing care rather than interpreted by the nurse herself or an onlooker (Nursing Council of New Zealand, 2002).

Self Assessment Checklist

The self assessment checklist detailed all the Nursing Council competencies and the specific FPA performance indicators that related to each competency (Appendix A, pp.184-189). Having completed the above assessment activities the nurses were then encouraged to complete the self assessment checklist to determine in what way they could provide the appropriate evidence to meet Nursing Council requirements.

Verification Record Sheet

Nurses were able to use the verification record sheet to document areas of extended practice for example mentoring new staff or teaching other health professionals (Appendix A, p.178).

Professional Development Record

Professional development activities were recorded on a specific form (Appendix A, p.177). This captured attendance at in service or workshops and detailed postgraduate study or relevant readings that the nurse had undertaken.

The nurses were asked to bring together all the above evidence to share with the assessor at the time of the clinical conversation or additional evidence they felt illustrated their competence. In this sense they produced a portfolio of evidence. The portfolio used within the context of clinical conversation was therefore a collection of evidence to illustrate how the nurse met the competency statements required by both the Nursing Council of New Zealand for annual accreditation and the Family Planning Association for appraisal. Here the distinction between appraisal, questionably a formative process which allows the nurse to be informed about her practice and revalidation, and a summative process, one which makes a judgement, is blurred. However, the explicit link between appraisal and accreditation aims to reduce the time and effort required by nurses to fulfil the

requirements of both processes. The main purpose of the portfolio used to accompany the clinical conversation process was not to enhance learning but to reveal continual learning required of all professions in the 21st century. As part of the format, future learning goals were discussed at the time of the conversation. These in theory should be returned to the following year, with newly acquired supporting evidence in the portfolio to show how the goals have been met. Clinical conversation aimed to be not only a record of professional development but also a record of practical clinical competence. Reflectivity, analytical and critical thinking through a reconstruction of practice may be captured in a written medium within the portfolio that accompanies the conversation; however it may be the conversation itself that reveals these processes.

The evidence compiled in the portfolio should fit within the categories of professional responsibility, management of nursing care, interpersonal relationships and inter-professional health care and quality management. The evidence can be varied, however all the nurses in my study chose to use the assessment activities offered. The majority of these had a reflective component. Violato, Lockyear and Fidler (2003) found that multi-source feedback from colleagues and clients could indeed inform and initiate change in the clinical setting. Whether nurses will change their practice having undertaken a clinical conversation remains to be seen.

After I had designed the supporting documentation for the process of clinical conversation (Appendix A & B) I undertook two appraisals with advanced FPA nurses in Auckland. In this way I gained hands-on experience of using the process in the nursing context and more importantly received direct feedback from the participating nurses which enabled me to refine the documentation and make alterations to the assessment tools. Both appraisals were also videoed; these videos were then used as a teaching resource in the training of the nurse assessors. All this took place before I carried out the research reported in this thesis.

The Process Of Professional Conversation

The process of clinical conversation is, as the name suggests, one of a conversation. The nurse discusses with the appraiser the evidence she has collected about her work as an FPA nurse.

The scene is set in the following way.

1. The appraiser welcomes and thanks the nurse for coming and outlines the process:
 - The starting point is that the nurse is competent and will share evidence she has collected that demonstrates this.
 - The nurse is in charge of the process and the appraiser's role is, on the whole, to listen.
 - There are three potential outcomes: competence is demonstrated, more evidence is required before competence is demonstrated, new or extra learning needs to occur before competence is demonstrated.
2. The session is confidential unless issues of harm are identified: either to the nurse, by the nurse, or to a third party in which case confidentiality will be broken as negotiated with the nurse.
3. The nurse is asked if she has any questions about the process.
4. The nurse is invited to start to share the evidence she has collected: "Where would you like to start?"

The appraiser actively listens to the evidence presented, may ask clarifying questions or explore any issues which arise. During the assessment the appraiser is sifting the evidence to ensure that all the requirements of the competency statements are being met. Assessor notes are recorded on the assessment matrix (Appendix A, p.180). The assessor decides if sufficient evidence has been presented to meet the competences within each domain or if more evidence is required. Verbal feedback is given under the domains of professional responsibility, management of nursing care, interpersonal relationships and inter-professional health care and quality management. If more evidence is required a plan of action is agreed with the nurse. If new learning needs to take place this is

also discussed at this stage of the process.

Following the actual appraisals the results are formally written up and a copy is given to the nurse for her own records (Appendix A, pp.182-183). This can then be used as evidence for Nursing Council if the nurse is called for audit.

Assessor Training

Within FPA the Locality Nurse Advisors (LNA) traditionally undertook the annual appraisal of nurses within their region. Whilst the LNAs were all experienced assessors they had not used the 'clinical conversation' format before. I facilitated a number of training sessions regarding competency based assessment and the mechanisms of 'clinical conversation'. During these meetings the following types of issues were discussed:

- The competency statements: Do performance indicators need to be added or changed? Do the statements capture the whole role of being an FPA nurse?
- The assessment activities: Are they fair? Taken as a whole are they the most streamlined activities capturing all aspects of the role of the FPA advanced nurse? What activity would the nurse find valuable or otherwise? Which activities would be resource efficient?
- The process of evidence collection: Can all FPA nurses undertake the assessment activities? Does each individual activity add value? Is there repetition of evidence? Are there gaps? Are the right questions being asked from verifiers?
- The results of assessment: What assessment decisions were hard to make and why?

Many of these questions have their origins in concepts of sufficiency of evidence, validity of evidence and reliability of evidence. Such debate constitutes moderation which is a quality assurance process which aims to work towards ensuring consistent and reliable assessor judgements.

Locality Nurse Advisors expressed anxiety concerning the management of this integrated assessment process as it combined so many competency statements. In this regard I developed and delivered a training programme to support their learning and skill development. The training programme dealt with issues such as how to conduct the appraisal, how to introduce the 'clinical conversation' and the ways in which the nurse could be supported to share her evidence. Attention was focused on how to use the assessment matrix to assist with decision making and how to offer feedback during and after the process. The use of inference as opposed to direct evidence was discussed as was the need to defend the judgement made and be accountable for the assessment decision.

Assessment Decisions

Part of the process of competency based education is to make the assessment processes transparent and to explain how decisions are reached. This is particularly important when assessment decisions are of significance, in this instance involving performance not only from the employer perspective but also from the regulatory body's perspective (Bowen-Clewley & Strachan, 1997). Such issues have their roots in the concepts of validity and reliability of assessment. Validity is increased when both the assessor and the person being assessed know what is being assessed (transparency), when there is sufficient evidence to cover all the requirements of the performance indicators (sufficiency) and when the activities and tasks are directly related to the competency statements (reliability).

Transparency

The appraisal format designed by FPA clearly outlines the assessment process and states how assessment decisions will be made in an attempt to increase the validity of the process. The descriptive nature of the performance indicators puts words rather than figures to nurses' achievement. Defining skill enables the nurse to see what she can do and what she still needs to do to achieve competence. A formative self assessment is used by the nurse as part of this appraisal process. She is asked to self assess against the required performance indicators. This task is formative in nature as it 'informs' the nurse of any gaps in knowledge, skills or

understanding which she may need to rectify prior to her appraisal. This self assessment becomes summative when requested by Nursing Council as their auditors will use it when making a judgement regarding competence. This illustrates that the formative-summative distinction applies not to the assessment tool itself but the use to which this evidence is put (William, 2001). The literature suggests that self assessment can be as much a learning activity as an assessment activity. Self assessment has added value when the people undertaking the self assessment discuss their judgements about their own performance with someone using the same evaluation tool (Boud, 1991; Gordon, 1999). The results of this study may shed light on whether the self assessment component of the clinical conversation process is in fact important from the nurse's perspective.

The evidence must be authentic and not the work of another nurse if assessment is to be valid (Rumsey, 1994; Thomson, 1995). Authenticity could be a concern with the case study; however client files can be checked to verify that the consultation between the nurse and the client actually took place. Client feedback forms can be prone to difficulties as only those that reflect well on the nurse may be given as part of the required evidence. This was discussed amongst the appraisers who felt that any negative client feedback sheets which did not reach them were still valuable as they offered an opportunity for the nurse to consider why she had received such comment.

Sufficiency

Assessors need to consider many things before reaching a decision concerning competence. Best practice assessment should use the least amount of evidence needed for the assessor to make a valid professional judgement that competency has been achieved. Yet the evidence must be wide ranging, allowing an holistic judgement to be made about whole performance. A tension exists here which can be difficult to overcome. Whilst assessment is essentially a sampling process, the sampling must be robust enough to assume that valid decisions are likely to be made (Harris et al, 1995). The feedback from the two nurses who undertook the

Auckland trial suggests that the volume of evidence is sufficient to reflect clinical reality; they felt that all parts of their practice had been captured within the assessment activities and subsequent discussion with the assessor. Assessors are able to request further evidence if they feel that competency has not been demonstrated sufficiently.

Reliability

Reliability of the assessment process is concerned with how the competency statements are interpreted by assessors and how they are applied consistently across those being assessed. Complete consistency can not be guaranteed but through the process of developing the statements, working with them, discussing their meaning and how this translates into acceptable evidence, movement towards consistency can be achieved. Much of this needs to occur between assessors themselves as they discuss the process and their experience with it. In this way “common” interpretation happens. FPA assessors met on at least three occasions to discuss issues of interpretation of standards and acceptable levels of evidence. Consistent interpretation is supported when assessment procedures and criteria are clear, unambiguous and well documented, assessors are well trained, multiple assessors are used and multiple sources of evidence are allowed (Gipps, 1994).

Clinical conversation is flexible in that it allows a range of evidence to be shared with the appraiser. The nurse can provide examples of practice that fit her personal situation and the assessor is then able to interpret this evidence in light of the standards. Such flexibility ensures that the assessment is fair and equitable as it does not disadvantage particular nurses in particular situations. For example a nurse working in a school-linked clinic should be able to use the process as easily as a nurse working in a large urban based centre.

From the experience of appraising the two Auckland nurses it would seem that the assessment tools have construct validity by revealing the intricacies and individual performance of working as a Family Planning nurse. As already outlined, validity is

increased when both the assessor and the person being assessed know what is being assessed, when the activities and tasks are directly related to the competency statements and when there is sufficient evidence to cover all the requirements of the performance indicators. The research reported in this thesis will assist with determining consequential validity; the outcome or consequences of the assessment process for the nurses involved.

Recognizing Excellence In Competency Based Assessment

A criticism of competency based assessment approaches is that they do not allow for merit or excellence to be recognised (Gonczi, 1993). From the Nursing Council perspective nurses either reach the standard or need to provide further evidence of proficiency before being allowed to continue to practice. The Nursing Council competencies define the 'bottom line' of what constitutes acceptable practice; however varied levels of clinical performance do exist (Benner, 1984). Wiles & Bishop (2001) suggest that this lack of recognition of nurse excellence can inhibit motivation and lead to dissatisfaction. This could become a very real issue for nurses being assessed annually against the same competency statements. Any appraisal process, be it a professional development and recognition programme or a 'clinical conversation' needs to recognise merit and excellence if it is to retain value for participants on an annual basis.

To summarize, the primary purpose of clinical conversation is two fold: to reveal the continuing learning and professional development of the practitioner and to illustrate clinical competence in its broadest sense. These goals are fundamentally managerial and regulatory in nature ensuring compliance with standards of safe practice. Whilst clinical conversation appears not to have been used in the nursing context before, some forms of nursing supervision share these goals.

Focus Of Inquiry

The mechanism of discussing practice with another clinician within a structured format may mean different things to different people. Whilst the tool of clinical

conversation aims to meet the goals of the Family Planning Association of New Zealand in terms of an annual appraisal process for nurses, it remains unknown how the process is perceived by both sets of nurses taking part, the assessor and the nurse being assessed. As the assessor in this situation is the guardian of professional standards and therefore the representative of the regulatory body, their perception of what the process means may be concerned with the way in which it meets its stated goals and allows a decision about competence to be made. It is the perception of the nurse undertaking the process that will really reveal what the process is actually about, the true nature of the encounter rather than the preordained belief from a regulatory perspective about what the process means. For this reason the research question was concerned with the perspective of the nurse being assessed and to this end the following question was developed.

What is happening for the nurse during a 'clinical conversation' to assess competence?

The assumptions I brought to this qualitative interpretive study were:

- Assessment should be a positive process for the assessed participant.
- Assessment of clinical nursing practice should be holistic addressing knowledge, skills and attitudes.
- Assessment should offer a process for reflection.

CHAPTER 2: LITERATURE REVIEW

Introduction

I undertook this initial literature review after I had observed two appraisals and interviewed seven of the nurses who had been assessed using the clinical conversation technique. At this time my thinking focused on two primary issues; firstly the relationship between the nurse and the assessor which seemed pivotal in the process and secondly, the role of reflection in terms of looking back and thinking about practice from a position of hindsight which created the potential for change. In light of this I explored the concept of nursing supervision: the dynamics of the supervisory relationship; the nature of feedback including methods of debriefing and the outcomes of clinical supervision in terms of nursing practice. I then reviewed three models used within nursing supervision: the stranded reflection model, the guided reflection model and the Derby model. By undertaking the literature review I was presented with alternative ideas with which I was able to challenge the data. I was mindful that the ideas generated by the literature review had to be handled with care for fear of superimposing them onto the data rather than using them to contest emerging concepts inherent within the data.

I was unable to source any literature relating to professional conversation, the assessment technique that most closely relates to clinical conversation as no research has been undertaken on this assessment strategy.

Supervision

Broad Principles

Psychotherapy and counselling were the first professions to formally use supervision. Supervision was initially developed as a teaching strategy to increase the understanding of the supervisee in terms of their patient in therapy and thereby positively affect client outcomes. Initially it was not intended to be used as a

technique to develop personal insight into self as a practitioner, however, within psychotherapy and counselling this was often the result (Yegdich & Cushing, 1998). Supervision was later adopted by mental health nursing and gradually found its place within nursing as a whole (Burrows, 1995).

The nature and role of supervision in nursing practice has been discussed and debated throughout the 1990s and into the 21st century. Various principles and processes for supervision exist but most share the broad concepts captured in Bishop's definition: "Clinical supervision is a designated interaction between two or more practitioners, within a safe/supportive environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patient service" (1998, p.8). Implicit in this are concepts of protected time, confidentiality, evidence based practice and shared expertise. Intrinsic to the process are the assumptions that the supervisees are professional, competent practitioners who share a common professional interest with the supervisor and that both see reflection as a major resource in the armoury of professional development (Burton & Launer, 2003). There is recognition of the importance of conversation in professional learning and the need to balance support with challenge (Launer, 2006). Overall, the hoped for benefits of supervision include enhanced client care, professional growth coupled with increased assurance and confidence, a broadened thinking and improved working relationships (Bishop, 2004; Butterworth, 1992).

Nursing definitions of supervision imply that learning, and consequently professional development, will take place through reflection and support. Also that managerial and organisational goals such as quality patient care will be achieved yet the results of research into the outcome of clinical supervision within nursing remain contradictory (Hadfield, 2000; Hyrkas, Appelqvist-Schmidlechner & Paunonen-Ilmonen, 1999).

Clinical conversation differs from supervision as it is an annual process only, nevertheless, initially it would seem that both have certain elements in common. Firstly, a one-to-one conversation takes place between the assessor and the nurse. Secondly, from the initial examination of the words of the nurses who took

part in this study the process appeared reflective, practice focused and had the outcome of creating change. Clinical conversation certainly incorporated not only managerial goals of ensuring quality care but also the goals of the regulatory body, the Nursing Council of New Zealand, in terms of guarding the public against unsafe practice.

The Supervisory Relationship

Dynamics

The intricate nature and dynamics of the supervisory relationship within nursing does not seem to have been explored in the same depth as the parallel affiliation in psychology and counselling. Faugier (1992) believes that it is the medium of the supervisory nursing relationship that leads to the application of theoretical knowledge, attitudes and the art of therapeutic communication. She suggests it is the piecemeal development of the nature of the supervisory relationship that has lead to the fragmented understanding of the importance of clinical supervision in clinical practice. She does not assist understanding by clarifying either the process or nature of supervision within nursing in other than non specific terms: “Just as one would expect the nurse to have the ability selectively to blend various clinical approaches in response to the patients needs, the supervisor should be able to demonstrate such an ability during clinical supervision” (Faugier, 1992, p.24).

While listing the general qualities of the supervisory relationship - generosity, openness, thoughtfulness, humanity, sensitivity, trust – Faugier (1992) offers little assistance in exploring the actual nature of the supervisory relationship in nursing practice. In fact, Clouder and Sellas (2004) go as far to suggest that very little is known about what makes the supervisory relationship effective.

Bishop (1998) believes there are three types of credibility required by nursing supervisors: personal, organisational and clinical. Research undertaken by Fowler (1995) identified relevant knowledge, supervisory/teaching and sound personal relationship skills as pertinent if supervisors are to be perceived as appropriate by

nurses. Essential requirements include facilitation skills, the management of personal and professional boundaries, emotional competence, effective listening and communication skills (Hawkins & Shohet, 2000).

Within the nursing context it would seem that a safe environment should be established to ensure a free and open discussion can take place between the supervisor and the supervisee. Confidentiality needs to be addressed at the start of the relationship and illustrations given as to when confidentiality will be breached. A briefing document can be useful to ensure all parties are aware of the purpose and structure of supervisory sessions, particularly when the hoped for benefits of supervision can be so broad (Landmark, Storm Hansen, Bjones & Bohler, 2003). Bishop (1994) believes that the discussion that occurs in supervision needs to be practice-led with a focus on affective, psychosocial dimensions and the practical issues of the job. The supervisor should ensure that the supervisee feels confident enough to discuss issues of doubts and concerns and walks a fine line between offering support and challenging practice to provoke professional growth (Cutcliffe, Butterworth & Proctor, 2001). Whilst seen as a guide rather than a judge the supervisor should follow the CCIS principle: challenge, be a catalyst, inform and support (Bishop, 1998). Within clinical conversation the balance between guide and judge is assumed to swing more towards evaluator and standard setter: further data analysis may confirm this.

At its worst, routine supervision can be a stale and repetitive tool for indoctrinating conservative forms of practice (Rolfe, 1998). Supervisors can appear as anxious case managers driven by theory or as a mouth piece for management. It can also be a time of inappropriate personal counselling. At its best, routine supervision encourages clinicians to “enter a life long cycle of reflection and learning, in which knowledge, ideas and experience continually nourish each other” (Burton & Launer, 2003, p.21).

Clinical conversation has clearly defined parameters which establish the preparation that needs to occur prior to the conversation, the role of the appraiser and the role of the nurse being appraised, the process of the conversation and the

nature of the feedback. A fundamental difference is that it is a once a year process with a clear beginning and end as opposed to an ongoing relationship. The discussion during the clinical conversation is assumed to be practice focused but it remains to be seen in what depth it covers the affective aspects of working as a Family Planning nurse as opposed to the practicalities of the job. Light may also be shed on the assessor/assessee relationship within clinical conversation and the degree of challenge and support that exists.

Supervisory feedback

Feedback is a vital element of the supervisory relationship and traditionally occurs after the supervisor has observed practice (Hawkins & Shoet, 2000). Such observation enables the supervisor to offer comment on not only performance but more specifically on clinical decision making skills, the emotional and moral dimensions of the case in point and finally the learning and development needs of the practitioner (Hewson & Little, 1998).

Fish and Twinn (1997) have developed a six dimension model for effective debriefing and feedback; included are the aim, the orientation, the modes, the pedagogical style, the format and the nature and use of evidence. The orientation of debriefing looks at the focus of the feedback; whether it is concerned with nurturing professional judgement or improving clinical skills. The aims are concerned with the intent to which this information will be used for example, to support reflection or to actually suggest new insights to the supervisee and assist with learning. Within clinical conversation feedback was given by a variety of people at different stages of the process. Clients gave feedback as did peers during the chart audit and the clinical observation. Managers and colleagues also provided feedback to the assessor. At the time of the actual conversation with the assessor the feedback may well have been both directive and facilitatory, further analysis needs to take place to establish this. Overall the aim and orientation of the feedback is clearly framed by the requirements of the Nursing Council of New Zealand encapsulated within the domains of professional responsibility,

management of nursing care, interpersonal relationships and inter-professional health care and quality management to ensure competent practitioners.

Four main modes of debriefing have been recognised: the critique mode, the reflective mode, the formal assessment mode and the self assessment mode. Brown and Knight (1994) suggest that feedback on performance is pivotal to both informal and formal learning. In the critique mode the positive and negative aspects of the episode under review are discussed in light of the supervisors own professional judgement (Pendleton, Schofield & Tate, 1984). It must be remembered however that error focused feedback at the expense of positive comments can have a negative effect on the person's sense of self esteem and be detrimental to their learning (Orrell, 2006). The reflective mode allows both the supervisor and the supervisee to reflect, consider and make adjustments to their perceptions; it is much more of a mutual development process (Branch & Paranjape, 2002). This reflective or co learning mode is when feedback is at its most useful. The formal assessment mode allows an official judgement to be made about an episode of practice in a formative or summative context (Higgins, Hartley & Skelton, 2001; Hyland, 1994). In the competency based world this judgement is made against competency statements. The self assessment mode transfers the responsibility of professional development onto the supervisee (Biggs, 1999). Here the feedback is facilitatory in nature, exploring why the supervisee acted or behaved in a particular way. The end result of such a process can lead to supervisees becoming proficient in assessing the quality of their own practice (Sadler, 1989).

Whilst initially the formal assessment mode of debriefing would assume to be that used by nurse appraisers undertaking clinical conversation, other modes may well be hidden within the overall discussion. Such modes may be teased out in the data analysis to reveal if different assessors use different modes or whether the same assessor uses different modes during different parts of the conversational process. The degree to which self assessment takes place on the part of the nurse may also be revealed.

The pedagogical style of the person giving feedback will influence the essence and content of their communication with the supervisee. In basic terms their approach can be dictatorial, telling the supervisee what they did and did not do and how it could be done differently or facilitatory, working with the supervisee to explore meaning and develop the learners self awareness and self assessment skills (Fish & Twinn, 1997). Again the pedagogical style of each appraiser may be gleaned from a further analysis of the data.

The nature and use of evidence is pertinent in any discussion concerning clinical conversation and the role of feedback. Fish and Twinn (1997) suggest two ways in which evidence can be used, either as the reason for critique (the evidence to support the decision that the assessor has reached) or as basis for discussion and further exploration. Whilst assessors using the clinical conversation format do use evidence presented to make a summative judgement about a clinician's practice they may still, within the actual conversation, use discussion and exploration as a means of formative assessment prior to reaching a decision about overall competence. This may in fact be the strength of the technique, a place where clinical supervision and assessment meet in a useful, legitimate way. It is beyond the scope of this study to examine the way assessors used the evidence shared with them to reach a decision regarding competence but this would be worthy of future study.

The Outcomes Of Clinical Supervision In Nursing Practice

Proctor (2001) describes three functions of clinical supervision, the formative, restorative and normative function. The formative function concerns issues of professional development. The process of professional development occurs through the sharing of clinical experiences with others. Revans (1976) believed that learning only takes place through the sharing of difficulties, concerns and clinical experiences in a supportive environment. It is the critical reconstruction of practice that leads to the expansion of skills, competencies and understanding. As Smith eloquently writes

We spend our lives experiencing...we do not necessarily optimise our learning from our experience. The only way this occurs, I believe, is in finding strategies, either individually or, preferably, with others to reflect: to find time and space to detach from the experience and reconsider it through recreating it, reframing it, looking at it from different points of view, being challenged about our assumptions and perceptions related to the experience and considering different alternatives and possibilities (2001, p.128).

Here the interlinking relationship between experiential learning and reflective learning is suggested, it is through reflecting on experience that learning can take place. The way clinical conversation incorporates or facilitates this process is yet to be revealed.

The restorative function of clinical supervision occurs through support. Offering nurses the opportunity to constructively discuss issues and concerns can reduce stress, reduce feelings of alienation and dislocation in the work environment and so decrease the likelihood of burn out (Scaife & Walsh, 2001). At this stage in the research process the restorative function of the clinical conversation appraisal process remains unresearched.

The normative function of clinical supervision concerns issues of professional practice and can be the most contentious aspect of the supervision process. Whilst clinical supervision is separate from individual performance review there are potential areas of overlap. It is recognised that the "clinical supervision model gives nurses the opportunity to audit the quality of their practice through reflection" (Norman, 1997, p.34) yet it remains unclear in what way such evidence should be used as part of a performance review process. Burton and Launer (2003) believe supervision should be entirely distinct from processes of appraisal whilst others are less rigid recognising that performance issues may become transparent through the process of supervision. Certainly within the fields of psychology and counselling, supervision often has a clear evaluative component (Yegdich, 1999a). If supervision claims to safe guard standards of nursing practice this is not only a professional issue but has ramifications for the management of any organisation and thus becomes an appraisal concern (Yegdich & Cushing, 1998). In an attempt to avoid confusion the literature suggests that clear guidelines for each process,

that of clinical supervision and performance appraisal need to be developed (Hawkins & Shohet, 2000; Yegdich, 1999b). The process of clinical conversation appears to be at the crux of this dichotomy. It may offer nurses an opportunity to audit their practice through self and guided reflection; however its primary purpose is certainly to offer the appraiser the opportunity to evaluate the nurse's practice through a process of sharing of evidence.

Models Of Clinical Supervision

A number of models of clinical supervision exist. van Ooijen (2003) has classified these as the psychological, the developmental, the reflective and the supervisor specific models. Each will be briefly discussed.

Psychological Models

The psychological models draw on the underlying philosophical approaches of the supervisor who overtly uses these as the process for supervision. For example, a supervisor trained in Gestalt methods would use such methods as the basis of their supervisory process. Within nursing it has been suggested that the supervisor should be from the same area of practice which would imply a "same theory" supervisory approach (Faugier, 1992). In clinical conversation it could be assumed that the appraiser and nurse are operating from similar models of practice as both work within the scope of sexual and reproductive health within an organisation that has a strong philosophical basis. It would be fascinating to undertake research into the assessor's theoretical perspective and their 'ways of knowing' to establish how these influence not only their assessment decisions but any learning that may take place within the clinical conversation context.

Developmental Models

The developmental models of supervision draw on the expertise and wisdom of the supervisor with the intent of supporting learning in the supervisee. Such a concept sits comfortably within nursing in respect of the theory-practice gap which has been recognised as limiting practical learning (Kramer, 1999). Often, experienced

clinical nurses can support newer nurses to put into practice the evidence based learning undertaken in academic institutions but which is not always easily transferable into the clinical setting. The developmental model also acknowledges the concept of levels of practice from novice to expert (Faugier, 1992; Kramer, 1999; Vance & Olsen, 1998).

The status of the supervisor continues to be debated within nursing. Butterworth (1992) favours a supervisor of equal status to the practitioner whilst Proctor (1987) sanctions those with a higher level of expertise. Within the clinical conversation format at FPA all the assessors were highly experienced clinicians who also had a managerial load. In some situations they may have been perceived by the nurses as having a higher level of expertise but as several of the nurses being assessed had over fifteen years of clinical service they may well have been regarded as having equal status in terms of clinical skills.

Reflective Models

The importance of reflection in nursing practice became prominent in the mid 1980s based on much of the work undertaken by Schon (1983, 1987). It was believed that through the process of reflection practitioners could continue to learn and develop; this would ultimately lead to professional and personal growth which in turn would improve client care. The process of reflection is one of reconstructing experience and looking at it from different perspectives to allow for a potential change in thinking and behaviour (Todd & Freshwater, 1999). A variety of models have been used within nursing to facilitate reflective thinking. Two will be discussed here: the “strands of reflection” model developed by Fish and Twinn (1997) and the “guided reflection” model developed by Johns (2002). Both of these models have been set within the framework of clinical supervision.

Strands of Reflection

The “strands of reflection” model provides different ways of looking at a clinical situation. The factual strand explores the perception of what actually happened, the event, the actions and the feelings of the practitioner. The retrospective strand

takes the factual strand to another level by looking at the event as a whole. Consideration is given not only to the nurse's perception but that of the client, family and other health professionals involved. Such a process can begin to identify patterns of behaviour on behalf of the nurse which are the precursors to identifying potential areas of change. The sub-stratum strand attempts to dig deeper and expose the assumptions, beliefs and values that influence any interaction with clients. The end point of this is to "encourage professionals to tolerate the idea that a range of views exist about procedures and there is no right answer" (Fish & Twinn, 1997, p.138).

Fish and Twinn (1997) believe this tolerance of alternative interpretation is essential if nurses are to confront the crucial gaps to be found between their beliefs and their practice. They believe that it is this strand in particular that is often neglected in evaluation and appraisal. It is interesting to consider if such a sub-stratum strand exists within the clinical conversation format of appraisal.

The final yet intertwined strand is called the connective strand; this again expands insight, placing practice within the theoretical, political, social and economic climate. The overall result of this stranded approach to reflection aims to uncover and explore tangible practice. Through this process any inconsistency between self belief about professional practice and actual professional practice can be revealed. Once such incongruence is exposed practitioners can work towards narrowing this gap. Fish and Twinn believe that it is learning about self in the clinical setting that can facilitate change. Their model leads to a thorough exposure of practice without a thorough exposure of self.

The work of Fish and Twinn (1997) draws attention to the role of the supervisor in the reflection process; it is the supervisor who assists with the exploration of practice. This can be done in an overtly systematic way by working with each strand over a period of time. The training that the assessors undertook prior to conducting the clinical conversations focused on managing the conversation in terms of hearing and discussing all the evidence that the nurse had collected. It in no way offered a prescriptive, systematic approach to exploring the material in

depth from a variety of angles. Analysis of the data, as the strands of reflection model illustrates, needs to identify the depth of the nurse's reflection. It also raises the question whether other parts of the appraisal process result in exposure of practice.

Guided Reflection

Johns (1995, 1997, 2002) developed a guided reflection process which focused on four domains of reflection: aesthetic, personal, empirical and reflective. The structure is such that usually, different issues are discussed at different sessions requiring an ongoing supervisory relationship. The focus is often on exploring relationships with clients and colleagues, understanding and critically analysing professional practice and perceiving new possibilities. Self awareness is encouraged to make transparent the needs and wants of the clinician in comparison to the needs and wants of the client.

