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THE EXPERIENCE OF BACCALAUREATE DEGREE SEEKING NURSING STUDENTS UNDERGOING THE PROCESS OF CLINICAL EVALUATION APPRAISAL

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ABSTRACT

This phenomenological qualitative study examines the experiences of nine baccalaureate nursing students undergoing the clinical evaluation process at two institutions. The clinical performance appraisal (CPA), an identified challenge for faculty and students alike, is a tool utilized for assessing nursing students' behaviors in the clinical setting. The national need for registered nurses that is projected to increase 22.2% by the year 2018 is cause for alarm. The importance for nursing faculty to understand and implement the clinical evaluation process is an important part of meeting this need while facilitating student learning. The lived experiences of nine student nurses were collected by way of semi-structured, digitally recorded, and in-depth interviews. Based upon the analysis of data, four major themes emerged: (a) the impact of an absent instructor; (b) all instructors are different; (c) input into the evaluation process; and (d) the evaluation process is a formality. Implications and recommendations for higher education are presented. To complete the study, recommendations for research and conclusions are made.

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First, I would like to acknowledge Dr. Beverly J. Reynolds whose study served as a platform upon which to continue my quest to study the experience of nursing students as they try to meet their personal and professional goal of becoming registered nurses. Through her generosity in sharing her earlier research on a similar topic, I was able to build upon a rich literature review of how faculty and students have struggled with meeting this goal in the clinical setting over decades of time. Since the time of the writing of her dissertation, I have been able to identify additional literature that incorporates the utilization of numerous and various performance appraisal tools, beginning in the early 1900s to current time.

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CHAPTER 1

STATEMENT OF THE PROBLEM

An issue identified within higher education in all areas of academe is that of evaluating the performance of students in a discipline's practice area. A significant number of researchers from multiple disciplines address this issue (M. A. Chambers, 1998; Connell, 2002; Cox, 2000; French, Immekus, & Oakes, 2005; Goldenberg & Dietrich, 2002; Priest & Roberts, 1998; Wiles & Bishop, 2001; A. S. Woolley, 1977). The challenge lies in how to objectively evaluate the performance of an individual without some degree of subjectivity by the observer. The answer most often given is that there is no absolute way to avoid this issue. A. S. Woolley (1977) addressed this by stating, "However an individual may try to avoid putting their values and beliefs into the expectations of the performance of others, there is always the risk of subjectivity" (p. 308). Recognizing that much literature related to the performance appraisal process exists across all practice disciplines, one can debate that the greatest number is noted to be within the area of the health disciplines and specifically the clinical performance appraisal (CPA) as it relates to nursing programs.

The CPA, an identified challenge for faculty and students alike, is a tool utilized for assessing nursing students' behaviors in the clinical setting. A. S. Woolley (1977) addressed this challenge by stating, "The clinical laboratory is the ideal place for this synthesis to occur, but true evaluation of its effectiveness is a lifelong process" (p. 315). Various tools developed over

the past century by colleges and universities across the country in an attempt to overcome inherent problems associated with this evaluation process have demonstrated little progress to date.

So why is the assessment of a student's clinical performance a concern? According to White (2003), narrative student findings have indicated that demonstration of appropriate clinical decision-making assists them in "gaining confidence in their skills, building relationships with staff, connecting with patients, gaining comfort in self as a nurse, and understanding the clinical picture" (p.115). Priest and Roberts (1998) also related the importance of assessing student performance to verify competence, measuring student achievement of objectives while predicting future behavior, monitoring student progress and motivation while protecting the public safety. However, Wiles and Bishop (2001) reminded nurse educators that focusing too much on safety can affect the perception of the student on their performance while being evaluated.

Another factor to consider in exploring the problem of the CPA process is that of the need for registered nurses (RNs) projected in the next seven years. According to a monthly report from the *Strategic Skills Initiative Occupational and Skills Shortages* prepared by the Indiana Department of Workforce Development (n.d.), nine out of the 11 Indiana districts, which includes Evansville, reflect the national shortage. The 2006 data predicted a shortage of RNs to 2010 with a need for 1,735 RNs across the state by the year 2007. The report continues to emphasize that the shortage of RNs in hospitals has an effect on the quality of care that health care institutions are able to provide. Inadequate staffing levels contribute to a higher risk of error by the nurses as they cover a greater number of patients and work longer hours (Indiana Department of Workforce Development [INWD], n.d.).

Nationally, the need for registered nurses demonstrates an increase of 22.2% by the year 2018, with the most significant source of post-secondary education being that of the associate degree nurse (United States Department of Labor, 2009). However, another consideration in determining what affects the number of graduates who are eligible to pursue the nursing licensure examination (NCLEX-RN) is the number of students who successfully complete their secondary education at a community college. According to a Lumina Foundation report, *Achieving the Dream: Community Colleges Are Focus of Broad Initiative*, despite their crucial role, community colleges face enormous challenges that take a toll on student success. Nearly half of all students enrolled in community colleges fail to complete their post-secondary education.

A recent study by the Community College Research Center shows that among students seeking an associate's degree or higher, only 53% earned a degree or transferred to a four-year institution within eight years of initial enrollment (Lumina Foundation for Education, n.d.). The report also addressed the variation in the percentage of completion rates for a certificate or degree, noting only 26% of Blacks and 29% of Hispanic students attained a certificate or degree within six years. This compares with 38% of White students and 39% of Asian students over the same period.

Taking into consideration the inherent concerns with the CPA process and the associated data indicating the demand for nursing program graduates over a predicted number of years, the purpose for exploring the issue of student perception associated with the clinical evaluation tool is evident. Concerns such as the availability of the instructor in proportion to the number of students monitored, the simultaneous teaching and evaluating in the clinical environment, the

potential for subjectivity, and the questionable vagueness of the evaluation tool all need consideration and are explored.

Purpose of Study

As opposed to the majority of the literature that focuses on the perception of the instructor in performing student clinical evaluations (Bowman, 1999; Cox, 2000; Wiles & Bishop, 2001), the purpose of my study is to focus on the perception or experience of the student undergoing the CPA. Previous research on clinical evaluation has evolved since the early 1900s with the purpose being that of assessing competence and motivating students to learn in a positive environment while protecting the safety of the public. A qualitative study by Loving (1993) explored the perceptions of baccalaureate nursing students experiencing clinical learning. However, it is a dissertation by Reynolds (2005), entitled *Clinical Performance Appraisal: The Lived Experience of Baccalaureate Nursing Students*, that revealed some perceptions of baccalaureate nursing students regarding the CPA process that specifically led me to the questions explored in this study.

Research Questions

Reynolds' (2005) study identified limitations that guided my desire to replicate her work. One limitation identified by Reynolds is the number of participants. She stated the six participants were adequate to meet the point of saturation, and thereby "better understand the CPA experience through the student lens" (p. 146). However, she does caution that her exhaustive search for willing participants may have limited other voices from which she could have collected other rich data.

Even though not specifically identified as a strong limitation by Reynolds (2005), she does admit that the study was comprised of a convenient homogeneous, geographically located

sample of three local schools. The evidence of predominantly White, female participants, in combination with other noted limitations, suggests the need for replication of the study. Therefore, the questions for this study are:

1. What is the experience of a baccalaureate degree nursing student undergoing the process of clinical evaluation appraisal?
2. Do baccalaureate degree nursing students perceive the clinical evaluation appraisal process as a means of meeting personal and professional goals?

Significance of the Study

The national need for RNs is cause for alarm with a projected increase of 22.2% by the year 2018 (United States Department of Labor, 2009). The importance for nursing faculty to understand and implement the CPA process is an important part of meeting this need while facilitating student learning. However, how students experience the clinical evaluation process is even more important in providing potential graduates of the baccalaureate of science in nursing program the opportunity to persist, and thereby the opportunity to take and successfully pass the licensing examination.

Therefore, the significance of replicating this study at other baccalaureate nursing programs could offer more students the opportunity to continue to voice their experiences with the clinical evaluation process. This phenomenological study continued to examine the how the student perceives the evaluation process versus the large number of studies available examining the perceptions of the instructor. Data obtained from the completion of this study has been examined and compared with previous studies. Some implications for practice in other nursing programs are provided.

Organization of the Study

The study is organized into seven chapters entitled:(a) statement of the problem; (b) literature review; (c) research methodology; (d) results; (e) results II; (f) discussion; and (g) conclusion. Chapter 2 provides a historical review of literature relevant to the development of CPA tools since the early 1900s. The comprehensive literature review reflects how faculty of varied disciplines has attempted to answer to the challenge of fair and objective evaluation of students in the clinical setting over decades of time. Chapter 3 presents a detailed discussion of the phenomenological methodology utilized for collecting data for this study. Chapters 4 and 5 report results of the study from two perspectives. Chapter 4 provides information discovered through in-depth participant interviews. Chapter 5 provides findings discovered through field notes of digitally recorded participant data in which themes were identified. Chapter 6 provides my interpretation of the study's findings related to the review of the literature. Finally, Chapter 7 concludes the study as implications and recommendations for higher education and research are identified to continue the quest to successfully evaluate student clinical performance.

CHAPTER 2

LITERATURE REVIEW

Historically, the clinical performance appraisal (CPA) process has been a documented concern for faculty in that teaching and evaluation must occur simultaneously in a dynamic learning environment. However, limited literature exists sharing the CPA process through the lens of the student. Therefore, the purpose of this study is to focus on the experience of the student undergoing the CPA process.

The first section of the literature review provides an overview of the development and challenges of the CPA process over decades of time. The historical review includes how different forms of evaluation tools and processes evolved over time as faculty of varying disciplines searched for a method that was fair and objective. Major problems identified with the CPA process centered on the environment in which the evaluation was performed including how and by whom it was conducted.

Perceptions and attitudes primarily from faculty, and some from the student, were also found to be contributing factors to the challenges experienced during the process. Additional review of the literature addressed the CPA process utilizing multiple approaches as well as experiences addressed not only regarding the tool itself, but also through differing applications of the activity associated with student evaluation. Lastly, the review of the literature focuses on safety, deficiency, and cognitive development aspects associated with the appraisal process.

The second section of the literature review explores student development aspects including psychosocial and identity. The third section focuses on literature addressing learning theories, such as experiential, active participation, and the importance of effective assessment planning.

Overview of Clinical Evaluation Process

Pellicer's (2003) caring principles, as they pertain to management practices, could be utilized in combination with learning principles associated with the clinical evaluation process. Ideally, the outcome would be that delivery of the CPA would result in the student leaving the process with a sense of caring. Duke (1996) stated, "Interactions between teachers and students are seen as caring occasions that celebrate the best ethical self and a hope for the good of the other" (p. 412).

Historical perspectives. In addressing the evaluation of student clinical performance, there exists a number of research and scholarly articles that address clinical evaluation tools as they have evolved over time. During the 1920s and 1930s, clinical evaluation tools were termed as "norm-referenced," in that faculty would judge student performance in comparison with that of their fellow students (M. A. Chambers, 1998; Goldenberg & Dietrich, 2002; A. S. Woolley, 1977). The instructor's judgment of who was the strongest versus the weakest student guided the evaluation process. Considering the inherent subjectivity of this approach, what followed was the era of the delineated objective-based appraisal tool in the 1950s. Known as the Tyler model, this form of evaluation continued for two decades. Throughout the 1970s into the 1980s was the advent of the "criterion-referenced," behavioral, objective-based evaluation tools (Bondy, 1983; Tower & Majewski, 1987). However, some faculty sensed these task-oriented tools were too

behaviorist in light of how nursing was moving toward a more contemporary type of education (M. A. Chambers, 1998).

Cox (2000) reinforced the idea addressing how clinical performance evaluations can tend to focus too much on categories and checklists found in the task-oriented tools and fail to point out the student's ability to utilize good judgment. This could lead to the student doing repetitive behaviors or actions without realizing what patient care cases he or she can indeed manage. Cox (2000) has stated "that intimate work relationship provides the opportunity for transferring not only practical knowledge and skills on the important cases . . . but also the expected professional behavior; therefore, flaws in performance should be dealt with on the spot" (p. 52).

From the late 1990s to the present, clinical appraisal methods reflect primarily the criterion-referenced tool based upon program-established objectives and an application of theory to practice. Additionally, these tools reflect evidence of evaluation of critical thinking, problem solving, and decision-making (Goldenberg & Dietrich, 2002; White, 2003). However, students have not always sensed the evaluation process to be a learning opportunity that accurately reflects their performances, but rather view it as a punitive experience.

Identified Problems

The atmosphere where the CPA process takes place varies by the student's level and the health care setting where the learning takes. Typically, a beginning student cares for one patient and an instructor is responsible for supervising a maximum of 10 students. The instructor's role is a facilitator of student learning, and the staff nurse assigned to the patient the student is caring for is ultimately responsible for the patient's care. Seeing how the instructor is responsible for the supervision and evaluation of this many students lends the evaluation process its problematic nature: How can one instructor see what 10 students are doing at any given moment in time or

place (M. A. Chambers, 1998; Mahara, 1998; Novak, 1988; Reynolds, 2005; A. S. Woolley, 1977)?

As students progress through the program's curriculum, the expectancies and number of patients increase. However, the ratio of faculty to student does not change. This scenario sets the stage for students to experience learning opportunities that are not always directly observed by the clinical instructor. At the end of a clinical day, on identical forms, the instructor and student separately attempt to evaluate how the student performed that day. What is often noted is that even though there may be evidence of a criterion-referenced evaluation tool, the faculty and student are many times not addressing what was accomplished that day based upon those identified criteria. Often the focus is pathophysiology, medications, diagnostic studies, and other such items addressing care of the patient, but not the criteria utilized in the CPA to evaluate the student (Reynolds, 2005).

The number of students per faculty member creates a situation where it is difficult for clear communication of how students meet the objectives outlined in the CPA. In their interpretive qualitative study, C. M. Clark and Springer (2007) examined faculty and student perceptions of incivility in nursing education. The study included possible causes and potential remedies of the perceived incivility. Fifteen of 36 (41.6%) and 168 of 467 (35.9%) of nursing students volunteered to complete four open-ended questions to capture perceptions of faculty and students. Recurring responses were organized into themes, and areas of agreement and disagreement were discussed until the researchers were confident the analysis was a valid representation of the shared comments. Through the process of narrative analysis, the categories of in-class and out-of-class disruption by students, uncivil faculty behaviors, and probable causes of nursing education incivility were discovered.

C. M. Clark and Springer (2007) found that overall environment and sense of lack of communication, including stress, disrespect, faculty arrogance, and a sense of student entitlement, served as overriding themes contributing to a sense of incivility. Continued conversation included that lack of communication at times created a sense of incivility between the faculty and student to the point of the student feeling threatened. C. M. Clark and Springer (2007) cited possible remedies including the following recommendations:

> Setting forth standards and norms, strengthening university policies and support for faculty, and enforcing campus codes of conduct . . . [the study recommends] incivility be addressed immediately and that open forums and mediation panels be developed to resolve conflicts related to incivility . . . that faculty and students learn conflict negotiation/mediation skills. (p. 96)

C. M. Clark and Springer suggested that further research on incivility should be done to address topics such as the following:

1. The nature of incivility and its impact on the educational process and on the profession as a whole
2. The relationships between student and faculty perceptions of incivility and ways to effectively address the problem
3. Whether there are gender differences in ways that faculty and students experience incivility
4. How civility experienced by students – or perpetrated by students – affects patients (p. 97)

This sense by the student that the instructor is a threat would indeed interfere with the learning and subsequent evaluation process. Fencl and Scheel (2005) discussed assisting the

students in believing in their own abilities, or self-efficacy, as a better alternative. Self-efficacy is explored as a person's belief that he or she can succeed in a given domain, thereby utilizing this theory as a key predictor of student achievement and retention. Fencl and Scheel further asserted that "self-efficacy is not a static attribute, but is affected by a person's experiences and is postulated to change according to the four sources of emotional arousal, vicarious learning, performance accomplishment, and social persuasion" (p. 20). In this study, 218 student volunteers (131 females and 87 males) completed a questionnaire that resulted in a bivariate correlation for teaching strategies as they relate to the four self-efficacy scores and subscores. They found positive contributing factors to self-efficacy and classroom climate, including collaborative and active learning and inquiry labs among other activities such as changes in confidence.