An integral part of self awareness concerns emotional competence. Johns (1997) regards emotional development as a legitimate concern of supervision for it is only emotionally competent practitioners who are able to support and best help clients in their own development towards emotional competency (Heron, 2001). Emotionally competent practitioners have insight into their actions and behaviours by monitoring and reflecting on their responses to situations that arise in the workplace. It is through the process of reflection that alternative frames of reference can be considered. It is this ability to understand, review and consider attitudes, beliefs and values through a variety of lenses that ensures ongoing culturally safe and responsive practice (MacCulloch, 1998).

Whilst Johns supports the promotion of emotional competence through supervision some feel that it can only be achieved through personal therapy which addresses life issues (Bernard & Goodyear, 1998; Yegdich, 1999a). Others take the view that personal and professional development are likely to arise in supervision and can be explored "whilst continuing to adhere to appropriate boundaries" (Scaife & Walsh, 2001, p.41). The stranded reflection model discussed earlier appears to

promote emotional competency to some extent, in a thorough exploration of reactions in the clinical setting. It is a question of degree that separates many of the supervisor models in terms of emotional competence.

Within Johns guided reflection model the supervisor tries to establish a collaborative relationship with the supervisee by using such techniques as listening, reflective questioning, summarizing and framing perspectives. He believes that through such collaboration anxiety can be reduced and the process of disentangling defensiveness can begin. Johns acknowledges the need for supervisors to be aware of their own reactions during the supervisory process as this subjectivity can contaminate the reflections of the supervisee. The ultimate goal is to influence the quality of care by ensuring the nurse experiences personal and professional growth through reflection. Here personal growth is at the crux of the process (Johns, 2005). What Johns highlights are the questions concerning personal versus professional growth; these issues will need to be considered during the data analysis phase of this study.

Reflective practice per se and guided reflection in particular, are currently in the critical spotlight. Rolfe and Gardner (2006) believe that not only does reflection increase the likelihood of “repressive self-surveillance” (p.593) on the part of the practitioner but can be seen as a “deliberate [management] strategy to produce a docile and compliant workforce” (p.594). It encourages the public expression of private thoughts that once out in the open are judged and normalised by both the supervisee and the supervisor (Cotton, 2001).

Rolfe and Gardner (2006) postulate that there are two forms of reflection. The first taps into a person’s tacit knowledge, the knowledge gained over the years that lies behind clinical practice. This knowledge is revealed through the processes simply described by Kolb’s learning cycle: that of doing, thinking and then redoing (1984). Such reflection primarily concerns learning about the supervisees practice. This type of reflection may well be captured by the process of stranded reflection where the end point is developing insight into alternative perspectives.

The second form of reflection is similar to that postulated by Johns. Here a practitioner is supported to reflect in a deep, soul searching way: "I believe that reflection always needs to be guided because it is profoundly difficult for practitioners to see beyond self, to see how their own self distortions and limited horizons...have limited their ability to know and achieve desirable work (Johns, 1997, p.198).

Whilst in psychology and nursing the role of the supervisor has been seen as one that extends the knowing of the other through teaching and offering alternative insights, what Johns seems to be inferring is much more of a self-actualising, almost religious experience. In particular he draws out parallels between guided reflection and Buddhism (Johns, 2005). Such an approach has concerned some academics who see guided reflection as a confessional experience based on a thorough exploration of self (Gilbert, 2001). Learning about self, rather than about one's practice under the influence of an enlightened guide might "degenerate into a subtle but persuasive exercise of power" (Rolfe & Gardner, 2006, p.593)

Within academic literature Rolfe (1999, 2000, 2001) has raised awareness of the dominant discourse of scientific, evidence-based practice, at the expense of other ways of knowing. Whilst initially he appeared to support reflective practice as a valid discourse which could reveal tacit knowledge, he is none the less mindful that taken beyond this, in terms of the search of true meaning and self enlightenment, it can become a dangerous process beyond the scope of supervision.

As the clinical conversation encounter is an annual experience the potential for self actualisation is limited. From initially examining the words of the participants it appears that reflection does take place and that the assessor is important to a number of nurses in this process. Data analysis needs to occur to establish the way practitioner growth occurs; whether through discussion with the assessor or through some other mechanism. Equally the extent of professional versus personal growth may be identified.

Supervisory Specific Model

The Derby Model

Within the nursing literature I was only able to find one supervisory model that had closer parallels to clinical conversation than both the stranded reflection model and the guided reflection model. This was the Derby model that was developed in the mid 1990s. The goal of the model was to “facilitate reflective practice, professional development and...improvements in the standards of patient care” (Friedman & Marr, 1995, p.239). Such goals frame the process in terms of professional development rather than the more contentious area of personal growth, nonetheless managerial goals remain important.

The goals were stipulated in the form of competency statements which related to levels of practice. The process used was a structured exchange between practising professionals to enable articulation of professional knowledge and the development of professional skills. Each practitioner was required to maintain a portfolio in line with the clinical competencies determined by the UK’s regulatory bodies. The supervisor’s role within the process was one of support, empowerment and development guided by the levels of practice captured in the competencies. Assessment of competence was determined by the presentation of the portfolio and an interview with the project team. The supervisor would make assessment judgements through observations in the clinical setting and these were recorded in the portfolio. The outcome of these judgements against competencies in some way informed the ‘Individual Performance Review’ process, but the way this occurred was not made explicit. It appeared that the supervisor had an ongoing professional relationship with the supervisee to ensure pre-ordained learning needs were met and in this way could be said to act as a mentor. This model seemed to be very relevant to the clinical conversation model but unfortunately I was unable to find an evaluation of it in the nursing literature.

As outlined above there is an array of approaches to supervision and as such it could be suggested that no two supervisors operate in the same way. Indeed it may be the skill and the expertise of the supervisor which will dictate the model used. Theoretically the model of clinical conversation appears to relate most

closely to the Derby model of supervision. Both models are based on competency statements yet the role of the supervisor in the Derby model would appear to be much more that of professional supporter whilst in the clinical conversation model the role of supervisor is actually that of assessor. The reflective models provide insight into issues of professional versus personal growth where the skill of the supervisor appears paramount.

The above literature review offered a variety of insights into the potential mechanisms of clinical conversation in terms of process, structure, the appraiser appraisee relationship and the use of feedback. It has raised a number of questions which need to be considered when analysing the data. Within clinical conversation:

- What is the role of the assessor in the process?
- What is the role of the nurse in the process?
- What is the relationship between the nurse and the assessor?
- What is the role of self audit in the process?
- How is the process of reflection supported?
- In what ways does learning occur?
- Is learning within the professional or personal domain?
- What is the outcome of learning?

The literature has highlighted possible parallels between clinical conversation and clinical supervision yet at this stage these remain suppositions. My research question will attempt to clarify what the process of clinical conversation actually is from the perspective of the nurse being assessed via this technique.

CHAPTER 3: THE RESEARCH PROCESS

Clinical conversation was designed as an assessment strategy to appraise advanced FPA nurses. It is a technique that appears new to nursing practice. Whilst on the surface it seems to have a number of parallels with nursing supervision it remains unknown what the exact nature of the process is from the nurse's perspective. In an attempt to answer this, the following research question was formulated.

“What is happening for the nurse during a “clinical conversation” to assess competency?”

My aim was to unravel the process from the nurses' point of view, to gain insight and understanding into their perceptions of the experience. In this way a substantive theory could be developed that would explain what was occurring. For such a qualitative research question I decided to use an interpretive approach to my study design. In order to explain and provide a rationale for why this paradigm was chosen, I will explore such concepts as epistemology (the theory of knowledge), the theoretical positioning that underpins the methodology, the methodology itself and finally the methods I used.

Epistemology

To illustrate congruence between methods, methodology and theoretical perspective I will first outline my own personal epistemological positioning. Epistemology is the branch of philosophy concerned with the nature of knowledge. The questions considered within this discipline include what is knowledge? What can humans know? What are the limits of knowledge and what does it mean to know? (Hergenhahn & Olsen, 2001).

Originally the concept of knowledge occupied the thoughts of philosophers such as Plato (ca.427-347 B.C.) and Aristotle (384-322 B.C.). In simple terms Plato

believed that knowledge was inherited and as such was contained within the mind of each individual. This knowledge was accessed through the process of contemplation and active introspection. In contrast Aristotle, a student of Plato's, believed that knowledge was gained through the senses, through experiencing the outside world and attaining empirical evidence. He too, like Plato recognised the importance of the mind in processing such information. Both thought that the process of rationalization (the pondering and thinking of the active mind) was vital in the attainment of knowledge. Aristotle not only believed that sensory experiences generated ideas but that other ideas resulted from the process of comparing ideas, identifying similarities, noting differences and seeing associations. In this way he defined a learning process and an explanation of how knowledge developed (as cited in Losee, 2001).

The concept of empirical evidence, pioneered by Aristotle, was not developed further until the sixteenth century. Frances Bacon (1561-1626), the founding father of the positivist paradigm, believed that knowledge could and should be determined through the process of scientific enquiry (Crotty, 1998). Descartes (1596-1650), proposed the separation of body and mind and with this came the notion that the body could be looked at from an empirical perspective, a scientific viewpoint. Science came to be seen as a distinct method of enquiry based on experimentation, observation and theory construction (Okasha, 2002). Unlike Bacon, however, Descartes believed in innate ideas which were integral to the mind and free from environmental influence. Other philosophers of the time strongly disagreed and so unfurled the continuing debate on the importance of experience (empirical and objective) in creating knowledge as opposed to knowledge being innate. In light of the prominent discourse of the time, the Seventeenth century has been called the period of Enlightenment, "the self proclaimed Age of Reason" where the overarching hope was for a society based on reason and natural law gained through scientific means, rather than fear and superstition (Crotty, 1998, p.18). It was believed that such a rational world order would result in a universal humanity capable of reaching perfection (Macey, 2000). An interesting thought in light of twentieth century critical theorists and

postmodernists who view the scientific method as controlling social order and maintaining existing power structures to negative effect (Benton & Craib, 2001).

From the earliest times the process of rationalisation, what we might nowadays call reflective thinking, has been closely allied with attaining knowledge. Both Plato and Aristotle recognised the importance of engaging thought processes in the exploration of ideas with the purpose of revealing new knowledge and understanding. John Locke (1632-1704) believed that ideas came from experience and that through reflection simple ideas could be combined into complex concepts. David Hume (1711-1776) took the debate concerning knowledge and the role of rationalism one step further. He believed all knowledge was subjective as it had been gained through experiencing the empirical world indirectly through the medium of an individual's ideas. He was not denying empirical knowledge but recognising that each individual interprets it in a way that is unique to them and thereby alters its meaning (as cited by Okasha, 2002).

Immanuel Kant (1724-1804) worked with the two main doctrines of the time to produce an explanation that would marry the seemingly opposing views of empiricism and instinctive knowledge. Kant suggested that innate mental faculties were superimposed over sensory experiences thereby providing them with structure and meaning (as cited by Hergenhahn & Olsen, 2001). It can be clearly seen how such innate mental faculties resonate with the beliefs of Plato.

The philosophical stance of what has been called post-positivism accepts that scientific knowledge has its place but questions its absolute objectivity and its belief that only scientific knowledge is valid. The arguments of scientists such as Heisenberg and Bohr suggest that "scientists actively construct knowledge rather than passively noting laws that are found in nature" (Crotty, 1998, p.29). Popper (1972) sees scientists engaging in a continual process of conjecture and falsification where scientific truths are only something that scientists have so far been unable to prove false. Philosophers such as Kuhn (1970) question the objectivity and value-free neutrality often alleged by scientific discovery and offers a constructivist description of how scientific paradigms shift. Feyerabend (1987)

meanwhile alleges that science is based on indoctrination and actually presents a threat to academic freedom.

From a personal perspective I would consider my epistemological stance to be one of constructionism; for me, meaning is not discovered but is constructed through interpreting the world, through working with the world and objects in the world (Crotty, 1998). It is the interaction between the object and the subject, the influence of each on the other that explains how meaning is made. In this way meaning is inherently interpretive in nature. Here there is a balance between the meaning making activity of the individual and the collective meaning making of communities which shapes the thinking of the individual.

Theoretical Perspective

Crotty (1998) defines five or more theoretical perspectives that influence social science research. These include positivism, interpretivism, critical inquiry, feminism and postmodernism. All interpretive traditions emerge from a theoretical position that takes human interpretation as the starting point for developing knowledge about the social world (Prasad, 2005). Human interpretation will occur at two levels in this study. Firstly the interpretation of the nurses who have been appraised using the clinical conversation format will be of interest. What is the experience like for them, what is their understanding of the procedure? Secondly I will interpret their understanding to determine the social process that is occurring.

The interpretive paradigm encompasses the philosophies of symbolic interactionism, phenomenology and interpretive hermeneutics (Crotty, 1998, Grant & Giddings, 2002). Symbolic interactionism stems from the work of American philosophical pragmatist George Mead (1863-1931) who believed that it is a human's ability to objectify themselves, to be aware of themselves in social situations that is fundamental to understanding the process of sense making and reality construction (as cited by Charon, 1998). From this standpoint all interpretation takes place. Mead does not dismiss shared reality construction; on

the contrary, he suggests that individual identity is in itself a social construct, nevertheless, it is from the perspective of the socially constructed self that interpretation takes place. People's ability to perceive themselves in social situations, to consciously decide on the role that they are going to play, in fact influences the playing of the role and the meaning they ascribe to it: "with the help of roles and self images, individuals make sense of any social situation and articulate for themselves (and others) their own place in it" (Prasad, 2005, p.20).

It is the balance between social and individual interpretation that shapes a person and their behaviour. Objects and events have no intrinsic meaning; meaning is assigned by individuals through the process of social interaction. Social interaction is mediated through the sharing of symbols, often language. Herbert Blumer (1969) defined three basic assumptions upon which symbolic interactionism rests; firstly that individuals act towards objects on the basis of the meaning that these objects have for them; secondly, such meaning arises out of the social interactions an individual has with society at large; thirdly, these meanings are not static but are constantly being modified.

Symbolic interactionist researchers seek an intimate understanding of social situations largely from the standpoint of the research participants themselves. It is from this standpoint that interpretation occurs. Such researchers are interested in uncovering the meanings for different people of the same phenomena. Working in the symbolic interactionist tradition implies paying close attention to process. Methods favoured in this tradition are observation and interview; interviews are usually in depth and meaning centred. The methodology of grounded theory has congruence with symbolic interactionism as throughout the process any emerging theory is firmly grounded in the data and does not arise from some other source (Prasad, 2005).

Phenomenology is another philosophical perspective within the interpretive paradigm. It attempts to return to the objects that present themselves to us prior to our knowledge of them (Moran, 2002). It is based on the concept of intentionality: the relationship between conscious subjects and their objects (Crotty, 1998). Our

culture and experiences gives a ready made sense which leads to a predetermined understanding. This sense needs to be laid aside. There needs to be a return to being and a minimising of the taken for granted. Whilst there may be an infinite number of potential ways in which experience can be interpreted, it is recognised that societal influences (cultural, historical, economic, political) have a significant impact on how individuals make sense of their world. This creates the tendency to arrive at common constructions and shared interpretations of reality, a phenomenon referred to as intersubjectivity (Berger & Luckmann, 1967). In this way thinking patterns are culturally derived; such enculturation creates a barrier between the object and subject which prevents it from being seen as it actually is. Thinking about an experience, in essence, erects an immediate barrier to the experience as it existed before thought (Crotty, 1998). The risk with intersubjectivity is that whilst on the one hand it allows for a shared understanding to develop it can also constrain interpretation. Critical phenomenologists believe that people's culturally derived meaning making systems equate to oppression and manipulation amongst other forms of injustice. Whilst all interpretation is subjective, once it is held by the majority of people it becomes regarded as objective reality and as truth: this phenomenon has been called reification (Berger & Luckmann, 1967). Recognising and peeling away layers of reification is what is needed to discover new meaning. Phenomenology requires us to engage with phenomena in the world and make sense of them directly and immediately. This is achieved by suspending or bracketing that which at first seems obvious. Husserl (1980) asserts that we need to "set aside all previous habits of thought, see through and break down the mental barriers which these habits have set along the horizon of our thinking...to learn to see what stands before our eyes" (p.43).

Previous understandings have to be put to one side; experience should be felt before it starts to be thought about. Through the process of suspending what is already known, new meaning becomes apparent. Once culturally derived meaning is abated new thinking can take place. This new appreciation will indeed be influenced by culture but it will be a reinterpretation of meaning. In this way phenomenology questions what is taken for granted to allow other perspectives to be seen. In terms of interpretive research the importance of phenomenology is to

remind the researcher to suspend, or at the very least recognise their immediate interpretations of data. These initial responses must not be taken for granted and accepted as truth but must be understood for what they are - culturalised responses which limit the possibilities of different realities. In the search for different meaning, phenomenology recognises that any new meaning is as much a construction as was the initial meaning yet this new meaning allows the possibility of fuller or renewed meaning. In its very essence phenomenology is critical; it does not take for granted that which presents itself.

Hermeneutics has been described as a philosophy, a theoretical perspective and a set of methodological protocols (Prasad, 2005). The philosophy of hermeneutics is fundamentally concerned with the interpretation of text. Interpretation can be seen as a complex process which involves both the text as a whole and the parts of the text within the whole. Herein lies the concept of the hermeneutic circle; the meaning of a part can only be understood as it relates to the whole; likewise the meaning of the whole can only be understood as it relates to its parts (Alvesson & Skoldberg, 2000).

For authentic interpretation to take place the interpreter must enter the lifeworld of the author, this can be achieved by understanding the author and their historical, cultural and social context (Dilthey, 1989). Heidegger, a German philosopher, took a different stance on hermeneutics and focused on the relationship between the interpreter and the text and, more specifically, how the act of interpretation took place. Heidegger (2005) believed that any text was approached from the perspective of the cultural doctrine of the interpreter. For new meaning to evolve this ready-made understanding has to be laid aside; here resonance with phenomenology can be seen. Gadamer (1989) took this theme further by naming this concept as “prejudice”, the interpreter’s unavoidable preconditions inherent within that are brought to the text through the act of interpretation. Gadamer named two types of prejudice: that which could enhance understanding and that which could limit understanding. Prasad (2005) explains: “in essence Gadamer seeks to... [make] interpreters aware of their tendencies to force a text’s meaning into a framework of personal beliefs, categories and constructs” (Prasad, 2005,

p.33).

Hermeneutic researchers, like phenomenologists, seek to understand the world of those being researched. However, Heideggerian researchers are acutely aware of their own interpretation and all that this brings to the research situation.

In general, the traditions of symbolic interactionism, phenomenology and interpretive hermeneutics all prescribe to the belief that our worlds are socially created. They recognise that this is possible only through the human ability to attach meaning to objects, events and interactions through the process of intentionality: the interaction between object and subject. All suggest that people are influenced by the world they live in, that there is no one truth and that meaning is subjective, historic, situational and contextual (Grant & Giddings, 2002). All inform my approach to this interpretive research project. Symbolic interaction focuses my attention on the relationship between object and subject, on the social construction of meaning yet the imperative of self in individual interpretation and understanding. It also highlights the importance of language in constructing and conveying meaning. Phenomenology reminds me that reality is not objective but is inextricably linked to a consciousness of it. A new consciousness can surface if the taken-for-granted is put to one side to allow alternative interpretations to surface. Hermeneutics makes me mindful of the process of interpretation and that the lived world of the author of the text and the lived world of the interpreter are both significant if new meaning is to be revealed. Here congruence can be seen between the constructionist epistemology underlying this research and the theoretical perspective of the study.

Methodology

The primary methodology that has influenced this research is that of grounded theory. The grounded theory methodology sits within the interpretive paradigm as defined by Crotty (1998). Grounded theory was developed in the 1960s by two sociologists, Barney Glaser and Anslem Strauss (1967). They argued that a social

process could only be truly understood by becoming immersed in the world of the research participants in order to study the particular phenomenon in depth. They proposed that theory emerges from the data by a process of alternating data collection and analysis; they named this process the 'constant comparison' method. The model they developed offers a highly systematic approach to study design.

Grounded theory is seeking to find the answer to the question "what is happening here?" (Giddings & Wood, 2000, p.8). It "searches to identify the core social psychological and/or social structural process within a given social scene" (Creswell, 1998, p.26). In this way grounded theory is an appropriate methodology to unravel the intricacies of a process such as clinical conversation to determine what is actually happening from the perspective of the nurses being appraised. Grounded theory makes its greatest contribution in areas where little research exists and can be considered a precursor for further investigation. Here again it fits with the topic under investigation as no research has been undertaken specifically looking at clinical conversation as an appraisal process within the context of clinical nursing.

The initial intent for this research project was to focus on the grounded theory approach developed by Strauss and Corbin in the 1990s (Strauss & Corbin, 1998). Congruence between their epistemology, the theory of knowledge and the grounded theory methodology they espoused is evident. Strauss and Corbin see grounded theory as one way of "gathering knowledge about the social world" and gaining "a greater understanding of how the world works" (1998, p.4). Both these comments are constructionist in nature illustrating that, for them, meaning is constructed and not discovered. Strauss and Corbin stress that reality cannot be known but it can be interpreted (McCann & Clark, 2003).

Symbolic interactionism is part of the theoretical framework of grounded theory. Strauss and Corbin (1998) outline several theoretical assumptions congruent with the idea of symbolic interactionism, for example "the realization that persons act on the basis of meaning" and "meaning is defined and redefined through interaction"

(p.11). It is the analysis of interaction that leads to phenomena identification. This positioning not only provides direction to the researcher when observing interactions but also alerts them to think about their own influence upon the observational situation or interview. When adopting the symbolic interactionist approach the researcher needs to be actively engaged in the world of the study (Blumer, 1969). In conclusion, the grounded theory approach developed by Strauss and Corbin can be seen as having a constructionist epistemology within a qualitative interpretive paradigm.

All variants of grounded theory include the following strategies as summarised by Charmaz (2004, p.313):

- simultaneous data collection and analysis
- pursuit of emergent themes through early data analysis
- discovery of basic social processes within the data
- inductive construction of abstract categories that explain and synthesise these processes
- sampling to refine the categories through comparative processes
- integration of categories into a theoretical framework that specifies causes, conditions, and consequences of the studied processes.

As will be discussed in more detail later, this study was unable to meet the grounded theory requirements of simultaneous data collection and analysis, however emergent themes were pursued, abstract categories developed and a social process identified. The goal of this study was not to test an existing theory but to develop a substantive theory to explain the social process occurring during a clinical conversation. A substantive theory is generated for a specific, circumscribed area of inquiry (Munhall & Oiler-Boyd, 1993). Substantive theory, however, may have important general implications and relevance and can be a strategic link in the formation of a formal theory (Glaser, 1992). The substantive theory that I have produced is grounded in the data but lacks, to a degree, the legitimacy of a true grounded theory study. However, it must always be remembered that any theory, whether firmly grounded or not, is fluid and

provisional (Schram, 2003).

Methods

In line with the interpretive nature of this qualitative study, the following methods were used: purposive sampling, observation of clinical conversation, interviewing the nurses following their appraisal, comparative analysis of data, abstract conceptualisation and substantive theory building.

Sampling

My primary method of sampling in this study was purposive; nurses who had undertaken an appraisal using the clinical conversation format were interviewed. It was their understanding of the process that I was interested in. Initially the intent of the study was for theoretical sampling to occur. Theoretical sampling has been defined as: “the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses data and decides which data to collect next to develop theory as it emerges” (Morse & Field 1996, p.159).

Theoretical sampling allows the pursuit of previously unforeseen lines of inquiry, enabling a closer inspection of reality. I had envisaged interviewing one nurse, analyzing the data and then interviewing the next nurse to further explore lines of enquiry until data saturation occurred. However, theoretical sampling did not take place for a number of reasons. The clinical conversation appraisal process was developed over a considerable number of months. This involved discussions with members of the senior management team and Locality Nurse Advisors. Once the package had come together in terms of the design of the assessment tools and the nurse and appraiser guidelines, it was then trialed on two advanced nurses in Auckland. From this, refinements were made and a teaching video developed. This was used to support the skill development of the nurse assessors who, although experienced assessors, had not used such an integrated assessment technique before.

Once the assessor training had taken place, the aim was to roll the new appraisal process out nationally to all advanced FPA nurses. At this stage in the project's development, senior management became concerned about the levels of practice that were initially contained in the documentation. Within the organization levels of practice 1-4 were associated with monetary rewards. Senior management felt that having such transparent indicators would result in requests by nurses to move up the practice levels and consequentially have significant financial implications. At this point two options were considered: to limit the roll out to research participants only, rather than all advanced nurses, or to remove the levels of practice. In the end both occurred, however the negotiations which culminated in this decision delayed the start of the study. Not only was the start date pushed back but the pool of nurses from which theoretical sampling could have occurred was greatly reduced. No longer would there be over forty nurses who had been appraised using clinical conversation and who could then be invited into the study to be interviewed; now the group was greatly reduced to only those who were prepared to be involved. In the end, two groups of nurses were invited into the study: those that were practicing as FPA advanced nurses and were willing to be appraised using the clinical conversation format, and those Locality Nurse Advisors who were prepared to be their assessors.

FPA advanced nurses were invited to participate in the study via a written invitation in the National FPA Memo. The request was issued by the National Nurse Advisor rather than the researcher to minimize any possibility of coercion. The invitation consisted of two parts: firstly to take part in the new appraisal process of clinical conversation and secondly, to be available at a later date to offer feedback to the researcher about the appraisal process (Appendix C). All nurses were made aware that they may not be interviewed; this would depend on whether the researcher felt that data saturation had occurred. Eight nurses consented to be part of the study and each undertook the appraisal process; in the end seven of these nurses were in fact interviewed (Appendix D). All six Locality Nurse Advisors, who have traditionally undertaken the annual appraisals of clinical nursing staff, were also invited into the study via a written invitation placed in the National FPA Memo (Appendix E). Three agreed to conduct the appraisals using

the new format (Appendix F).

My inability to collect data on the basis of theoretical sampling weakens the results of my study. In reality I have been strongly influenced by the theoretical perspectives of grounded theory and the methods they employ but as will be discussed in the following sections my study lacks the methodological nuances required to be a true grounded theory research project.

Data Collection

Data collection included two observations of clinical conversation by the researcher and seven semi-structured interviews with the nurse after they had been appraised. Most of the interviews took place within a fortnight of the appraisal and all interviews took place over an eight week period. Five of the interviews were face to face and two were conducted over the telephone. Each interview was recorded onto tape and later transcribed by a professional transcriber who signed a confidentiality agreement (Appendix G). During the observations of the clinical conversations notes were taken and written up as memos. Chenitz & Swanson (1986) define memos as “written capsules of the analysis [which] serve to store the ideas generated about the data” (p.8).

All interviews started in the same way by acknowledging that the nurse had been through a process of talking and sharing evidence of practice with the assessor. I then asked the following question:

“What was the process like for you?”

As soon as I had conducted my first interview I started to think about the responses I had been given and what their meaning might be. Armed with these thoughts I undertook the second interview. After this interview I thought closely about what I had heard and looked for similarities and differences between both interviews. I carried on conceptualising and comparing ideas throughout the data collection process; in this way there are parallels with theoretical sampling. For example, my

first interview was with Bet. She talked about the process being reflective, rigorous, and objective; such concepts influenced my hearing of the responses of the second interview and so on. The depth of analysis at this stage, however, was limited. I went to each new interview with thoughts and ideas from what I had heard before but did not overtly challenge these by seeking clarification or divergent comment from the nurse; rather I let the interviewee describe and talk about the process of the appraisal from her perspective. At this very early stage of thinking about the data the main themes that I identified were those of supervision, reflection and change in practice; it was these that informed my literature search. Later, as I explored the data in much more detail, other concepts became prominent.

Data Analysis

Within the interpretive paradigm there are two predominant methods of data analysis: analytical induction and grounded theory (Bryman & Burgess, 2000). Both analytical induction and grounded theory can be considered as theory-building approaches to analysis. In the situation of clinical conversation, the analytical inductive approach would be an examination of the phenomena to determine a likely hypothesis for what was occurring. This hypothesis would then be challenged to establish if it does indeed fit with clinical conversations on all occasions. Such an analytical approach goes beyond the scope of this study where only seven nurses were interviewed.

The analysis of data in this study has again been informed by grounded theory. As previously mentioned, there had been some meshing of theorising and data collection over the eight week period of data collection followed by the literature review. After this a closer analysis of each interview took place. From this considered analysis of the data “categories” were generated. These categories were challenged by existing data until I felt they had meaning and were of importance within the social process that was emerging. I worked with the categories to examine their relationship one with another and to establish any interconnections between them. From this, ideas about categories and their

relationships developed; these were explored until a unifying explanation for the social process revealed itself, as will be discussed.

Through observation and interview the data gathered underwent careful scrutiny. Initially the text of each interview was examined in detail to allow concepts to be named and described. These concepts were then compared to the data from other interviews to identify similarities and differences; this process of constant comparison started straight away and continued through all stages of the analysis process. It is this process, which grounded theorists call 'open coding', that "leads to a fractioning of the data and a close examination of possible meanings" (Strauss & Corbin, 1998, p.32). The process of open coding uncovered the following concepts and themes: *making practice transparent, affirming practice, learning, non threatening, challenging, outside perspective, changing mind, time and reflecting/looking closely at practice.*

In order to challenge or affirm these early concepts I returned to the data to explore them in more detail and to identify possible linkages between them. Already I was aware that my initial thinking that had influenced my literature search was being developed further through a closer examination of the data. On returning to the data I became aware that the participant interviews differed in the extent to which they talked about the process of the appraisal as a whole compared with detailed discussion about the intricacies of each individual assessment activity. Jane, for example was systematic in her comments about each individual assessment activity, and talked about how each formed part of the process and the value, or otherwise, of each procedure. The data from Bet was much more affective in content with global comments regarding the process as a whole. Sue, on the other hand, provided a mixture of comment, some relating to the assessment activities whilst others were more generic in nature.