Personal self-appraisal has been explored through comparing the concepts of self-efficacy versus self-esteem. Whereas self-efficacy is concerned with the capability of an individual, self-esteem is more associated with self-worth. Bandura (1997) wrote, "People need much more than high self-esteem to do well in given pursuits" (p. 11). Self-assurance enables individuals to approach difficult tasks with confidence. However, someone who continuously experiences self-doubt will have difficulty approaching and managing difficult tasks in spite of high-level skills. Therefore, the student experiencing the instructor as a threat could have negative thoughts that undermine his or her performance. As opposed to the student who is unable to perform due to thoughts of inadequacy, individuals with a sense of efficacy are able "to apply what they know consistently, persistently, and skillfully, especially when things are not going well" (Bandura, 1997, p. 223).

Student to faculty ratio is a topic of concern as the issue of anticipated clinical performance errors are thought to interfere with the ability of a clinical instructor as they simultaneously teach and evaluate student behaviors (M. A. Chambers, 1998; Mahara, 1998; Novak, 1988; A. S. Woolley, 1977). Formative and summative evaluation are often utilized in an effort to allow the student to display error in the process of learning, but only critical elements of the student's performance displayed at the end of the experience would be assessed in assigning the final grade.

Duke (1996) addressed problems with the CPA process from the aspect of the increased need for sessional clinical instructors. Sessional clinical instructors are utilized for one or more semesters; however, they are not consistently in contact with the objectives expected of the student in clinical courses, as would be the full-time faculty person. Duke's phenomenological study was conducted with a purposeful selection of 18 individuals who participated in unstructured interviews and written scenarios. Concepts of role theory, oppressed group behavior, and ethics of caring emerged and were utilized as conceptual frameworks for the purpose of interpreting data in relation to the evaluation of undergraduate students. Findings revealed that although the sessional instructors were skilled in identifying student problems, they were reluctant to make difficult evaluation decisions based upon their personal learning experiences and ethics of caring. Implications would be associated with concern for the credibility and integrity of nursing courses in respect to clinical instructors who influence the profession through preparation of potential graduate nurses who will become licensed practitioners.

Perceptions and Attitudes

Bowman (1999) addressed the issue of keeping evaluation more focused on the expectancies or criteria as opposed to focusing on the individual's personal characteristics. This practice included addressing individual strengths and weaknesses as a part of the discussion with recommendations on how to improve performance based on clearly outlined behavioral expectations. M. C. Clark, Owen, and Tholcken (2004) expanded this thought by suggesting faculty include students in deciding what was evaluated based upon student perception of what was important in regard to mastering clinical skills. This method would promote students learning skills and content deemed important and valued by the nursing students. Therefore, M. C. Clark et al. (2004) conducted a study of 80 third-semester baccalaureate students to measure how students receive and appraise course material. M. C. Clark et al. referred to this student perception of importance as self-efficacy based upon the assumption that people take action when they hold that certain expectations or outcomes are worthwhile. In response, faculty developed a clinical evaluation tool that measured both self-efficacy and perceived importance, which they called the Self-Efficacy for Clinical Evaluation Scale (SECS). M. C. Clark et al. (2004) stated, "The scale was constructed with two parallel parts: a self-efficacy subscale and a perceived importance subscale" (p. 549). Nursing faculty developed a 50-statement item pool based upon course objectives that were positively stated. After student input was considered, the result was a 30-item evaluation instrument that students considered as easy to read, understand, and complete. Subsequently, faculty were able to identify areas in which students felt unsure, including situations where learners believed the skills or content were important. To validate the outcomes from this study, graduates need to be followed into their new practice settings to test the hypothesis that enhanced evaluation does indeed lead to improved nursing care.

Exploration of the complexity of the evaluation process continued as others continued the quest for the ideal performance appraisal process. Girot (1993) professed, "Whilst [*sic*] specific skills are easily measurable, attitudes and the intangible elements of measurement are much more difficult" (p. 118). In a phenomenological study, Girot interviewed 10 participants responsible for evaluating the performance of nursing students. The study posed the following research questions: What attributes characterize competence and non-competence in learner nurses? How do they recognize these attributes in practice? How do they measure competence at different levels of preparation? The meaning of language utilized in determining practice competence was explored for the purpose of assisting future clinicians as assessors. Findings indicated four common themes associated with the attributes of competent and non-competent students alike. The four themes included trust, caring, communication skills, and knowledge/adaptability (Girot, 1993).

A study of feedback, particularly within the context of positive information sharing between the instructor and the student, was researched in the writings of Ovando (1994). He explored the use of constructive feedback as a way to enhance teaching and learning. His argument centered on the belief that students learned more from teachers who emphasize praise and encouragement in rewarding student behaviors versus criticism and punishment. Ovando stated, "The feedback process for learning involves at least eight steps that include expectations, criteria, student progress, students' accomplishments and strengths, areas needing further study or practice, recognition of students' efforts, suggestion about learning activities, and encouragement" (p. 19).

The author reinforced the importance of feedback with the assertion that an unsuccessful student evaluation reflects teaching and learning that was not successful. Three types of

evaluation identified as diagnostic, formative, and summative showed how an instructor could express feedback in the hope of improving student performance and engage the student in the teaching-learning process. Ovando (1994) wrote that feedback can be more meaningful to students and faculty by performing the following:

1. Reducing the inherent threat and negative reactions associated with evaluation of performance;
2. Keeping comments as impersonal as possible and focusing on the behavior;
3. Collecting descriptive data while observing actual performance;
4. Offering support and optimism that students can develop their unique potential;
5. Establishing regular mechanisms to offer feedback and using levels or point scales to rate performance;
6. Using written statements highlighting achievements and providing encouragement; and
7. Giving specific suggestions and praising both teacher performance and student achievements. (p. 22)

The concept of a CPA process that leaves the student with the sense of an evaluation from an instructor who cares was explored in a study of the nursing student experience with interactions of caring and not-so-caring faculty (Hanson & Smith, 1996). The study's purpose was to describe the lived experience of baccalaureate nursing students with the two types of faculty. A small private liberal arts college and state university were the settings for 32 primarily White volunteer student interviews lasting approximately 30 to 60 minutes. Students were asked to respond to the following: "Tell me about a caring interaction with a faculty member and tell me about a not-so-caring interaction with a faculty member" (p. 107), with appropriate probing

questions such as “How did you feel about that?” (p. 107). Data from each school were analyzed separately to compare findings from the two different settings; however, the findings were noted to be similar adding validity to what was discovered. The findings from this study reported evidence that faculty who convey actions and attitudes of caring positively impacted learning through increasing motivation, positive feelings, and self-esteem of the student. This is in contrast to giving students the impression that they were keeping faculty from their work, but instead that the students are an important part of their work.

Loving (1993) conducted a comparative qualitative analysis of baccalaureate nursing students and their perceptions of learning in the clinical setting using grounded theory as a methodology. Twenty-two purposefully selected, female, recent nursing program graduates from a Midwestern state university participated in the study. The primary data collection consisted of formal, unstructured interviews lasting from one to two and one-half hours. The participants responded to questions related to how they viewed the teaching/learning of clinical judgment with the following examples: “What comes to mind when you think of clinical nursing judgment? How would you describe clinical nursing judgment? And how do you learn?” (Loving, 1993, p. 416). Transcripts, coding, and memos were maintained throughout the study.

Following review of the results of the study, Loving (1993) stated, “Experimentation is often thwarted by the threat of evaluation; the student may perceive that experimentation resulting in failure will result in an unfavorable evaluation, thus decreasing his or her self-competence perception” (p. 420). This is in contrast to the students having the sense that they can engage in reflective thought with the instructor, a role model, to enhance their learning. Loving continued, “If viewed through a learning context lens by both faculty and students,

evaluation episodes could conceivably be considered as supportive, corrective feedback" (p. 420).

Multi-Method Approach

In her study, Reynolds (2005) addressed clinical performance evaluation as one of the greatest challenges facing nurse educators. She cited,

> The main purpose of this phenomenological study was to gain a better understanding of the nursing student's experience with the CPA process . . . to provide nursing educators with a greater appreciation for our roles as teachers and evaluators. (p. 3)

The research questions posed by Reynolds include the following:

1. What is it like to be a baccalaureate nursing student undergoing the process of clinical evaluation?
2. Do baccalaureate nursing students find their current CPA process to be helpful or beneficial to them? If no, what would make the process more helpful? If yes, what is it within the process that is most helpful?
3. What limitations do nursing students feel are inherent to the CPA process?
4. How do nursing students perceive that the CPA process assists them in meeting personal and professional goals? (p. 3)

Formal, semi-structured interviews and document analysis comprised the methodology for this study of six female baccalaureate nursing students from three different Midwestern colleges, which were a mix of private and public schools. Reynolds identified these major themes from student responses:

> It depends on the instructor; I don't know how decisions are made; some of this seems so vague; I need to know where I stand; I rarely see her; it's a lot of work for no grade; the experience: what it's like; about mistakes. (p. 56-93)

Reynolds then addressed more themes that focus on interpersonal factors: "Relationship with staff; relationship with instructor; advice for students; advice for faculty; and increased awareness" (p. 93–115).

Multiple methods of evaluation including trait-based, behavior-based, and results-based have been reported (Bowman, 1999). The preferred method asserts advantages and disadvantages in respect to promise, problems, and prospects of these person-centered appraisals considered in the development of a performance evaluation. Bowman (1999) wrote that the rating instruments, which should strive for simplicity not complexity, are derived from job analysis training that is provided to all employees and managers, grounded on accurate job descriptions and actual ratings that are based on observable performance. He further asserted that the rating instruments should include preliminary results that are shared with the ratee, contain some form of upper-level review that includes an appeal process, prevents a single manager from controlling an employee's career, and offers performance counseling and corrective guidance services.

Reynolds (2005) referenced how Bowman's (1999) standards could be applied to the CPA process in that she has purported usage of level-appropriate clinical competencies in the performance appraisal tool. Students are evaluated in place of employees; teachers perform the appraisal based upon clinical objectives as opposed to job descriptions; behavioral indicators or criteria would be what are observed; and in the practical skills lab, faculty advisor and counselors would be available to promote an environment that enhances student learning.

Reynolds (2005) recognized at the end of the study was that frustration with the CPA process was shared between the student and the instructor. From the student's perception, accessibility of the instructor is more important than conceptualized as well as the student's perceived power of the instructor. Therefore, Reynolds recommended that nurse educators consider opportunities that empower students in the CPA process, including having students as the center of their evaluation process. Mutual goal-setting and skills-performance attainment between the instructor and the student is a major part of this process. Recommendations also included introducing students to the concept of self-evaluation early in the program as a means of decreasing frustration and promoting early understanding.

Instructor subjectivity is an inherent problem associated with the CPA process. However, nursing educators struggle with the request from those in health care who desire graduates to understand the importance of accountability, defined standards of care, and cost effectiveness while evaluating students in the clinical setting. G. R**.** Woolley, Bryan, and Davis (1998) explored the potential for the subjective tendencies of the CPA in a rare study done with an associate degree nursing program's attempt to develop a comprehensive summative clinical evaluation tool.

The tool was developed with the intent of incorporating the three domains (cognitive, affective, and psychomotor) through the measurement of a variety of behaviors, including the ability to consistently exhibit professional behaviors, random skills performance examination, plan of care examination, critical situations examination, and required course assignments. The process was implemented with 250 students over the course of one year. Collective feedback from students and faculty who utilized the tool was received resulting in the decision to continue

implementation of the tool. A recommendation to pilot and implement the process in other nursing schools was made.

Mahara (1998) continued discussion of the concern of the subjective nature of the CPA process from the perspective of how the teacher-evaluator and formative-summative emphasis could negatively affect student learning through inquiry. Mahara stated, "The teacher-evaluator and formative-summative dualism is challenged on the basis that its primary purpose is to maintain power differentials that impoverish teacher-student relationships" (p. 1,340). Mahara described the concept of the fourth generation evaluation, described as constructivism, where the student is not only involved in the formative phase of the evaluation but also actively contributes to the summative part. She also suggested that the teacher-evaluator not be two dichotomous entities, but that evaluation should be a part of the teaching process.

Mahara (1998) suggested that performance evaluation is a form of inquiry. She expanded this thought by stating "the purpose of clinical evaluation is a form of research in the discovery and verification of the process and product of the teaching and learning of nursing practice" (p. 1,342). Mahara offered a case for utilizing multiple methods of evaluation in that "the incorporation of multiple ways of knowing and judging expands the possibilities for describing and verifying the outcomes of clinical education" (p. 1,344.)

Orchard (1992) conducted an extensive review of the literature, which identified six themes related to the clinical evaluation process. The themes identified by Orchard were described as particular variables selected to measure students' performance:

> The relationship between the complexity of students' clinical performance expectations and the degree of subjectivity of appraisals; evaluators' expectations of students' professional socialization; evaluators' expertise in assessment of students' performance;

> degree of inter- and intra-rater reliability of evaluators' assessment of students' clinical performance; and personal values of evaluators. (p. 309)

Variability exists as to what is important in the evaluation process, including problem-solving and performing of skills, as well as appearance and evidence of meeting objectives.

This dynamic learning environment challenges nursing faculty in evaluating the affective domain or decision-making process of students that culminate in the patient's plan of care. Therefore, Orchard (1992) emphasized, "No matter which type of evaluation system is used, there will always be problems in accurate identification of measurable standards by which to compare students' performance" (p. 310), and "clinical evaluation of students will always contain an element of subjectivity in the appraisal of their performance" (p. 312).

Orchard (1992) suggested practices that could decrease the likelihood for factors that were identified as potential for interfering with the CPA process, including preparation of nurse educators, orientation of new faculty, and faculty practices. Orchard stressed that preparation of nurse educators should include faculty who have graduated from specialized programs that have curricula that focus on preparation for application of the clinical evaluation process. This informative program would include studies of evaluation theory, processes, and appraisal tool development and use. Identification of critical variables for assessment, and standards for their measurement, would also be a necessary component.

Also included within the program would be components that relate to the development of critical thinking in learners such as observation techniques, appropriate documentation of patient observations, counseling skills, teaching techniques, and how to facilitate student learning in decision-making strategies. Seminars that ease discussion of the role expectation of educators, especially in relation to the variety of interests to which they must respond, should also be a part

of the preparation for new clinical faculty. New faculty should be extensively oriented to the evaluation tools and optimally paired with an experienced faculty member. In regards to faculty practices, all involved in the process should agree what decision-making skills students are expected to display in planning patient care (Orchard, 1992). Evaluation by more than one instructor is also recommended.

Since 1975, medical schools have utilized the objective structured clinical evaluation (OSCE) as another method of evaluating student clinical performance. Rentschler, Eaton, Cappiello, McNally, and McWilliam (2007) conducted a study with 49 senior baccalaureate nursing students in which the OSCE objective evaluation method was utilized. In this descriptive study, the OSCE method involved the assessment of students on any three of six patient simulation stations in combination with one of two stationary stations without patients. Formative and summative evaluation of student performance was conducted, including "knowledge, application of nursing process and judgment, and interview skills" (p. 135) for the purpose of individual feedback and program evaluation. Case studies were developed reflecting differing patient situations across the curriculum, including a variety of growth and development levels and diagnoses across the lifespan. The researchers developed an evaluation tool to consistently evaluate each case study for each student. Student feedback was also solicited to include more opportunity for evaluation. Overall student response was positive in that they sensed confidence in their knowledge, interpersonal skills, and clinical skills (Rentschler et al., 2007). Student suggestions for future implementation included that the OSCE be mandatory and utilized earlier in the curriculum.

An advantage to the OSCE method is the large number of students that can be assessed in knowledge and skills in one examination period. Given the controlled situations in which the

students were being evaluated, useful information in a safe environment could be provided in regards to the students' cognitive, psychomotor, and interpersonal skills. However, caution would be warranted in substituting this controlled setting for real life clinical experiences.

Guinn (1992) discussed another form of the use of simulation for evaluating student knowledge with decreased subjectivity. Each student is presented a videotaped patient scenario for the purpose of measuring critical decision-making ability in a controlled, predetermined environment. The student is then asked to identify the nursing diagnoses evident in the video with supportive data from a simulated patient chart. Prior to utilizing the scenarios, nursing faculty and students who have completed the courses intended for the simulation activity view the film and confirm that proposed nursing diagnoses are identifiable. Similarities in the faculty and student lists are verified. Advantages inherent to this form of evaluation are the controlled environment and standardized patients. Potential disadvantages would be the inability to observe psychomotor skills and the resources required for purchasing and filming the scenarios.

The following reflections about the assessment process were related by Heady (2000) to be statements upon which everyone in education would probably agree:

> State legislatures and accrediting agencies are increasingly interested in campus and program assessment in some form; faculty, administrators, legislatures, and students all have their own feelings about how best to document learning in a meaningful manner, if at all; and the fact that we assess our students daily in our classrooms does not seem to alleviate the mistrust or suspicion about others' motives. (p. 415)

Given these stated assumptions, Heady explored the theoretical aspects of assessment, offered practical ideas and resources on effectively assessing a student, and finally, outlined how to assess improvement in student learning.

Heady (2000) proposed a statement from the American Association for Higher Education (AAHE) to initiate discussion regarding a definition for assessment:

> Assessment is an ongoing process aimed at understanding and improving student learning. It involves making our expectation explicit and public; setting appropriate criteria and high standards for learning quality; systematically gathering, analyzing, and interpreting evidence to determine how well performance matched those expectations and standards; and using the resulting information to document, explain, and improve performance . . . (p. 415)

To complement this definition of assessment, Heady reinforced implementation of AAHE's principles as they apply to student learning. She asserted that assessment must consistently measure what is identified as important for students to learn, over a period of time, to demonstrate consistency and reinforce student understanding. Heady emphasized that instructors should utilize multiple types of assessments to demonstrate continuous improvement that reflects what is actually being measured. She further proposed that the educational community, including those who are not teaching faculty, should be involved with the assessment process.

Heady (2000) reinforced these principles by stating that "the best assessment practices will include the components of clear standards and goals; trust; total campus commitment; constant and continuing assessment; and incorporation of assessment research into practice and policy" (p. 417). Heady concluded by reinforcing that the main goal should be to address the need for the development of better learning skills through the utilization of diagnostic, formative, or summative assessment and should include the four important elements of fairness, importance to the discipline, interest to students, and support and promotion of student learning.

Another study of program evaluation, situated in the United Kingdom, included primarily performance indicators and action research (Leatherwood & Phillips, 2000). Identified were methodological, practical, and political issues that influence the development of curriculum evaluation research. The researchers voiced concerns regarding action research in that it primarily served the instructors and improved their teaching performance in the formative stages of the course versus assisting the student's learning process. Additional concerns discussed in the study included how the wide usage of summative evaluation that focused primarily on outcomes spoke nothing of the formative or feedback type of evaluation that demonstrates the student is being informed of progressively meeting objectives prior to course completion.

The case study groups were comprised of five to six same program students who were interviewed at the beginning of the second year, during the third year, and post graduation. The case study explored the students' learning histories and perceptions of their learning as they progressed through the degree of study and after graduation. Graduation interviewees could also report their perception of how what was learned related to student achievement and subsequent career performance. From this study, Leatherwood and Phillips (2000) concluded that,

> The programme [*sic*] of curriculum evaluation research that has emerged has the potential to provide a rich body of data enabling detailed examination of learning processes and assessment outcome, the on-going formative evaluation of the curriculum, and an analysis of the contribution that degree study makes to these graduates' subsequent careers and achievements. (p. 326)

A multi-level strategy of evaluation including new student demographic questionnaires, the use of an "approaches to studying" inventory, and individual case studies was recommended as a result of their investigation.

Safety, Deficiencies, Cognitive Development

Wiles and Bishop (2001) explored the difficulty nurse educators have with effective student clinical performance evaluation. The discussion included how safety has historically been a major consideration in measuring minimal student expectations. These researchers related that what is missing with focus on safety are other important factors, one of which is the impact of the student's perception on his or her performance while being evaluated. Overall student/faculty satisfaction and the question of developing a reliable evaluation tool affect the process. Discussion included the importance of an evaluation tool that linked classroom objectives with clinical performance expectations ultimately resulting in providing safe patient care.

This discussion continued with identifying deficiencies that are inherent in the various CPAs employed (Wiles & Bishop, 2001). Concerns in CPA deficiencies include subjectivity, inconsistency, perceived negative relationships between instructors and students, and grade versus learning focus of the student. Another issue is how the clinical grade was determined. The determination of the A, B, and C grade did not seem appropriate for all clinical experiences; however, the pass/fail option did not always motivate students to perform to their highest level or give them a sense of accomplishment for their perceived hard work for nothing more than a passing grade. Furthermore, Wiles and Bishop (2001) discussed the students' desires for feedback during the CPA process, but sensed this demonstration of ignorance would result in punitive action. Structured formative feedback from faculty to students resulted in improved student performance, thereby alleviating the concern and misconceptions that grew during the semester leading up to the final or summative evaluation.

It was found that faculty followed the recommendation of previous studies to perform an inter-rater reliability of a newly developed CPA tool (Wiles & Bishop, 2001). In this study, faculty viewed films of students performing nursing skills at varying levels of competency. Faculty then independently scored students' performance and discussed their findings. After that, the new tool was revised based upon the established inter-rater reliability; revisions were made after the first semester of use. Ultimately, the desired outcome of higher-level student performance that positively influences the quality of patient care is an outcome that all involved in the CPA process can appreciate.

French et al. (2005) who addressed student motivation and how it impacts success explored cognitive variables of the evaluation process. French et al. examined student success and persistence including both cognitive and noncognitive variables. Cognitive variables included high school rank, university cumulative grade point average, and Scholastic Aptitude Test (SAT) scores. Noncognitive variables included institution involvement and academic motivation.

The researchers sampled 1,756 subjects across two cohort groups for the quantitative study (French et al., 2005). This allowed for identification of significant variables and cross-validation with three regression analyses conducted. Findings suggested that programs that promoted retention focus on academic achievement. Increased motivation contributed to the student continuing in the major of choice; therefore, an atmosphere of reinforcement of satisfactorily met objectives on the CPA and how to improve upon those not mastered would be more desirable to student success, as opposed to repeatedly focusing on the unsatisfactory behaviors. In conclusion, they stated that "a strong academic background, achievement of good grades, and academic motivation are needed" (p. 424).

Another theoretical perspective that can be included in this area of factors affecting student performance is evaluation theory. Connell (2002) addressed evaluation issues at a meeting in 1999 sponsored by the National Council for Accreditation of Teacher Education. He stated,

> The artificial distinction which is faced in nearly every evaluation between how one records the evaluation process itself as opposed to merely recording the products that are to be evaluated . . . if we adopt a more robust view of knowledge . . . a checklist approach is clearly inadequate; . . . knowledge . . . cannot be captured by a simple awareness – but is rather a network of relationships between justification systems, truth, and belief. (pp. 17-18)

Connell (2002) wrote another view of the evaluation process from an epistemic perspective. He discussed that in order to make the process meaningful; a shared justification system is desired. He stressed that all individuals involved in the evaluation process should possess a mutual understanding of what is being measured and how measurement occurs. Connell stated,

> Once a shared understanding of what is to be measured is determined, this item of measurement . . . may then be explored and measured by examinations of the systems of justification accepted, truths shared by the parties to the evaluation, and beliefs expressed. (p. 21)

Clauser, Clyman, and Swanson (1999) presented performance assessment data in two different studies conducted on two different groups in differing ways. The first study addressed the assessment of 100 subjects, who were given a specific task to perform in response to a patient case situation, by a committee from varying medical schools working as a group. This allowed

for rater-related variance within and between committees. The second study involved each evaluator judging separate performances on two separate occasions with 200 subjects across eight cases. All raters were practicing primary care physicians. Clauser et al. (1999) discovered the precision of assessment expectations was more important with evaluation by a committee than with performance check on separate occasions. Minimal impact on error variance was noted on separate occasions. The researchers emphasized that the consideration of measurement error should be taken in situations that require professional judgment of complex behaviors, including student evaluation in the clinical practice setting.

Recognizing that nursing is not the only program to utilize some form of evaluation, other disciplines that employ performance appraisal were also examined. D. W. Chambers (1999) addressed how a dental school developed a competency-based education model designed to evaluate "assessment of understanding as well as performance of procedures, diagnosis and judgment, and patient management" (p. 86). In place of a daily grading system, students were assessed quarterly and demonstrated "excellent face validity and rater consistency . . . demonstrating that the ratings satisfy the school's standard for grade defensibility" (p. 86). D. W. Chambers (1999) reinforced concerns voiced in an earlier discussion of the pitfalls of teaching and evaluating student competency at the same time, and therefore, concluded with supporting evidence, the validity and reliability the competency-based model lends to this appraisal system.

Having explored the CPA process from the perspective of the tool itself, including faculty perception of the process of evaluating stated objectives, more attention will now be given to what has been researched with respect to the best time to examine student behaviors for the purpose of providing instructor to student feedback, and thereby, achieving expected outcomes.

Pugh (1992) reviewed feedback from the perspective of timing to how much and by what means. Noted was that some faculty provide feedback on a daily basis and others wait until formal formative and summative evaluation times. Pugh reported her examination of feedback in respect to its purpose, definition, and observation of skills performed, inclusion of written work, student self-evaluation, and ultimately, how all these components impact the CPA process.

Pugh (1992) began by reviewing the purpose of feedback. She discussed the provision of feedback to verify correct or incorrect behavior versus sharing the information between the instructor and the student through display of written comments to improve performance. The latter purpose of giving explicit feedback would facilitate learning through the analysis of the learner's performance and provision of ways to improve; therefore, at the time of the summative evaluation, "the learner will have learned self-correction and will be able to perform at the expected level" (p. 5).

Pugh (1992) defined feedback as "information given to a learner about how his or her performance compares with the expected standard" (p. 5). In contrast, if no feedback is provided, the learner cannot be expected to demonstrate performance improvement. Pugh cited research in recognizing the role feedback plays in various forms of learning, including psychomotor skill performance and written work. With respect to the demonstration of skills, there was no difference in learning skills in regards to feedback being immediate while the skill was being performed versus at the end of the behavior performance. Noted also was that there was no recognized improvement in the skill if no feedback was shared between the instructor and the student. Visualization and opportunity for practice were also recognized as important in facilitating learning.

As for written work, Pugh (1992) emphasized the importance of written comments facilitating student learning. She implied that even though written comments would seem an obvious thing to do, many students reported faculty would return work with nothing more than a check mark. Added to the importance of returning formative comments to facilitate learning, timeliness of receiving the feedback is also important to allow the student opportunity to assimilate and ask questions prior to moving to the next assignment. Positive comments that reflect where work is noted to meet or exceed the standard should also be included to provide a balance to promote student morale and motivation.

Pugh (1992) added student self-evaluation as an opportunity for "inner conversations" that will add another dimension to the learning process. An important part of self-evaluation is timely feedback from the instructor as to what the student is sharing. Faculty response to student self-evaluation is important in that it can assist in verifying that what the student is sharing about their learning is progressive or, if needed, provide comments to facilitate student learning in a more desired direction. Therefore, it was recommended that student-reported self- evaluation be completed, and responded to, on a weekly basis. The result being that timely feedback will facilitate student learning in the formative stages of the course. In conclusion, feedback should be:

> Fair – explore all possible reasons for success or failure. Encouraging – look for the positive, what has been achieved since you last gave feedback to this student. Expectant – expect the student to learn from your observations and suggestions. Diagnostic – identify problems, and explore how they can be overcome. Balance – point out what was correct and what needs further work. Apt – give feedback promptly and skillfully. Considerate – give feedback in private, when you have time and opportunity for

> clarification and discussion. Kind and caring – be considerate of the student's feelings. (Pugh, 1992, p. 7)

Consideration as to how to measure student performance as part of the appraisal process was also discovered in the literature reviewed for this proposal (Cox, 2000; Perrin, 1998). Perrin (1998) addressed his ideas on performance measurement and how he sensed it is misused and suggested strategies for effective use. Perrin began by sharing the history of performance measurement from the 1960s to the time of this article in 1998. Discussed is the misuse of performance measurement utilized independently to assess outcomes and allocate resources. However, Perrin suggested that when performance measurements are utilized in combination with other methods of evaluation, they could be an important component of a comprehensive evaluation strategy.

Some inherent flaws and limitations of the use of performance indicators to determine program outcomes written by Perrin (1998) included:

> Varying interpretations of the same terms and concepts; goal displacement; use of meaningless and irrelevant measures; cost savings versus cost shifting; critical subgroup differences disguised by misleading aggregate indicators; limitations of objective-based approaches to evaluation; useless for decision making and resource allocation; and less focus on outcome. (pp. 369-374)

Conversely, Perrin suggested these strategies for effective use of performance measures:

> Recognition that performance indicators are most appropriate for use in planning and monitoring and not for evaluation. Recognize that every evaluation method, including performance measurement, has limitations, which can only be overcome through the use

> of a combination of methods. Be strategic in recognizing that performance indicators are not always appropriate in all activities. (p. 374)

Therefore, Perrin stressed that in order for performance measurement to be used effectively, programs need to be provided adequate resources for the development of performance indicators, stakeholders need to be actively involved in development and utilization of the measures, and adequate time needs to be allotted to develop, test, refine, revise, and update the performance measures.

Cox (2000) addressed concerns surrounding the recording of CPAs in medical schools. Many times what occurs is that the examiner may make judgments regarding an individual performance based upon observations without prior knowledge of expected behaviors outlined in the tool. Therefore, the examiner tries mold what was observed into the expected behaviors. Cox challenged the utilization of checklists and objective structured clinical evaluations by noting they are not comprehensive or realistic enough to accurately assess the learner. He concluded by stating that

> only those working closely with trainees can know how they respond interpersonally and intrapersonally in managing everyday clinical tasks . . . [which] provides the opportunity for transferring not only practical knowledge and skills . . . but also the expected professional behavior. (p. 52)

Cox stressed that qualitative information should be included in the evaluation process and that flaws in performance should be responded to immediately.