In light of the above I decided to analyse the data by individual assessment activity to offer a different perspective from the thematic analysis I had observed up until that point and to explore the possibility of how the themes related to each other. For example I focused on the case study; I looked to see how the participants felt

about it, in what way practice was revealed, how doing the case study affected thinking and what learning or changes to practice were identified by the participants. I began to see how the concepts were linking together in the form of a process. The looking at practice in a detailed way lead to an evaluation of practice which resulted in seeing things differently, feeling differently about practice and, for some nurses, actually deciding to practice differently. This initially seemed like a linear process, however, I then became aware that the change - either thinking differently, seeing different ways to practice or doing things differently - seemed to be occurring at different times. Evaluation and review of practice sometimes occurred when discussing the case study with the assessor; equally for some nurses it occurred during the process of thinking about and preparing to write the case study. Similarly with the chart audit, for some nurses it was the self review that altered perception, whilst for others it was having the external perspective and the ensuing discussion with a peer that seemed to be the catalyst to thinking and feeling differently. Whilst analysing data pertaining to individual assessment activities I became aware of comments referring to the whole appraisal process, the total package. This made me mindful of the fact that maybe the whole was more than the sum of the individual parts.

The above process has parallels with that of axial coding, a grounded theory process that starts to put the data back together in a conceptual way after fracturing has occurred (Strauss & Corbin, 1998). Here then is the start of construction at a theoretical, conceptual level requiring inductive and deductive thinking. It has to be remembered that this interpretation is none the less grounded in the data. There is a fine balance between sensitivity and objectivity at this point in the process of theory building between the forcing and emergence of outcome. Sensitivity has been defined as having insight into, and being able to give meaning to, the events in the data, to look beneath the obvious; objectivity ensures that the interpretation of the researcher is a "reasonable, impartial representation of a problem under investigation" (Strauss & Corbin, 1998, p.53). I believe that my analysis walks the line between sensitivity and objectivity, a decision that each reader of this research will need to determine for themselves.

By looking deeply at their practice the nurses felt differently about their practice and saw themselves in practice in a different, new way. I then wondered if these changes occurred for all nurses at the same time. Were there nurses who learnt from self reflection as a solitary exercise compared with those who learnt from narrating their experience to and with others? This thought sent me back to further analyse the data. From a closer examination it appeared that this was not necessarily the case. For some nurses a significant part of their learning occurred during the self reflection and internal dialogue part of the process; however, awareness was also raised during discussions with the peer and assessor. For other nurses learning predominantly occurred as a result of the clinical conversation with the assessor. The predominance, however, did not mean that learning did not occur at other stages of the process. This suggested to me that the clinical conversation appraisal process is sufficiently flexible to allow different ways for learning to occur and at different times.

The above process of analysis again has parallels with the concept of selective coding inherent in grounded theory. Selective coding discovers the central phenomena under investigation by allowing the structure and process of the phenomena to be described. It is the process of integrating and refining categories towards building theory. Theorizing is the “act of constructing from data an explanatory scheme that systematically integrates various concepts through statements of relationships” (Strauss & Corbin, 1998, p.25).

I surmised that the core category central to my theory of clinical conversation is one of narrative learning. Within this are three levels: reflective discussion with self (an internal dialogue); reflective discussion with peer(s); and reflective discussion with the assessor. I use reflective in the sense that the discussion reflects on, and looks back at, the individual’s clinical reality. This clinical reality is framed and contextualised by the competency statements which directly relate to domains of practice. Having narrated work experience in all these ways the outcome is an evaluation of practice which leads to thinking differently about self in the work context and seeing how individual practice could change. The clinical conversation appraisal process could be summarised as creating a perspective alteration: a

mind shift. The process occurs through three distinct yet interrelated narrative learning cycles; each cycle can be a potential catalyst for change. For a detailed explanation of this theory see Chapter 6.

Reliability And Rigour Of Research

Qualitative research methods are now commonly used in the arenas of both social science and medicine. Their intrinsic value is generally accepted yet discussion persists on how best to ensure and enhance rigour (Barbour, 2001). Rigour is a means of assessing integrity and competence of the research process to judge its legitimacy. Rigour protects against bias and enhances the reliability of the research findings (Mays & Pope, 1995). Interestingly, grounded theory was developed in answer to criticism by positivists that qualitative research was unscientific because it lacked rigour (Smith & Biley, 1997).

Relevance Of Research

There are a number of proposed criteria for assessing rigour (Chiovitti & Piran, 2003; Lincoln & Guba, 1985). The first consideration needs to be whether the research will add to existing knowledge (Mays & Pope, 2000). The clinical conversation appraisal process is a new work-based assessment tool that, to my knowledge, has never before been used in the New Zealand health sector for assessing nursing practice. Revealing the social process of a clinical conversation will provide new information; this could lead to a discussion of its place within the wider scope of nurse assessment.

Credibility

The question of the researcher's credibility can occur at a variety of levels. Internal consistency concerns the 'fit' between the methodology, the methods, the research question and the philosophical beliefs of the researcher. As previously discussed, I suggest there is internal consistency between the research question and the broad principles of the grounded theory methodology and methods that informed this study. My personal epistemology favours constructionism as it incorporates the

belief that individual practitioners, within the scope of sexual and reproductive health, interpret information in a unique way. I believe there is no one absolute truth, only individual perception and understanding. Grounded theory has symbolic interactionism as a theoretical principle and, as clinical conversation is essentially a discussion about shared meaning and understanding, this seems an appropriate fit.

Credibility also relates to the 'fit' between the participants' views and the researcher's representation of those views. Various tools have been suggested to increase this credibility: member checks, peer debriefing, prolonged engagement with the participants, persistent observation and audit trails (Lincoln, 1995). The process of data collection and analysis inherent within my study has some of these mechanisms built in.

Engagement with the participants was significant; interviews were lengthy ranging from forty to sixty minutes, whilst the observations of actual clinical conversations took over an hour. As I designed the assessment package I had to lay aside my preconceived ideas about what the process was and truly hear the words of the nurses as they spoke to me about their experience of it from their perspective. This, I believe, I achieved as the process I describe is not one of assessment but of learning, something which I had not considered in detail before. Whilst I had assumed prior to the study that all good assessment involved learning I had not appreciated the extent to which, nor the process of how, learning took place within the clinical conversation framework.

The description of my analysis is in some way similar to an audit trail as it details my ideas, thoughts and rationale for the decisions that I made. I decided not to engage in member checking and peer debriefing, both contentious issues within the methodology, as different constructs may potentially bring differing results and thereby lead to confusion of interpretation. As Strauss and Corbin (1998) remind us, interpretation is the product of the researcher alone yet it must make sense to those involved. I did debrief with my supervisor who helped to clarify my thinking on a number of issues; her comments were exploratory and never prescriptive.

Transferability

As this is the first attempt to research the social process of clinical conversation within the specific context of sexual and reproductive nursing the transferability of the results remains uncertain. I hope to have provided sufficient descriptive data for others to evaluate the applicability of the theory to their context.

Dependability and Confirmability

Dependability is concerned with transparency of process and reflexivity of the researcher; confirmability refers to the objectivity or neutrality of the data analysis (Polit, Beck & Hungler, 2001). I have attempted to describe the process of data collection and analysis. The analysis is supported by direct quotes from the research participants; their words have been used in the context in which they were spoken. I have described how themes related to concepts and lead to the building of a substantive theory. Issues of dependability and confirmability must again be judged by the reader.

Ethical Issues

Criteria developed to assess the ethical considerations of qualitative research include informed consent, the doing of no harm to the participants and the maintenance of confidentiality (Tolich & Davidson, 1999). In addition there is my obligation to Te Tiriti o Waitangi, not only for the possible inclusion of Maori participants but also acknowledging research undertaken in New Zealand has an ethical responsibility to recognise tangata whenua and issues of sovereignty.

Te Tiriti o Waitangi

Research within New Zealand should consider the core principles within the Treaty of Waitangi: participation, protection and partnership. I liaised with the FPA Director of Maori Services and the FPA Maori caucus (made up of Maori employees throughout FPA) for guidance with my research proposal and to seek specific input regarding issues of participation, protection and partnership. The feedback I received was positive and no alterations to the research proposal were

suggested.

Historically Family Planning had employed few Maori nurses. Of the study participants one identified as Maori/Pakeha, the other seven nurses were of European decent. All nurses were aware of the research process; that the clinical conversation appraisal format would replace the existing format for appraisal, that a Locality Nurse Advisor would assess them and that I, a European, would then interview them and analyse the data.

As clinical conversation is primarily an oral assessment tool, its relevance to the different cultural groups within New Zealand may differ. It would be fascinating to undertake a similar study with a group of Maori nurses in particular. From an indigenous perspective the basis of knowledge creation seems to be the “dynamic relationships that arise from the interaction of people with the environment, generations with each other and social and physical relationships” (Durie, 2004, p.5). Any assessment strategy for assessing Maori nursing practice needs to recognise this; it needs to go beyond the positivist paradigm. As Durie (2004) so succinctly reminds us: “Most indigenous people live at the interface of both scientific knowledge and indigenous knowledge...the challenge is to afford each belief system its own integrity” (p.13).

Ideally, separate competencies, assessment tools (and possibly assessors) should be used to assess these two types of knowledge. In practice, an assessment system that acknowledges and respects indigenous knowledge rather than judging it would be safer than one which denies or misjudges such knowledge. Clinical conversation may go some way to achieving this; here the assessor in some instances may be the expert, but at times they are also the partner and, I would suggest, the learner. This study, however, is too small to explore these complex issues.

Do No Harm

Participants must be unharmed by the research process; in the case of my

research this includes both the assessors and the nurse participants. Assessors must feel adequately trained to undertake the new process and nurses must feel that the process is a legitimate one in terms of meeting their annual appraisal requirements. To this end a significant amount of time was taken to develop and refine the process and assessors were trained in how to use the technique.

I had undertaken the ongoing professional development and training of FPA assessors and was often consulted regarding assessment decisions. I was aware that this was a difficult situation within the context of my research study as I did not want to be perceived by the assessor as assessing their performance, nor by the nurse being assessed as secondarily assessing the presenting evidence. For the duration of my study the National Nurse Advisor took over the responsible of supporting both nurses and assessors alike in terms of assessment decisions. At the start of both observations I discussed my role as that of observer only, and not judge, in terms of assessing competence of either the nurse or assessor.

Voluntary Participation

As I was perceived as part of the senior management team by the nursing workforce and therefore potentially powerful within the organization, it was important that nurses felt no sense of coercion in terms of joining the study. It was for this reason that nurses were invited to partake via a written invitation sent by the National Nurse Advisor rather than by me. Several nurses had their questions answered by the National Nurse Advisor prior to enrolling for the study.

Informed Consent

All participants, both the nurses and the assessors, received detailed information in the form of participant information sheets prior to consenting to be part of the study. Participants were given the opportunity to ask any questions about the research prior to signing the consent form (Appendix D & F). On the information sheet the participants were alerted to the fact that they could withdraw at any point of the research process and no explanation would be sought.

Confidentiality

Confidentiality has been maintained by removing all identifying information, securing data in a locked filing cabinet, undertaking the analysis of data myself and using pseudonyms where necessary. Complete anonymity can not be guaranteed within an organisation the size of Family Planning but every effort has been made to maintain confidentiality particularly in the writing up of the study.

Summary

To summarise this study sits within the interpretive paradigm of social science research. I have attempted to demonstrate congruence between my epistemology, the theoretical position of the research, the methodology and methods used. The grounded theory methodology and methods espoused by Strauss and Corbin (1998) underpin my research. Unfortunately I have been unable to adhere to the methods completely in terms of constant comparative analysis. Whilst this renders the results less than optimal I hope, nonetheless, to have developed a substantive theory which has resonance for the research participants, in particular, and readers in general.

CHAPTER 4: DATA ANALYSIS AND RESEARCH

Findings

Introduction

In this chapter I present the findings. I explain the three distinct yet interlinked learning episodes that emerged from the analysis of the data. The types of learning will be organised into three sections, depending on their source; firstly as a result of completing the assessment activities, secondly as a consequence of the peer review and finally as part of the interaction with the assessor. The learning is predominantly concerned with new insights into self as a practitioner.

Reflective Discussion With Self

In preparation for the appraisal each nurse had to collate evidence of her clinical practice. A variety of assessment tools were developed to assist with this process (see Chapter 1). Collecting examples of practice and the thinking about practice at this stage of the appraisal process can be seen as an internal dialogue; thinking about self in the work context. When interviewed the study participants talked about specific assessment activities and the outcomes of undertaking them but they also spoke in broader terms about looking at practice and evaluating practice. For this reason results will be separated into those relating to individual assessment activities followed by those relating to the assessment activities as a whole.

Viewing And Reviewing Practice

Case Study

The case study provided an opportunity to examine and reflect on a complex or interesting consultation in detail. It seemed to be the most challenging part of the preparatory evidence. Firstly, finding a complex detailed consultation to meet the necessary criteria was taxing.

"The most tricky part was finding a suitable case study" (Sally, p. 1).

"The case study was a bit of a pain, mainly because I couldn't think of one that was difficult but after discussion it probably was easier than I thought" (Meg, p.2,).

Secondly, the thought of actually writing a piece of work was off putting and caused trepidation. The initial response was one of anxiety.

"It was daunting to start off with but once you got into it, well that was fine" (Sue, p.1).

"Certainly the case study thing was probably the most difficult bit for me...but when you actually get to do it, its not threatening, easy to do " (Louise, p.5).

"I haven't actually written one myself for quite a while and I thought how was I going to do this...that was slightly more challenging" (Bet, p.1).

"I thought 'oh do a case study, do I really want to do a case study?' Then actually having sat down, it came very quickly. I just was able to write it quite quickly" (Bet, p.1).

The nurses' thoughts about the case study altered as they successfully constructed their written account of a complex consultation. As illustrated in the following quotes, the writing of the case study triggered thinking to occur in a variety of ways: thinking about the specific clinical situation in question, thinking about their own practice in general but detailed terms, thinking in terms of reviewing and evaluating their practice. I have interpreted such thinking as an internal dialogue with self. At this stage of the process the case study was not shared with the assessor; it was an exercise undertaken by the nurse which she would later narrate at the time of the appraisal.

The case study facilitated an in-depth look at the nurse's clinical reality.

“It certainly made me look at my practice” (Louise, p.5).

Indistinguishable from the looking at practice came the thinking about practice; the actual representation of practice in a written form deepened thinking about the consultation under consideration. The exercise of constructing a piece of written work triggered a more conscious thinking than before.

“Thinking around all those issues and putting it down on paper makes you actually think about it more....The case study, particularly if you chose something not straight forward, is quite a good reflection exercise” (Bet, p.6).

The thinking was not the normal type of thinking but was different in some way, another perspective was at play.

“It was thinking more outside, not just the basic stuff that we do” (Bet, p.6).

The outcome of, looking at, and, thinking about, clinical practice in this way was more than just a description of a consultation; it actually identified how practice was carried out.

“I think it just made you think about how you do things” (Meg, p.4).

Being able to think about the actual process of work rather than the result of work suggests a depth of reflection.

The case study allowed for thinking in detail about a specific clinical situation. For Jane the thinking had been detailed prior to the writing of the case study.

“It was interesting to write. The case I chose was one I had to give a lot of thought to because it was about someone who I knew was coming in to see me and I’d had to do quite a bit of preparation for” (Jane, p.1).

For nurses Bet and Sue, however, the thinking that occurred as a result of writing the case study allowed for different conclusions to be drawn about the consultation.

“When I finished, I thought she actually came for one thing but there were all sorts of other issues” (Bet, p.6).

“There were a whole pile of issues that arose from this consultation” (Sue, p.5).

The expansion of possibilities that occurred for Bet and Sue appeared to relate to a specific client within a specific consultation and therefore may not be transferable across the whole of their clinical practice; in this way it can be regarded as a deepened, situation specific, insight which created a change in perception. In addition to this Bet gained new insights, triggered by writing the case study, which she could then transfer across her practice. She became aware of the importance of relating to clients and establishing what is important for them, from their perspective, during the consultation.

“I had to think about issues, about relating to clients and what was important for clients” (Bet, p. 6).

The view of practice was altered through the process of writing the case study. Individual consultations were thought of differently from before and alternative interpretations considered. For one nurse the new insight she gained from thinking about the consultation she could apply across her clinical practice.

Thinking about practice naturally involved reviewing and evaluating practice. As a consequence some nurses felt differently about themselves as practitioners whilst others were able to see ways they could change their practice.

One nurse identified how the case study made her evaluate her practice.

“Putting it in writing makes you actually think about whether what you are doing is actually working” (Meg, p.4).

The evaluation concerned her effectiveness as a practitioner: whether what she was doing had a positive impact on her clients. She was able to reveal to herself, through the process of the case study, the degree of her expertise - her skill as a practitioner.

"I guess you don't really realize that what you're doing has a certain degree of expertise until you actually analyse it, you just think it's your job and you're doing it... you don't really realize analytically that you are working at that level until you actually go through something and prove that you are in writing" (Meg, p. 4).

For Meg this revelation was legitimate and justifiable because it occurred as a result of an analytical review which implied a depth and a detail to the process. A shift in perception about self in practice occurred.

For some, the review and evaluation of practice facilitated by writing the case study prompted thoughts about how they could practice in a different way.

"[It] really makes you think about what you would do differently" (Louise, p.5).

"Putting it down on paper makes you think about it. Writing about it makes you think about it. It's putting that down and thinking and reflecting about it and you know if you could've done it slightly differently or slightly better" (Bet, p.6).

The writing and the thinking, separate yet intertwined allow new possibilities to be considered.

The review and evaluation was not exclusive to self in practice. One nurse's evaluation included a review of the organisation (FPA), their policies and their place within the broader provision of health care services.

“I found it very useful because I think it is good to reflect and basically you can be open in it so I did a bit of criticising of policies as well, I felt quite comfortable doing it that way...to have a say in what I thought could change” (Sally, p.3).

For the majority of nurses their internal dialogue was altered as a result of writing the case study. Their thinking changed. Some felt differently about the consultation under review and some felt differently about their practice in general. They were able to identify areas of potential change and in one instance were able to identify ways in which the organisation could change.

Chart Audit

Although the nurses undertook the chart audit with a colleague some spoke in a way that suggested that, by doing the audit, an internal dialogue occurred. One nurse described the process of undertaking the chart audit as:

“Good to look sort of from outside looking in” (Meg, p.1).

Another nurse said:

“When you look back you realise you don’t always do what you think you do” (Sally, p.1).

Looking ‘back’ and looking from the outside ‘in’ suggests a different perspective is being brought into play. The reality of what the nurse actually did is being considered from an alternative standpoint. This new position allowed practice to be seen in a new way. The new way is implied by the use of the words “you don’t always do what you think you do”. The process of the chart audit enabled the nurse to challenge her ideas and beliefs about what she thought she did by seeing what she did in reality. This allowed her to gain new insight into how she actually practiced.

Interestingly two nurses used the word 'outside' to describe a different way of seeing their practice, Sally in relation to the case study and Meg in relation to the chart audit. This suggests seeing differently, maybe more objectively, and having new realisations into self as a practitioner. This may be achieved by the nurse having an internal dialogue from an altered standpoint. The standpoint is one of reflecting back on practice, this reflecting allows new interpretations to be revealed, yet this reflection is contextualised by the structure of the audit tool.

"I found it, from a personal development point of view, much more useful because you've got time to reflect on it" (Sally, p.2).

For some nurses the internal dialogue that seemed to occur because of the chart audit not only enabled practice to be revealed but also evaluated. Such an evaluation led to the identification of potential areas of change.

"Just going through your audit too, it pulls you up, oh yes there were a couple of little things I could've located or paid more attention to" (Bet, p. 3).

Here Meg identifies a part of her practice where change was needed.

"You could see how important it was to have the documentation at a level that any provider could come in and know exactly what you were talking about" (Meg, p.1).

The internal dialogue was seen by one nurse as necessary if change was actually to take place.

"Initially you think "oh well that's alright" and then you think "no actually it's not alright and I'm going to make changes" without feeling threatened about it so you actually self reflect a lot better...if you're doing it yourself you're much more likely to make changes" (Sally, p.2).

Sally was able to learn about herself from viewing her practice retrospectively. She identified her current practice and decided that she wanted to practice in a different way. She implied that such change may not have occurred if it had been suggested by someone else. As the realisation about self was personal she was willing and able to act on it.

During an observation of a clinical conversation one nurse spoke of how the chart audit highlighted the fact that she did not give clients the choice regarding how their cervical smear should be taken. She took the smear and placed it on a slide without offering the option of using a liquid based technology. She did not discuss this with her peer; it was an observation that she made herself when undertaking the audit. Since realising this she has made a conscious effort to change her practice and found she

“...was quite surprised with the change” (Rachel, p. 1).

Rachel also decided to make a change to her practice regarding the use of templates on the computer.

“I was hopeless before but now I fill in more templates...it actually made my practice a little bit more up to scratch” (Rachel, p.1).

It appears that the chart audit offered the nurses a non-threatening, in-depth review of their individual clinical practice. They were able to make a judgement in their own minds as to what was acceptable and what was not acceptable practice. For the study participants quoted above, this internal dialogue lead to identifying potential change in practice, seeing a way of doing things differently and, for Rachel, implementing the changes.

Professional Development Activities

The nurses were asked to collate all their professional development activities on to a record sheet. Three nurses commented on this during their interviews. By undertaking this activity one nurse gained insight into her lack of in-service training.

“This was a very interesting one for me, it highlighted that I’d really missed in-service” (Jane, p.2).

Another nurse realised that she had not documented the readings she had done the previous year.

“I haven’t actually written a list of what I’ve read or what my learning outcome was from that. And that’s something I need to do” (Bet, p1).

Here more clearly, the assessment activity provided the altered standpoint from which professional development could be viewed. Yet ownership of this insight was personal as can be seen by the use of the word “I”. For Jane, looking at her practice in light of her professional development activities created a change in behaviour.

“In this appraisal it goes one step further and says to make a note of what you’ve learnt which is very valid and a good idea [otherwise] you read something and just move one....And so I’ve started doing that and I will continue to do that because I think it is a really, really good idea” (Jane, p.2).

For Sally the professional development record sheet highlighted an area of potential change.

“I think one of the things that it brought up for me was that I should have kept better records of my readings” (Sally, p. 2).

Reviewing practice in this way fostered potential change for two of the nurses and actual change for one.

Verification Record

The verification record provided an opportunity to document and gain external verification, by way of signature, concerning the different roles that the nurse had within FPA. One nurse specifically mentioned that the verification record sheet influenced how she perceived herself. Here again new insights were developing which, for this nurse, were affirming and supportive:

“...it was also interesting seeing that in actual fact I have achieved a lot more than I realised” (Jane, p.2).

Client Feedback Forms

The majority of nurses did not comment on the client feedback forms. Of those that did, receiving the client’s perspective on service was a positive experience:

“Completing the client feedback forms that was easy...it was actually very affirming” (Jane, p.1) and

“I thought it was useful giving the client feedback forms” (Sally, p.2).

Being seen as affirming suggests that the feedback was considered and a conclusion reached about what it meant. For such a conclusion to have been drawn an internal dialogue – thinking - must have occurred. Whilst the client feedback forms were discussed with the assessor no nurse specifically commented about this during the interviews. It was at the time of self-review that they seem to be most pertinent.

Self Assessment Form

The self assessment form addressed the competency statements within each domain of practice. It was completed by the nurse at the end of the gathering of

evidence phase and prior to the clinical conversation. It asked the nurse to check off the evidence she had collected against the competency statements ensuring that she had met all the requirements. Only two nurses specifically commented on the self assessment form. One nurse had a similar emotional response to it as others had towards the case study; initially it seemed daunting and complicated yet on further consideration seemed less so.

“Oh my, don’t like the look of that...then realising that it’s not too bad at all”
(Rachel, p.1).

Another nurse identified how it enabled her to review and evaluate her practice.

“Its cut and dry and I’m a cut and dry person, and I like that; it let’s you know what you haven’t done...It gives you a clear cut picture very quickly of exactly what you’ve achieved, what you haven’t achieved and where the gaps are, and it was quite detailed” (Jane, p. 4).

Again the self assessment form offered another perspective from which practice could be viewed. Such viewing engaged thinking; an internal dialogue with self.

The Assessment Activities As A Whole

Some nurses talked about how the assessment activities as a whole gave them the opportunity to look at their practice. Their comments were not related to a specific activity but were more global in nature.

“[the activities provided]...an opportunity to make me look at my practice”
(Louise, p.6).

The use of the word “clear” by Rachel in this context suggests an unfettered look, a real seeing:

"[the activities]...gave me a clear look at myself to see how I work" (Rachel, p.1).

Looking, in this way moves beyond the surface, the superficial, to what lies beneath.

"You look at things a lot more in depth" (Bet, p.1).

"[the activities were]...very comprehensive" (Rachel, p.3).

This deep looking revealed practice, made it overt and transparent:

"...how I do what I do and where I do it" (Rachel, p.3).

For Bet this way of seeing was new and required time. Thinking afresh and rethinking suggested a change of perception, the possibility of new insights.

"You need a fresh look at it...you need to take time to rethink" (Bet, p.6).

For this to occur a mind shift has to have taken place. The appraisal process enabled her to reflect in a different way; this difference changed Bet's perception about how she previously thought she practised.

"This is a mental exercise...you have to get your mind into tune...it's the frame of mind your in, it's a thinking process....Some things we do all the time, we're not actually putting it into words or writing it down, we're doing it sub-consciously" (Bet, pp.2-6).

The 'outside' perspective that was mentioned in relation to the chart audit and the case study may be similar to the 'rethinking' and the 'thinking' afresh here. I believe that the altered perspective is facilitated in part by the assessment activities; the extent to which this occurs and the mechanisms involved remain unclear. The thinking anew may be triggered by the very fact of being able to

stand back and consider one's work in depth as the assessment activities demand. This alone may be responsible for the altered perception. It may also be due to the competency statements which reframe practice in a way that may be new to the nurse and so provoke thinking. Finally the triggering of the internal dialogue by either or both of these processes can lead to the development of new insights and altered perceptions.

For Jane the internal dialogue appeared to be the predominant narrative. She summed up her experience of the clinical conversation appraisal process as follows, clearly stating how she was able to review and evaluate her practice.

"This appraisal brings out the gaps in practice because of lack of opportunity but also the weaknesses in practice where opportunities haven't been taken up...I think it gives a much better picture of where your strengths and weaknesses lie" (Jane, p.2).

The use of the word 'weakness', on two separate occasions is interesting; it implies areas of practice where further skill development needs to occur. The insight about potential areas of change is balanced by recognition of strengths and achievements.

"You can literally follow your path, see where you have been, see where you have achieved things...see where one needed to fill in a bit more of a page in the future....Putting all my experience together, it was only then seeing the appraisal done in this form that I realised just how much I had done" (Jane, p.2).

Jane also highlighted the clinical focus and the comprehensive nature of the appraisal.

"I think [the appraisal] relates well to my clinical practice through your self assessment, through your peer review, through your chart audit and the client

feedback. I can't really see how else you could do anything or what more you could do to make it relate to your practical work" (Jane, p.8).

In summary, undertaking the assessment activities, in preparation for the clinical conversation, appears to have created an opportunity for the nurses to engage in an internal dialogue which reflects on and looks back at their practice. Singularly they are reviewing their practice and thinking about it in a detailed way. This reflection has taken place from an altered standpoint; this altered standpoint may have been facilitated by the structure and nature of the assessment activities which provided another frame of reference from which to view routine practice. From this altered viewpoint the nurses see differently and take ownership of this seeing. This new seeing appears in itself to generate alternative frames of reference from which new perspectives are born.

Reflective Discussion With Peer

The nurses had two opportunities to have a discussion about their practice with a nursing colleague. One was while undertaking the chart audit and the second occasion was after the peer observations.

Viewing And Reviewing Practice With Peer

Chart Audit

The process of undertaking the chart audit seems to have allowed a thorough look at clinical practice.

"...all those consultations we have to have a good look at. How that consultation went, what we did, where we went with it, the ongoing relationship with that client. I had to keep going back to subsequent client visits and printing out more and adding them to the first one. With some of them I just have a single session but others I had to go back into it." (Rachel, p.2).

Some found it was a lengthy process yet relaxed, useful and affirming.

“The chart audit, again it was reaffirming....It took us about two hours” (Jane, p.2).

“Neither of us felt any pressure...I think it benefited both of us” (Sally, p.2).

When interviewed, several nurses spontaneously spoke about the discussion with their peer at the time of the chart audit. In addition to the internal dialogue that was occurring during the chart audit, as already discussed, the external dialogue seemed to have been significant for some. Sally enjoyed the opportunity of undertaking the chart audit with a colleague.

“It was fabulous doing my own chart audit with somebody” (Sally, p.2).

In particular, a specific issue for both Sally and Meg concerned the thoroughness and legibility of documentation. They decided to be each other's peer and so were able to compare and contrast a variety of consultations. They recognised the importance of adequate levels of documentation and identified ways in which their own documentation was lacking.

“I think it's a good thing to look at your own charts again with someone else. It does make you aware of whether or not you are falling into the trap of poor documentation...I found out what a poor typist I was at times. It's a wonder anyone could have understood it” (Sally, pp2-5).

‘It was good to look over what you had written with someone else...the spelling was usually terrible....You've got to be conscious of documenting everything because otherwise it looks like it could be quite risky” (Meg, p.1.).

Here both nurses are reassessing how they practice by auditing their records in the presence of a peer. Meg was not only able to identify the ways in which she needed to make changes to her documentation, she was also able to see a different way by observing how her colleague recorded her consultation. By viewing another's practice she was able to learn from this experience.

“The chart audit we both found really valuable....Doing it together and auditing each other’s was quite valuable so that you could see the way someone else did something and you took that on as practice or that they took something on of yours....I could see that I could do more around condoms, and blood tests and write better descriptions [physical examination findings] (Meg, p.1).

Meg was able to see her own practice in detail and decided, as a consequence, what changes she could make to her clinical work. For Louise the evaluative nature of the audit was enhanced by being able to review her work with another nurse alongside. She suggested seeing her practice in a changed way.

“I think it’s always good to have a look and particularly with somebody else along side to go back into your practice and it certainly was good in that respect to really make me look... the bits that I should have done and didn’t do or bits that I didn’t have to do” (Louise, p.2).

The use of the words ‘really make me look’ is interesting in two ways. Firstly it alludes to the depth of the reflection and secondly Louise takes ownership of this process by using the word ‘me’. The peer may have been an important part in assisting with such a deep looking but does not appear to be dictatorial or judgemental, rather, facilitatory. When asked at the interview “so which bits do you do that you don’t have to do, do you think?” she replied

“Oh, I blather on sometimes [laughing]” (Louise, p.3).

For Jane part of the discussion with her peer concerned the interpretation of one of the audit requirements. Initially both disagreed on what “documents communication with multidisciplinary team” meant (Appendix B, p.191).

“My peer and I disagreed on the meaning of some of what we were looking at and we both had a different view on what it meant” (Jane, p.1).

By both being able to discuss their interpretation they were able to reach a common position, in this instance to agree to disagree yet none the less proceed with the audit. This suggests that the process enables progress beyond conflict. In terms of an assessment process that demands input from others this is particularly important. A dialogue with others about the intricate and intimate nature of the individual's clinical practice needs to be non-threatening yet remain challenging in order to promote the likelihood of extending personal insight.

In general the chart audit, in terms of the dialogue that occurred with the peer, can be summarised as facilitating change by again viewing practice from a different perspective. This can create a shift in perception which facilitates the possibility of working differently. Such a shift allows things to be seen that were previously hidden or at least not fully recognised. Examples here include poor documentation and providing too much information to clients. Once made overt, practitioners can then decide whether to change their practice.

Clinical Observation

When interviewed, not all the nurses specifically talked about this assessment activity, however several nurses found it a positive experience and supportive of their clinical practice.

"...so that was a good process and she affirmed some things" (Bet, p.1).

"Peer observation and feedback were again very affirming" (Jane, p.1).

Later in the interview Jane implied that the process of peer review was slightly unnerving.

"She made the comment that nobody's perfect and I appreciated that" (Jane, p.4).

The inclusion of 'I appreciated that' suggested that the supportive comment of 'nobody's perfect' took a potentially anxiety-provoking process and made it more comfortable. In contrast, Sally did not seem to have felt threatened or unnerved by having her practice observed by a colleague.

"The clinical observation, yeah, I thought that was very useful, very useful having somebody else there" (Sally, p.2).

It was interesting to note that for Sally her peer was her junior in both age and years of experience, within the scope of practice, whilst for Jane her peer was of equal status.

Rachel made reference to the result of the dialogue that occurred during the peer observation.

"The peer observation made you look at your practice in depth" (Rachel, p.2).

This seems slightly more detached than Louise's use of the word 'me' when referring to the looking that occurred as a result of the chart audit. Nonetheless the peer observation enabled her to hear the perspective of another on her own practice; this perspective was then thought about and mulled over.

In general, the peer observation offered a different perspective for the nurse to consider. For Sally this led to new learning about self in practice. Here she mentions how the comments of her peer made her recognize why her consultations took more time. This same realization is reinforced later during her discussion with the assessor.

"[My peer] said 'you're thorough' and I realized why I am a bit slower...so that made me aware of that" (Sally, p.4).

While seeing her thoroughness as a reason for her slowness she was also able to recognize that talking was an issue, separate from thoroughness.

“My main fault is I probably do talk too much at times” (Sally, p.4).

One of the nurses who had been observed by the assessor rather than a peer felt that this added an additional dimension to the peer review. Having another nurse, who she had not previously worked with, observe her in the clinical situation added legitimacy to the feedback she received.

“In some ways it’s quite good having someone from outside who hadn’t seen you working before because it was a rather more objective approach (Bet, p.1).

Both the nurses who were observed by the assessor commented on this in their interviews. Here the feedback offered by the assessor suggests alternative ways to practice; it seems thought provoking yet supportive rather than judgmental.

“...and she picked up on things that wouldn’t have been picked up on before. So that was a good process and she affirmed some things.” (Bet, p.1).

“It was quite interesting to think of different ways that you might attack something or look at it differently” (Sue, p.2).

Change was triggered through the process of discussion with a peer. Whilst on the whole the peer discussion was illuminating and supportive there is the recognition that such feedback can be anxiety provoking and in fact disagreement can occur; however, such disagreement does not have to hinder the process. The discussion with the peer that accompanies the chart audit and the clinical observation offered a different perspective for the nurse to consider. From this came change, insights were altered, alternatives considered and for some, new practices initiated.

Reflective Discussion With Assessor

When I interviewed the nurses after the appraisal some commented specifically on the discussion with the assessor regarding individual assessment activities whilst

others made more general comments about the dialogue with the assessor. Both will be looked at separately.

Viewing And Reviewing Practice Again

Narrating The Case Study

As previously discussed some nurses found the writing of the case study thought provoking. For other nurses talking about the case study with the assessor seemed equally important in terms of gaining new insight into practice. The *talking* about the case study can be separated out into two distinct processes; each process appears to create differences in the way that practice is viewed. It may be the creation of such multiple views which is the precursor for changing practice. Firstly, the act of actually verbalising something that had only previously been thought about and expressed in the written format appears to alter thinking. This is the talking *to* the assessor by talking through the case study; the process is led and driven by the nurse; here the role of the assessor is one of listener. Secondly, the talking *with* the assessor, having a conversation about the case study, again offers opportunities to view things in a different way. On occasion both processes are so intertwined that it was difficult to separate them.

Louise decided on a consultation and wrote it up for her case study. She initially thought that neither the writing of it nor the discussion with the assessor would change her practice but once having done both these things she saw how she might work differently in the future.

“So yeah maybe I’d do things differently but when I thought at the end of the consult after she’d gone, ‘oh interesting case study write up’, what would I have done differently clinically or decision wise I don’t know if I would’ve done anything. But there now might be an opportunity that I might” (Louise, p.6).

It is not possible to unravel the process to say whether it was the writing of the case study, the telling the story of it to the assessor or the subsequent discussion with the assessor that created the possibility for change.

Rachel clearly outlined the process that occurred for her doing the case study: thinking about it, writing it down and finally sharing it with the assessor. All three parts were explicitly identified and together enabled her to recognise her practice. The outcome of such a process was a reconsideration of her practice:

“Just going back into that and redoing the whole consultation really in my head and on paper and then talking about it. Yeah, just going back into things and reassessing how I work. The things that I do well, the things that I don’t do so well, just recognising it, sometimes I really do quite well but sometimes I’m also not so good” (Rachel, p.2).

The ‘just recognising it’ suggests the tacit knowledge is being brought to the surface through the process of thinking about practice, writing about practice and talking about practice, all of which increase self knowledge. The ‘talking about it’ is a significant part of the process; it is unclear whether for Rachel it is the actual verbalisation per se that made her see things differently or the discussion with the assessor following the verbal presentation of the case study. Yet having chosen the words ‘talking about it’ the emphasis seems to lie with the teller of the story. Rachel did not describe this process as a discussion thereby suggesting a two way process; the implication is much more that she had the lead role. She also uses the word ‘I’, so the process can be seen as very much belonging to her. Her thinking is expanded by verbalising the consultation under consideration; thus gaining further personal insight.

“learning a few bits and pieces about myself that just fell into place a bit more” (Rachel, p.1).

Learning about herself and seeing herself more clearly in the clinical setting is valuable learning. At a practical level this learning translated into clinical changes.

“It actually made my practice a little bit more up to scratch, filling in the bits and pieces, dotting the i’s and crossing the t’s, all that stuff” (Rachel, p.1).

For Sue it can be more easily seen that learning occurred for her from the two processes mentioned above, one of verbalising the case study and secondly talking with the assessor about the case study. When talking with the assessor two distinct strands of the process were identifiable. One strand involved the assessor making direct suggestions about the case under consideration; here Sue is hearing an outside perspective and considering it. The second strand seemed to be a renewed internal dialogue, not so much because of any suggestions that the assessor was making, but because of the facilitation of altered thinking.

The viewing of practice through the medium of talking expanded Sue's thinking.

"It was interesting talking through the case study, the reasons I chose that consultation, and the whole pile of issues that that raised" (Sue, p.1).

Here Sue is implying that the actual talking offered an alternative to the mere writing of the case study. The depth and breadth of thinking that occurred during the verbal description of the case study appears greater than had been achieved by the construction of the case study on paper. Sue was able to identify that the actual talking facilitated learning. The external narrating of the consultation with the assessor offered a different process that facilitated new personal insights.

"Having to go talk through and present orally your case study was a much better learning process" (Sue, p.6).

Sue described the narration of the case study as a learning process. Hearing herself describe the situation affected her internal processing of the information, provided new information from which to learn and fostered new personal insights. Not only did she develop new insights from the verbalising of the case study but also from hearing the perspective of the assessor.

"[The assessor] suggested some things that I could have done which I wondered about later" (Sue, p.4).

Hearing the perspective of the assessor was thought provoking; it seemed that the assessor's suggestions were not taken as 'read' but were returned to at a later date for further consideration.

The talking *with* someone not only allowed the other person's suggestions to be heard but also facilitated thinking to occur in a different way.

"It was interesting to talk through the case study with someone, to think about what else could have happened" (Sue, p, 4).

Through the discussion with the assessor Sue was able to think about how she could change. The learning here was deep; the use of the word 'you' in the following quote suggests some level of personal ownership and a real consideration of how she could make changes to her clinical practice. This altered perspective, this new insight, was a powerful precursor to change.

"It really made you think about some things and why things happen and what you could do that you could change" (Sue, p.1).

For Sue the change may have been on an emotional level as well as a practical level; she 'felt better' having discussed the case study with the assessor. Not only was she emotionally stronger but she could see ways in which, by altering her behaviour, she could move forward from this difficult consultation. The change is seen as positive, empowering, not occurring due to external forces, or even in response to suggestions made by the assessor but a considered, valued change that she sees as important.

"I felt better about it after I had discussed it with someone else, actually shared it with someone else" (Sue, p.5).

This suggests that there is a relationship between emotion and learning. Exploring alternatives to her practice may have been hindered if her negative feelings about the consultation had dominated the discussion with the assessor.

To summarise, feelings about clinical practice altered through the verbalising of the case study *to* and *with* the assessor. For Louise the discussion with the assessor increased the likelihood of change in clinical practice, a change that she previously saw as highly unlikely. I observed this nurse gaining theoretical knowledge at the time of the discussion with the assessor about her case study. However, in my subsequent interview with her she did not acknowledge this. The receiving of theoretical knowledge does not mean that learning or change in practice will occur. For Rachel the discussion with the assessor, as well as the thinking about and the writing up of her case study provided an opportunity to reassess her workplace performance. The reassessment increased awareness about the aspects of practice where she performed well compared to those that she felt she did less well. Recognising strengths and weaknesses is often the first step in making changes. Sue clearly stated that she saw the process of presenting the case study orally and the ensuing conversation as a learning process. This learning was not merely the synthesis of theoretical knowledge nor just the taking on board of another's suggestions; at a deeper level it was where ways of practicing and the feelings engendered by practice were being explored.

Verbal Verification

Evaluation Of Practice

Prior to the appraisal the assessor spoke with colleagues of the nurse who was being assessed. This was to seek verbal verification about the nurse's communication within the health care team, her working relationships and her clinical practice in terms of supplying contraception within the strict standing order requirements. Only one nurse commented on this aspect of the appraisal.

"She said she had spoken to some of the staff to see how they found working with me and that it had all been positive" (Jane, p.6).

As discussed previously, it was Jane that specifically commented on the comprehensive nature of the assessment. She may have felt that seeking verbal verification added to the validity of the assessment process as another perspective

was brought into the discussion with the assessor. This perspective may have added to her feeling of the process being comprehensive.

Viewing And Reviewing Practice

Talking With The Assessor In General

Some nurses talked, in general terms, about the discussion they had had with the assessor. Here a similar process emerged, that of viewing and reviewing clinical practice. This leads to thinking about practice in a different way, seeing self differently within practice and potentially altering practice in the future.

The intricacies of this process are again revealed through a close analysis of the data. Exploring practice with the assessor allowed reassessment of practice to occur which raised the possibility of change, both in clinical practice and in organizational terms. The nurse's comments suggested that the assessor was able to facilitate an in-depth review of practice by raising awareness about practice, offering alternative approaches to practice and facilitating insight into how practice could change.

For Bet, the outside perspective of the assessor, added a different dimension to viewing practice and enabled the taken-for-granted, the subconscious, to be made more transparent.

"I think you can do a lot of things out of routine or out of habit and you need someone there to look at what you're doing" (Bet, p.2).

This process takes time; it may be the time taken to view practice that allowed for a looking in a different way.

"It was good to have time to review what we've been through" (Bet, p.3).

Bet was able to see herself in a different light through the discussion with the assessor; the outside perspective provided by the assessor altered her thinking around how she believed she was perceived by others in the team. This new

knowledge provided an alternative viewpoint for consideration and may well have challenged her sense of self:

“We don’t always see ourselves as other people see us” (Bet, p.5).

The assessor can be seen to offer direct input on areas where she considers change could occur. For Bet these were worthy of consideration.

“She found my clinical practice good, that I have good communication skills...she made me aware of some areas I could improve on, working in the clinic, working with everyone” (Bet, p.7).

For Sue the discussion with the assessor, the actual process of talking and sharing her clinical experience, altered her own internal dialogue; her thoughts and feelings about what she did as a nurse.

“Talking through things made you think about things...what you had done and why” (Sue, p.1).

Here again Sue is suggesting that talking with the assessor can be seen to trigger an internal dialogue with self: this is apparent by the use of the words ‘you’ which suggests a possible ownership of the process. Sue was thinking about what she had done and why she had done it, the focus was very much about gaining new insights about self. Here the assessor was not offering alternative perspectives, although this had happened when discussing the case study, but was facilitating or supporting Sue’s different, exploratory thinking. This appears to be in contrast to Bet where it was the perspectives of the assessor that were being thought about; how these perspectives were being internalised is not clear from the data.

For Sue talking is linked to thinking. The ‘talking through’ suggests a detailed conversation; not purely a description of practice but also a rationale for practice: the why of what was done. This expansive thinking was triggered by the external

dialogue with the assessor. Thinking and explaining the reasons for clinical decision making makes the behaviour overt. Such transparency can lead to the grasping of new insights and identification of ways in which change can occur. Here the transparency occurred due to Sue's own internal dialogue supported by the conversation with the assessor, whilst for Bet the transparency appeared to be due to direct feedback given by the assessor having observed Bet's practice.

The assessor did offer suggestions to both Bet and Sue on how their practice might change. However, a careful examination of their comments suggested that both perceived this differently. The use of the word 'she' in the quote relating to Bet (see previous page) implies that the assessor was being directive whilst for Sue, the use of the word 'we' indicates that the assessor was working with Sue to explore options. Interestingly, both Bet and Sue had the same assessor; she can be seen here to be perceived as working in a different way with each nurse.

"There are times when you need to be able to talk and discuss issues with someone else....it was good to look at issues that challenge us and work out how we could change, how we could put things in place" (Sue, p.4).

Talking with the assessor did create the possibility for change for Sue.

"We looked at things that would make certain situations better" (Sue, p.4).

This change was not limited to self in practice; talking with the assessor also brought up possible ways in which the organisation could change. This suggested that the discussion with the assessor was both deep, revealing what lies behind behaviours, and broad in terms of how these behaviours were contextualised.

"[The discussion with the assessor]...made me think about how we [FPA] could do things differently" (Sue, p.3).

Sue, as well as working for FPA, worked for a District Health Board and had taken part in a Professional Development and Recognition Programme (PDRP). The

PDRP process is related to levels of practice and consequently pay scales. She had to present a portfolio and was interviewed as part of the process. For her the clinical conversation review was different.

“Going through with someone, having to say, you know talk through, what you’ve done and why, that was one step further than an PDRP [professional development and recognition programme]. You actually felt that you got more out of it doing it this way. This way you got feedback” (Sue, p.1).

By ‘feedback’ Sue may be referring to what has been identified already from analysing her interview transcripts: namely the facilitation of altered thinking whilst conversing with the assessor and secondly, the hearing of alternatives proffered by the assessor. In terms of feedback it was the assessor feedback that seemed most important to Sue; other nurses found collegial feedback and client feedback valuable.

The discussion with the assessor was seen by one nurse, Sally, as safe and supportive, so much so that she was able to discuss what she perceived to be her areas of weakness. The level of trust that was present must have been significant to enable this to occur. It has to be remembered that the clinical conversation is primarily an assessment process where judgements about competence are made. Being able to openly criticize herself revealed a degree of insight into her own behaviour and also a sense of security regarding the way such information would be viewed. It is interesting to consider whether the level of trust and support felt by the study participants affected the degree to which they were able to critically reflect with the assessor.

“I was able to criticize myself and not feel uncomfortable about that....From the discussion I recognized minor parts of practice that I could do better at” (Sally, p.4)

The outcome of viewing herself, through conversing with the assessor, was an evaluation of practice. Here the assessor supported the development of fresh

insights. Although facilitated by the assessor, the study participant takes ownership of her new insight as indicated by the use of the word 'I'. The assessor became the vehicle through which new insights were gained.

"It confirmed what I thought of myself and brought up one or two points that I need to improve on" (Sally, p.4).

For Louise, the conversation with the assessor triggered thinking; the implication being that new ways to practice were being thought about. The ownership of the thinking was again captured in the use of the word "I".

"I'd probably not thought of doing it differently before" (Louise, p.6).

For Meg the ownership of new-found insight was firmly grasped.

"Just looking through and discussing things with the assessor, I can see that I need to slow down a bit more" (Meg, p. 3).

The intricacies of the process of viewing and reviewing practice that occur through sharing clinical experience with the assessor have been identified more clearly. The verbalising of experience, in particular via the medium of the case study, creates a renewed internal dialogue with self which has the potential to alter perception. Alongside this the talking with the assessor has two potential influences: firstly, that of hearing suggestions made by the assessor and thinking about these and secondly, that of deepening personal insights facilitated through dialoguing with the assessor. All three strands to the process of narrating clinical experience with the assessor can potentially facilitate alternative thinking. Altered thinking on the part of the nurse can be interpreted as new learning. This learning was significant; it occurred at a personal level but in the professional realm. Here the nurses felt differently about themselves in practice.

The Role Of The Assessor

Affirmation of practice occurred during all three narrations: with self, with peer and particularly with the assessor. Meg found the assessor helpful.

“I found her really supportive through the process” (Meg, p.5).

Sue expressed the importance of talking with the assessor. Not only did it expand her thinking, as has been illustrated, but it occurred in a supportive, reassuring way.

“Going through all the written stuff verbally with [the assessor] I actually found quite good and quite affirming...I felt that the opportunity to sort of talk through what you are doing, to see if you are validated in what you are doing and how you were feeling was really good... [it was good] just to feel ok and safe to talk about things” (Sue, p.5).

Sue found the verbalising offered a validation of practice. Here she seemed to imply that she wanted validation not just in terms of her practical work but also in terms of her emotional response to aspects of her work. The link between emotion and learning is again suggested. If Sue had been made to feel that her emotional responses were unacceptable or inappropriate, the degree to which her personal insights were altered could have been affected.

Bet found the process of sharing evidence with the assessor encouraging.

“She affirmed the facts” (Bet, p.6).

From Bet's perspective the appraisal process had been more objective than previous appraisals. The use of the word 'facts' further illustrates this perception.

Sally perceived the skill of the assessor to be one of facilitation.

“She was very professional and was able to get the best out of me” (Sally, p. 4).

The professionalism that Sally felt the assessor had may have affected her willingness to be openly critical of herself. She felt that such criticism would be judged in a professional manner and not necessarily negatively affect the overall assessment decision.

Louise spoke the most about the assessor. Her feedback included the relaxed nature of the process and the delight of having a person take a keen and focused interest in how she worked. She appreciated the assessor’s ability to understand the nuances of care: such that the outcome of care in objective terms might be the same but the process could be very different.

“Having someone personally interested in the way you deliver your services is extraordinary I think...she’s such a good communicator and easy to talk to....We can make differences and I know that the assessor knows that, not necessarily change the outcome but make a difference” (Louise, pp.5-8).

Having observed two clinical conversations I would describe the dialogue as open and honest. The nurses I observed both appeared to feel comfortable sharing in detail their clinical practice with the assessor and both were prepared to discuss options and explore new ideas.

The Process Of The Clinical Conversation: The Nurse’s Perspective.

Meaning

Four nurses commented on how the process was significant. Making meaning out of experience is an important aspect of the learning process.

“It had meaning to my practice” (Sally, p.5).

"It's much more meaningful" (Jane, p.2).

"You get a lot more out of it or a lot more satisfaction out of having done something that has meant something to you" (Sue, p.6).

"It's written by someone who knows the business; its not just bits of paper in a portfolio, its actually got some meaning" (Louise, p.9).

The use of the word 'meaning' reinforces my interpretation of ownership of learning. Learning that is significant and likely to create change does so because it makes sense to the person, it offers meaning and is therefore valued.

Assessment

It is fascinating to note that only one nurse specifically spoke about the fact that the clinical conversation was an external assessment process. None of the others referred to this part of the process in overt terms. Ironically, assessment was implicit within the interviews in terms of the nurses' focus on the self assessment of their own practice. This strongly suggests that the process was one of an internal dialogue supported and extended by an external dialogue. The assessment undertaken by the assessor seemed secondary to the nurses' thoughts about the process to say the least.

"Did I think it was an accurate assessment of my clinical practice? Oh I think so!" (Louise, p.7).

"If the Nursing Council came and did an audit on me how would they know anything about me? Whereas all the stuff that I've now got in my portfolio will give them a better idea...well it's pretty stunning really" (Louise, p.8).

Bet and Sally commented in general terms on the process as a whole.

"I think this is a more thorough process....It is more rounded, more a total package" (Bet, p.3).

“I thought it was a very good tool and I think you got a good overall picture....I actually found it a very good process, I was so impressed, it was like going onto another planet compared to what I’ve done in the past” (Sally, pp.5-6).

The use of the words ‘total package’ and ‘overall picture’ suggested that the clinical conversation appraisal process was comprehensive and captured the many aspects of the role of an FPA advanced nurse. Whilst other appraisal and assessment processes aim to do this, one nurse commented how clinical conversation goes beyond the more usual format of a written portfolio.

“I think it is a much more useful tool to work with than just a whole pile of words written on a page [i.e. a portfolio]” (Sue, p.7).

The reason it may be more useful could relate to the learning and meaning that ensued. This learning seemed to be the result of viewing practice within the frames of reference of the assessment activities and reflecting on practice through dialogue with self, dialogue with peer and dialogue with assessor which offered the opportunity of multiple frames of reference. As suggested by Sue in the quote below the process requires a significant amount of work, on the part of the nurse, both in terms of completing the assessment activities, collating the evidence and sharing personal insights related to clinical experience.

“You’ve got to be much more productive and reflective for this process” (Sue, p.6).

Two nurses commented on their enjoyment of the process.

“I thought it was very good and I certainly enjoyed it” (Sue, p.7).

“I enjoyed doing it and I think it’s probably the first time I can say this about an appraisal, ever!” (Jane, p.10).

One nurse particularly liked the narrative aspects of the process.

“Well I’m a great talker so it’s wonderful to talk about myself [laughter]” (Sally, p.4).

The opportunity to talk about oneself also relates to a previous comment of having someone personally interested in your work. The role of the assessor as active, interested listener was pivotal to the process.

To summarise, the conversation with the assessor facilitated an exploration of self in practice in a number of different ways; the verbalising of practice as a singular exercise, the talking through and sharing clinical experience with the assessor and the hearing of alternatives proffered by the assessor. All three strands of the process facilitated an altered understanding of self, an increased perspicacity. This can be described as learning; not a learning of external fact but an internal learning about self within practice. Such learning about self engenders meaning. On a personal level this may be profound, and on a clinical level this can be the catalyst for changing practice.

Conclusion

Narrative Learning Cycles

The process occurring for the nurses who undertook the clinical conversation appraisal procedure appeared to be primarily one of learning. Here, learning is predominantly concerned with the acquisition of new personal insights: perceiving of self within practice in a different way. It is from this standpoint of new considerations that clinical practice can actually change to more closely mirror the practitioner’s individual interpretation of desirable practice.

The learning is fundamentally facilitated through narration, through telling the story of clinical practice, which in its very essence is reflective. Telling a story requires a looking back and a consideration of what has gone before. The story of clinical practice is narrated in three ways through three cyclical processes which are both separate and interlinked (Figure One, p.106).

The first narrative cycle is facilitated through the medium of the self assessment activities. Here the narration is a solitary experience where exploration of practice happens as an internal dialogue, an internal thinking process. The second narrative cycle is facilitated through the medium of discussing practice with a peer. Here the dialogue is both external - a discussion of practice - and internal, when thinking anew is triggered. The third narrative cycle is facilitated through the medium of talking with the assessor. Here again the dialogue is both internal and external. Thinking is triggered by verbalizing experience out loud, by hearing the suggestions of the others and by thinking deeply and differently.

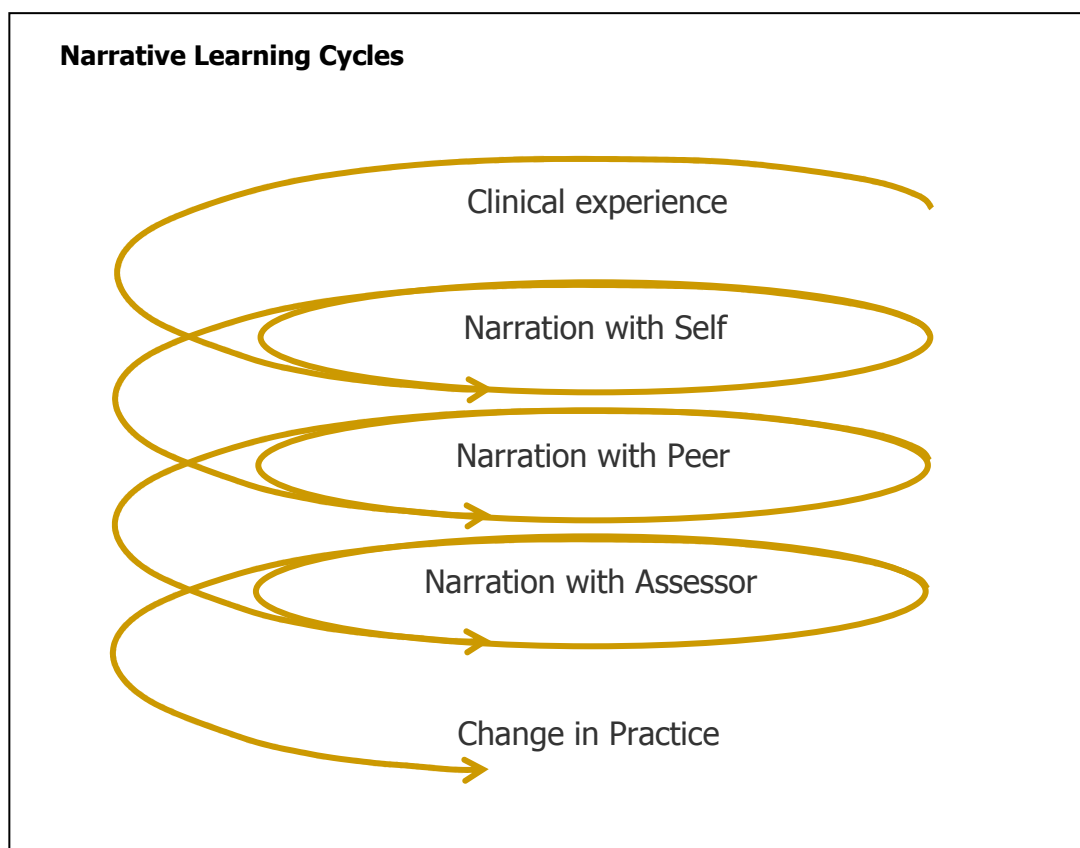


Figure One: Narrative Learning Cycles

All three narrative cycles can result in learning, yet for some nurses there is a predominance of one conversation over another. The predominant learning catalyst for Jane was triggered by undertaking the assessment activities; here the discourse with self seems most significant in terms of changing her thinking (Figure

Two, p.107). For Louise and Rachel each narrative seems to be equally weighted in terms of predominance (Figure Three, p.107).