Developmental Theory Aspects

This section of the study is devoted to research of literature exploring theoretical aspects of student development as they progress not only through the nursing program, but also

simultaneously through life's phases and stages. Several developmental theories can be considered with respect to the student participants who are experiencing not only the CPA process, but also the effects of attending college. Cognitive and psychosocial theorists have explored these experiences throughout the decades in a number of settings and situations. In preparation for planned meetings and interviews with college-age students, several relevant theories will be explored.

Howard-Hamilton (2007) writes McEwen's ideals in explaining the rationale of why integration of theory to practice should be evident in the decisions and practices that administrators make every day. Rationale for supporting the integration of theory into practice is that it provides a theoretical basis for knowledge, expertise, and practice that serve as a foundation for a profession. Theory lays the foundation for a mutual way of knowing and understanding what is communicated among student affairs professionals and serves as a common language within a given community involved in the educational process.

Torres, Howard-Hamilton, and Cooper (2003) discussed developmental identity in examining Erikson's eight psychosocial stages in which movement through polarized phases create a change in one's identity. Individuals can move from one stage to the next with a positive resolution concerning their ability to deal with personal and social issues or a self-recognition that interferes with their ability to handle situations of discourse later in life. Challenges that students encounter in college, including those identified in the CPA process, could set the stage for a sense of developmental dissonance interfering with their end goals. Torres et al. continued this discussion:

> Erikson's theory has eight psychosocial stages, with movement from one stage to the next creating a change in our identity. Stages have a cumulative relationship or influence on

> each other stage. Two polarized attributes are part of each stage. One can emerge from a stage feeling positive about his or her personal and social capacities or with a sense of self that may become debilitating later in life. (p.10)

A potential example of dissonance in a student's experience of being appraised in the clinical setting would be Erikson's stage of trust versus basic mistrust. The student who senses her or his clinical experience influenced by a negative or positive relationship with the instructor could potentially alter the performance outcomes.

Chapter 1 of this study identified that consideration should be given to exploring the issue of the need for RNs projected in the next six years. The predicted need for registered nurses reflects an increase of 22.2% by the year 2018 nationally (United States Department of Labor, 2009). Therefore, the concern for persistence of students who are seeking a degree in nursing is one that demands more attention. Cabrera, Nora, Terenzini, Pascarella, and Hagedorn (1999) stated, "Academic ability, parental encouragement, perceptions of prejudice, academic performance, goal commitment, and institutional commitment explain 56% of the variance in African Americans' decision to persist in college" (p. 140). This is in comparison to a 39% variance for Whites. Therefore, in practice, the authors recommended that "institutional policies and practices that address the students' needs rather than his or her ethnicity would be effective not only in fostering tolerance among students, but also in retaining all students, be they minorities or non-minorities" (Cabrera et al., 1999, p. 143).

Universities, and more specifically program-level courses, have focused primarily on intellectual development resulting in preparation for an occupation or employment (Pascarella & Terenzini, 2005). Nursing programs echo that expectation in classroom, lab, and clinical settings. Added to this exchange is the dynamic learning environment, which further challenges

the student's abilities and self-confidence. How the student handles each situation is determined by individual growth and the development stage that each is experiencing resulting in stasis, progression, or regression in learning. Multiple personal and comparison activities with peers within the nursing program impact student beliefs in their individual capabilities. Conversely, students report benefits from interaction with faculty they find to be supportive and intellectually challenging. Therefore, a student who perceives a nursing instructor as a threat or as unapproachable may not be able to benefit from a supportive learning environment.

Recognizing that females are the primary gender in a nursing program, exploration of the student learning experience through the lens of the female will be explored within the next two developmental theories. Belenky, Clinchy, Goldberger, and Tarule (1985) wrote results of a study performed with 135 females from various backgrounds and professions who were asked about their ways of thinking critically and about themselves as knowers. Belenky et al. related the belief that most efforts in demonstrating females' intellectual competence have been heard primarily through the male voice.

These females described five different ways of knowing that they utilized while attempting to make sense of their experience in the world. These five ways of knowing were identified as silence, the voice of others, the inner voice, the voice of reason, and the integration of voices. Through these five ways of knowing, a female could shift her orientation to listen to her own inner voice while simultaneously listening to others' voices, resulting in a blending of rational ideas (Belenky et al., 1985).

The knowledge that females pose questions more than males do has often been considered a weakness (Belenky et al., 1985). However, Belenky et al. (1985) noted that even well-known scholars, such as Socrates, refrained from openly expressing their thoughts and ideas

due to fear that this would prevent individuals from working out their ideas independently. Belenky et al. wrote that allowing individuals the opportunity to develop their own ideas and emotions results in personal development of one's own mind and personhood. However, given that nursing programs are comprised of primarily females, male voices may be found to be expressed primarily through female voices. The consideration of these voices will be explored further in research conducted by Gilligan (1982).

Gilligan (1982) voiced how in listening to people over a span of 10 years, she noted a distinction in the way individuals described their relationships between others and themselves. As the discovery of the two modes were explored further, Gilligan observed difficulty in interpreting female development because all theoretical studies related to psychological research excluded females. Therefore, Gilligan sensed the need to examine the aspects of both male and female voices so all truths about life could be considered.

Gilligan's (1982) studies led her to the understanding that, as opposed to the well-known findings of male moral development based upon justice in respect to self, female morality demonstrates itself through the lens of care based upon increased understanding of others. As noted in Pascarella and Terenzini (2005), Gilligan's three stages of female moral reasoning development were listed:

1. Level I - *Orientation to Individual Survival* – Focuses clearly on the self and the individual's desires or needs that can preclude recognition of or engagement with moral dilemmas. Isolation from others could be a result of this focus on self. This leads to the first transition period of 'From Selfishness to Responsibility' as one recognizes the need to care for self as well as others, and care and responsibility become criteria for moral decision-making.

2. Level II – *Goodness as Self-Sacrifice* – Caring and responsibility for others become the basis for acceptance. Subordination of the individual's needs or wishes to those of others is central to maintaining connections to others. Noting the inequality between self and others, leads the individual to question her own interests being second to others, thus leading to the second transition period of 'From Goodness to Truth' in which the search for responsibility to self and others results in reconsideration and redefinition of responsibility to include caring for others and oneself.
3. Level III – *The Morality of Nonviolence* – Resolution is achieved when equilibrium is found between individual needs and the expectations of conformity and caring in conventional notions of womanhood. This equilibrium is based in nonviolence as a moral principle and is the basis for decision making. (p. 44)

Again, since the majority of nurses are female, Gilligan's research of the female voice is of particular interest.

However, the relationship of the female voice to the male voice is one that was also addressed by Gilligan when she asserted that the male wished to share ideas through what was only expected of the female, thereby suppressing the male view. How the students perceive nursing faculty expectations through their individual developmental level influences their experience with the CPA process. Assessment of where the students are in their development is a consideration for the faculty member as they evaluate each student.

Learning Theory Aspects

Review of the literature focusing on the topic of CPA and theoretical aspects addressed thus far gives rise to thoughts of Freire (1993) and his ideas on the concept of oppression. Freire

focused on students being active participants in their learning as opposed to the traditional teacher-centered approach. His ideas originated in the slums of Brazil, where he sensed that instead of learning information relevant to their knowledge of life, students were receptacles that contained information they were fed or banked (Freire, 1993).

Freire (1993) described how one should move from being one who just receives, digests, and regurgitates information to an individual who is capable of assimilating the information and transforming it into something liberating in his or her life. Freire related this thought in stating that "they will not gain this liberation by chance but through the praxis of their quest for it, through their recognition of the necessity to fight for it" (p. 45).

Within the CPA process, there exists potential for the nursing student to express a sense of oppression, whereas the dominant faculty group is seen as one who possesses the power to determine the student's ability to successfully progress through the program. The question arises: How can faculty look for ways to assist in decreasing the sense of oppression and afford the student the opportunity for praxis affording the opportunity to succeed?

Freire (1993) continued this thought by sharing the correct method for liberating the oppressed: the use of dialogue. He related that "the conviction of the oppressed that they must fight for their liberation is not a gift bestowed by the revolutionary leadership but the result of their own *conscientizacao*" (p. 67). It is through the conscious effort of the leadership and the oppressed that there is open dialogue and evidence of both the teacher and the learner participating in critically assimilating knowledge that is shared. This thought parallels that of the readings shared thus far in the literature review of multiple ideas for allowing the instructor to facilitate student learning as opposed to the absence of faculty feedback. Student self-evaluation in combination with instructor feedback would promote raising the learner's consciousness.

The concept of student input into their own learning through the process of self-evaluation is in contrast to the learners being a "container" into which information is deposited (Freire, 1993). Freire (1993) spoke of this further in his discussion of an educational model where the instructor deposits information into a student. He noted, "Instead of communicating, the teacher issues communiqués and makes deposit which the students patiently receive, memorize, and repeat" (p. 72). Freire described the "banking" concept of education, in which the "scope of action allowed to the students extends only as far as receiving, filing, and storing the deposit" (p. 72). However, Freire wrote it is the student, and not just the information, that is filed away as there is no allowance for inquiry, creativity, and transformation of information. He professed that "for apart from inquiry, apart from the praxis, individuals cannot be truly human" (p.72). Therefore, if the student experience of the CPA is one that does not allow for natural inquiry and practice, how will the free exchange of knowledge necessary for analytic thinking occur? Freire asserted, "Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry human beings pursue in the world, with the world, and with each other" (p. 72).

Freire (1993) compared and contrasted the terms critical thinking and naïve thinking. He described critical thinking as a true dialogue in which all dialoguers are fully engaged in exploring a topic; whereas, naïve thinking is defined as one individual holding fast to a thought that is only shared or imposed upon another. Freire continued to relate that

> Authentic education is not carried on by 'A' *for* 'B' or by 'A' *about* 'B', but rather by 'A' *with* 'B', mediated by the world – a world which impresses and challenges both parties, giving rise to views or opinions about it. (p. 93).

Review of the literature regarding performance appraisal also addressed the importance of the student developing critical thinking, which means the learner needs exposure to activities reflective of Freire's thought that all be involved in expressing ideas and opinions through mutual dialogue.

Morey (2004) discussed the usage of fieldwork or clinical performance evaluation as a method of program outcome assessment that explicitly answers to course objectives as opposed to a standardized instrument. Morey stated, "We are trying to make sure that all core faculty understand the importance of articulating student learning objectives and the relationship of those objectives to program goals and assessment" (p. 61). The expectation of understanding the importance is that due to the utilization of individual course objectives as the formative and summative part of the student evaluation process, the comprehensive expected outcomes of the program would be reflected. This expectation is examined more in the philosophy, conceptual framework, and CPA tool utilized in the nursing program intended for this proposed study.

Dewey (1938) stated, "The belief that all genuine education comes about through experience does not mean that all experiences are genuinely or equally educative" (p. 25). That is to say, that experience and education are not directly equal since not all experiences are educative. This is of particular note when literature review of CPAs reveals the challenges of their application in the nursing education process. The outcome of the performance appraisal process could arrest further experience for the student if not performed in a manner that promotes learning.

Dewey (1938) wrote that experience alone is not the answer, but that everything depends upon the quality of the experience. Dewey explained:

> The quality of any experience has two aspects. There is an immediate aspect of agreeableness or disagreeableness, and there is its influence upon later experiences. The first is obvious and ready to judge. The effect of an experience is not borne on its face. It sets a problem to the educator. It is his business to arrange for the kind of experiences, which, while they do not repel the student, but rather engage his activities are, nevertheless, more than immediately enjoyable since they promote having desirable future experiences . . . wholly independent of desire or intent, every experience lives on in further experiences. Hence, the central problem of an education based upon experience is to select the kind of present experiences that live fruitfully and creatively in subsequent experiences. (1938, pp. 27-28)

In support of these ideals, Dewey further compared the concept of experiential learning to that of teaching with a sense of democratic versus autocratic attributes.

Dewey (1938) visualized the democratic principles of learning as empowering to the learner with regard for decency and kindliness of human relations versus the utilization of coercion, repression, or force. Therefore, the adult should exercise the wisdom his or her vast experience gives without imposing external control over the learner. Furthermore, an educator should be able to identify attitudes that are conducive to continued student growth and display sympathetic understanding of students as individuals, which gives the instructor an idea of what is actually going on in the minds of those who are learning for basing education upon lived experience.

Dewey (1938) continued the discussion of basing education upon individual lived experience by stating the formation of purposes is then a rather complex intellectual operation, which involved:

> Observation of surrounding conditions, knowledge of what has happened in similar situations in the past, a knowledge obtained partly by recollection and partly from the information, advice, and warning of those who have had a wider experience, and judgment, which puts together what is observed and what is recalled to see what they signify. A purpose differs from an original impulse and desire through it translation into a plan and method of action based upon foresight of the consequences of acting under given observed conditions in a certain way. (pp. 68-69)

The experiential learning model lends some discussion to the experience that an individual undertakes when acquiring and applying knowledge in an educational setting whether in the formal classroom or out in the field. Kolb's (1984) model was created out of four elements including concrete experience, observation and reflection, the formation of abstract concepts, and testing in new situations that can begin at any one of the four points approached from the perspective of a continuous spiral. These elements are definitely observable in the learning process of the student nurse involved in the CPA process.

Kolb (1984) developed his model from the teachings of many influences including Dewey, Piaget, and Lewin. From them, Kolb's learning styles of converger, diverger, assimilator, and accommodator was evident. In his model, Kolb integrated Dewey's (1938) developmental nature of exercise with the cognitive development of Piaget and Lewin's action research. Strengths and weaknesses were identified in each of the learning styles; therefore, it is wise for the clinical instructor to have an awareness of the student's style in order to formulate a plan that best facilitates individualized learning. Kolb stated, "To learn is not the special province of a single specialized realm of human functioning such as cognition or perception; it

involves the integrated functioning of the total organism – thinking, feeling, perceiving, and behaving" (p. 31).

Kolb (1984) continued the premise of how life experiences play into experiential learning theory by identifying the transactional relationship between an individual and the environment. Kolb called upon the influence of Dewey (1938) in describing this influence:

> Experience does not go on simply inside a person. It does go on there, for it influences the formation of attitudes of desire and purpose. However, this is not the whole of the story. Every genuine experience has an active side, which changes in some degree the objective conditions under which experiences are had. The difference between civilization and savagery, to take an example on a large scale, if found in the degree in which previous experiences have changed the objective conditions under which subsequent experiences take place. The existence of roads, of means of rapid movement and transportation, tools, implements, furniture, electric light and power, are illustrations. Destroy the external conditions of present civilized experience, and for a time, our experience would relapse into that of barbaric peoples. (p. 39)

Therefore, Kolb theorized that, because of our individual past life experiences, in combination with the demands of the present environment, most people develop learning styles that emphasize certain abilities, described as:

> Some people develop minds that excel at assimilating disparate facts into coherent theories; yet these same people are incapable of or uninterested in deducing hypotheses from the theory. Others are logical geniuses but find it impossible to involve and surrender themselves to an experience. (p. 77)

These individualities are what precipitate the challenges noted in the literature review of the CPA process. Student experiences and abilities brought to the evaluation process set the stage for disparate interpretation of demonstration of learning.