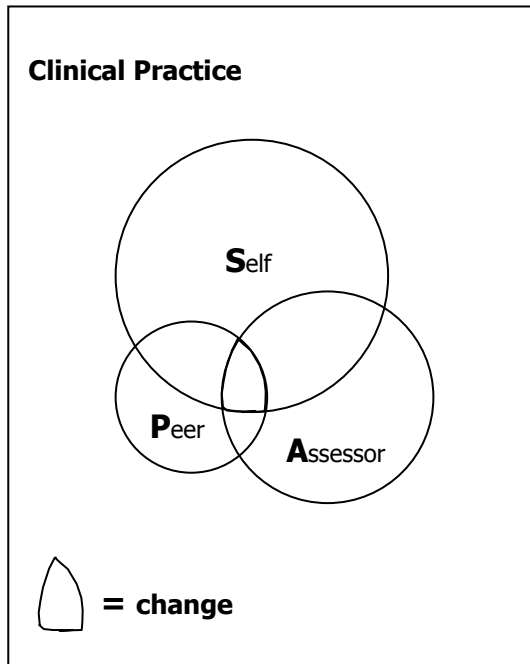


Figure Two: Jane: Predominant Learning Catalyst

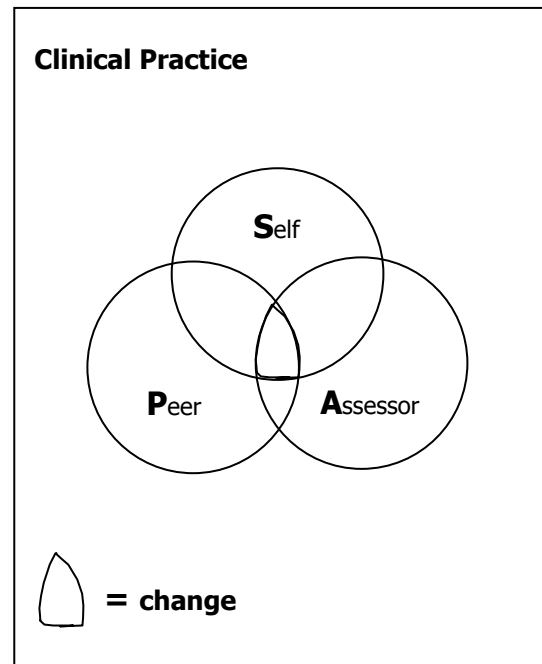


Figure Three: Louise and Rachel: Predominant learning catalysts

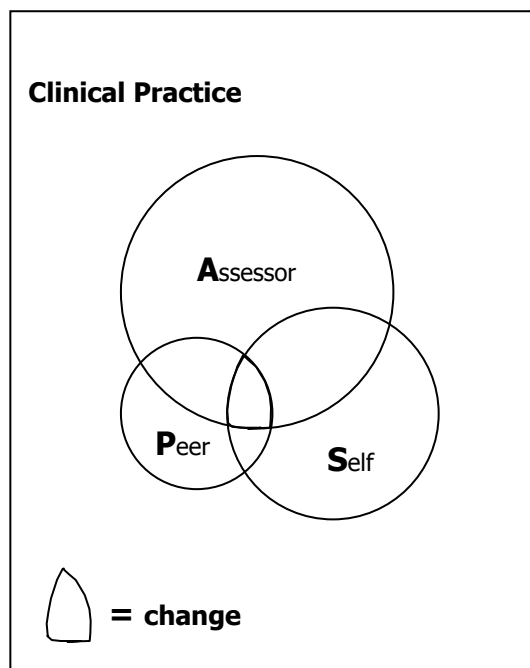


Figure Four: Sue: Predominant Learning Catalyst

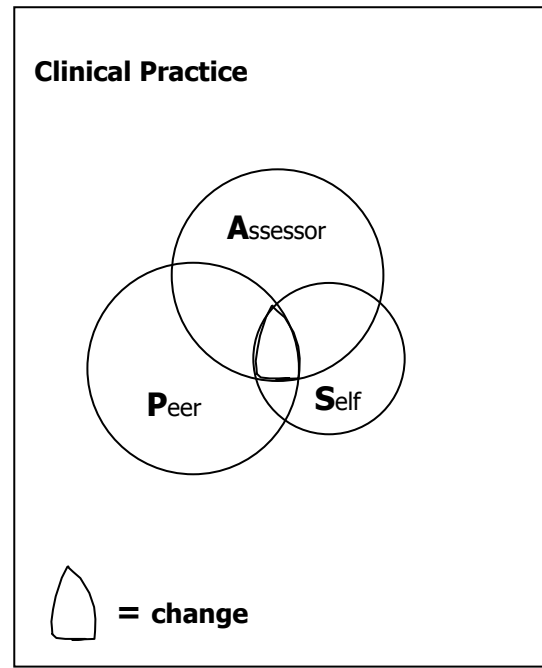


Figure Five: Meg & Bet: Predominant Learning Catalyst

For Sue the most significant learning resulted from her discourse with the assessor (Figure Four, p.107).

For Meg the discourse with self seems the least dominant, though the more significant dialogues with peer and assessor seem equally weighted. Such a pattern is similar for Bet; however, the self assessment activities and ensuing internal dialogue were of more prominence than for Meg (Figure Five, p.107).

For Sally learning seems to have occurred predominantly through dialoguing with her peer (Figure Six, p.108).

What these results suggest is that all three narratives are significant in terms of learning for each individual nurse; however, one narrative may dominate over another. In this way the clinical conversation appraisal process may accommodate different learning styles and preferences. Most research would need to be undertaken to determine this.

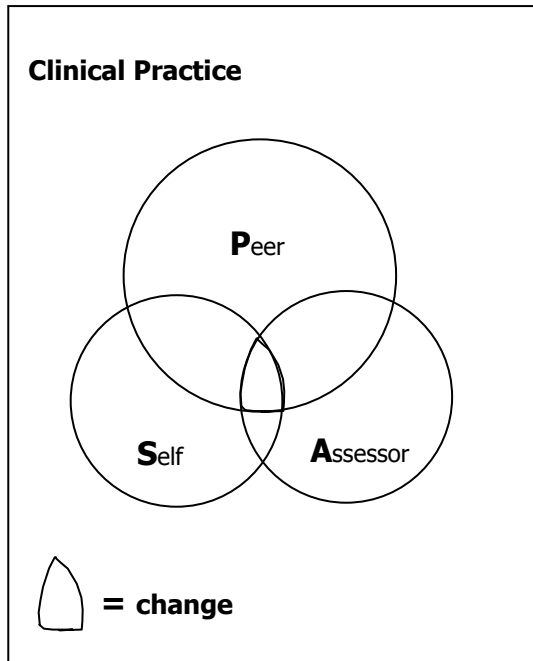


Figure Six: Sally: Predominant Learning Catalyst

CHAPTER 5: DISCUSSION

Introduction

Learning as a result of the clinical conversation appraisal process occurred through the internal and external narration of clinical experience. The role of the assessor was important in this process but so too was input from colleagues and the ability to self-reflect as a solitary exercise. Thinking was triggered by all three experiences. The learning that resulted from these experiences resided in the professional rather than the personal domain. Learning included the development of new insights into self as a practitioner. Such insights created a mind shift; this shift revealed inconsistencies between beliefs about practice and the reality of individual practice. It was the revelation of incongruence between belief and behaviour that was, primarily, the catalyst for change.

This discussion chapter initially details the parallels between the clinical conversation appraisal process and nursing supervision. However, having identified the process of clinical conversation I need to return to the literature to situate it within the theoretical framework of learning in an attempt to add greater clarity and substance to my findings. I am interested to determine in what way the concepts of experiential and reflective learning are inherent within the process of clinical conversation as both would seem to have significance. The discussion chapter continues by exploring the relationship between these paradigms and establishing the way clinical conversation is positioned within them. It concludes, by suggesting in more detail, how each narrative learning cycle facilitates change.

Parallels Between Nursing Supervision And Clinical Conversation

The literature review (Chapter 2) explored the concept of nursing supervision in terms of the dynamics of the supervisory relationship, the nature of feedback and the outcomes of supervision. These issues are important within clinical

conversation yet the results of this study suggest that clinical conversation is a process that encompasses much more than this.

The broad aims of supervision have resonance with the outcomes of the appraisal process. Supervision is seen as a teaching strategy with the intended result of improving client care and supporting the development of the nurse's insight into self as practitioner (Bishop, 1994, 1998; Butterworth, 1992). While clinical conversation is not intended to be a teaching strategy the outcome is certainly one of learning. All study participants reported a change in how they viewed themselves within their practice. Each identified strategies of how they could change their behaviour to align their beliefs about self in practice with their actual practice in reality.

All nurses were able to have a detailed discussion with the assessor about themselves as practitioners. I believe that such a critical analysis of self in practice can only happen in an environment where trust and respect exist. Assessors were able to create this environment which the supervisory literature suggests is vital (Butterworth, 1996; Hawkins & Shohet, 2000). The critical analysis of care occurred in several ways, and at differing times, throughout the process. The assessment activities enabled a viewing and reviewing of practice; the peer observation and chart audit again encouraged a returning to actual practice and a close examination of it; the conversation with the assessor once more explored practice. Each cycle can be seen as a potential catalyst for the critical analysis of self within practice to occur. Not only were the nurses able to criticize their individual practice but they were also able to offer their analysis concerning organizational issues. This suggests that the process supported a depth and breadth to their analysis.

The content of the discussions that occurred within the clinical conversation appraisal format were very much practice led. They encompassed the practicalities, the psychosocial and the affective dimensions of care. These are all issues which Bishop believes belong within the domain of supervision (1998). Such content was determined, to a significant extent, by the assessment activities

and the competency statements underlying them yet the individual thinking that occurred as a result was multifaceted and had meaning.

Assessor feedback was important in the process of clinical conversation as was the feedback from clients and peers. Feedback from the peer would seem to fit in the 'critique mode'; where both the positive and negatives of observed care were discussed (Fish & Twinn, 1997; Pendleton, Schofield & Tate, 1984). Feedback from the assessors can clearly be seen to encompass the critique mode, the reflective mode and self assessment mode (Biggs, 1999; Branch & Paranjape, 2002; Sadler, 1989). Within the critique mode the assessors clearly analysed the evidence presented and offered comment, often affirming practice and at times suggesting alternatives. These suggestions had the flavour of a 'sharing of expertise' rather than a prescriptive, 'thou shalt' approach. In this way the pedagogical style of the assessors seems more facilitatory and supportive rather than dictatorial. The assessors were able to facilitate reflection on the part of the nurse and supported the nurses to self assess. As within supervision, a number of *modus operandi* were utilized by assessors. It must be remembered, however, that clinical conversation supported self assessment in other ways apart from assessor feedback as will be discussed later.

The outcome of the clinical conversation has parallels with supervision in terms of being formative, restorative and normative (Proctor, 2001). From the results of this research it can be seen that the process was primarily formative as it supported professional development. It was restorative in that the nurses felt affirmed in their practice. Only one nurse mentioned the fact that the appraisal was normative – that it allowed assessment to take place. Whilst all nurses self audited very few were concerned with the appraisal outcome at the end of the process – the assessor judgment. From the assessors perspective, it can be assumed, that the process was very much normative allowing them to make a decision about competence.

The reflective models discussed in the literature review need to be considered in light of the study findings. Whilst the process of clinical conversation is primarily

reflective, a looking back at practice, such reflection is less structured than within either the 'stranded reflection' or the 'guided reflection' model. The 'strands of reflection model' offers layers of reflection made possible by the input of the supervisor (Fish & Twinn, 1997). Within clinical conversation levels of reflection are evident but not necessarily as a direct result of the interaction with the assessor. Jane was able to reflect most deeply during the self assessment part of the process. The factual strand, concerning actual practice, was explored during the peer assessment. It was intertwined with the retrospective and the sub stratum strands during the self assessment activities and the discussion with the assessor. On occasion the discussion with the assessor also encompassed the connective strand where care in the broader context of the sociopolitical climate was considered. The overall aim of the Fish and Twinn model is a thorough exposure of practice without a thorough exposure of self. The same may be said of the clinical conversation appraisal process. The overall aim of Johns 'guided reflection' model (2002) is one of personal growth; however, the influence of clinical conversation lies in the realm of profession rather than personal growth.

As learning is at the very core of the process of clinical conversation it is necessary to look more closely at what learning is and how it occurs. Theories of learning are many and varied, yet in line with my personal constructionist approach to knowledge acquisition I feel the learning inherent in clinical conversation fits within the fields of experiential and reflective learning. To this end I will discuss the nature of personal constructs, the significance of primary and secondary experience in learning and the role of reflection in experiential learning. I conclude by exploring further how each narrative cycle works as a catalyst to create a shift in thinking.

The Constructivist Approach to Learning

The constructivist perspective posits that learning is an active process whereby people construct their own subjective representations of objective reality. Constructivism is based on the work of educational philosopher John Dewey and

educational psychologists Jean Piaget, Lev Vygotsky and Jerome Bruner among others. They believe that the purpose of actively constructing knowledge is to gain meaning, this is achieved by reflecting on experience (Bruner, 1972, 1990; Dewey, 1938; Piaget, 1971; Vygotsky, 1978). The concepts of experience and reflection are already interlinked and indeed appear inseparable.

Constructivists suggest that the acquisition of new knowledge is not gained in isolation from what is already known but is an extension of what already exists. What already exists is situated in a social and environmental context from which individuals cannot be separated. The triggers for learning are events in which a tension occurs between what is known to the person and what appears new or challenging. Hence people are not passive accepters of knowledge but actively seek to make sense of it in a way that is unique to them (Boud, Cohen & Walker, 2000). Knowledge creation happens in a recursive way, where experiences are revisited and reconsidered in light of something new or different to reveal altered understandings. The process of clinical conversation facilitates the revisiting of clinical practice; it is this revisiting that leads to the outcome of change, not only in behaviour but in thoughts and feelings. Inherent within the constructivist approach is a focus on the individual and their personal constructs, their internal structuring and processing of information (Hergenhahn & Olsen, 2001). Personal constructs, the nature of experience and the concepts of experiential and reflective learning as they relate to clinical conversation will now be discussed.

Personal Constructs

The Structure Of Cognitive Processing

Many theories have been developed about the internal structuring and processing of information which translates into learning. Jean Piaget developed a model of cognitive development in which balance was central. Any new piece of information, which by its very nature is a potential challenge to the status quo, has to be either assimilated or accommodated by the person in order to adapt to the constantly changing environment (Piaget, 1971). The clinical conversation appraisal procedure can be seen as engaging the nurse in a process that requires

adaptation in thinking; it is this adaptation that Piaget suggests facilitates cognitive development and hence learning. The adaptation may occur in any one of the three narrative cycles depending on when the individual nurse identifies new information. This new information can be described as dialectic because it creates a tension between ideas and beliefs that the nurse already holds and those that she is now presented with. This new information is either assimilated or accommodated within her pre-existing cognitive concepts.

Assimilation can be seen as an internal experience, one of consideration, where new material is thought through from a greater or lesser variety of different frames of reference (Moon, 2004). These frames of reference are extremely complex involving emotion, meaning, understanding and existing knowledge structures. New material is filtered through these multitudes of frames of reference in order to make sense of it. Assimilation occurs when there is integration of external elements into the person's cognitive structures; for example Louise sees a different way of interpreting the guidelines concerning migraine, adolescents and combined oral contraception after discussion with the assessor. This new way, if taken on board and assimilated into her existing cognitive structure could lead to a change in practice. Accommodation, on the other hand, is the adjustment of internal structures to be situation specific; here the existing schema are broken down to accommodate new information and in this sense a person both gives up and reconstructs something. Assimilation and accommodation are internal experiences which create change through adaptation; such internal experiences of adaptation are facilitated by what I have called internal dialogue, a process of thinking and reflecting. As a result of such internal dialogue change can occur which constructivists would regard as learning. Baker, Jensen and Kolb (2002) observed: "Learning is both the process of making something strange familiar and at the same time making something familiar strange. Unlearning old ideas is necessary to learn new ideas" (p.3).

Constructivists believe it is through these mechanisms of learning that individuals develop their own mental models of the world; these models are unique, person specific and are influenced by culture, gender, class and race. Vygotsky (1978)

described the area of potential growth or change as the zone of proximal development. The narrative learning cycles within the appraisal process could be said to build upon the nurses' own intellectual scaffolding to extend their personal constructs, here the learning takes place in the zone of proximal development. Jane illustrates how internal dialogue with self (thinking deeply about her work), extended her personal constructs, while the experience of narration with peer and assessor has been shown to equally extend the personal constructs of other nurses. My study findings suggest that an individual's personal constructs may respond differently to different types of stimuli, different dialectics. Meaning may become apparent through deep thinking as a solitary exercise, whilst different or further extension of meaning may be facilitated by discussion with peer and assessor - a different type of stimuli, a different experience.

From a constructivist perspective the idea of difference is fundamental to the concept of learning. Not only does new information need to be perceived as different for it to be assimilated or accommodated but the outcome of the process requires a difference to have taken place. To have learned something means that the person is different, is changed from what they were before. I suggest that this difference can be represented as both an internal and an external experience. Sue and Bet think differently about their case study consultations at the end of the appraisal process; this can be seen as an adaptation to a cognitive structure as a result of learning. It can also be seen as an alteration in perspective where self and practice are no longer perceived in the same way. Here the change is internal; if this then translates into changing clinical practice the change can be described as external.

Further understanding of the process comes from the work of Moon. Moon (1999) has identified a five stage map of learning which includes noticing, making sense, making meaning, working with meaning and finally transformational learning. Noticing is the conscious recognition of something new. It is influenced by what people already know, their emotional response to the new material and the way it is presented. Noticing does not mean, however that learning will occur. It could be said that the clinician conversation appraisal process presented clinical experience

in such a way that made it noticeable. Jarvis (2005) would challenge this first stage of Moon's learning model; he believes that people also learn without noticing, a preconscious absorption of information which can be regarded as tacit knowledge.

The second stage of Moon's model is 'making sense'. Here, new information is learnt and absorbed but not in the context of prior knowledge or experience. This has been defined by other theorists as mechanical learning which is devoid of context, meaning and personal significance, for example the rote learning of times tables (Illeris, 2005).

Meaning making returns to the concepts developed by Piaget; new information is assimilated into a person's unique, core frame of reference, their cognitive structure. The process of assimilation may modify the new information; equally the new information may modify the cognitive structure (accommodation). Working with meaning explains how through thinking about and reflecting on new information, ideas are generated; these ideas become new information for consideration which in turn can generate further ideas. Transformational learning occurs when there is a conscious evaluation of an individual's own frame of reference. Moon would suggest this occurs through thoughtful and reasoned discussion. This evaluation leads to a change in perspective. Such a change in self can have a cognitive, emotional or social-societal dimension (Mezirow, 1990, 1998).

Experiential Learning

In the 21st century the idea of experiential learning, firmly grounded within constructivist theory, can be separated into two elements: the learning that is gained from the experiences of life as opposed to the teacher driven process of generating experience to facilitate learning (Houle, 1976). In the narrow context of this thesis, experience gained from undertaking the appraisal process and informed by previous work experience will be considered.

Experience occurs at the “intersection of the self in the world and the world itself” (Jarvis, 2005, p.5). It is the boundary between self and the world where experiences are felt. Experiences are neither totally physical nor totally mental; they “comprise an internal relationship between the subject and the world” (Marton & Booth, 1997, p.122). It is the external experience and its relationship to the internal experience, the internal dialogue that are integral parts of the clinical conversation appraisal procedure. External and internal experiences, as a consequence of the process, are reflected upon by the nurse; it is this reflective internal dialogue that facilitates change. The relationship of experience to learning and the part played by reflection are complex theoretical issues undergoing continued debate. What seems clear is that experience must be processed in order that knowledge can result from it and that reflection offers one such processing tool (Moon, 2004). It is important to examine the concepts of experience and reflection to understand them more fully in the context of clinical conversation. What is meant by experience? What is experiential learning? In what way are experiential and reflective learning similar? How do they all relate to the process of clinical conversation?

Primary And Secondary Experience

Before a discussion concerning the role of reflection in experiential learning takes place it seems important to establish and define the type of happenings the nurses underwent during the clinical conversation appraisal process. There are two types of external experience inherent within the clinical conversation appraisal process: those that can be described as primary, a first hand experience, and those that are said to be secondary, mediated through another frame of reference (Moon, 2004).

New or primary experiences include the peer observation where a colleague observes the nurse’s clinical work and offers feedback. Whilst collegial feedback and observation may have occurred before, here it can be considered a primary experience as it has not occurred in this way, in this time and place within the constructs of the activity.

The secondary experiences facilitated by the appraisal process include such assessment activities as writing the case study, completing the self assessment checklist, reading the client feedback, compiling the professional development activities list and the verification checklist. All these activities represent clinical experience; however it is through this re-representation of experience, mediated through the requirements of the assessment activities, that clinical experience can be considered anew. The case study is an example of how a client consultation can be re-represented in four different ways; each way becomes a different representation of external experience which has the potential to trigger learning if new information is revealed. The very construction of a piece of writing changes the event that a person is thinking about. Writing up a particular consultation is reflective because events in the past are reconsidered and captured on paper. This reconsideration offers the possibility of new insights as Moon (2004) suggested: “reflective writing is not a direct mirror of what happens in the head but a representation of a process within a chosen medium – in this case writing” (p.80) and as Bet confirmed

“Thinking around all those issues and putting it down on paper makes you actually think about it more” (Bet, p.6).

The actual written case study, once constructed, then becomes a representation for new consideration. Written text can be revisited and reflected upon several times.

“... [it] really makes you think about what you would do differently” (Louise, p.5).

When verbalized to the assessor the case study becomes another representation of experience and finally, through discussion it is once more transformed into yet another representation of experience.

“Having to go talk through and present orally your case study was a much better learning process” (Sue, p.6).

Here then four representations of the client consultation occur. Each offers the potential for new material of learning which can trigger thinking at a meaning making level.

The chart audit can be considered as both a primary and a secondary experience; primary, as it is undertaken with a peer who offers feedback and comment and secondary, as it re-represents the clinical consultations that the nurse undertook and allows the consultations to be considered anew. This distinction is captured in the data analysis where Jane seems to have learnt from the representation of experience through the medium of the chart audit whilst nurses Sally and Meg learnt through the primary experience of undertaking this activity with a colleague.

The structure of the assessment activities will have mediated the learning to some extent as the experience of clinical practice had to be considered from a variety of established frames of reference inherent within the activities (Moon, 2004). The criteria governing the peer observation, the chart audit and the written case study would have provided the initial context for consideration yet once thinking is triggered by this initial new experience, a recursive process that is one step removed from the learning material takes over. The recursive process involves contemplation, thinking about the new information, what it means, how it relates to what is already known, the different ways in can be interpreted. From this analysis new ideas can be generated which are once more analysed and thought about. Analysis continues until the nurse is able to synthesis the information within her mental model. The analysis, synthesis and evaluation of both new materials, and ideas and thoughts triggered during the recursive process of thinking, are unique to the individual nurse. In this way learning outcomes can not be predicted and the subjective nature of learning is recognised.

The subjective nature of learning can be further inferred by looking closely at the appraisal process. Here the experience itself was broadly similar for each nurse yet the outcome individually specific. Each narrative cycle within the appraisal procedure was interpreted by each nurse in a different way, some triggered a more significant amount of internal dialogue and learning than others (see Figures Two –

Six, pp.107-108). For nurses Meg and Sally the predominant catalyst for thinking occurred during the experience of undertaking the peer observation and chart audit; this is where most learning occurred for them. On the other hand for Sue the predominant dialogue occurred with the assessor and it was here that most learning occurred.

This highlights two important points; firstly that the experience was interpreted in an individualistic, subjective way and secondly, that learning occurred from some experiences but not all experiences (Jarvis, 2005). Experiences which are perceived as more challenging or as ill-structured are thought provoking and so provide fertile ground for learning (Moon, 2004). Experiences which are easily understood and support existing mental models do not engender learning. Both the new external experiences and the represented experiences affirmed individual practice for some nurses. In this instance learning is unlikely to have occurred; rather a reinforcement of mental models will have taken place. Some external experiences however did challenge the nurse's sense of self or sense of practice; this challenge was thought provoking, triggering reflection. It is through the process of reflection that challenging experiences can be made sense of and learning occurs. It would be interesting to consider in what ways affirmation and dialectic tension relate to learning for these nurses. Do nurses learn when they feel most challenged or when there is a balance between challenge and support? Unfortunately the data provides minimal insight into this issue. What can be said is that all nurses reported feeling that their clinical practice was affirmed and all felt that they had changed through the process - both positive outcomes.

From the analysis of the data it can be seen that external experience can be classified as primary and secondary and that each experience was interpreted in a subjective way by the individual nurse, this subjectivity lead to differing learning outcomes.

The Role Of Reflection In Experiential Learning

Experiential learning has been defined by Chickering (1977) as: “Learning that occurs when changes in judgements, feelings and skills result for a particular person from living through an event or events” (p.63).

The outcomes for all the nurses having ‘lived through’ the experience of the appraisal process was change in some form or other: either change in practice or change in how they felt about themselves and their practice. More recently Jarvis (2005) offered the following definition of how, from experience, people learn: “It is in relationship – in the interaction of the inner person with the outer world - that experience occurs and it is in and through experience that people learn” (p.1).

David Kolb and Roger Fry (1975) created the now famous experiential learning cycle in an attempt to refine the debate in more specific terms about how experience shapes learning. Kolb (1984) believed that “learning is the process whereby knowledge is created through the transformation of experience” (p.38). The theory presents a cyclical model of learning consisting of four stages, however learners can start at any point within the cycle. Firstly there is the concrete experience, then reflective observation, followed by abstract conceptualization and active experimentation. In the case of clinical conversation the concrete experience could be defined in terms of primary and secondary experience related to clinical practice. The reflective observation occurs when the nurse consciously reflects back on the experience in terms of details and events. This is followed by abstract conceptualization which involves thinking, generating ideas and concepts. Through reflection and conceptualization new ways of thinking and perceiving can occur. For the nurses this translated into seeing afresh and thinking differently. This can then lead to a change in practice to ‘test out’ new insights. Hence the change in internal processing may ultimately lead to a change in behaviour. What seems of equal significance for the nurses in this study was not only the change to their clinical practice as a result of the process but also the change in how they felt about their practice and themselves: a change in perspective. It is interesting to consider whether feeling differently about your practice translates into practicing differently; it seems that for some it may and for others it may not.

Argyris and Schon (1974, 1978) added a new dimension to Kolb's model of experiential learning and also provided the framework for much of the ensuing discussion regarding reflective practice. They recognized that there was often a discrepancy between how a person behaves in a given situation (theory-in-action) and how they thought they behaved (espoused theory). They observed that the greater the discrepancy the less effective the person was in a work situation. When a person recognizes that the way they behave is different from how they think they should behave two outcomes are possible. Firstly, the person can change their behaviour to stay in line with their espoused theories; this they called single loop learning and appears similar in nature to Piaget's concept of assimilation. Alternatively the person can challenge and potentially change their espoused theories; this they called double loop learning which seems to have parallels with accommodation. Sally decided to improve her documentation as, on reflection, she felt it was not at an acceptable level; this can be considered single loop learning. If she had altered her beliefs about what actually constituted appropriate documentation this could be considered double loop learning.

Argyris (1997) believes that it is the process of reflection that allows for an exploration of both espoused and in-action theories and can result in increased congruence. This idea has been grasped by the proponents of reflective practice who consider that by aligning espoused theories with actual behaviour true enlightenment occurs (Johns, 2002, 2005). What is so important in terms of experiential and reflective learning is that Argyris and Schon named the function of abstract conceptualizing as devised by Kolb. The function of abstract conceptualizing they believe, is to reveal the incongruence between theory-in-action and espoused theory. By using reflection it is possible to unlearn old ideas, to unpack and explore assumptions and prejudices and align behaviours with beliefs.

Later Kolb, Baker & Jensen (2002) refined the Kolb model to build upon the ideas of Argyris and Schon. They suggested that experience can be understood in two ways: the concrete experience (apprehension) which is felt, sensed and is tangible yet subjective, and the abstract conceptualization (comprehension) which involves

thinking and analyzing and is hence, they considered, more objective. These processes can be seen within clinical conversation. Here there are opportunities to explore concrete experiences to capture the subjective nature of them yet also opportunities for comprehension, through solitary reflection and conversation. Kolb et al (2002) suggest that integrated knowing is achieved when people equally engage in apprehension and comprehension. This latter extension to Kolb's thinking will be discussed in more detail during consideration of the learning that took place in conversation with the assessor. Kolb (2002) sees conversation as a "process where concrete knowing and abstract knowing are revealed" (p.57).

As has already become evident, intertwined with the concept of experiential learning is the concept of thinking and reflecting. Their relationship to experiential learning requires further attention.

Reflective Learning

Dewey (1938) believed that not only was experience subjective but also a "form of thought, but those thoughts are constructed and influenced both by our biography and by the social and cultural conditions within which they occur" (p.37).

It can be seen that experience and thinking go hand in hand; thinking is an integral part of experience, it is what makes sense of it. Thought, an internal process, an internal experience, is under the influence of emotion, culture, history and the specific context in which the experience is taking place; as such experience and thought are never neutral. It is the thinking inherent in experiential learning that best relates to the process of reflection. Boud, Keogh and Walker (1985) suggest that reflection is an activity in which people "recapture their experience, think about it, mull it over and evaluate it" (p.10). Without reflection, experience in itself offers limited learning (Jarvis, 2005). The two key stages to reflection consist of the inner discomfort caused by a discrepancy between what is known and what is now presented and analysis of the situation which leads to the development of new perspectives (Atkins & Murphy, 1994).

Moon (2004) believes that reflective learning is an essential part of experiential learning when the experience is a significant challenge and as such is thought provoking to the learner. The experience of preparing for and taking part in a clinical conversation can be seen as challenging and thought provoking. Such provocation of thought has an innately reflective component to it; in the process of considering the new, thinking returns to what is already known, what is already familiar, and reconsiders it. This is captured in the data analysis in terms of viewing and reviewing practice. Practice is viewed anew through both the representation of experience and the new experiences that have taken place as a consequence of the appraisal. Yet this viewing is grounded in what has gone before. The process of reflection allows the past and the present to be considered to determine the future. Such consideration includes an evaluative element. Is what is being contemplated in line with espoused theories? Can it be assimilated or does change need to occur? It is the realization about and insight into practice that creates the possibility for change.

It was the later work of Donald Schon, following on from his work with Chris Argyris, that brought the concept of reflective practice to the fore in the 1980s, particularly in the field of nursing. He observed the way professionals used reflection in their everyday work to cope with ill-structured or unpredictable situations (Schon 1983, 1987). He defined two types of reflection; the first was 'reflection-in-action', which for nurses occurs at the time of the consultation. Reflection-in-action is triggered when the nurse encounters a challenging or unusual consultation and is required to think on her feet. In the midst of the client contact she works out how she is going to progress forward and manage the situation. The thinking draws on past experiences and tacit knowledge and any decisions made will be drawn from a broad, contextual knowledge base (Hull, Redfern & Shuttleworth, 1996). The second type of reflection Schon called 'reflection-on-action'. It concerns an active looking back and thinking about practice with the intent of increasing self-awareness in terms of actions taken and decisions made. Schon believed that learning occurs when the realization of practice becomes transparent and the practitioner chooses to change their behaviour. Here again is the recurrent theme of aligning beliefs about practice,

with practice, to achieve congruence. Clinical conversation could be said to create cycles of reflection-on-action; reflective dialogue with self (on-action as involves representation of experience); reflective dialogue with peer (on-action as although the chart audit and peer observation have been described as new experiences they none the less allow for a looking back at practice) and reflective dialogue with assessor (on-action in a holistic sense of considering practice as a whole). The three cycles of reflection allow for the breadth and depth of practice to be examined. This is important as learning occurs from reviewing consultations that went well, as well as those that did not (Ghaye, 2005). The three cycles of reflection also cater for the individual learning styles of the nurses, one nurse may learn from the process of self reflection whilst another may learn from verbalizing and sharing reflections with the assessor.

Depth Of Reflection

The depth of reflection is an important issue to consider. Gibbs (1995) broke down the process of reflection in order to offer nurses a framework by which they could self reflect. Her reflective cycle firstly necessitates a thorough description of an event, and then it addresses the feelings of the practitioner at the time including an overall evaluation of whether the experience was good or bad. The next step is one of analysis in which the experience is explored from a variety of angles in order to make sense of it. This is followed by reaching a conclusion where insights into own and others behaviour are established. Finally, there is the action stage where the practitioner considers how she would act differently if a similar situation arose again (Jasper, 2003). In terms of the appraisal, the writing of the case study would most closely mirror the process just described. The stranded reflection model developed by Fish and Twinn (1997) and discussed in the literature review in more detail, is similar to that devised by Gibbs. The points of difference are the substratum and connective strands: the substratum strand focuses the nurse's attention on her assumptions and beliefs in an attempt to develop congruence between her espoused and in-action theories whilst the connective strand encourages a critical perspective through consideration of the political, economic and social climate occurring at the time of the consultation. Here the overall aim is

to deepen reflection to increase learning, the implication being that this can only be achieved through supported reflection rather than self reflection.

As previously discussed in the literature review, Johns (2005) among others, feels that reflection needs to be guided if it is to result in deep and meaningful learning. Ghaye (2005) suggests “there are limits to solitary reflection and to learning alone” (p.32).

Johns (2002) believes that the role of the guide is to offer alternative frames of reference from which the nurse can consider her practice. He has developed a framing perspective system which acts as cues to further develop thinking:

Of the framing perspectives, philosophical and role framing are fundamental in establishing the current boundaries of viewing self as an effective practitioner. Theoretical framing enables the practitioner to establish what is known to be ‘effective’ in terms of extant knowledge. Reality perspective framing enables the practitioner to see self within the context of the cultural and political forces that give shape to his/her practice....Problem framing concerns the way problems within experience can be posed or framed and clarified for what they are. Temporal framing enables the practitioner to make a connection between the present situation and past experiences, while anticipating future possibilities...parallel process framing makes clear the connection between what is taking place within guided reflection and clinical practice. (p.238).

Here the complexity of reflective practice and the many possible levels at which it can work have been teased out. Yet the underlying purpose remains: “...to expose, understand the nature of, and learn through the contradictions between desirable practice and actual practice (Johns, 2002, p.237).

For Johns, the unique and individual frame of reference (the cognitive structure) of the practitioner is gently challenged by the guide by offering alternative frames of reference to consider; the outcome of such a process can be described as transformational learning. Transformative learning occurs when the taken-for-granted frame of reference that informs people’s beliefs and behaviours is changed to become more open and inclusive. A person’s frame of reference acts as a filter through which experience is judged. The frame of reference encompasses

assumptions, expectations and prejudices, all closely linked with emotion. As Mezirow (2000) describes it, a person's frame of reference becomes an internal standpoint through which all experience passes in the search to find meaning. Mezirow believes that it is not until the meaning making frame of reference is altered that new learning can take place. He feels this can be achieved through constructive discourse, a view supported by Johns. Dialogue allows for a collaborative way of working whereby those in conversation co-construct meaning. Moon (2004), however, suggests that individuals can in fact, alter their own meaning making frame of reference through reflection. Reflection can involve the re-ordering of internal experience in order that new ideas are developed from existing experience. These new ideas can in themselves create different perspectives which challenge the existing standpoint. Once challenged change can occur. Individuals may have a differing ability to alter their frame of reference. Some may do so through solitary reflection whilst others may need new material of learning; others again may do so through conversation; finally, some may be changed by all three.

The clinical conversation appraisal process is made up of cycles of reflection. The depth of reflection achieved within each cycle seems to have been person specific again emphasizing that individuals reflect and learn in different ways. Reflective learning occurs when there is both new material of learning and when there is no new material of learning. New material may present itself from a new experience or a representation of experience. Here the new material is considered and analysed in search of meaning. Individuals use a variety of internal frames of reference in order to make sense of the new material; this process can be assisted by the provision of external frames of reference. External frames of reference in relation to the clinical conversation appraisal process include the guidelines of the assessment activities which mediate the learning and the input of the peer and the assessor which offer a different perspective to consider. Where there is no new material of learning, reflection involves a re-ordering of internal experience in order that new ideas are developed from existing experience. This is done by engaging with different internal frames of reference within the internal experience. Here the nurse is working with her existing cognitive structure but the outcome is a

reorganisation of cognitive structure with accommodation to newly developed ideas.

I will now return to each of the three narrative learning cycles in an attempt to determine how learning is facilitated within each.

Clinical Conversation As A Catalyst For Learning

Narration With Self

Representation Of Experience And Self Reflection

The specific assessment tasks that the nurse undertook as part of the appraisal process can be seen as representations of experience (Moon, 2004). In the narration with self the nurse returned to the experience of clinical practice and investigated it further by representing it in a new way. The process of thinking about and reflecting on these new representations of reality can be thought of as an internal experience (Marton & Booth. 1997). Meg captures this sense of a new looking, seeing clinical experience in a different way:

"[it was] good to look, sort of, from outside looking in" (Meg, p.1).

During the process of representation, reflective thinking is triggered as the experience is returned to and examined closely. This in itself is a learning process.

"When I finished [writing the case study] I thought she actually came for one thing but there were all sorts of other issues" (Bet, p. 6).

Moon (2004) believes that once the concrete experience is captured through representation it becomes a vehicle to further challenge personal constructs through further reflection. "In making a representation of personal reflection, we shape and model the content of our reflection in different ways and learn also from the process itself" (p.80).

Not all of the assessment activities undertaken by the nurses offered opportunities for new learning: rather it was the subjective interpretation by the nurse of the represented experience that either facilitated recognition of new material of learning or affirmed existing knowledge. As Moon (2004) further suggests: “learners mediate their own experience through the process of bringing prior experience into the present and bringing this to bear on the new material of learning” (p.77).

The nurses viewed any new material, revealed through the process of representation, in the light of their existing knowledge. Once new material was viewed in this way, through the integral frame of reference, new ideas were generated and a further internal dialogue was ignited. In this instance the internal dialogue considers how new material was related to what was already known; in what way it was similar or different? Any new insights or ideas become new material of learning which could be considered again. In this way an internal cycle of reflective dialogue ensues (see Figure Seven, p. 130). Bakhtin (1981) suggests that thoughts are in fact internalised conversations whose function is to make meaning out of experience. Here the internal conversations are often ubiquitous in nature and continue long after the assessment activities have been completed. As Bet revealed:

“I thought about it afterwards...” (Bet, p4).

Crow and Smith (2005) describe reflexivity as a process of self questioning where ideas and beliefs are taken as data to be subjected to examination. In this, the first part of the appraisal process, the nurses are given the opportunity to examine their ideas and beliefs about practice. The assessment activities offer alternative frames of reference from which to consider practice.

“I guess you don’t really realize that what you’re doing has a certain degree of expertise until you actually analyse it” (Meg, p. 4).

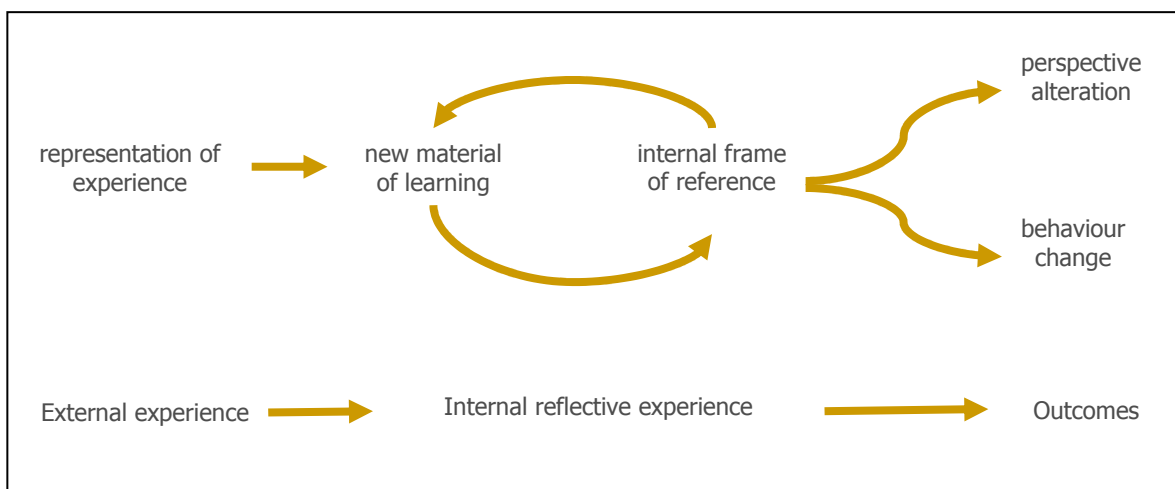


Figure Seven: Narration With Self

By undertaking the assessment activities, the nurses were presented with external evidence of practice which either verified how they felt about themselves as practitioners or presented a challenge to their beliefs. Verification may add to the sense of affirmation that many of the nurses felt at this stage of the appraisal process. Challenges, however, are looked at closely in order to make sense of them; the outcome of such a close examination of personal practice can be the development of self knowledge about blind spots (Laireiter & Willutzki, 2003).

“When you look back you realise you don’t always do what you think you do”
(Sally, p.1).

This quote suggests that the nurse’s espoused theory, (what she believed her practice should be), and her theory-in-action, (what her actual practice was) were at odds. This discrepancy came to light through undertaking the chart audit and could be described as reflective learning from the representation of experience which reveals new material of learning. Here, significant insight occurred through a process of self reflection without the need for external dialogue with an assessor or guide. For this nurse the insight was all the more powerful because it came from her own internal dialoguing, triggered initially by the representation of experience. As a result she was prepared to make a change in her practice because, as she says, it is she who had identified the incongruence herself.

“Initially you think ‘oh well that’s alright’ and then you think ‘no actually its not alright and I’m going to make changes’ without feeling threatened about it so you actually self-reflect a lot better” (Sally, p.2).

A similar outcome for another nurse occurred during the chart audit process where an increase in congruence between her concrete and abstract knowing took place. She realized that her practice was not up to the standard that she thought it was.

“Just going through the audit too, it pulls you up, oh yes there were a couple of things I could’ve located or paid more attention to” (Bet, p.3).

For Rachel, seeing practice from a different standpoint altered previously held perceptions and created change:

“It actually made my practice a little bit more up to scratch” (Rachel, p.1).

The case study initiated a detailed review of clinical practice; this led to alternative interpretations of case-specific events but also to an alternative interpretation of self as practitioner. By undertaking the case study clients were perceived in another way; assumptions the nurses had made were revealed and thoughts about how the nurse could have practiced differently were generated. The insights into practice did not only pertain to the consultation under consideration, but could be applied to all consultations. For example, one nurse was able to see the importance of being able to relate to clients through having written and thought about the case study. This new insight created change that was then applied across her clinical practice. For another nurse the case study challenged her sense of effectiveness; through thinking differently she was able to see that her practice did actually have a degree of expertise. She found such a revelation affirming.

The level of critique engendered by the case study was both personal and political. Personal in the sense that new insights about self in practice were made. Political

by the inclusion, for one nurse, of wider organizational policy issues. This suggests that the frames of internal reference she was considering had a critical element and she achieved this level of analysis without the support of a guide.

There was variation in the extent to solitary self reflection for each nurse engendered learning (see Figures Two - Six, Chapter 4, pp.107-108). For Sally and Rachel self-reflection was not the predominant discourse and yet both experienced significant learning in terms of aligning concrete and abstract knowing through this process, this could be called perspective transformation (Moon, 1999). For Jane internal reflective dialogue with self was the predominant discourse which created the most change. Her self perception changed as a result of the process.

“It was also interesting seeing that in actual fact I have achieved a lot more than I realized... gives a much better picture of where your strengths and weaknesses lie” (Jane, p.2).

From these altered perspectives her practice changed. Her actual depth of reflection and the significance of the learning is harder to determine. What can be said is that out of all the three reflective learning cycles, for her, most learning occurred through this mechanism of self reflection compared to reflection with the peer and assessor. Whether her learning was transformational in its truest sense, that is altering her own frame of internal reference, is difficult to judge. Her use of the word ‘meaningful’ to describe the process suggests that transformation, at some level, may have occurred:

“It’s much more meaningful” (Jane, p.2).

The reflective narrative with self was triggered by undertaking the assessment activities. Here the experience of clinical practice was returned to, viewed again from a different standpoint, feelings were attended to and a re-evaluation occurred. The outcomes of the process were new ways of thinking, feeling and practicing. Rolfe (2000) believes that new knowledge gained through reflection, which he sees as a form of naturalistic research, is more legitimate than knowledge gained from

assimilating the findings of randomized control trials which is non naturalistic, decontextualised and therefore of limited value. This view is supported by the work of Tony Ghaye (2005) who sees reflective learning as something that can be made use of. The ability to reflect on failure as well as success leads to the discovery of practical wisdom and can achieve tangible rewards; here the lessons of experience are truly learned.

Narration With Peer

A New Experience Which Initiates Reflection

As part of the clinical conversation appraisal process two of the assessment activities involved peer input. Both the chart audit and the clinical observation required the peer to provide feedback on practice. These aspects of the chart audit and clinical observation can be described as new experiences which initiate reflection (Moon, 2004).

The chart audit involves a review of documentary evidence pertaining to ten clinical consultations. During this review reflective thinking is triggered as the nurse thinks back on the consultations and audits them with the peer. Similarly, two clinical observations take place where the peer observes practice and offers feedback. It is during the feedback that reflective thinking occurs as the nurse revisits the consultation in light of the comments made by the peer.

New material of learning can occur in two ways, firstly from direct comments made by the peer and secondly through ideas generated by the nurse herself (see Figure Eight, p.134). The direct comments made by the peer can challenge the existing thinking of the nurse, at this juncture another perspective is being offered up for consideration. Kolb et al (2002, p.45) would describe this as an “outside in” learning process where the external ideas and events act upon individuals and shape their knowing. For Bet the comments made by the peer are thought of as impartial yet valuable, offering an alternative approach for consideration.

“In some ways it’s quite good having someone from the outside who hasn’t seen you working before because it was [a] rather more objective approach...she picked up on things that wouldn’t have been picked up on before. So that was a good process” (Bet, p.1).

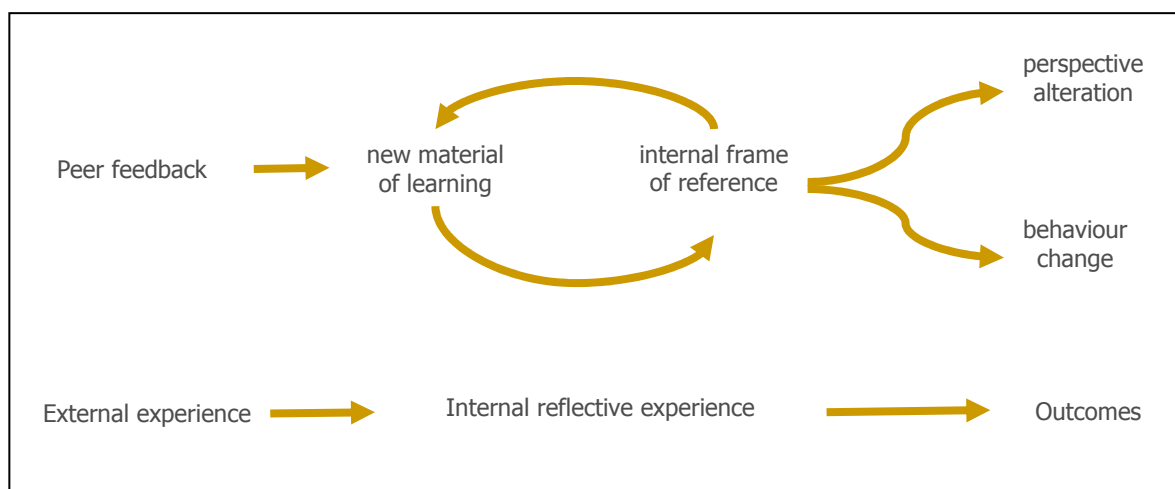


Figure Eight: Narration with Peer

Sue’s comment suggests that the dialogue with the peer did indeed offer differing frames of reference from which to consider practice:

“It was quite interesting to think of different ways you might attack something or look at it differently” (Sue, p.2).

Sally and Meg were both peers for each other and offered each other new material of learning. One comment made by Meg increased Sally’s level of awareness about her own practice.

“She said, ‘you’re thorough’ and I realised why I am a bit slower” (Sally, p.4).

Here the comment of her peer, the new material of learning, is considered. Sally recognised a truth about her practice and consequently developed a new insight. It is unclear whether this insight led to a change in practice, nevertheless it can be presumed to have created a perceptual shift in thinking.

For Meg seeing how someone else led their consultations was enough to trigger reflective thinking which had the end result of her changing her clinical practice.

“Doing it together and auditing each other was quite valuable so that you could see the way someone else did something and you took that on as practice”
(Meg, p.1).

From the discussion between Sally and Meg, Meg developed new insights into her practice. She saw the importance of succinct, detailed documentation in terms of maximising the potential for clients to receive optimum care across a range of clinicians; this included a thorough description of clinical findings. She also recognised opportunities where she could screen clients for sexually transmissible infections and discuss safer sex practises.

The second way that new material of learning may occur during the peer observation and chart audit process is through ideas generated by the nurse herself as part of thinking and analysing both the comments of the peer and her interpretation of the events (Moon, 2004). This happens as an internal dialogue:

“The peer observation made you look at your practice in depth” (Rachel, p.2).

For Rachel the depth of reflection is evident in both the peer observation and the chart audit. The chart audit she describes as affording a “good look at” clinical practice; similarly the peer observation really made her look at her own practice. The result was of seeing her practice in a different way. Part of this included recognition of the amount of talking that she did in consultations; she began to consider that this might not always be appropriate.

With most new material of learning the nurse’s internal frame of reference is confronted; here the new material of learning came predominantly from the feedback given by the peer. Alongside the thinking triggered by the peer’s comments comes a second, almost inseparable thinking, whereby the nurse

generates ideas of her own and takes ownership of the thinking which can result in change on both a practice and perceptual level.

Each nurse varied in the extent to which narrative discussion with a peer created change (see Figures Two-Six, Chapter 4, pp.107-108). For Meg and Sally, in particular, this part of the appraisal process was most significant in terms of learning outcomes, whilst for nurses Jane and Sue it was least significant.

Narration With Assessor

Conversational Learning

The reflective dialogue with the assessor is a form of narrative communication; here the story of clinical practice captured in the portfolio is discussed: “Sharing learning through narrative communication is itself further learning from the original experience” (Cortazzi, Wall & Cavendish, 2001, p.252).

The form of reflective learning occurring during the conversation can be initially described as that resulting from no new material of learning (Moon, 2004). Here the content of the portfolio is already known and has been previously considered through both the narration with self and with peer. When talking with the assessor the nurse is working with her existing cognitive structures which may have been newly altered through her recent conversation with the peer and reflective conversation with self (see Figure Nine, p.137). However, it is this reflective dialogue with the assessor that for some nurses allowed for yet more fresh ideas and insights to be developed. Moon (2004) observed: “Where there is no new material of learning, reflection involves a reordering of internal experience in order that new ideas are developed from existing experience” (p.101).

Verbalizing Experience

At the start of the conversation with the assessor the nurse is asked to narrate her case study, to tell her story of the consultation under consideration. Narratives help to organize, interpret and give meaning to experience (Bruner, 1990; Candy, Harri-Augstein & Thomas, 1985; McDrury & Alterio, 2002; Mishler, 1986). Fish

(1998) would go as far as to suggest that the reframing of a story, which happens when it is being verbalised, dramatically increases understanding in terms of what it meant. This seems to be the case for Rachel and Sue where the actual process of verbalisation allowed them to represent their experiences which affected a change within them and led to new meaning. Vygotsky's (1978) work supports this interpretation of events. He believed that thought undergoes change when it turns into speech; it is the speaking that turns thought into existence. When words are being spoken and listened to the speaker feels an increased connection to self (Remen, 1996). Here, by verbalizing the nurse comes to know; this new knowing influences her being. The knowing, once expressed through conversation, becomes "an inside-out learning" (Kolb 2002, p. 60). Further, "learners stand face to face with their own deeply held values, feelings and thoughts" (Kolb, 2002, p.77).

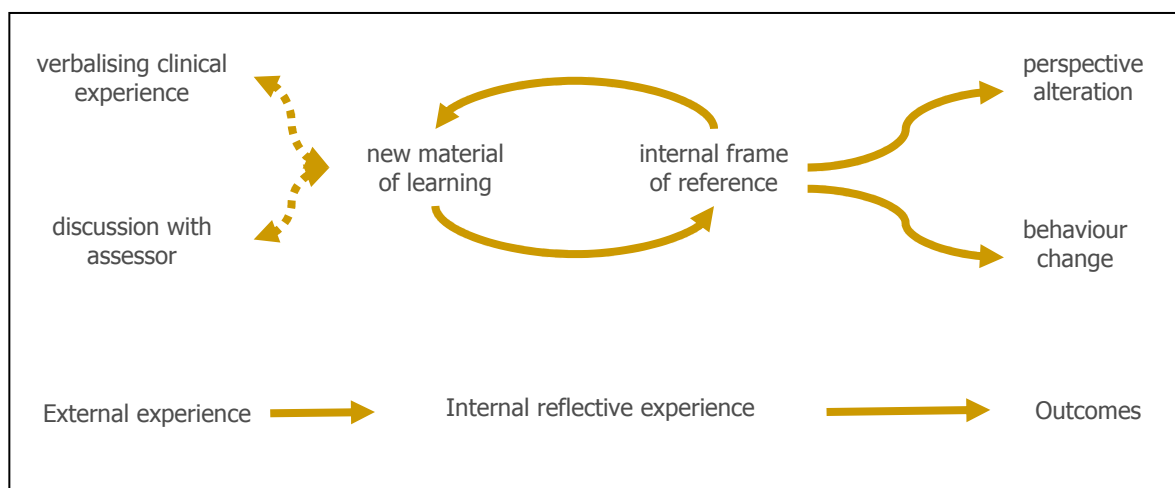


Figure Nine: Narration with Assessor

This inside-out learning creates an active examination of emerging self awareness. Assumptions and prejudices can be brought to the surface and named; the naming of them makes them conscious and enables them to be further considered. For Rachel, tacit knowledge is brought to the surface through the process of thinking about practice, writing about practice and talking about practice; all three processes seem integral to the revealing of what previously remained hidden.

Rachel had two learning outcomes, primarily learning more about herself in practice.

“...learning a few bits and pieces about myself” (Rachel, p.1).

This personal insight about self implies increased congruence between espoused and in-action theory. Here a shift in perspective is occurring. This new insight led to a change in clinical practice, the second learning outcome. Through this process she was able to value the aspects of her practice that she considered appropriate and make changes to those which she felt were not up to “scratch” (Rachel, p.1). Whilst there is no new material of learning in its strictest sense, by putting experience into words new material of learning occurs through representation of experience. This representation facilitates learning. Similarly, for Sue, verbalizing the case study raised a number of issues, here by talking she is self generating a number of different frames of reference through which new consideration of the case can occur.

Conversational Learning

A conversation between the nurse and the assessor followed the case study discussion and focused on the remaining evidence in the portfolio. Conversation has been described as a means of interpreting and understanding human experience; a joint meaning making and sense making process which results in learning (Kolb et al, 2002). This stance is certainly supported by those nurses who learnt from the discussion with the assessor. For example, Sally claims:

“It had meaning to my practice” (Sally, p.5).

Whilst ideas are formed in the minds of individuals through the process of learning, Nonaka (1994) believes that it is the interaction between individuals that can play a role in developing these ideas further. Conversation creates a space in which learning can occur. Fundamental to conversational learning, as in other forms of learning, is the interplay between tacit knowledge and explicit knowledge. Tacit

knowledge has been described as the intuitive knowing and doing of practice that cannot easily be captured, put into words or shared (Polyani, 1966). Constructivists believe that explicit knowledge by itself is unusable; it is in relationship to a person's tacit knowledge that it becomes understood and creates the potential for change. Conversation allows for the overt exploration of both types of knowledge; from this, links between them can be created, inconsistencies highlighted and new ways of learning considered (Lave & Wenger, 1991). Again the ultimate goal seems to be one of reducing the incongruence between espoused and in-action theory (Argyris & Schon, 1978).

Kolb et al (2002) support this belief about the type of learning inherent in conversation and have explored this theory further. They believe that in conversation both concrete knowing and abstract knowing are revealed through the processes of apprehension (the speaking about a concrete experience), and comprehension (the perceiving and conceiving of ideas). In this way new meaning is revealed. During conversation a person's epistemology - their theory of knowledge - is made explicit, whilst through the process of conversing their ontology - the nature of their being - is questioned, reconsidered and new meaning made possible.

In conversation not only is there "inside out learning" where a person's beliefs and ideas are verbalised and thereby developed and clarified, but there is also an "outside in learning" where others perspectives are considered (Jensen & Kolb, 2002, p.45). This 'outside in learning' involved hearing the perspectives of the assessor.

"[the assessor] suggested some things that I could have done which I wondered about later" (Sue, p.4).

This new information once again triggered thinking and created the possibility of idea-generation by the nurse herself. Inside out learning and outside in learning meet within the medium of conversation. For Sue, talking to and with the assessor

facilitated perspective transformation; an inside out and an outside in learning process.

Within conversation it is not a pre-existing meaning that is transmitted from one person to another, but together a deep meaning is created. Gadamer (1989) suggests: "A conversation has a spirit of its own...it allows something to emerge which hence forth exists" (p.374).

Much of Jensen and Kolb's thinking has resonance with the work of Jurgen Habermas. Habermas (1984) believes that knowledge develops through communication. By engaging in open supportive communication, implicit and explicit influences which affect perspective can be made transparent. The aim is to uncover hidden meaning and nurture critique with an outcome of emphasising the value of subjective understanding, valuing historical and lived experiences and encouraging respect for diversity.

Jensen and Kolb (2002) suggest that learning occurs during conversation in five potential ways which they describe as the "five streams of meaning making" (pp.126-135). The first stream is "resonating and reflecting". Learning takes place by listening to another's experience and then reflecting on this. Such reflection leads to an understanding of one's own experience in a new way; here the focus is on hearing others. The stream of "listening and analyzing" is similar in nature to the previous stream but contains an analytical element. Here the individual's own experience is compared and contrasted with those that are being listened to. The third meaning making stream is that of "attending and appreciating"; learning takes place by listening and being aware of others emotions, beliefs and behaviours, leading to a deeper appreciation of self and of others. These three streams of meaning would appear to relate to any learning that may occur on the part of the assessor during the process of clinical conversation as the assessor is the predominant listener and hearer within the appraisal process. However, on occasion, the nurse becomes the listener, hearing comments from the assessor who sometimes offered directions in terms of clinical practice. But later remembered:

“She made me aware of some areas I could improve on, working in the clinic, working with everyone” (Bet, p.7).

This could be considered as an instance where the nurse listened to the assessor; this listening resulted in an increase in self awareness.

The other two streams of meaning making that Kolb et al (2002) describe are those of “expressing and interacting” and “interacting and conceptualizing”. Sue would seem to fit into the category of meaning making through expressing and interacting. By verbalizing her experience and discussing it with the assessor she was able to use the interaction to develop new perspectives, particularly on the affective front.

“I felt better about it after I had discussed it with someone else, actually shared it with someone else” (Sue, p.5).

Other nurses were able to develop new perspectives on the practice front following the discussion with the assessor. Sally, Meg and Louise all identified areas where practice could be improved, for example slowing down the speed of the consultation. The sense is one of changing practice, not due to the directions given by another but through taking ownership of insights.

The degree to which the last making meaning stream of “interacting and conceptualization” took place during the dialogue with the assessor is harder to determine. Here conversation takes on the form of an in-depth, rigorous debate. For some people this process clarifies perspectives by identifying contrasts with others. Such a debate could have taken place between Jane and her peer. They were unable to reach a consensus over how to interpret the chart audit yet both heard the others opinions, clarified their own and were able to move forward to continue to work through the process together.

Another way to interpret the conversation with the assessor is more closely in line with the supervisory models discussed in the literature review. The assessor in the

clinical conversation component of the appraisal process can be seen as offering feedback on a continuum from directive to facilitatory. In some instances direct comments about practice were made and alternative to approaches suggested, while on other occasions nurses were supported to develop their own understanding and reach an individual meaning of events.

In broad terms the conversation with the assessor allowed practitioners to simply understand their practice better. Such integration of personal and explicit knowledge externalized through conversation allowed the nurse's interests to gain clarity and focus. In this way the process becomes relevant and personal, the learning unique and specific. This seems particularly pertinent in issues of professional development where practitioners are already highly skilled. Jarvis (2005) concludes: "Reflective learning and human growth and development are all facilitated in the process of genuine human interaction" (p.245).

To summarize, talking with the assessor creates a conversational space in which the nurse can view and review her practice. When the stories of clinical practice are communicated several things happen: meaning is shared and often develops into new meaning through the process of dialogue; the person narrating has a sense that their voice matters. As the study findings reveal this can result in validation and affirmation of practice, transformation of emotion, altered perspective on practice and the finding of meaning in work activities.