Summary of Literature Review

This literature review explored the CPA process as a historically documented concern for faculty and students in that both teaching and evaluation of learning occur simultaneously in a dynamic environment. Since limited literature exists sharing the CPA process through the lens of the student, the review process was primarily through the eyes of the faculty. The limited review of literature of the CPA process through the lens of the student presents the need for ongoing research in this area. Therefore, other potential methods of examining the experiences of the student undergoing the CPA process, including concepts from developmental and learning theories, were also included in this chapter.

The first section of literature review provided an overview of the CPA process including its historical foundation as it pertains to the process's evolution over decades for a number of disciplines; problems identified with the CPA process, including the environment in which it took place and how and by whom it is conducted. Also explored in the review of the literature were perceptions and attitudes toward the CPA process viewed primarily through the faculty lens and minimally from the experience of the student. Exploration of multiple approaches to the evaluation process and additional perspectives that addressed safety, deficiencies, and cognitive development specific to the tool and its differing applications completes this section.

The second section explored literature addressing student development including psychosocial, moral, and identity development. The final section focused on literature review addressing learning theories such as experiential, active participation, and the importance of

effective assessment planning. It is anticipated that the literature included in this chapter will provide a foundation for a phenomenological investigation of the student experiencing the CPA process that will provide meaning to those who read the results for individualized applicability of theory to practice in their respective settings.

CHAPTER 3

RESEARCH METHODOLOGY

The purpose of this study was to focus on the perception or experience of the nursing student undergoing the clinical evaluation appraisal. Two research questions were asked to guide the study. The first question sought to explore the essence of the nursing student as they lived the experience of the clinical evaluation process. The second question sought to answer if the student perceived the experience to be one that met her personal and professional goals. In an attempt to fulfill this purpose, the following questions were posed for the study:

1. What is the experience of a baccalaureate degree nursing student undergoing the process of clinical evaluation appraisal?
2. Do baccalaureate degree nursing students perceive the clinical evaluation appraisal process as a means of meeting personal and professional goals?

The desire to hear the voices of the nursing students as they related their experiences with the clinical performance appraisal (CPA) process was the goal of this study; therefore, the phenomenological methodology approach proved to be the best method for this purpose. Since nursing programs historically enroll predominantly White, female students, my original concern was the potential for the participants to be too homogenous in nature. However, I discovered the number of participants who chose to be interviewed for this study were a blend of women and men and included an African woman. The original intent was to conduct a case study with

nursing students at a private, Midwest, Liberal Arts University. However, to hear the story of a desired number of participants to the point of saturation, another Midwest Public University was chosen.

Methodological Approach

This study focused on the experience of the baccalaureate degree seeking nursing student undergoing the clinical evaluation appraisal process. As the statement implies, the plan was to meet with individual nursing students to hear their voices as they shared stories of their experiences with the process. Therefore, I employed a qualitative inquiry to engage "in an in-depth study using face-to-face techniques to collect data from people in their natural settings" (McMillan & Schumacher, 2001, p. 35). Creswell (2007) defined this type of qualitative research as a process that

> begins with assumptions, a world view, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning of individuals or groups ascribed to a social or human problem . . . include the voices of participants, reflexivity of the researcher and the complex description and interpretations of the problem, and it extends the literature or signals a call for action. (p. 37)

Data from interviews were digitally recorded and transcribed. Significant statements were highlighted and organized into themes or what Creswell (2007) describes as "structural and textural descriptions" (p. 62). Subsequently, at the end of the experience, I was able to write what was revealed in the interviews through the essence of the individuals being interviewed.

Research Design

Speziale and Carpenter (2003) noted, "Because professional nursing practice is enmeshed in people's life experiences, phenomenology as a research approach is well suited to the

investigation of phenomena important to nursing" (p. 51). Therefore, the phenomenological research design lent itself to this study of the lived experience of the nursing students as they participated in the clinical evaluation process. McMillan and Schumacher (2001) supported this thought with their assertion that "a phenomenological study describes the meanings of a lived experience" (p. 36).

Van Manen (1990) reinforced the idea that phenomenology is an example of the field of human science. He expanded upon this idea in asserting that the difference between natural science and human science resides in what it studies. Van Manen asserted,

> Natural science studies 'objects of nature', 'things', 'natural events', and 'the way that objects behave'; human science, in contrast, studies 'persons', or beings that have 'consciousness' and that 'act purposefully' in and on the world by creating objects of 'meaning' that are 'expressions' of how human beings exist in the world. (p. 3-4)

Therefore, the phenomenological method of inquiry chosen for this qualitative study resulted in the dialogue between the participants and me leading to the rich information included in this study. Van Manen continued the discussion of phenomenology, emphasizing that the goal is to gain a deeper understanding of what is meant by everyday experiences one encounters through the examination of what it means to an individual. He further asserted,

> The essence of a phenomenon is a universal which can be described through a study of the structure that governs the instances or particular manifestations of the essence of that phenomenon; in other words, phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience. (p. 10)

Speziale and Carpenter (2003) added, "Phenomenology is a science whose purpose is to describe particular phenomena or the appearance of things, as lived experience" (p. 52).

Moustakas (1994) described the lived experience unique to the individual by stating that "in phenomenology, perception is regarded as the primary source of knowledge, the source that cannot be doubted" (p. 52). As opposed to other forms of qualitative study, phenomenology does not attempt to find similarities or differences among participants. Instead, phenomenology searches for the unique essence of each participant related to the experience. Therefore, data reflects what each participant brought to the study through his or her individual voice of experience with the clinical evaluation appraisal process. Moustakas furthered this thought by saying, "In phenomenological studies, the investigator abstains from making suppositions, focuses on a specific topic freshly and naively, constructs a question or problem to guide the study, and derives findings that will provide the basis for further research and reflection" (p. 47). McMillan and Schumacher (2001) reinforced this by stating that "the researcher 'brackets' or puts aside all prejudgments and collects data on how individuals make sense out of a particular experience or situation" (p. 36).

In regards to McMillan and Schumacher's (2001) statement regarding bracketing, I would like to elaborate on how personal experiences with the clinical evaluation appraisal process were framed. The need for me to recognize my own sense of the nature and meaning of something is a necessary component of the research process, to make a decision regarding truth and value as well as considering the point of view of the participants (Moustakas, 1994). Bracketing for my personal experiences with clinical evaluation included my participation in the CPA process as a nursing student, as someone who assisted in the development of such a tool for a nursing program, as well as an instructor who has conducted performance appraisals.

Moustakas (1994) stressed that the interview should allow for variance to enable the participant to strengthen data collected on the topic stating that

> The phenomenological interview involves an informal, interactive process and utilizes open-ended comments and questions. Although the primary researcher may in advance develop a series of questions aimed at evoking a comprehensive account of the person's experience of the phenomenon, these are varied, altered, or not used at all when the co-researcher shares the full story of his or her experience of the bracketed question. (p. 114)

Participant Selection

Participants were purposefully selected from senior level baccalaureate degree nursing programs at two Midwest four-year universities: one a private, liberal arts university and the other, a public comprehensive university as described on each of the college's websites. Through personal meetings, both nursing program department chairs positively responded by providing a method of acquiring student names for the study. The department chairs provided 94 names of senior nursing students that they sensed could provide rich data for this study: 19 from the private university and 75 from the public.

The nursing department chair from the private university provided a list of personal student information allowable by the Family Educational Rights and Privacy Act (FERPA). Since the students were not on campus at the time of my first inquiry, the researcher contacted the 19 potential students at the private university by mail to seek his or her willingness to participate in the study (see Appendix A). I received one student response from this inquiry and an appointment was made to meet her at the University for an interview. Based upon this minimal response, I emailed the remaining 18 prospective interviewees to investigate their desire to participate. The wording of the email introduced the recruitment letter (see Appendix A) inviting the participant to participate in the study and read as follows:

> I am a researcher conducting a qualitative study for the purpose of gaining an understanding of the experience of the baccalaureate degree seeking nursing student undergoing the process of clinical evaluation appraisal. Your name was provided to me by a faculty member in the nursing program you are attending, who sensed you would be a good candidate that could provide rich information in regards to the clinical evaluation process, and who possesses the criteria of the participants that I would like to include in the study. The study is anticipated to take approximately two hours of your time. If you are willing to be a part of this study, please read, sign, and return the attached letter to me at the address indicated at the end of the document.

Having received no response to the email inquiry, I contacted the nursing department chair at the private university, and she suggested I visit a senior-level nursing course the first week of the fall 2009 semester and relate my desire for student participation in the study. Three students expressed interest in being interviewed for the study and provided me their contact information. The interviews took place on the campus of those individuals. All four interviews at the private university took place in a quiet, secluded study room within the campus library. During the course of the interviews, additional demographic data pertaining to the study participants were collected through both digitally recorded interviews and paper and pencil documentation (see Appendix B). Since my desire was to have a minimum of eight participants, I expanded my reach for additional participants to a different four-year, baccalaureate nursing program within the Midwest.

Therefore, I met with the nursing department chair from the public university who invited me to attend a senior-level nursing class of 75 students to present the option to participate in the study. Twenty students indicated interest in participating by way of providing their email

contact information. All 20 students were contacted by email and, based upon my desire for a diverse demographic pool of participants, five were selected for the study. The participants were once again allowed to select the area in which they would like to be interviewed. Two of the interviews took place at the public university campus in a secluded study room within the media center of the School of Health Professions building. One interview took place within a quiet area of a public library, and the remaining two occurred within a secluded area of a local coffee shop. In correlation with the private college interviews, additional demographic data pertaining to the study participants were collected through both digitally recorded interviews and paper and pencil documentation. Between the two universities, nine participants were obtained, exceeding my original goal of eight.

The nine participants shared their stories in this phenomenological study to fulfill the purpose of increasing "the utility of information obtained from small samples" (McMillan & Schumacher, 2001, p. 401). The rationale for the number of participants chosen was centered on the number agreeing to voice their perceptions and the time that was taken to allow each participant to completely share the essence of the individual experiences through in-depth interviews. An attempt was made to have a pool of participants reflecting maximum variation of characteristics including age, race, ethnicity, and gender to enrich the data collection process (Lincoln & Guba, 1985).

Data Collection Procedure

As discussed earlier, data collection at each institution included collaboration with the nursing department chair, the faculty, and the students who agreed to participate. The department chair from each university was contacted and the study described for the purpose of recruiting students who were in the last year of the program. The rationale for choosing students

in their senior year was the assumption of more historical data from which they could draw. Each department chair provided a copy of the CPA tool utilized with the level of student chosen for the study. It was through interviewing nine, diverse participants that a point of saturation of data was attained.

Every individual who expressed an interest in participating in the study was contacted, and a brief overview and explanation of the purpose of the study was conducted, including the estimated time that would be required of each individual. Participants were assured of the appropriateness and confidentiality of the study and asked to complete the Consent to Participate in Research form (see Appendix C). Data were collected by way of semi-structured, 45 to 60 minute, digitally recorded, in-depth interviews. Each participant was interviewed at a private location of their choosing. Sensitivity toward participants was in constant check as "protection of human subjects is without question a critical component of any research study" (Speziale & Carpenter, 2003, p. 48).

To hear the essence of the experience of the nursing students undergoing the clinical evaluation process, and to study how this activity affects their meeting of personal and professional goals, an interview protocol was used as a guideline (see Appendix D). The actual questions included in the discussion between each participant and myself were guided by the study protocol as well as the direction the individual chose to take the dialogue.

At the beginning of the interview, each participant selected a pseudonym to ensure confidentiality. Data from the interviews were collected digitally and transcribed. Since a transcriptionist was used for the transfer of data retrieved, a confidentiality form was signed prior to her being allowed to hear the voices of the students (see Appendix E). Significant statements, or what Creswell (2007) described as "structural and textural descriptions" (p. 62) were

highlighted, field notes were made, and themes emerged, thereby allowing me to write what was revealed in the interview through the essence or experience of the person being interviewed. Follow-up questions clarified and validated content, otherwise known as member checking, to add authenticity to the study. Additionally, each participant was given the opportunity to review the typed transcript of their individual dialogue to verify accuracy.

Recorded and transcribed data were bracketed (Creswell, 2007) as themes began to emerge. Bracketing (Creswell, 2007) included a check for personal biases, which I have experienced during the clinical evaluation process both as a student and an instructor. My experience with the clinical evaluation process as a student includes my graduation from an associate, baccalaureate, and masters in nursing program. As an instructor, I have been involved in the development of a number of CPAs, as well as utilized the tool in the nursing faculty role to evaluate student behavior. A last consideration for bracketing was checking personal values and beliefs to avoid obvious bias for the faculty or student experience.

Next, I triangulated data to verify what was being experienced by the participants. Lincoln and Guba (1985) asserted, "triangulation improves the probability that findings and interpretations will be found credible" (p. 305). Triangulation in naturalistic inquiry involves the multiple modes of data collection. For the purpose of this study, I utilized the methods of information-sharing, interviewing, and member checking. Lincoln and Guba continued the discussion of triangulation by saying that "the member check, whereby data, analytic categories, interpretations, and conclusions are tested with members of those stake-holding groups from whom the data were originally collected, is the most crucial technique for establishing credibility" (p. 314).

After transcribing the recorded data and including inferential field notes, participants were given the opportunity to review and offer input as to what had been written for verification. Data were then examined for applicability. Applicability within the naturalistic framework implies transferability (Lincoln & Guba, 1985). Given the knowledge that truth has value implies the inability to generalize the words of participants in one setting to another, transferability is what the researcher expects to apply within other contexts. I will elaborate more on the potential for transferability of what was learned from the study in the discussion area of the study.

Data Analysis

An analysis of the clinical evaluation tool utilized by each program was done prior to meeting with the participants. The tools analysis gave me a richer understanding for what the participant was sharing about the experience as well as serving as a method for comparing the tool utilized by the nursing program with those identified in the literature review. Analysis of the tool will also assist in understanding the students' perceptions of the evaluation method utilized within their programs.

As each interview was completed, digitally recorded audiotapes were transcribed into written text for thorough listening, reading, and interpreting what the participants wished to reveal regarding their experiences. This phenomenological process assisted with bracketing my personal feelings and experiences, as well as chunking data into themes. Lincoln and Guba (1985) described the concept of bracketing as neutrality from the conventional thought of objectivity that is examined from the phenomenological viewpoint of confirmation of data. The goal of my objectivity was that of observer inquiry that was value-free, which in phenomenology I employed member checking and bracketing.

Lastly, in an effort to decrease the potential for researcher subjectivity, two administrative individuals not involved in this study or with any nursing education programs, were requested to review the research conducted and provide feedback regarding the findings. This peer debriefing strategy was utilized to assist in monitoring and evaluating subjectivity on the part of the researcher as well as pose any other questions that could enhance the study (Lincoln & Guba, 1985; McMillan & Schumacher, 2001; Merriam, 1988, 2001). McMillan and Schumacher (2001) describe a peer debriefer as "a colleague who facilitates the logical analysis of data and interpretation" (p. 412). Both peer reviewers in this study are individuals employed at higher education institutions and have a minimum of 10 years experience within post-secondary education. Each peer debriefer was sent a letter requesting comments regarding the findings of the attached study (see Appendix F).