CHAPTER 6: CONCLUSION

The Clinical Conversation Appraisal Process As A Learning Catalyst

The process occurring for the nurses undertaking the clinical conversation appraisal procedure is primarily one of learning, in particular the acquisition of personal insights into self as practitioner. The learning occurs through three distinct narrative cycles, each of which can be viewed as an experiential learning episode (see Figure Ten, p.143). The learning cycles are narrative in nature as the major vehicle of learning is dialogue, both internal and external, and involves telling the story of clinical practice to self and to others. The experience of undertaking the assessment activities creates a narrative with self (an internal thinking experience); the experience of working with a peer creates an additional narrative (a mutual dialogue); the experience of sharing practice with an assessor creates a further narrative (a more extensive conversation). Each narrative is loosely framed by the assessment activities which closely relate to the competencies that define clinical practice as determined by the Nursing Council of New Zealand (2005).

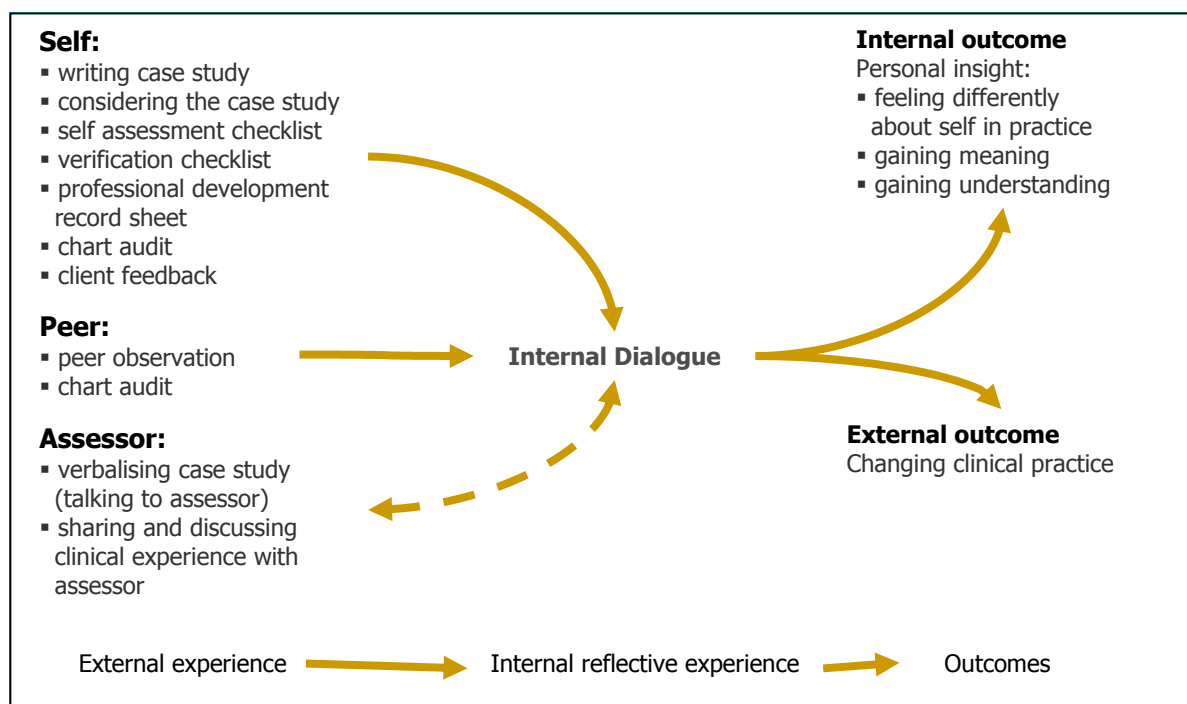


Figure Ten: The Clinical Conversation appraisal process

Not only does the clinical conversation appraisal process involve experiential learning, it is also closely linked to reflective learning. Moon (2004) suggests that there are three occasions when reflective learning occurs:

- when there is new material of learning
- from the process of representing learning
- when there is no new material of learning but where there is an internal processing of existing ideas.

Each three types of reflective learning are inherent within the clinical conversation appraisal process. When the nurse undertakes the assessment activities she is representing prior learning, in this case clinical practice. This representation offers an opportunity to learn (see Figure Seven, Chapter 5, p.130). A second reflective learning opportunity occurs during the peer observation and chart audit. Here, as a result of peer feedback, there is potentially new material of learning to consider (see Figure Eight, Chapter 5, p.134). The sharing of evidence with the assessor is an occasion where initially there is no new material of learning. The evidence contained within the portfolio has already been considered and is well known.

On one level what occurs during the discussion with the assessor is a processing of existing ideas. However, within this there seem to be distinct sub-processes occurring. The experience of verbalising the case study in particular and clinical practice in general, allows the nurse to contemplate practice from an altered position. Here the nurse is talking **to** the assessor. This in a sense becomes a representation of learning from which new learning occurs; an inside out learning where tacit knowing is brought into the open and is available for fresh consideration (Kolb et al, 2002). The discussion **with** the assessor in some instances can offer new material of learning. Here suggestions and observations are made by the assessor and if considered by the nurse an outside in learning can take place. Equally the discussion with the assessor can be the catalyst for altered thinking in a different way. No new material of learning may be present but existing ideas are explored further by the nurse in conversation with the assessor. Here there is interplay between tacit and explicit knowledge; such interplay leads to the development of joint meaning making (see Figure Nine, Chapter 5, p.137).

Within each narrative the internal experience of thinking (internal dialogue) is cyclical. The cycle is triggered by the experiences outlined above. Each experience has the potential to challenge existing cognitive structures, the core frame of reference through which all thoughts are processed. By contemplating clinical practice, by reflecting and analysing, new ideas are created. These ideas become new material of learning and can be considered afresh triggering the internal experience of thinking once more. The outcome of such consideration is internal and external change. Internal change takes place when new insights into self and practice develop; this can be described as an alteration in perspective, a mind shift. External change involves an alteration to actual clinical practice.

The results of this research suggest that, each time narration of clinical experience occurred, consciousness about practice was raised. In this way clinical conversation is a catalyst for change. For some nurses the predominant learning catalyst was the discussion with self instigated by undertaking the assessment activities, for other nurses it was the discussion with the peer or the assessor. These individual learning catalysts may relate to the different learning styles of each nurse.

It has to be remembered that learning was not the primary intent of the appraisal procedure, yet as revealed by the data, the process clearly describes how structured self assessment and discussion of practice does indeed facilitate learning. Clinical conversation provided the conditions for meaningful learning experiences to occur outside the formal learning context. It can be described as the catalyst for learning through post-experience reflection with self and with others. Such post-experience reflection becomes a new experience in itself; it is from this new experience that learning occurs.

Recommendations And Limitations

Recommendations For Future Research

My study has raised more questions than it has answered. The nature of the learning inherent within the process of clinical conversation has been identified however, much else remains unknown. The perspective of the nurses who were assessed using this technique has been explored yet the perspective of the assessors is still to be considered. Research needs to be undertaken to determine the assessor's theoretical perspective. It would be of interest to establish the way in which their perspective influences not only their assessment decisions but also the learning of the nurses they assessed. The way the assessor reaches a decision regarding competence may be directly related to their theoretical perspective. They may judge competence to be primarily about the acquisition of scientific knowledge rather than the ability to care for clients in a number of ways. If the assessors themselves practice from a positivist stance they may be more directive in their feedback to the nurse; if they practice from a constructionist position they may be more facilitatory in their interactions. Such assumptions warrant further investigation.

Lovat (2004) suggests that assessors can potentially work in a variety of ways; expert, partner, listener and learner. Within the conversations that were observed each role appeared to take place. Assessors seemed to move back and forward between these roles in response to the conversation with the nurse however additional research needs to explore this observation further.

Annual appraisal can be a contentious issue for health professionals who may resent being assessed on such a regular basis. This can be even more pertinent for practitioners with many years experience who see little value in yet again having to present evidence of competence. However, as discussed in the background chapter, the notion that competence can lapse remains valid. With the introduction of the Health Practitioner Competency Assurance Act 2003 health professionals have a legal requirement to stay updated in terms of their clinical

practice and it is for this reason that annual accreditation occurs. This rationale, however, may not be enough to ameliorate the anxiety felt when one health professional makes a decision about another's competence, particularly when such a far reaching consequence as ongoing registration is at stake. How this situation of unequal power affects the assessor nurse relationship remains unknown and is deserving of further study. The results of this study suggest that, even though this was the annual appraisal for each nurse participant, the most powerful judgment that was made during the process of clinical conversation was in fact the self judgment by the nurse. Proving competency to oneself may be the ultimate affirmation of practice for advanced practitioners. This may not be so for more junior practitioners where the judgment of the assessor may be more emotionally significant. Equally it may be the personalities of individual nurse's and their response to authoritative figures, rather than their years of experience, that is significant in terms of the power dynamics within the assessor-assessee relationship.

Within the power dynamics of the assessor nurse relationship the concepts of support and challenge could be further investigated. From this research it can be gleaned that the assessors affirmed much of what they heard however they also challenged practice and offered alternatives. The relationship between the degree of affirmation and challenge may positively or negatively impact on the degree and the nature of the learning that took place.

As the primary modus operandi of clinical conversation is verbal its value across different cultural groups would be interesting to study. The traditional system of norm referenced assessment which relies largely on written work can be particularly challenging for people who have English as a second language or who feel more comfortable expressing themselves verbally. A verbal technique such as clinical conversation may allow for more valid assessment decisions to be made as a wide range of evidence is considered. Such an approach may also be a more supportive process for the participant. Whilst professional conversation, from which clinical conversation derives, has been used widely in New Zealand and the Pacific with a variety of public sector employees, its relevance to other groups of

health professionals remains unknown. As all health workers are required to be accredited on an annual basis, the clinical conversation format may be one solution to meet this requirement. Further research to determine its applicability across the health sector would be valid.

Practice Implications

My research has established that it is the professional development needs of the nurses which have been met through the process of clinical conversation. They all saw ways in which their practice needed to change as a result of the process. It remains unknown whether clinical conversation as an appraisal tool meets the managerial requirements of FPA, however, since completing this study FPA have implemented the clinical conversation format as an annual appraisal tool which implies they see it as a valid assessment method. The Nursing Council of New Zealand has also reviewed it and considers it to be sufficient to meet their accreditation requirements.

Having been a senior member of the Family Planning Association of NZ has had both positive and negative consequences in terms of my study. The implementation of a process such as clinical conversation and the attuning of it to address the nuance for a particular scope of practice were only made possible by working within the sector and having an intimate knowledge of the functioning of the organisation. Developing and implementing such a process was time consuming and complex, as was ensuring that management, nursing and accreditation body needs were met. I was able to utilize the skill and expertise of FPA nurses to refine and rework the process to make it as clinically relevant as possible during its development stage. I also provided training to the nurse assessors which ensured that the assessment process was utilized in accordance with its philosophy of a conversation rather than an interview. However, I did not accurately predict the management implications of the appraisal process and so was unable to implement it organization wide in the first instance. This meant that I could not undertake theoretical sampling but rather had to enroll a small group of nurses into the study and collect data over a set two month time frame. The

results of the study would have been strengthened if I had been able to utilize the technique of constant comparative analysis in its strictest sense.

Having been so entrenched with the development of the process of clinical conversations raises questions about the reliability of the research findings. I feel that I was able to monitor any presuppositions and expectations as I returned to the data again and again to challenge my interpretations of emerging themes and their relationship to each other. The data analysis actually took place six months after I had left FPA. This meant that I no longer had such an emotional investment in the outcome of the research, my focus was on interpretation only and not the wider, messier implications of implementing a strategy I had developed.

I am hopeful that this research will support nurses in the future as they face the challenge of ongoing assessment and appraisal. I am also hopeful that it will extend the debate on the outcome of appraisal processes. Not only are appraisal processes about ensuring current competence, they can also support the individual to grow within their professional domain. My study has informed my practice both as a teacher and an assessor.

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APPENDIX A:

How to Appraise FPA Advanced Nurses: *Guidelines For Appraisers*

The purpose of the annual appraisal process is to:

- affirm nurses individual clinical practice
- provide evidence which demonstrates safety to practice as a registered nurse for both FPA and the Nursing Council of NZ
- provides sufficient evidence if the nurse is audited by the Nursing Council of NZ (professional development summary record sheet, formal appraisal feedback sheet and self assessment checklist: appendix E, J & K)
- offer a process of reflection
- set learning goals for the future and establish ways in which FPA can support these

The appraisal will take the form of a “clinical conversation” in which the nurse presents and discusses evidence to illustrate her competence. Competence is assessed against FPA competency indicators based on the domains established by the Nursing Council of NZ (see appendix A):

- professional responsibility
- management of nursing care
- interpersonal relationships
- interprofessional health care and quality management

The LNA (or appointed substitute) will coordinate and undertake the appraisal; however the nurse being appraised is required to take an active part in the process. The LNA contacts the nurse one month prior to the appraisal to establish:

- The date when the appraisal will take place
- The evidence which needs to be presented at the appraisal and how this evidence can be gathered. The LNA must give the nurse the document “Annual Appraisal Process: Guidelines for FPA Advanced Nurses”. This document should be presented to the nurse in a folder which then becomes her portfolio.

Evidence

The nurse is asked to collect the following evidence and gather it into a portfolio. The nurse can choose to present other evidence as long as it is relevant to the competencies.

Client feedback form (Appendix B)

Two client feedback forms must be completed. The medical receptionists most commonly will approach clients once they have left the consultation and ask them to complete the form. The nurse can choose to reflect on the clients comments and add her own thoughts.

Chart audit (Appendix C)

The nurse will undertake her own chart audit, with a peer, on at least ten consultations. She will be asked to print off the client records and include in her portfolio as this provides useful evidence to the appraiser. After the chart audit it is expected that she will reflect and comment on her practice.

Case study presentation

This offers an opportunity to examine a complex or interesting consultation in detail. The case study can be written and is to be given orally at the time of the conversation. The following points must be covered:

- Family/whanau perspectives taken into consideration
- Assessment taken as per electronic templates
- Client risk factors identified and discussed
- Information provided to client to allow for informed consent
- Decision making involves client preferences and previous experiences
- Reflection on own practice and values and how these impact on the nursing care in relation to clients age, ethnicity, culture, beliefs, gender, sexual orientation and / or disability

Cervical smear adequacy rate

A copy of the cervical smear adequacy rate from the National Cervical Screening Programme should be included.

Peer observation (Appendix D)

Two peer observation forms need to be completed. These can be completed by the same nurse peer or by two different nurse peers. The nursing colleague is required to observe the consultations and complete the feedback sheet. Rotating

peers is most valuable however in smaller clinics this may not be possible. One of the observed consultations should include a physical examination. The purpose of the peer observation is to generate discussion, between the nurse and her peer and offer an opportunity to reflect on her practice. The LNA can be the peer if necessary.

Professional Development Activities

The nurse will be asked to do two things:

1. place all her certificates of attendance at in-service and other professional development activities in her portfolio which she will bring to her appraisal
2. collate all certificates of attendance onto a summary sheet (appendix E) which **you** will need to sign off at the end of the appraisal

Verification checklist (Appendix F)

The verification checklist asks a variety of people within FPA to confirm tasks other than pure clinical work which the nurse may be involved in. This recognises the breadth of skill and diversity of role some FPA nurses have within the organisation.

Prior to the conversation taking place the LNA will need to contact a variety of people (a nursing colleague, the clinic manager, the authorising doctor) to seek feedback about the nurse on the following:

- Communication skills, professionalism and teamwork
- Implementing CPSG guidelines
- Working within standing and repeat medication order guidelines
- Contribution to the organisation
- Number of clinical hours worked

The LNA must document who she spoke to and the comments made. This can be done on the LNA confirmation sheet (**Appendix G**).

Nursing Council of New Zealand: audit requirements

This appraisal process will collate evidence required by Nursing Council should the nurse be called for audit. All the nurse will need to present as evidence to Nursing Council will be:

- Self assessment checklist (appendix K)
- Professional development summary record sheet (appendix E)
- Formal appraisal feedback sheet (appendix J)

Self assessment checklist (Appendix K)

This includes all the competency statements. The nurse is asked to comment on how she demonstrates competency. The checklist is to be signed off by a nursing colleague or LNA. This is required by Nursing Council if chosen for audit but is not required by FPA.

Clinical conversation

It is anticipated that the clinical conversation will take up to one hour. During the conversation the nurse being appraised will discuss the evidence she has collected in her portfolio. The LNA will listen, may ask clarifying questions and will offer comment on the verbal feedback she ascertained from colleagues prior to the conversation. The LNA will document the evidence on the assessment matrix (appendix H). The LNA is required to make an overall judgement about the nurse's competence using all the evidence provided. Remember the nurse is being judged against the four domains determined by the Nursing Council of NZ and in accordance with the Health Practitioner Competence Assurance Act 2003.

Three outcomes are likely from this process:

- The nurse is judged competent
- Further evidence is required before a positive outcome occurs
- New learning has to take place before the competencies can be met.

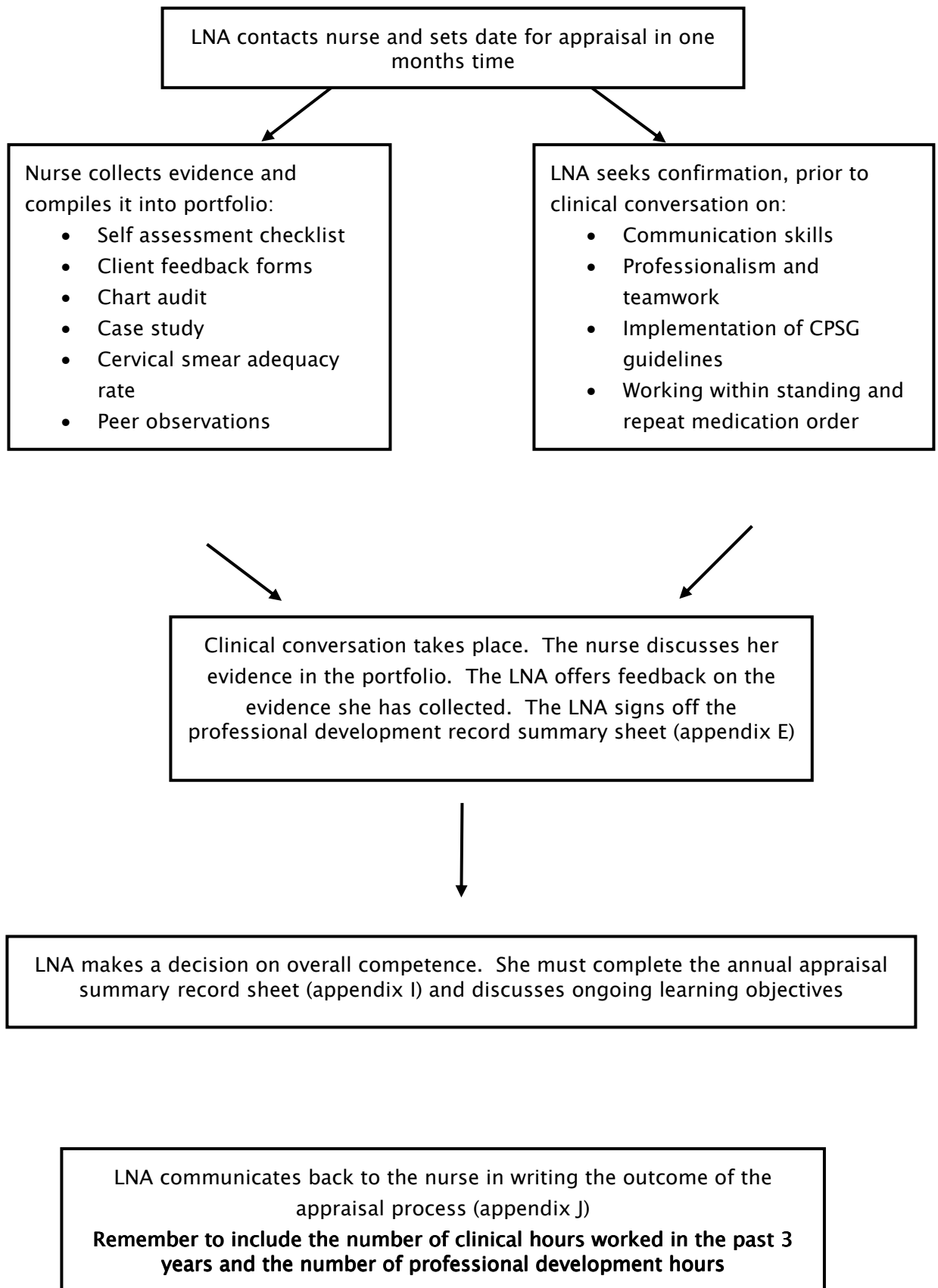
If the outcome is successful the LNA will need to write a summary of the appraisal (appendix J) which the nurse can keep in her portfolio, this will provide the required evidence for Nursing Council audit as long as it is accompanied by the professional development record summary sheet (appendix E) and the self assessment checklist (appendix K). The clinical conversation will establish where the nurse is now in terms of her role within the organisation. The discussion of learning goals will ensure that her professional development needs are identified and documented. In the summary letter (appendix J) the LNA can document how FPA can support the ongoing development goals of the nurse.

Guidelines for conducting a clinical conversation

1. Welcome and thank the nurse for coming
2. Outline the process
 - The starting point is that they are competent and will share with you evidence they have collected that demonstrates this

- They are in charge of the process and your role is on the whole to listen
 - Three potential outcomes : competence is demonstrated, more evidence is required before competence is demonstrated, new or extra learning needs to occur before competence is demonstrated
5. Address confidentiality issues
 6. Ask if they have any questions about the process
 7. Invite them to start to share the evidence they have collected in the portfolio “where would you like to start?” (A good place is with the case study as they do the talking and you do the listening)
 8. Record the evidence presented on the assessment matrix (Appendix H)
 9. Once they have completed presenting the evidence, review the feedback you got regarding communication skills, professionalism and teamwork, implementing CPSPG guidelines, working within the standing order framework and their contribution to the organisation.
 10. Complete the professional development summary record sheet (appendix E)
 11. Make an assessment decision: if you are unsure tell the nurse that you will reflect on all the evidence and get back to her. Discuss any issues with the NNA. If possible document assessment decision on the Annual Appraisal Summary Record Sheet (Appendix I) which needs to be signed by you and the nurse being appraised at the time of the appraisal. Make a copy and give to the nurse
 12. Agree on learning objectives for the next twelve months and determine organisational support if appropriate
 13. Use the appraisal feedback template (Appendix J) to complete and formalise the appraisal process once all evidence has been collected and reviewed.

Flowchart of appraisal process



Appendix A FPA Nursing Competencies

Domain One: Professional Responsibility

1.1 Accepts responsibility for ensuring that her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements.

FPA indicators:

Appraisal indicator	Evidence could include:
Maintains client privacy and confidentiality	Peer observation
Ensures informed consent prior to practice	Client feedback and peer observation
Practises within the law with regards to sexuality and adolescents	Peer observation
Works within the legal framework of standing orders and repeat medication orders	LNA confirmation

1.2 Demonstrates the ability to apply the principles of the Treaty of Waitangi to nursing practice

Appraisal indicator	Evidence could include:
works in a non judgmental way with all client groups	Client feedback form and peer observation
Respects each persons identity, rights to hold personal beliefs, values and goals	Client feedback form
Acknowledges family/whanau perspectives and supports their participation in services	Case study presentation

1.3 Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by nurse assistants, enrolled nurses and others

Appraisal indicator	Evidence could include:
Supports student learning e.g. medical students, nurses attending National Certificate course, new clinician/reception staff	Verification
Mentors new nurses	Verification
Facilitates the annual appraisal process of nursing staff	Verification
Assist in the development and review of effective mentoring and preceptor ship programmes	Verification

1.4 Promotes an environment that enables client safety, independence, quality of life and health

Appraisal indicator	Evidence could include:
Actively participates in maintaining a safe working environment	Peer observation
Uses incident report forms in an appropriate manner	Professional development record
Implements the infection control policies	Peer observation

1.5 Practices nursing in a manner that the client determines as being culturally safe

Appraisal indicator	Evidence could include:
Respects each persons identity, rights to hold personal beliefs, values	Client feedback form
Reflects on own practice and values that impact on nursing care in relation to clients age, ethnicity, culture, beliefs, gender, sexual orientation and /or disability	Case study
Assists the client to gain appropriate support and representation from those who understand the client's culture, needs and preferences	Case study

Domain Two: Management of nursing care

2.1 Provides planned nursing care to achieve identified outcomes

Appraisal indicator	Evidence could include:
Negotiates priorities with clients	Peer observation
Demonstrates sound clinical reasoning	Peer review, chart audit, case presentation
Supplies medication within the standing order/ repeat medication order framework	LNA confirmation
Conducts physical examinations (male and female) with skill, sensitivity, accuracy and consideration	Peer observation
Demonstrates 80% cervical smear adequacy rate or above	Adequacy rate from NCSR

2.2 Undertakes a comprehensive and accurate nursing assessment of clients in a variety of settings

Appraisal indicator	Evidence could include:
Undertakes assessment in an organised and systematic way in line with electronic templates	Chart audit, peer observation and case study
Uses HEADSS assessment to facilitate a comprehensive plan of action	Case study and chart audit
Assessment goes beyond that required to complete the standardised template and affects clinical reasoning/decision making	Case study, chart audit and peer observation

2.3 Ensures documentation is accurate and maintains confidentiality of information

Appraisal indicator	Evidence could include:
Demonstrates computer skills necessary to record, enter, store, retrieve and organise data essential for care delivery	Chart audit

2.4 Ensures the client has adequate explanation of the effects, consequences and alternatives of proposed treatment options

Appraisal indicator	Evidence could include:
Provides appropriate information to clients to protect their rights and allow informed decisions	Client feedback form and peer observation
Takes the clients preferences into consideration when providing care	Peer observation
Demonstrates awareness of stages of adolescent development and tailors information giving accordingly	Case study

2.5 Acts appropriately to protect oneself and others when faced with unexpected client responses, confrontation, personal threat or other crisis situation

Appraisal indicator	Evidence could include:
Understands FPA emergency procedures	Incident reports included in portfolio Professional development record showing attendance at CPR training

2.6 Evaluates client's progress toward expected outcomes in partnership with clients

Appraisal indicator	Evidence could include:
Reflects on client feedback on the evaluation of nursing decisions	Chart audit and case study
Reflect on practice with peers or senior colleagues	As above

2.7 Provides health education appropriate to the needs of the client within a nursing framework

Appraisal indicator	Evidence could include:
Checks clients' level of understanding of health care when answering questions and providing information	Client feedback form and peer observation
Uses informal and formal methods of teaching that are appropriate to the client's abilities	Peer observation
Promotes good health and illness prevention by identifying risks and taking opportunities to discuss these with the client	Peer observation and chart audit
Identifies client's risk and resiliency factors	Case study

2.8 Reflects upon and evaluates with peers and experienced nurses, the effectiveness of nursing care

Appraisal indicator	Evidence could include:
Accesses advice, assistance, debriefing and	LNA confirmation

direction as necessary	
Reflects on practice with peers or senior colleagues	Peer observation

2.9 Maintain professional development

Appraisal indicator	Evidence could include:
Implements recommendations from Clinical Professional Service Group meetings and clinical memos	LNA confirmation
Ensures 60 hours of professional development activities are undertaken over three years. For example: attends in-service, conferences, workshops, forums, maintains a reading log.	Professional development summary record sheet
Undertakes postgraduate study towards advanced nursing practice	Professional development record
Mentors new nurses	Verification
Teaches on PDU courses or FPA internal/training sessions	Verification

Domain three: Interpersonal relationships

3.1 Establishes, maintains and concludes therapeutic interpersonal relationships with client

Appraisal indicator	Evidence could include:
Initiates, maintains and concludes therapeutic interpersonal interactions with client	Peer observation
Establishes rapport and trust with client	Client feedback form
Establishes ongoing relationship with client over a significant period of time	Chart audit

3.2 Practises nursing in a negotiated partnership with the client where and when possible

Appraisal indicator	Evidence could include:
Undertakes nursing care that ensures clients receive and understand relevant and current information concerning their health care that contributes to informed consent	Peer observation

3.3 Communicates effectively with clients and members of the health care team

Appraisal indicator	Evidence could include:
Communicates clearly and effectively with clients and members of the health care team	LNA confirmation
Comfortable discussing all matters relating to sexuality and sexual practices (vaginal, anal and oral sex etc)	Case study
Communicates effectively within a multidisciplinary team	Chart audit

Domain four: interprofessional health care and quality improvement

4.1 Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care

Appraisal indicator	Evidence could include:
Documents evidence necessary for continuity of care	Chart audit
Uses task facility on computer appropriately	Chart audit
Makes appropriate formal referrals to other health care team members and other health related sectors for clients who require consultation	Chart audit
Facilitates effective communication both within the centre and to the locality manager and LNA	Verification

4.2 Recognises and values the roles and skills of all members of the health care team in the delivery of care

Appraisal indicator	Evidence could include:
Collaborates, consults with and provides accurate information to the client and other health professionals within FPA about the prescribed intervention or treatments	Chart audit
Collaborates, consults with and provides accurate information to other health professionals outside FPA with clients consent	Verification

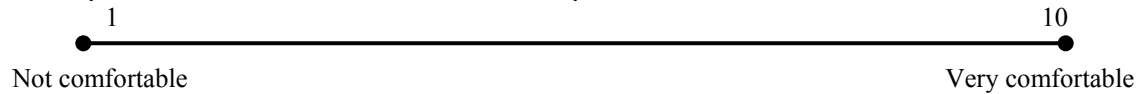
4.3 Participates in quality improvement activities to monitor and improve standards of nursing

Appraisal indicator	Evidence could include:
Undertakes annual audit of own files for the purpose of reflection	Chart audit
Sets learning goals on an annual basis	Annual appraisal

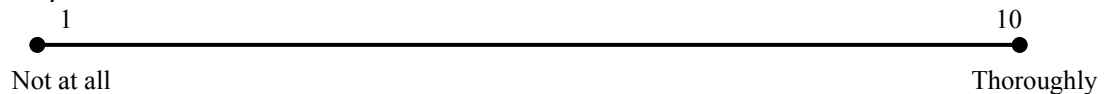
Appendix B: CLIENT FEEDBACK FORM

The nurse that you have just seen is having her yearly review. Several clients will be asked to complete a questionnaire about the consultation they have had with her. Please could you answer the following questions? Your answers will be anonymous.