Plan for Study Results

The results of this study are planned to assist nursing instructors toward a greater understanding of the clinical evaluation process through the lens of the student. The plan is to share the results with the nursing department chairs that assisted with the study in the hope that, in turn, these results will be reported to their respective faculty for potential enrichment of the appraisal process within the program. Discussion of the results will also explore other options that could be implemented for student performance evaluation. The potential for publication as well as replication within other institutions who are interested in this phenomenon is being considered.

Consideration for Participants

Upon gaining Institutional Review Board (IRB) approval, consideration for the study participants was a priority in providing a setting comfortable for the interview, including the time

taken for follow up. McMillan and Schumacher (2001) asserted, “Interactive qualitative inquiry is an in-depth study using face-to-face techniques to collect data from people in their natural settings” (p. 35). Every consideration was taken to be certain the participants felt safe throughout the process with freedom to speak their thoughts and feelings to the interviewer without fear of recourse. Member checking, as well as listening to the voices of the participants multiple times, ensured that what information was voiced in the interview was transcribed.

CHAPTER 4

RESULTS

The purpose of this study was to focus on the perception and experience of the nursing student undergoing the clinical performance appraisal (CPA) process. In an attempt to fulfill this purpose, the following questions for the study were posed:

1. What is the experience of a baccalaureate degree nursing student undergoing the process of clinical evaluation appraisal?
2. Do baccalaureate degree nursing students perceive the clinical evaluation appraisal process as a means of meeting personal and professional goals?

This chapter provides information discovered throughout the study related to what I learned from in-depth interviews with nine participants from two Midwestern four-year universities. Data reported includes demographic and other rich information as to the experiences the participants voiced as a part of the clinical evaluation process. Although each participant brings her or his personal stories to the evaluation process, additional nursing program factors influence the overall lived experience of the student while in the clinical setting.

Reporting results begins with a table illustrating demographics of each participant including his or her pseudonym, age, gender, ethnicity, and type of university for the nursing program. Recognizing unique characteristics of two of the participants, I note additional rich information about them. Second, to set the stage of the experiences shared by each participant, I

share the evaluation process utilized by both schools. Finally, at the conclusion of the reporting of the results, I respond to the two questions that guided this study mentioned at the beginning of this chapter.

Participants

The participants in this study were six females and three males from two Midwest, four-year universities who were enrolled in a baccalaureate nursing program. One of the universities described itself as a private, Liberal Arts College and the other, a public institution, reflected itself on a website as comprehensive. Semi-structured interviews, at a site selected by the individual, set the stage for each participant to share lived experiences as a nursing student undergoing the clinical evaluation process as seen through her or his personal lens.

I found participants to be very open in presenting their stories. The diverse group of individuals that emerged who were willing to participate in the study enriched the data collection process. I was at first uncertain if they would openly volunteer their time and experiences, but I found them willing to provide both.

Diversity in a nursing program is not always easy to find as personal experience reveals most nursing students as female and of European descent. However, I was pleasantly surprised that three White males and a woman, who self-identified herself as pure African, were open to sharing their stories. Although I was cautioned by nursing program faculty that the female of African descent was often reluctant to speak with others associated within the nursing program, she spoke the most in sharing how the nursing program had played a major role in "transforming" her life. Of the nine participants, one held a prior degree in psychology; seven entered the nursing program immediately after completing high school; and one individual, "Aban," was beginning her higher education experience at the age of 47. Table 1 illustrates

characteristics of the nine participants listed in alphabetical order by their self-selected pseudonym.

Table 1

Participant Characteristics

Pseudonym	Gender	Age	Ethnicity/Race	Educational Level	Institution
Aban	Female	47	African	Senior	Private
Amanda	Female	22	White	Senior	Public
Amber	Female	24	White	Senior	Public
Brittany	Female	22	White	Senior	Public
Charles	Male	22	White	Senior	Private
Constance	Female	24	White	Senior	Public
JC	Male	23	White	Senior	Public
Jenna	Female	22	White	Senior	Private
Jim	Male	22	White	Senior	Private

Recognizing that seven of the nine participants entered college immediately following high school, there is limited descriptive data to note. Nonetheless, I report what was learned from all the participants as they shared their personal stories to date through their personal reflections of the clinical evaluation process. What each participant within the 22 to 23 year age range disclosed was similar regarding educational experiences prior to entering the nursing program. The less-experienced students revealed how they discovered the expectancies in higher education, and more specifically the nursing program, to be less prescriptive and more open to interpretation. Conversely, those who have had either earned a previous degree or experienced more throughout their life had more to add to their personal stories.

The first student who had much to reveal regarding her personal story is Aban. Aban prides herself in being of African descent, thus the choice of using an African name as her pseudonym. She expresses satisfaction in having left Africa with her three children and beginning a new life in the United States. To allow others the pleasure I experienced in hearing Aban's story, I have expressed her words in the same essence she shared them:

> I am 47 years old. It's so . . . exhausted . . . why did I have to put myself in this situation [reference to college]? But it's harder for me because English is also my second language. This is my best. It's more a challenge for me, so . . . Yeah, but that's okay; I'm in my final year. Actually, I consider myself as an African; I'm not a African American . . . I'm a pure African from Africa. A foreigner, actually. I'm here with my three children. My son is 21 years old at local public university . . . pre-med. And I have my 15-year-old at local public high school and then my 10-year-old at local public grade school.

Aban continued dialogue regarding her experience with the clinical evaluation process as a method and revealed her sense of transformation not only as a student learning about the nursing profession but also as an individual learning another culture. The following are her thoughts referencing this transformation:

> For me being an older student, returning to school, and then, also English as a second language . . . and getting used to the culture, I have a lot of questions so I always make myself available to my professors. Every professor that I know is going to lead me through a semester of clinical; I make the professor notice of my little things that were bothering me at clinical . . . and then I take it from there. I think my first clinical . . . it was a wonderful, wonderful experience. At first I had a little, a much like setback. I didn't know which problem to meet. I was kind of scared also about the American

> culture. What do I know? You're in clinical, touch/don't touch? What do you say? I speak a little bit faster. Would people understand me? And all those things were things that were actually bothering me before initial clinical, but you know, instructor was able to see me through a lot of things that as a nurse you should be there for your patient. You do what you were taught in class. We have a lot of simulations so that is how you approach it, you know. So, actually, I wouldn't say that my instructor, views me, during the evaluation, they view me differently than the others. I think they view all of us the same, but I seek a lot of help from them. I seek a lot of help from them so . . . I wouldn't say probably they would do to me more than the others.

Aban continued to voice the transformation that has occurred due to the obvious cultural differences between the two countries. She talked of how she finds comfort in familiar experiences that assist her with learning what is very dichotomous. Here is some dialogue that reflects this experience through her personal lens:

> OB [obstetrics] wasn't something I was scared of. I was more open. I knew what I was going to expect. And actually, I was able to learn easily . . . I was able to relate to the nurses. Most of them are older so . . . we could, I could talk business with them. So we chose some things that really, really helped me. And my professors actually saw that my relationship with, uh, the nurses just awesome and the patients is really great, yeah! And then, peds [pediatrics], I just performed wonderfully. Yeah. By the time I was going to peds, I know more about children already. You know, even though it wasn't my favorite, I know more about peds. And then went to mental health so that be just awesome. I think in mental health, was where I had another kind of an apprehension, because I was looking at mental health from my own culture point of view because like in my country,

> we don't see mental health is a disease to us, but we really actually don't see it as their true disease.

Aban continues her story in the following way:

> Sometimes you see the women in the streets, you know, unlike here where you, here you actually take time to put them in an institution. We have an institution, too, but many mental health people just walk in the street. Children come through and, you know, that kind of lack of education . . . it's, you know, their education is not there. Even though the government does work to kind of accommodate them. There's a mental institution back home, but probably because of no resources, most of them kind of roam the streets. And, you know they can pose a danger to public. I went into mental health clinical thinking that I would, you know, I've never seen anybody roaming the street so, but that's the kind of tall tale I went to mental health with. But at the end of it, I was really transformed.

Next to relate her personal story was Amanda. Amanda entered the nursing program immediately following high school and shared that her desire to enter the profession was based upon knowledge of the need for nurses combined with her desire to assist others. However, Amanda explains that what she experienced in her secondary education was more structured and less self-directed than what was expected in the clinical portion of the nursing program. She voiced that without clarification as to what the student should share with the instructor the evaluation tool leaves itself open to individual interpretation. Therefore, she is not always certain that what she is voicing in her part of the evaluation is what the instructor wants to hear to meet expectations of the course. Amanda explains her uncertainty in the following example:

> I think there needs to be clarification as far as what they want in the comment section. It would be better if it would ask for your strengths and weaknesses instead of a big blank

> spot for student comments. There's no direction as to where should I go. So I just write 'I loved this clinical' because I don't know anything else to write. I think if it gives you a spot for strengths, I can pick those out. And weaknesses with a plan for improvement, that's a little more goal-directed. If there are [new students] like I was, it's a whole different experience. You don't know anything so you need to have a little direction as far as what they [instructors] are looking for.

Amber is another student from the public institution who is 24 years of age. Amber does not possess a previous degree but attended college directly from high school and took general education coursework related to the nursing degree until she reached her long-awaited goal of admission into the nursing program. She also reports that her secondary education did not compare to what is expected of her in the nursing program regarding the clinical evaluation experience. Amber expands on this thought in the following way:

> I don't like evaluating myself, but they [instructors] say you have to do that all throughout your professional career so they went over the paper in Med Surg I. They didn't really expound on it a lot saying that basically everything is self-explanatory. I think that they [instructors] have a better idea of what direction we're heading than we do. They gave you the paper and you could look over it and if you had any questions you could ask, but I think we were all so excited about getting to go to the hospital that we didn't look at the tool that well.

Amber reports that each new course presents new challenges for application of theory to practice, which makes her nervous. She states,

> I've thought I've fallen below, like I messed up something or I didn't catch something, and I just thought it was the end of the world. The instructor was really encouraging

> saying, ‘You're going to get better’; I felt like I didn't meet certain standards in using application of my knowledge, and it is really hard in the beginning. It is still hard with each new clinical focus.

Brittany is a 22-year-old female who was admitted to the nursing program at the public university directly out of high school. Brittany says her desire to serve others in the health profession has been a goal for several years. Prior to admission to the program, Brittany voiced she performed missionary work through her church and plans to expand her service as a nurse. The expectancy of the student to demonstrate initiative in the clinical setting is one part of the clinical evaluation process that Brittany found challenging. She voiced that collaboratively working with others in the clinical setting is unlike what was expected in her previous educational experiences. She also disclosed that quiet students, like her, could not always be fully evaluated with the current process in place due to the nature of the form and the experiences. Brittany elaborated that expectancies listed on the evaluation tool did not always appear consistent with what was expected of the student and that additional behaviors that the student exhibits are absent. Brittany reveals this dichotomy in the following way:

> Sometimes, I don't think it [the clinical evaluation tool] reflects what is to be evaluated. Because like the first part of clinical, I think it should have been like, ‘You [student] checked the five rights when giving medicines’. I think it should incorporate that a little bit more. For example, when you [student] did this, you used aseptic technique. I don't think it goes [reads] like that. It's kind of like you worked with the nurse or you . . . it's more the collaborative thing; I mean they want you to talk to the nurses and doctors, but I just think they could probably add [other things] to it.

Charles is a 22-year-old male who was admitted to the private university immediately after completing his high school requirements. He also works as a certified nursing assistant (CNA) in a hospital in his hometown that is not the same as where he attends college. He senses this was a first major step toward his achieving the goal of become an RN. Charles finds the post-secondary education in the nursing program to be different from high school in that there are a variety of methods in which students are assessed for one course. The clinical course is evaluated in a number of ways including performance in the clinical setting, standardized and math examinations, journaling, care plans, simulation activities, and group work. Charles enjoys the free journaling where he is able to openly express how he performed and what he accomplished in the clinical setting. Charles describes his overall experience with the evaluation process in saying, "It's given me ways to look at like improving myself and showing me things I wasn't quite noticing that I need improvement on."

Constance, a 24-year-old female, has a previous degree in psychology. She voiced a sense that her previous degree finds herself in a role where younger, less-experienced students seek her guidance. Constance expressed her thoughts in the following way:

> As a seasoned student, I don't think I was as exuberant as the sophomores. 'Cause like I say, I was a seasoned student at that point. So to hand me an evaluation tool, I'm like, 'Oh, look, it's an evaluation tool.' Really, I'm not even aware. I just go about my clinical experience and try to learn as much as I can because I know that that's the way I learn. I ask questions, I get answers. One of the best ways for me to learn is to teach. So, a lot of the other students in my clinical will come to me and ask me questions, and I'll work it through with them. And then I learn it better doing that than actually reading it out of a book. And being a psychology graduate . . . I think that clearly affects that.

Constance continued the discussion of her previous experience by suggesting how nursing instructors could utilize the methodology she employs with her fellow students in the previous quote by sharing:

> I think that it would be good if the instructors were instructed how to do this Socratic method with their students. I think they would learn infinitesimally more in clinical if they sat down . . . right there with us and saying okay, now what would you do now and why and . . . what makes you think that way? And why do you think the doctor is doing this?

Next is 23-year-old JC who is a White male senior who attends the public university. JC entered college immediately following high school and currently works as a student nurse at a hospital near the college. He describes his first experience in the clinical setting stating, "It was like, oh my God, the hospital; I remember my first day going in . . . I was scared to death!" However, he relates his work as a student nurse reinforces what he has learned in the clinical course as well as his long-awaited desire to become an RN. He also notes that the clinical instructor was supportive in areas of mutually identified areas that need improvement.

Twenty-two-year old Jenna is a White, female, senior nursing student who attended the private university directly out of high school. Jenna reveals that her personal family history of medical challenges, as well as the expressed need for nurses, serves as the basis for her pursuit of a nursing career. Jenna was unique in presenting how she applied what she learned in theory to the clinical practice setting when describing her experience with the process. She came to the interview with a folder containing materials that noted the philosophy and conceptual framework of the program and how it is integrated throughout the program. Jenna described her experience with the clinical evaluation process in the following way:

> It gets less tedious the older you are. They kind of put it [evaluation tool] in front of us and they were like, 'You guys know what to do,' but at the beginning we went through it, basically word for word. I think it's pretty straightforward and our professors are very understanding. They tell us to put down what we feel and just everything that we've done and if there's a part we don't understand, we can always go back to them afterwards and ask them. A lot of the professors are good about saying, 'Hey look what you did today. Make sure you write that on your evaluation.' So, they keep it in the back of our minds the entire time.

Jim is the last of the nine participants I interviewed about their experiences with the clinical evaluation process. Jim is a 22-year-old, White, male nursing student who attended the private university immediately after completing his secondary education. He reveals a family history of those who have practiced in the professional nursing role as well as the sciences, with a grandfather who taught medical microbiology. He describes his personal experience with the evaluation process by sharing the following:

> From sophomore year on, we're kind of given a tool, that delineates what is expected of us during clinical and so starting sophomore year, it's more simple [fundamental] things as far as are you competent in bed baths then as we go on it becomes more complex; they add on to [expectations] as we go.

Jim continued to explain how the clinical performance expectations varied within the differing foci and levels of the program:

> The main points are very similar so you have [for example] critical thinking, leadership, or management, and depending on where you're at as far as within clinical, so, it becomes more focused on like the management and leadership as you get further along in the

> critical thinking than it does [for example] in fundamentals; so it's weighted differently as you progress in the program. However, the main categories generally stay the same and as you get further along they weigh things more just because that's where you should be at that point in time than when you were first starting off.

Jim also voiced that his experience with the clinical performance evaluation process differed from that of the primarily theory-focused course with more focus on evaluation of the student's ability to apply theory to practice:

> They do look at how you are working with the patient, if you're doing procedures correctly, taking vital signs correctly, and so forth. But then they also look through your paperwork as well to see that you're actually thinking about the important things. So whether it is through nursing diagnosis or whatever, evaluating if you're critically thinking through and analyzing the data that you're gathering. They [instructors] kind of combine the two. What they actually do is they put the papers into our clinical evaluation.

Evaluation Tool Analysis

As shared in Chapter 2 of this study, there are a number of methods and tools employed to evaluate student behaviors in the clinical setting in several disciplines. To assist with understanding the dialogue students engaged in the clinical evaluation process at the two universities, I reveal some information regarding the tools employed.

Private Institution. The clinical performance evaluation tool employed at the private university contains multiple factors for consideration. First, there is a scale numbered one through five with associated behaviors assigned to each number. The numbers associated with the scores assigned to each student is based upon an adaptation of the Bondy Scale (1983).

Second, there are five major categories, divided into subcategories, that each student is then assigned a number from the scale. The five categories are nursing modalities, critical thinking, management, leadership, and therapeutic relationship. Each student is to attain a minimum overall score of three, as well as a minimal number of three within each category on the final evaluation tool, in order to pass the course. Each of the modalities is assigned a percentage that adds up to 100%. Additionally, if a student's performance is found to be unsafe or unethical, a grade of no higher than a D will be assigned. A minimum grade of C is required to pass the course.

The clinical performance component of the program is a course separate from its co-requisite theory course; therefore, a separate letter grade is assigned for the clinical course. The traditional model of students being evaluated by program faculty throughout the entire program is practiced. Conversations with students revealed that they do not see the assignment of a letter grade for the clinical component to be an issue as much as the difference in how each instructor assigns it. Students and faculty meet formally at the midterm and final intervals of the course to share each other's thoughts as to how objectives are being met at that time. Participants revealed that the midterm meeting with the instructor is a good time for both to have input into student progression and opportunity for improvement, if needed.

Students disclosed that several factors played into the earning of the final grade. Some semesters were noted to focus upon one major area, such as medical-surgical, and another semester may focus on several. In the semester where more than one major topic is evaluated, such as five weeks each of pediatrics, obstetrics, and mental health, the earned scores from the three areas are averaged to arrive at the final assigned grade. Other factors that played into meeting the course objectives were assignments such as care plans, medication cards, group

presentations, and math quizzes. Student logs were kept for sharing their thoughts about what they accomplished or what opportunity they needed for more experience or improvement. Participants shared that some instructors viewed these logs with great interest because it kept them aware of student progression that the faculty were not always aware versus other faculty members who just occasionally glanced at them to see that they were completed.

Jenna shared her thoughts in regards to this method of clinical evaluation:

> At the beginning, they give us these papers . . . and it goes through nursing modalities, and it shows us everything like 'teaching increased knowledge of pediatric teaching and discharge instructions'. And you kind of keep this with you every day when you're in clinical and then you reflect on what you've done that day so you know if I did some teaching . . . They have a date that we have to turn this in and then they'll go through it and they also keep notes as to what we've been doing and they compare notes. I think it's pretty straightforward and they're, our professors are very understanding. They tell us to put down what we feel and just everything that we've done and, um, if there's a part we don't understand, we can always go back to them afterwards and ask them and, um, a lot of the professors are good about saying, 'Hey look what you did today. Make sure you write that on your evaluation.' So, they keep it in the back of our minds the entire time.

Aban remarks how she utilizes the clinical evaluation process to maintain ongoing communication between herself and her instructors. She sees her clinical instructor as the expert who is there to assist her, the student, with learning what is needed in the clinical setting. Aban states,

> In all my clinical rotations, I never have any thoughts for me, it's coming from an idea that I am learning. Probably my interview with you will be different from somebody who

> is from here [United States] because really I am the oldest . . . so for me, I am really learning and I'm not going to be biased. I'm looking at my professor knowing more than I do. I'm looking at this from a cultural perspective that this is my professor, she's been there. She knows exactly what she stands in front of me to teach. I view that professor as knowing how help me in this mind that I'm going to need Aban to do this and do it perfectly . . . to reflect. So every grade they give me, I say myself that is exactly what I deserve. I am there, I am doing the procedures; I know I am doing it.

Charles relates his sense of how the instructor plays a major role in the formulation of the clinical evaluation grade process in the following statement:

> We usually have two evaluations every semester, just a midterm and a final and it's pretty, well, you just go in there and [after] we fill out our own little thing to kind of help them [instructors] know what we did. Throughout the semester, they kind of see what we do throughout clinical and then they just kind of go over with us and see how much we agree with it, although the grade's usually pretty final.

Jim adds the following thoughts to the CPA conducted at the private university:

> It's a four-point scale. A percentage is assigned to each point. The 4.0 is 95% and so on down the scale; you can't get 100%. I feel that it's fair. I tend to not like the fact that the 4.0 is 95%. I understand the rationale why it's 95% and not 100% because no one is perfect. So like to get 100% would mean perfect in clinical practice, which is hard to attain. Sometimes messes with your psyche just a little bit because you're like, ‘Man, I if only I was able to get just a percentage above then I would've gotten a better grade in the class from like an A minus to an A,’ or something like that, but, overall I think it is a fair system.

Jim continues with how perspectives of student performance are a shared experience:

> I think one of the good things is they actually make you evaluate yourself and then they have their evaluation of you. I personally tend to be a little harder on myself than they would be and so when they see that then they let you explain the reasons that you gave yourself that grade and so and in many cases you've said something that they didn't catch that you've done so that raises your grade even higher.

Public Institution. The clinical performance evaluation tool utilized at the public university included several factors for consideration according to the students who experience it as a part of their appraisal. At the public university, the clinical evaluation and theory components combine for one grade, and the student and faculty share formal input at primarily the end of the semester. Students reveal that although formal input is at the end of the semester, faculty informally provides individual feedback throughout the semester to allow opportunity for improvement. In the last year of clinical courses, the students are assigned to a hospital-based preceptor with whom they work with in meeting their clinical objectives.

Five major parameters comprise the tool, addressing behaviors such as critical thinking, safety, communication, professionalism, and leadership. A list of subtopics under each of the major behaviors specifically addresses the expectations of how to meet the objectives of the course. A "meets" or "exceeds" must be achieved by the student in areas that are indicated as critical elements (indicated by an asterisk). The other two measurements utilized in the tool are "does not meet" and "not observed." If a student does not meet the expectations of the clinical component of the course, he or she will fail the course, regardless of how the individual performed in the didactic portion. JC expresses his thoughts in regards to this method of clinical evaluation:

> There's a bunch of little tasks and there's a like a 'meet', 'does not meet', 'excels' and stuff like that. Like our general knowledge of things and how we are with the patients. How comfortable we are in the clinical and they go from what they see. We have like a little section that we can write our own comments and what we think our strengths and weaknesses are . . . and the teacher also writes their thing so we get to read the teacher's and then we write something about ourselves. And, uh, we do that also when we evaluate the course. It's all one course. We don't get actual letter grades on clinicals. It's basically a fail/pass.

Amanda adds her thoughts regarding the fail/pass option for the clinical component of the nursing course:

> I like pass/fail. A, B, C, D, F [grades] terrifies me. I guess it would be nice to get a letter grade. I do like my A's, but pass/fail is fine by me. I know what I've done. If I think it's good enough. But it also gives you a chance to break down your strengths and weaknesses and write down your own comments.

Amber voices a comfort with the evaluation tool and the related process of the public university in stating:

> I think it [evaluation tool] does a good job because at the end it gives you room to write about some things that you want to address that are not included on the tool. So it leaves it open in the end so you can explore all parts of your experience and if you had a problem, you'd be able to address it there.

Brittany expresses mixed feelings regarding orientation and implementation of the public university clinical evaluation process:

> I honestly think they [instructors] kind of say this is what we're going to do, this is what we expect of you; kind of read through it, have an idea; if you're not meeting things, we're going to tell you before you get evaluated. That way you can try to improve stuff. I mean it . . . most of it was just kind of read it, and we'll [instructors] tell you if you're not doing something right. I don't know that there's much you can really do, I mean we're used to getting stuff thrown on us by now. I didn't like it. I was like, well, I don't know about this evaluation thing. It was nerve-racking though 'cause you're one on one and you're like, oh, what are they going to say? They better say something good. Sometimes they might say, like, you said you exceeded in this area; I'm not sure that you really exceeded; you're doing what you need to, but you really could go further. They want to know why you think you exceeded.

Lastly, Constance lends her voice to the public university's utilization of the clinical evaluation process:

> There's this five-page checklist, and you have to 'meet' or 'exceed' certain aspects of what they're [instructors] looking for. We fill it out first and then we sit down with our instructor who also evaluates us. Then they [instructors] sit down with us and talk to us about it in every class and related clinical area such as Gero [geriatrics], Mental Health, Peds [pediatrics], and Medical-Surgical that dealt with oncology and wound care. We did one [evaluation] for each of them just at the end [of each experience]. It's pass/fail. I don't think it actually affects the grade or anything. It's a way for us to use what we're learning in the classroom in real life. We have to meet the expectations on the checklist to pass. Certain ones we have to meet have an asterisk by them. If you don't 'meet' the

asterisked ones, you don’t pass the course! If you don't pass clinical, you don't pass the course. I guess that's how it affects your grade!

CHAPTER 5

RESULTS II

Themes

Field notes of digitally recorded participant data were verified and examined for applicability and four common themes were identified. Van Manen (1990) identified the thematic approach as one mean of reporting phenomenological findings such as the results of the study I am presenting. These emergent themes are divided into four sections within this chapter for clarifying findings that are applicable to each of them. Participant voices are shared within each category. A summary of the results, as they correlate to each emergent theme, is provided at the end of the chapter.

Upon completion of the semi-structured interviews, a repetitive review consisting of listening to the participant transcripts ensued. The last several times spent listening to participant voices, in correlation with review of the transcripts, my field notes were inserted, clusters of data evolved, and four themes emerged. The emergent themes are as follows: (a) the impact of an absent instructor; (b) all instructors are different; (c) input into the clinical evaluation process; and (d) the evaluation process is a formality.

The Impact of an Absent Instructor. Both the private and public nursing program students shared that their clinical experiences began with a semester that found them very connected to the instructor. The first clinical component consisted of a medical-surgical focus

that concentrated on basic nursing care under close instructor supervision. Subsequently, students from both schools also shared that as the expectations of the student in clinical increased, the visibility of the instructor decreased. Therefore, the method of communication of student learning and student evaluation changed accordingly. The number and type of assessments used for the purpose of evaluating student fulfillment of clinical objectives were implemented. Brittany shared utilization of the clinical log:

> Sometimes we use a . . . clinical log . . . like if we got to go off the unit or special things that we got to do so that you could submit that with your evaluation that way they could say, 'Oh, I didn't realize you did that'; 'cause they don't see you do everything so I don't know how they can really evaluate you on all that stuff. I just don't see how they see it. I mean I guess they see it in some of your paperwork, but as far as being with you, they aren't with you 24/7, they're just . . . they'd like to be, but they can't be; I mean, that's what . . . like right now our teachers are, we're in ER or ICU, I mean, so they're floating around; You can't always say, 'Hey, I need you.' Uh, well, I mean, we evaluate ourselves and then they evaluate us so . . . I don't know, we just . . . I always just put 'meets' on there.

Constance added the following perception as to how the instructor availability affects student learning in saying, "Yeah, I've done it [procedure] on a mannequin . . . It was easy on the mannequin . . . I haven't done it on a person . . . and my instructor has no idea I haven't done it on a person."

Jim shared his sense of uncertainty given the inability of the instructor to offer real time reinforcement of skill proficiency:

> So I guess it's . . . you get both worlds in many senses and . . . they can't be everywhere at once so they really want to make sure that they've gotten the full picture of who you are on that evaluation form. Um, so, and there have been times when they've caught stuff that I didn't catch. And then, um there have been a few times when I said, 'Oh yes, I actually did do that' and I, I told them the exact date I did it and so forth and then they're like, 'Oh, okay, well then we can write that down' so that would make it even higher.

Amber continued the conversation of the concern associated with the faculty not always observant or aware of what the student is doing in the clinical practicum setting:

> I haven't seen much of my faculty in my rotation. I'm in my critical care rotation now, and I haven't seen them as much so I think in that case, they're going to be relying a lot on our paperwork and maybe by what the nurses that we're with are seeing, but I think it is mostly paperwork at this point. I've had a little problem because I don't feel like my instructor could really fully evaluate me because she has never seen me do anything, and I haven't seen her so much because it's really hard because the people are spread out.

She continued to describe her uncertainty with how an absent instructor could affect her clinical evaluation by saying:

> There's a group on one floor and there's another group on another floor, so I don't really feel like she'd be able to evaluate me fully. I mean, if I've made it this far, I guess they have some sort of confidence in you, but as far as seeing me actually do something or give a medicine to a patient, she hasn't seen me do that this eight weeks so far. And if they would come up more often, that may be give them a better idea of where I'm at.

Jenna added her input as to the instructor not always being available and her perception of what activities are in place to provide missing information needed to complete the evaluation process:

> The instructors tell us to fill in as much as you can because they can't be with you all the time in clinical; I also brought my journal for our community rotation last year . . . our professor wanted us to write in the journal and just reflect on our day, and she had guidelines . . . because she couldn't be at every community site, I mean, there were like ten different sites.

Finally, Amanda relates her thoughts as to who would best provide input into the student performance evaluation given the absence of the instructor:

> I think we work very closely with the nurses, especially in the ICU [Intensive Care Unit] this semester. We're assigned to a nurse, and we just go with them for their assigned patients, and I think it would be nice to know the nurses' input because our clinical instructor is not always with us. Especially when it comes to giving medications and knowing classes [of medications] administered.

All Instructors are Different. A common response by participants as to how the clinical evaluation process occurred was that it depended upon the instructor. Students revealed their thoughts as to how they sensed each instructor was different in how they arrived at their final grades. Students voiced disparity in instructor expectations based upon the focus of the semester as well as individual interpretation of how the evaluation tool should be utilized in making a final grade determination. Jenna disclosed how one instructor interpreted use of the evaluation tool for assigning a final grade:

All the professors are different. There's one professor that feels like you start at the bottom and work your way up so it's like you go from a 0% to 100%. There're other ones that start you at 100% and deduct so she never gives above a 'B' on her evaluations. That makes it kind of difficult. I understand why they do it. You cannot be perfect. So, that's how we're graded. Well, with the professor that doesn't give above a B, I guess there would be some differing there because of the grading, but in a way, I guess I understand her point of view and accept that it's always a learning experience. You're always going to grow so that's something that you just need to work on.