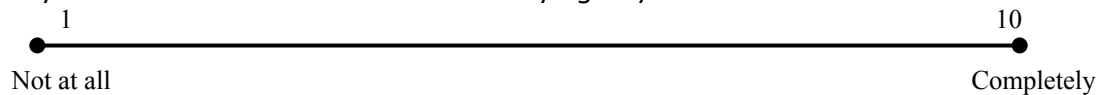
1. Did you feel comfortable to discuss what you wanted to with the nurse?



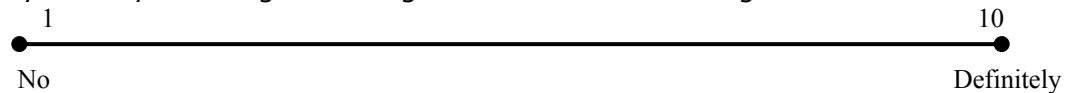
2. Was your main issue addressed?



3. Did you understand what the nurse was saying to you?



4. Did you feel you were given enough information to make a good decision?



5. Would you choose to see this nurse again? *(please circle one)*

YES

NO

6. Did anything happen in the consultation that you didn't like or you would like to have been done differently? *(Please comment below)*

Please complete the following if you feel comfortable to do so:

Your ethnicity: _____

Your age: _____

Date: _____

Thank you for your participation

Appendix C: Chart Audit

Please print off and review, with a peer, ten recent consultations that you have undertaken and comment on the following:

Type of consultation:										
Consultation:	1	2	3	4	5	6	7	8	9	10
Client risk factors identified, documented and discussed For example: unsafe sexual practices, family violence, smoking, obesity.										
Comprehensive clinical assessment documented, appropriate templates completed										
Assessment undertaken in an organised and systematic way										
Sound clinical reasoning evident										
Client feedback taken into consideration when making nursing decisions										
Rationale for decision making and plan of action documented										
Documentation comprehensive enough to allow for continuity of care to occur (ie what decisions were made and what intervention occurred)										
Task facility on computer used appropriately to ensure records are signed off for hormonal contraception										
Referrals made to other health care team members within FPA and other health related sectors outside FPA as appropriate										
Undertakes HEADSS assessment: identifies risk and resiliency factors										
Establishes ongoing relationship with client over a significant period of time										
Documents communication with multidisciplinary team										

What did you discuss with your colleague about your documentation and clinical practice?

What insights into your practice did you gain from doing this chart audit?

Date: _____

NB: Include the printed off consultations in your portfolio whilst ensuring identifying information has been removed

Appendix D: PEER OBSERVATION

Guidelines for implementing the peer observation process.

You have been asked to observe one or two consultation with a peer as part of her annual appraisal process. Please comment on the following using the sheet provided.

Clinical assessment skills

- Organised and systematic assessment
- Goes beyond that required by the standardised templates

Physical examination skills

- Appropriate
- Implements infection control policy

Communication skills

- Privacy and confidentiality
- Non judgemental approach
- Initiates, maintains and concludes therapeutic relationship with client

Clinical decision making skills

- Sound clinical reasoning
- Reflects on clients feedback when making clinical decisions
- Identifies and discusses clients risk taking behaviours

Information giving skills

- Ensures informed consent
- Checks clients level of understanding
- Provides information in a variety of ways
- Tailors information to adolescent stage of development

Organisational / efficiency skills

- Negotiates priorities with clients
- Is efficient in service provision

Overall clinical competence

- Practices within a legal framework
- Maintains a safe clinical environment
- Manages consultation effectively, with sound judgement

If you feel comfortable please discuss your observations with your peer.

Peer observer: _____ Date: _____

Nurse: _____ Age of client: _____ Sex: _____

Reason for consultation: _____

Clinical assessment skills

1	2	3	4	5	6	7	8	9
Not yet competent			Competent			Expert		

Physical examination skills

1	2	3	4	5	6	7	8	9
Not yet competent			Competent			Expert		

Communication skills

1	2	3	4	5	6	7	8	9
Not yet competent			Competent			Expert		

Clinical decision making skills

1	2	3	4	5	6	7	8	9
Not yet competent			Competent			Expert		

Information giving skills

1	2	3	4	5	6	7	8	9
Not yet competent			Competent			Expert		

Organisational / efficiency skills

1	2	3	4	5	6	7	8	9
Not yet competent			Competent			Expert		

Overall clinical competence

1	2	3	4	5	6	7	8	9
Not yet competent			Competent			Expert		

What did you like about the way your peer conducted the consultation?

What would you have done differently if you had conducted the consultation?

Signature: _____

Appendix E: PROFESSIONAL DEVELOPMENT RECORD: SUMMARY SHEET

Summary sheet: professional development activities (60 hours over three years)

Date:	Activity	Explain what you learnt from this activity	Hours spent	LNA sign off

Total number of hours:

Verified by:

Designation:

Address:

Phone number:

Appendix F: VERIFICATION CHECKLIST

	Verifier	Signature	Date
Supports student learning, for example: medical students, nurses attending clinical placements, new clinicians			
School linked clinic nurse			
Collaborates, consults with and provides accurate information to other health professionals outside FPA			
Mentors new FPA nurses			
Facilitates the annual appraisal process of nursing staff			
Teaches on PDU courses or FPA internal teaching/training sessions			
Facilitates effective communication both within the centre and to the locality manager and LNA			

Appendix G: LOCALITY NURSE ADVISOR CONFIRMATION:

<ul style="list-style-type: none">• Works within the legal framework of standing orders and repeat medication orders
<ul style="list-style-type: none">• Supplies medication within the legal framework of standing orders and repeat medication orders
<ul style="list-style-type: none">• Implements recommendations from CPSG
<ul style="list-style-type: none">• Communication, team work and professionalism
<ul style="list-style-type: none">• Contribution to the organisation
<ul style="list-style-type: none">• Number of clinical hours worked

Appendix H: ASSESSMENT MATRIX: ANNUAL APPRAISAL PROCESS

Name: _____

Date: _____

Domain 1: Professional responsibility Professional/ethical/legal practice Applies principles of T of W Supports other clinicians Client safety promoted Culturally safe practice	Domain 2: Management of Nursing Care Planned care to meet identified outcomes Nursing assessment Accurate documentation Informed consent Manages aggressive clients Evaluates client's progress Health education Reflects upon nursing care Maintains professional development
Domain 3: Interpersonal relationships Therapeutic interpersonal relationship with client Works in partnership with client Communicates effectively with client and team	Domain 4: Interprofessional health care and quality improvements Works effectively in team to coordinate care Recognises and values role of team members Quality improvement activities

Appendix I: ANNUAL APPRAISAL SUMMARY RECORD SHEET

Appraiser: _____

Nurse: _____

Date: _____

Domain	Competent (C) Further Evidence Required (FER)
Professional responsibility	
Management of nursing care	
Interpersonal relationships	
Interprofessional health care and quality improvement	

Further evidence required:
Number of clinical hours in past three years:
Number of professional development hours in past three years:

Learning Goals for next twelve months
•
•
•

Appraisers signature: _____

Nurse signature: _____

Appendix J: BLUE INDICATES COMMENTS TO BE ADDED. PLEASE DELETE THE INSTRUCTIONS

Copy and paste on to letterhead

4 June 2008 (*line 1*)

Attn: *Insert name*

Address Line 1

Address Line 2

City

Dear *insert name*

Thank you for taking part in the appraisal process. I will address your appraisal under the four competency domains identified by the Nursing Council for New Zealand.

Professional Responsibility

Insert comments here:

Management of Nursing Care

Insert comments here eg. Client care, expertise & practice etc. Smear adequacy rate

Interpersonal Relationships

Insert comments here

Interprofessional Health Care and Quality Improvements

Insert comments here

Domain	Competent (C) Further Evidence Required (FER)
Professional responsibility	
Management of nursing care	
Interpersonal relationships	
Interprofessional health care and quality improvement	
Further evidence required: <i>Insert comments here if applicable</i>	
Number of clinical hours in past 3 years	
Number of hours spent on professional development activities in past 3 years	

Your goals for 2006/2007 are:

- *Insert goals*
- *Say how FPA can support learning goals*

In summary, *etc...*

Thank you for your commitment to FPA.

Regards,

Name

Title

Appendix K: FPA NURSING COMPETENCIES: SELF ASSESSMENT CHECKLIST

You must comment on each competency statement 1.1 – 4.3. Ask your nursing colleague to sign this checklist once you have completed it. If you are audited by Nursing Council they will require this piece of evidence.

Domain One: Professional Responsibility

1.1 Accepts responsibility for ensuring that her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements.

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Maintain client privacy and confidentiality Ensure informed consent prior to practice Practice within the law with regards to sexuality and adolescents Work within the legal framework of standing orders and repeat medication orders 		

1.2 Demonstrates the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> work in a non judgmental way with all client groups respect individual identity, right to hold personal beliefs, values and goals acknowledge whanau/family perspectives and support their participation in services 		

1.3 Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by nurse assistants, enrolled nurses and others

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Support for student learning e.g. medical students, nurses attending the National certificate course, new clinicians/reception staff Mentor new nurses 		

<ul style="list-style-type: none"> Facilitate the annual appraisal process of nursing staff Assist in the development and review of effective mentoring and preceptor ship programmes 		
---	--	--

1.4 Promotes an environment that enables client safety, independence, quality of life and health

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Maintain a safe working environment Implement infection control policies 		

1.5 Practices nursing in a manner that the client determines as being culturally safe

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Respect each persons identity, rights to hold personal beliefs and values Reflect on your own practice and values that impact on nursing care in relation to clients age, ethnicity, culture, beliefs, gender, sexual orientation &/or disability Assist clients to gain appropriate support and representation from those who understand the client's culture, needs and preferences 		

Domain Two: Management of nursing care

2.1 Provides planned nursing care to achieve identified outcomes

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Negotiate priorities with clients Sound clinical reasoning Supply medication within the standing order/ repeat medication order legal framework Conduct physical examinations with skill, sensitivity, accuracy and consideration Demonstrate 80% cervical smear adequacy rate 		

2.2 Undertakes a comprehensive and accurate nursing assessment of clients in a variety of settings

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Undertake an assessment in an organized and systematic way in line with electronic templates Utilize HEADSS assessment to facilitate a comprehensive plan of action Assess beyond that required of the standard templates and that this assessment affects clinical reasoning and decision making 		

2.3 Ensures documentation is accurate and maintains confidentiality of information

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Record, enter, store, retrieve and organize data on the computer essential for care delivery 		

2.4 Ensures the client has adequate explanation of the effects, consequences and alternatives of proposed treatment options

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Provide appropriate information to clients to protect their rights and allow informed decisions Take client preferences into consideration when providing care Identify stages of adolescent development and tailor information giving accordingly 		

2.5 Acts appropriately to protect oneself and others when faced with unexpected client responses, confrontation, personal threat or other crisis situation

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Understand FPA emergency procedures 		

2.6 Evaluates client's progress toward expected outcomes in partnership with clients

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Reflect on client feedback on the evaluation of nursing decisions Reflect on practice with peers or senior colleagues 		

2.7 Provides health education appropriate to the needs of the client within a nursing framework

Self assessment checklist

Do you:	Yes	Comments:
<ul style="list-style-type: none"> Check the client's level of understanding when answering questions and providing information Use informal and formal methods of teaching that are client appropriate Promote good health and illness prevention by identifying risks and taking opportunities to discuss these with clients Identify client's risk and resiliency factors 		

2.8 Reflects upon and evaluates with peers and experienced nurses, the effectiveness of nursing care

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Access advice, assistance, debriefing and direction Reflect on practice with peers or senior colleagues 		

2.9 Maintain professional development

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> Implement recommendations from Clinical 		

Professional Services Group meetings and clinical memos <ul style="list-style-type: none"> • Demonstrate that you have undertake sixty hours of professional development activities over the past three years • Undertake study towards advanced nursing practice • Mentor new nurses • Teach on PDU courses or FPA internal/training sessions 		
--	--	--

Domain three: Interpersonal relationships

3.1 Establishes, maintains and concludes therapeutic interpersonal relationships with client

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> • Initiate, maintain and conclude therapeutic interpersonal interactions with clients • Establish rapport and trust with clients • Establish ongoing relationships with clients over a significant period of time 		

3.2 Practises nursing in a negotiated partnership with the client where and when possible

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> • Undertake nursing care that ensures clients receive and understand relevant and current information concerning their health care that contributes to informed consent 		

3.3 Communicates effectively with clients and members of the health care team

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none"> • Comfortable discussing all matters relating to sexuality and sexual practices • Communicate effectively within a multidisciplinary team 		

Domain four: interprofessional health care and quality improvement

4.1 Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care

Self assessment checklist

Do you:	Yes/ No	Comments:
<ul style="list-style-type: none">• Document evidence necessary for continuity of care• Use task facilities on the computer appropriately• Make appropriate formal referrals both within FPA and other health related sectors• Facilitate effective communication both within the centre and to the locality manager and locality nurse advisor		

4.2 Recognises and values the roles and skills of all members of the health care team in the delivery of care

Self assessment checklist

Do you:	Yes	Comments:
<ul style="list-style-type: none">• Collaborate, consult with and provide accurate information to both clients and FPA health professionals about the prescribed interventions or treatments• Collaborate, consult with and provide accurate information to other health professionals outside FPA with client consent		

4.3 Participates in quality improvement activities to monitor and improve standards of nursing

Self assessment checklist

Do you:	Yes	Comments:
<ul style="list-style-type: none">• Undertake annual audit of own files for the purpose of reflection• Set learning goals on an annual basis		

Signed: _____

Date: _____

Nursing colleague verifier: _____

Designation: _____

Date: _____

Address & phone number: _____

APPENDIX B:

Annual Appraisal Process: Abridged Guidelines For FPA Advanced Nurses.

The purpose of the annual appraisal process is to:

- affirm your individual nursing practice
- provide evidence which demonstrates your safety to practice as a registered nurse for both FPA and the Nursing Council of NZ
- offer a process of reflection
- set learning goals for the future and establish what support FPA can offer you to meet these goals

It is expected that FPA nurses working at advanced level will take ownership of their appraisal process. As a health professional each nurse is individually responsible for ensuring she undertakes an annual appraisal (refer Health Practitioner Competence Assurance Act, 2003). The nurse can gather a variety of evidence to show that she is a competent practitioner. All the evidence collected can be arranged into this portfolio to present at the time of your annual FPA appraisal and to the Nursing Council of NZ if requested.

Nursing Competencies

The Nursing Council of New Zealand has developed four domains of competence for the registered nurse scope of practice. The domains are:

1. Professional responsibility
2. Management of nursing care
3. Interpersonal relationships
4. Interprofessional health care and quality management

Evidence of safety to practise as a registered nurse is demonstrated when the nurse meets the competencies within all four domains.

Each domain has several overarching statement or competencies. Each competency statement then has potential “indicators” against which nursing practice can be measured. For each competency FPA nursing indicators have been developed (Appendix F).

FPA nurses need to provide evidence to show their competence within each domain. This can be achieved by using the framework outlined below or by providing other forms of evidence. One piece of evidence can show competence across a variety of indicators.

The Process

Your Locality Nurse Advisor (or appointed appraiser) will negotiate with you a date for your appraisal. Prior to the appraisal you will need to collect a range of evidence in this portfolio and bring it with you to the appraisal. The LNA will contact the clinic manager, a team member and a doctor who signs off your files for comment on the following. Your:

- Communication skills
- Professionalism and team work

- Contribution to the organisation
- Use of Standing Orders and Repeat Medication Orders
- Implementation of CPSG guidelines

The appraisal is expected to last an hour and takes the form of a conversation where you will discuss the evidence you have collected and the LNA will feedback on the information she has received. Learning goals for the future will be agreed upon.

Gathering Evidence

To meet the requirements of the competencies you need to provide a variety of evidence, using the tools below will ensure that you have provided evidence for each domain:

- Completed client feedback forms (appendix A)
- Chart audit which you undertake with a peer (appendix B)
- Case study presentation: written but discussed at the appraisal
- Cervical smear adequacy rate
- Peer observation and feedback (appendix C)
- Record of attendance at inservice, CPR and anaphylaxis updates, courses attended, postgraduate study, readings collated into the professional development record summary sheet (appendix D)
- Verification record (appendix E)

Evidence

Client feedback form (appendix A)

You need to have two client feedback forms completed. Ask the medical receptionists to approach your clients once they have left the consultation. You may choose to reflect on the clients comments and add your thoughts to the feedback form.

Chart audit (appendix B)

Undertaking a chart audit allows consideration of how you practice. You and a peer need to print off and review ten consultations using the chart audit form. Include the print outs in your portfolio removing client name and all identifying information. After this process it is expected that you will reflect and comment on your practice.

Case study presentation

This offers an opportunity to examine a complex or interesting consultation in detail. It will reveal your skills as a clinician working in the challenging field of sexual and reproductive health. Make sure you cover all the following points:

- Family/whanau perspectives taken into consideration
- Assessment taken as per electronic templates and beyond
- Client risk factors identified and discussed
- Information provided to client to allow for informed consent
- Decision making involved client preferences and previous experiences
- Reflection on own practice and values and how these impact on the nursing care you provide in relation to clients age, ethnicity, culture, beliefs, gender, sexual orientation and / or disability

The case study should be written and included in your portfolio but is to be presented orally at the time of the appraisal. The case study needs to include your thoughts and

reflections about the consultation. The Nursing Council document “Guidelines for Cultural Safety” located on the x drive may provide useful points for consideration.

Cervical smear adequacy rate

Please include a copy of your cervical smear adequacy rate from the National Cervical Screening Programme.

Peer observation (appendix C)

Two peer observations need to take place; they can be undertaken by one or two nursing colleagues. Ask the nursing colleague(s) to observe two of your consultations and complete the feedback sheet for each. It is most useful if one of the consultations includes a physical examination. The purpose for this is to generate discussion, between you and your peer, about your style of consultation and offer an opportunity to reflect on your practice.

Professional Development Activities

You need to do two things regarding evidence of professional development:

1. Place all your certificates of attendance in this portfolio and bring to your appraisal. This could include attendance at FPA inservice, external courses, workshops, forums, postgraduate study etc
2. Collate all your professional development activities on to the summary sheet prior to your appraisal (appendix D). Leave the last column blank as your LNA will sign this off, at the time of the appraisal, having sighted your original documents. If you are audited by the Nursing Council they will want the summary sheet signed by your LNA and not the individual certificates of attendance.

Verification checklist (appendix E)

The verification checklist can be used to show evidence of work outside the strict scope of clinical nursing.

Self assessment checklist (appendix F)

The self assessment checklist is a requirement of the Nursing Council if you are called for audit. It asks you to document in what ways you meet the competencies. It needs to be signed off by a nursing colleague. It is not a requirement of the annual FPA appraisal process.

Nursing Council of New Zealand recertification programme (audit)

Nurses applying for an annual practising certificate under the HPCA Act (2003) will be asked by the Nursing Council of New Zealand to declare that they have met the required standard of competence. Approximately 5% of nurses will be audited. This appraisal process will ensure you have adequate documentation if audited by the Nursing Council as it provides:

- Documentation of practice hours (in appraisal feedback letter)
- Documentation of professional development hours (appendix D)
- Self assessment signed off by a nursing colleague (appendix F)
- Assessment by your LNA or appointed appraiser (summarised in appraisal feedback letter)

APPENDIX C:

Participant Information Sheet

Participant Information Sheet for FPA Nurses	 AUT UNIVERSITY <small>TE WĀNANGA ARONUI O TAMAKI MAKAU RAU</small>
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Date Information Sheet Produced:
8.5.06.

Project Title

What is happening for the nurse during a “clinical conversation” to assess competence: a grounded theory study

Invitation

On behalf of the researcher I invite you to be a participant in a study looking at the appraisal process soon to be introduced into FPA. The appraisal is based on competencies that FPA has developed in line with the Nursing Council of New Zealand’s competencies for the registered nurse scope of practice. The appraisal will take the form of a clinical conversation between you and a Locality Nurse Advisor. During the conversation you will share evidence that you have collected which will illustrate your knowledge, skills and attitudes.

What is the purpose of this research?

The purpose of the research is to explore what happens during a clinical conversation from your perspective. This will provide valuable information about the usefulness of the technique. It will allow clinical conversation to be compared to other assessment strategies used within nursing to determine competent practice. This research forms part of a Masters degree.

How are people chosen to be asked to be part of this research?

When it is time for FPA nurses to have their annual appraisal they will be offered the choice of following the existing appraisal format or being part of the study and trialling the clinical conversation format. You are invited into the study by way of this information sheet. If you do want to be part of the study but your Locality Nurse Advisor does not want to take part then another LNA who has agreed to be part of the study can conduct your appraisal.

What happens in this research?

Two types of data will be collected. Firstly the researcher may observe the clinical conversation that you are part of and secondly she will interview you at a later date to discuss your thoughts and feelings about the clinical conversation. Both will be arranged at a time convenient to you. The interview will be taped; the tape will be transcribed by the researcher or a transcriber who has signed a confidentiality agreement. The researcher will not be assessing

you during the clinical conversation but observing the process of the conversation and seeking your feedback.

Not all nurses who agree to be part of this study may be included. Data collection stops in a grounded theory study once no new information is being uncovered. It is unknown when this might happen but it is anticipated that six to eight nurses may be interviewed.

What are the discomforts and risks?

You will be asked to be frank about your thoughts and feelings of this assessment process; you may feel uncomfortable about this.

The research is not an opportunity to discuss the outcome of the appraisal. If you are unhappy with the assessment decision you can discuss this with me, Rose Stewart, the National Nurse Advisor, in the first instance.

How will these discomforts and risks be alleviated?

Every attempt will be made to create an environment where you can feel comfortable to discuss how the process of the clinical conversation was for you. Everything you say will be confidential. You can withdraw from the research at any time without having to provide an explanation. If you feel you need counselling as a result of taking part in the study three free counselling sessions are available either through FPA or Auckland University of Technology.

What are the benefits?

This study will provide nurses with an opportunity to offer feedback about the new FPA appraisal process. Such feedback will help determine if clinical conversation has a place in assessing nursing competence.

How will my privacy be protected?

All information obtained from both the observed clinical conversation and the interview will be confidential. No identifying information will be available to anyone other than the researcher and a transcriber who will have signed a confidentiality agreement. Tapes and data analysis will be held in a locked filing cabinet in a secure place. The researcher's work and home computer are both passworded. The presentation of the findings will be done in such a way that your identity will not be revealed.

What are the costs of participating in this research?

The main cost is your time to partake in the interview which will take up to an hour. The researcher is able to travel to your place of work or your home at a time that is convenient to you.

What opportunity do I have to consider this invitation?

If after thinking about the information on this sheet you are interested in being part of the research please complete the consent form attached and return it to me, Rose Stewart, as soon as possible via the internal mail. I will then forward it on to the researcher, Jenny Grainger. If you are unsure and would like more information please don't hesitate to contact me.

How do I agree to participate in this research?

Please complete the attached consent form and send it to Rose Stewart via internal mail.

Will I receive feedback on the results of this research?

The researcher will discuss with you how you would like to receive feedback. She will use the FPA intranet to post progress reports and also the final findings.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Jan Wilson, jan.wilson@aut.ac.nz, 09 921 9999 ext 7808.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Who do I contact for further information about this research?

Rose Stewart

Family Planning Association of New Zealand

Private Bag 999 29

Newmarket

Auckland

Tel: 09 524 3345 (work) or 021 153 2250 (mobile)

Email: rose.stewart@fpanz.org.nz

Project Supervisor Contact Details:

Jan Wilson

Senior Lecturer

Auckland University of Technology

Private Bag 92006

Auckland

Tel: 09 921 9999 ext 7808

Email: jan.wilson@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 12 June 2006, AUTECH Reference number 06/61

APPENDIX D:

Consent to participate in research: FPA nurses

Title of Project: What is happening for the nurse during a “clinical conversation” to assess competence: a grounded theory study

Project Supervisor: Jan Wilson

Researcher: Jenny Grainger

- I have read and understood the information provided about this research project (Information Sheet dated 8.5.06)
- I have had an opportunity to ask questions and to have them answered.
- I understand that the clinical conversation may be observed and that the interview will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research: tick one:

Yes ☐ No ☐

Participant signature:

Participant name:

Participant Contact Details (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on
12.06.06

AUTEC Reference number 06/61

Note: The Participant should retain a copy of this form.

APPENDIX E:

Participant information sheet for Locality Nurse Advisors

Participant Information Sheet for Locality Nurse Advisors	 AUT UNIVERSITY TE WĀNANGA ARONUI O TAMAKI MAKAU RAU
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Date Information Sheet Produced:

8.5.06.

Project Title

What is happening for the nurse during a “clinical conversation” to assess competence: a grounded theory study

Invitation

On behalf of the researcher I invite you to be a participant in a study looking at the appraisal process soon to be introduced into FPA. The appraisal is based on competencies that FPA has developed in line with the Nursing Council of New Zealand’s competencies for the registered nurse scope of practice. The appraisal will take the form of a clinical conversation between the nurse and yourself as Locality Nurse Advisor. During the conversation the nurse will share evidence that she has collected which will illustrate her knowledge, skills and attitudes.

What is the purpose of this research?

The purpose of the research is to explore what happens during a clinical conversation from the nurse’s perspective. This will provide valuable information about the usefulness of the technique. It will allow clinical conversation to be compared to other assessment strategies used within nursing to determine competent practice. The research is part of a Masters degree.

How are people chosen to be asked to be part of this research?

As a Locality Nurse Advisor you are being invited into the study. All LNA’s (even those who do not want to be involved in the study) will be asked to offer their nurses either the existing appraisal format or to become part of this study using the clinical conversation format. Those nurses who opt for the clinical conversation format do so knowing that they may be included in the study.

You can decide not to be part of the study but if your nurses choose to be part of the study another LNA will undertake the clinical conversation on your behalf.

What happens in this research?

Two types of data will be collected. Firstly, the researcher may observe the clinical conversation that you are part of for which I require your consent however, it is anticipated that only observe two or three conversations will be

observed. Secondly, the researcher will interview the nurse at a later date to discuss her thoughts and feelings about the clinical conversation. The focus of the questioning is on the process of clinical conversation not on the outcome of the appraisal or your role as an assessor. The researcher will not be seeking your feedback at the data collection stage of the research as the focus is on understanding how the process of clinical conversation is for the nurse being assessed. She may, however, come back to you at a later date to seek your comment on the findings.

What are the discomforts and risks?

You may feel uncomfortable about having the researcher present during the clinical conversation. You may also be concerned about what her role would be if the nurse disagreed with the assessment decision that you made.

How will these discomforts and risks be alleviated?

The focus of the study is not on your role as an assessor but on the process of the clinical conversation from the perspective of the nurse.

If the nurse disagrees with the assessment decision that you make the researcher will not be available to offer comment to either yourself or the nurse. The established complaint process would need to be followed by discussing the issue with me, Rose Stewart, National Nurse Advisor, in the first instance.

You can withdraw from the research at any time without having to provide an explanation. If you feel you need counselling as a result of taking part in the study three free counselling sessions are available either through FPA or Auckland University of Technology.

What are the benefits?

It is hoped this study will provide nurses with an opportunity to offer feedback about the new FPA appraisal process. Such feedback will help determine if clinical conversation has a place in assessing nursing competence.

How will my privacy be protected?

All information obtained from both the observed clinical conversation and the interview will be confidential. No identifying information will be available to anyone other than the researcher and a transcriber who will have signed a confidentiality agreement. Tapes and data analysis will be held in a locked filing cabinet in a secure place. The researcher's work and home computer are both passworded. The presentation of the findings will be done in such a way that your identity will not be revealed.

What are the costs of participating in this research?

The main cost is your time in discussing with the nurse the existing appraisal process compared with the clinical conversation format.

What opportunity do I have to consider this invitation?

If after thinking about the information on this sheet you are interested in being part of the research please complete the consent form attached and return it to me, Rose Stewart, as soon as possible via the internal mail. I will then forward it on to the researcher, Jenny Grainger. If you are unsure and would like more information please don't hesitate to contact me.

How do I agree to participate in this research?

Please complete the attached consent form and send it to Rose Stewart via internal mail.

Will I receive feedback on the results of this research?

The researcher may discuss the findings of the study with you at a later date. She will prepare summary documents to include on the FPA intranet to inform everyone concerned about the progress of the study.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Jan Wilson, jan.wilson@aut.ac.nz, 09 921 9999 ext 7808.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Who do I contact for further information about this research?***Intermediary Contact Details:***

Rose Stewart

Family Planning Association of New Zealand

Private Bag 999 29

Newmarket

Auckland

Tel: 09 524 3345 (work) or 021 153 2250 (mobile)

Email: rose.stewart@fpanz.org.nz

Project Supervisor Contact Details:

Jan Wilson

Senior Lecturer

Auckland University of Technology

Private Bag 92006

Auckland

Tel: 09 921 9999 ext 7808

Email: jan.wilson@aut.ac.nz

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Approved by the Auckland University of Technology Ethics Committee on 12 June 2006, AUTECH Reference number 06/61

APPENDIX F:

Consent to participate in research: Locality Nurse Advisors

Title of Project: What is happening for the nurse during a “clinical conversation” to assess competence: a grounded theory study.

Project Supervisor: Jan Wilson

Researcher: Jenny Grainger

- I have read and understood the information provided about this research project (Information Sheet dated 8.5.06)
- I have had an opportunity to ask questions and to have them answered.
- I understand that the appraisal I am conducting may be observed and that the nurse being appraised will be interviewed at a later date about the appraisal process.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research: tick one:

Yes ☐ No ☐

Participant signature:

Participant name:

Participant Contact Details (if appropriate):

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Date:

Approved by the Auckland University of Technology Ethics Committee on
12.6.06 **AUTEC Reference number 06/61**

Note: The Participant should retain a copy of this form.