Jim also voiced his idea of how instructors are different from the perspective of how the student performance evaluation is delivered:

It depends on how the clinical instructor addresses . . . handles the evaluation as well. Because there's a very upfront way of 'you did this wrong, you did this wrong, you did this wrong and this is why I gave you this grade', instead of 'you really did this well. I saw that you kind of struggled with this; maybe we need to work on this in clinical.' I've had more of the 'I've seen you struggle with this' or 'you did really good at this, you need to keep that up' kind of thing, than the in your face, 'you did this wrong, you did this wrong, you did this wrong', which I appreciate. I mean, each instructor is obviously biased to, to their own category, that they would really like to focus on, but majority-wise, I would say that all of them are very, as far as like, what they would, how they would grade and so forth. I think it would probably depend on the teacher and probably just their outlook on, I don't want to say on life, but in many senses that's kind of how it is. It's like is the glass half full or half empty kind of thing; I think it probably depends

> on the personality of the person they are evaluating and do they get along with that person.

Jim continued this thought in his description of differing ways in which instructors observe student performance in the clinical setting by stating:

> I would say it depends on the instructor because I've had instructors who have really just let me go, and their whole point is like you're there for clinical to learn. Now you need to do that in a safe way, which I totally agree with; I don't think that learning should be an unsafe experience for you or for the client that you are caring for, which is very much their stance on that. Every instructor is very much like that. Some instructors tend to be a little more over your shoulder and want to be with you every time that you're doing something, so it just depends. I would say I personally enjoy my instructors who really let me go and kind of let me experience things on my own as far as like being with the client and so forth. I know that they're looking over me because they've looked at my paperwork before I go in there and that might be another reason they let me go is because they've looked over my paperwork and said, 'Okay, he actually understands what's going on here; I need to focus on someone who is not understanding some of that.' I'd say it probably depends on the instructor as far as how much they weigh it . . . one a little more than the other if they see that within clinical you really are doing a lot of the critical thinking behind it. Your paperwork doesn't show it as much, but they still see it within the paperwork. They are more willing to, to kind of let that go just because they know your personality and so forth.

Charles spoke more to the personality of the instructor saying, “Well, there's, of course, slight differences based on the personality of the teacher, but for the most part, most of the guidelines are kind of similar to each other.”

Amanda spoke as to how the difference in the instructor influences how a student is evaluated:

> Every instructor is different . . . and it takes pretty much to the end to figure out . . . how they look into things and how they judge and evaluate . . . but I think they grade our care plans "pass/fail" each week and through that you can kind of see how they, I mean, if you do well on your care plan and they say that you pass that week, you pretty much know that you're doing what they want you to do.

Jenna voiced more concern regarding discrepancy as to how instructors interpret utilization of the evaluation tool to assign clinical grades:

> This instructor is the same in clinical as the other ones, it's just she has a different perspective on it. I mean I can understand where she’s coming from, if you've never done it before, how can you start out at 100? But . . . it's still frustrating.

Brittany concluded with, “Some of the instructors are real good at coming to get you when there is an opportunity to learn a new skill and others aren’t.” She also voices that some, but not all, instructors request the student let them know when they are performing a skill so they can personally see the level of performance. Brittany senses this would be a way for the instructor to better evaluate student performance without relying upon secondhand knowledge shared through either the clinical log or the nurse.

Input into the Clinical Evaluation Process. The participants had much to share regarding who should have input into their evaluation. The majority of the students voiced that

the nurse who spends a great deal of time with them would be a good resource as to how they performed in the clinical setting. Amanda asserted that the on-site nurses should have input into the evaluation process. She stated:

> I think it would be nice to know the nurse's input because our clinical instructor is not always with us. Especially when it comes to giving medications. As far as knowing classes . . . and knowing what you're doing, the nurse is more with you than . . . your clinical instructor so I think their input would be valuable because they've been there for awhile . . . and they know what could help you improve . . . and their input would be valuable.

Aban added her perception of how nurses could contribute to the student evaluation process:

> I consider the nurses are also part of my evaluation. Yeah, because . . . some nurses will choose to tell you, 'Oh Aban did a very wonderful job today. She did this, she did this.' So we hear those things that your nurse is telling your professor or your clinical leader, or you know that I just say feedback . . . and it will help your professor to make a determination on your evaluation.

However, the majority of student responses to this question were mixed as Amber shared:

> I think . . . if the clinical instructor would go and ask them . . . what do you think and how . . . what have they been able to do, what have they done, and that, I think that might add another flavor to it. I guess you would kind of have to sift things because everybody has their own personality and you know, have to be non-judgmental 'cause you may just not get along with somebody and that happens sometimes, but I think it could be useful, yeah, to do that.

Jenna shared those same ambivalent thoughts regarding the input of others in the clinical evaluation process in saying:

> I don't feel like the patients and the nurses that you work with so much should just from experience, um, because the patients, when they hear you're a student, they get a little nervous anyways . . . so they automatically get that idea of 'Oh my gosh, this student is working on me; I don't like that.' Sometimes I feel that way with the nurses, too. They just get frustrated because they have students and, you know, we can be in the way, and I understand that being a student takes me 20 minutes longer than what it would the nurse. So I don't feel like they should necessarily.

Jim also voiced mixed reactions to the input of others into the evaluation process stating:

> I will say that the healthcare staff, um, should maybe have input, a little bit. Um, I'm cautious of saying that though because I think that there is bias in many, many situations with that. I think it should be taken with a grain of salt and, um, they should give reasons behind why they either felt the person did really well or they thought the person didn't do well at all, and they should receive a grade for that day that was a lot lower kind of thing.

Brittany voiced her experiences thus far with input into her clinical performance evaluation from multiple resources:

> Well, sometimes they do ask the nurses, 'How are they doing?' Which I mean, I guess helps a little bit. They get the nurse's input on what we're doing, but I don't know. I've had my teacher come in while I'm taking care of my patient and said you know, 'So, if you had to give her a grade for the day, what grade would you give her?' I've had the teacher do that multiple times. Luckily the patients are like, 'I'd give her an A.' Well, since we all have our own individual patients, I mean, it . . . unless we're working

> together, and we're not really, then they wouldn't know a whole bunch. Did they meet the deadlines? Did they do what was asked of them? Did they do their part? Did you have to take up their slack?

Constance expressed an interesting analogy that asserted how informative the perspective of student clinical performance, by those not directly associated with the program, could potentially occur. She suggested a type of five-point system whereas student behaviors observed by the community could be shared in a consistent manner by external resources. Constance offered the following example:

> I think it would be helpful. Kind of like in Hell's Kitchen, where the consumers fill out response cards: How did this person help you out today? And then all our response cards are accumulated. I think that would be way more work for the instructor . . . one through five. I think most people, unless it's absolutely horrid, just fill in all fives.

Charles added, "I don't think it would be a bad idea. How exactly you'd get that information like if the nurses just . . . talk to the . . . clinical professors so I think that's a perfect idea."

Several students were very vocal in their opinion as to if a peer should have input into each other's evaluation. Jim stated:

> Peer-wise, I would say no. I don't think that your peers should have a whole lot of say in how you are evaluated because, um, again there's that bias, and . . . I know I have views on my peers, and I feel like that some of them are skewed from what I see outside of the classroom . . . not so much of how they function as a real nurse. Classmates . . . there might be a few who might could see that potential or really see how well you're doing, but the majority of them are in their own little world, and they should really be focusing on themselves and not on others.

Amanda added to these same concerns in saying:

> As far as peers . . . some would be valuable and others would not be. Some people have their friends who would give them a good evaluation . . . regardless. And others really take it serious, so I think it depends on who you ask to give an evaluation from your peers.

Brittany explained how the helping relationship between classmates could interfere with the peer clinical evaluation concept:

> Some people do, but other people don't because they know that certain projects are, you know, they help your grade out so they don't want their peer to do bad . . . So they just give them a good grade . . . unless they're really irritated at them, and then they give them bad scores.

Positive responses to the prospect of peer evaluation primarily coincide with the group presentations that comprised part of the final clinical grade. Aban supported this thought by saying:

> Now, you stand in front of your peers. And probably just do your presentation. They can critique you, or, you know, things like that. So, I also see that they are also part of it.
>
> And I think that they should be, your classmates should be a part of your evaluation.

Jenna continued the idea presented by Aban in the following:

> I think the peers and the, um, other classmates, I think that's a good thing, and we actually have done that on certain things. Like when we do, um, our presentations for clinical.
>
> You have the peer evaluation, and you go through and rate your peer on a scale from 0 to 10 with 10 being the best, and then you have to say why you've given them that score.

Finally, JC added this final thought as to how others could potentially add input into the student clinical evaluation. He stated, "Maybe they [instructors] could give the nurses that you work with, and possibly the patients, a little evaluation sheet or a score card or something that would indicate how a student performed on a scale of maybe 1 to 5." This score could be considered in instances where the instructor sensed there were fewer opportunities for direct student observation.

The Appraisal Process is a Formality. To examine the study question regarding the sense that baccalaureate degree nursing students perceive the clinical evaluation appraisal process as a means of meeting personal and professional goals, participants were posed this question. The theme that emerged is that the students did not see a direct correlation between the appraisal tool and attaining the goal of becoming a registered nurse. However, what they did correlate with their meeting of personal and professional goals is the dialogue shared with their clinical instructor(s).

Although there was one student who could fluently voice how the tool was developed and utilized in the clinical course, the majority of the students were not able to fully disclose that information. The insinuation by many were that the appraisal process was a formality, with no real connection to what took place in the clinical setting, and was performed for a purpose irrelevant to meeting the student's personal and professional goals.

Constance shared her perception of the clinical performance appraisal tool:

> It's pass/fail. I don't think it actually affects the grade or anything. I think that these are the bare minimum things that you have to be as a nurse before you can move on. To be honest, I don't really pay attention to what the different guidelines are, and I just know that they're small, like one, two sentence . . . paragraphs that are very, very highly . . .

> intelligently worded. I'm not really sure what it's [the evaluation tool] asking, but I think I met that. If the instructor thinks that you're going to pass clinical, you met everything no matter what, so. I mean you'd have to like, kill someone. I look at it as a piece of paper I fill out.

Constance then shared what makes the clinical evaluation tool meaningful by stating,

> The part of the evaluation process that really does something for me is when I actually sit down with my professor because it's like, yeah, sure, I 'meet' this meaningless sentence, but what does she see in me that she thinks would make me a good nurse? What does she see in me that I need to improve to be a better nurse? I mean, what do seasoned people see? You know, what would make me a bad nurse? And I think that helps me more than filling out, um, the meaningless sheet of paper. The meaningless sheet of paper is good because it gives the school something to hand over to the Boards to say, 'Look, this person has met all our expectations,' and I think for that reason it serves a purpose, but as for my learning experience? I don't even know what's on it! I really don't know.

Brittany addressed more in regards to utilizing the tool as part of the evaluation process:

> We evaluate ourselves, and then they evaluate us. I don't know, we just . . . I always just put 'meets' on there. I mean, we evaluate ourselves and then they evaluate us so it's I don't know, we just . . . I always just put 'meets' on there.

Jim added his thoughts as to if the evaluation process has changed him personally or professionally by stating:

> I would say the way my teachers have used it and explained it, I would say yes. I wouldn't necessarily say the tool has changed me, just because throughout clinical, I'm thinking about a lot of those things, and that might just be an outpouring of my teachers

> that are looking at the tool, but in many senses I tend to rush through the tool and kind of just . . . I'm like, 'Yes. Check. I did this', and so, um, I tend to not evaluate myself in that manner. So I wouldn't say it necessarily has changed me.

However, Jim continued Constance's thought in that it is through conversations with the instructor(s) that the impact of the evaluation process is realized:

> I would say really sitting down with my instructors has really kind of changed where I'm at and so forth and how I've looked at my clinical experience by the end of it. We used the same tool as the clinical instructor uses, so normally the clinical instructors will write stuff down after clinical, and they tell us to do the same. I mean it also depends on what mood you're in and if you're really willing to hear some of the things that they have to say. In many senses, I do believe that it is very fair in that at the very end it also leaves room for comments that the teachers can make as well after each section, so it leaves room for the teacher to really explain, 'This is the reason I gave you this grade in this section.' And every teacher I've come in contact has been very fair with how they've evaluated me.

Additional mixed comments continued as the students sensed that the tool itself was not useful as part of the evaluation process as much as the dialogue that it generates between the instructor and the person that is being evaluated. Aban highlighted more in regards to this way of thinking by stating, "I use the tools. I use some. I don't go exactly according to the tool." JC added,

> There's a bunch of little tasks with a 'meet,' 'does not meet,' 'excels' and stuff like that [that measures] our general knowledge things and how we are with the patients, how comfortable we are in the clinical, and they [instructor] go from what they see. We have

like a little section that we can write our own comments and what we think our strengths and weaknesses are, and the teacher also writes their thing so we get to read the teacher's [input], and then we write something about ourselves. You'd have to be pretty bad I guess to not pass.

In closing, Amanda disclosed this final thought in regards to the perception of the clinical evaluation appraisal process serving as a means of meeting personal and professional goals:

A lot of people don't take it seriously, they just write, 'M', 'M', 'M', 'M' [meets] all the way down, but I really think everyone needs to take the time to read what it says and really think about, does it, do I really meet that criteria?

CHAPTER 6

DISCUSSION

The purpose of this study was to focus on the perception or experience of the nursing student undergoing the clinical performance appraisal (CPA) process. In an attempt to fulfill this purpose, the following questions for the study were asked:

1. What is the experience of a baccalaureate degree nursing student undergoing the process of clinical evaluation appraisal?
2. Do baccalaureate degree nursing students perceive the clinical evaluation appraisal process as a means of meeting personal and professional goals?

In review, the history of student clinical performance evaluation spans decades since the early 1900s. A number of research and scholarly articles exist that address clinical evaluation tools as they evolved over time. Clinical evaluation tools in the 1920s and 1930s were termed as "norm-referenced" in that faculty would judge student performance in comparison with that of their fellow students (M. A. Chambers, 1998; Goldenberg & Dietrich, 2002; A. S. Woolley, 1977). In an effort to decrease the subjectivity associated with the norm-referenced tools, the 1950s and 1960s came to be known as the era of the Tyler model, a delineated, objective-based appraisal tool. The 1970s and 1980s saw the beginning of the "criterion-referenced," behavioral, objective-based evaluation tools (Bondy, 1983; Tower & Majewski, 1987).

This chapter presents discussion and interpretation of the findings associated with the study questions. This discussion and interpretation is expressed through the results associated with discovery regarding participant characteristics, the evaluation tools, and the four emergent themes found in Chapters 4 and 5. Integration and application to the literature that was reviewed in Chapter 2 serves as the backdrop for this dialogue.

To reflect, Chapter 4 focused on the rich description of the participants and the CPA evaluation tools utilized at the two universities included in this study. Chapter 5 revealed the cluster of themes that emerged from participant stories shared with me during the study, including: the impact of an absent instructor; all instructors are different; input into the clinical evaluation process; and the evaluation process is a formality. Each theme is discussed through the examination of the relationships interpreted within each by exploring the main ideas that evolved.

Participant Reflection

Developmental Theory Aspects. As shared in Chapter 2, a number of cognitive and psychosocial developmental theories are worthy of consideration as the voices of the study participants are heard in this study. Torres et al. (2003) discussed developmental identity in examining Erikson's eight psychosocial stages in which movement through polarized phases creates a change in one's identity. It is the positive resolution of dealing with personal and social issues that allows an individual to move on to the next stage or phase of life. Conversely, self-recognition that interferes with an individual's ability to handle situations lends to discourse later in life. Challenges that students encounter in college, including those identified in meeting CPA objectives, have the potential to set the stage for developmental dissonance interfering with meeting their personal and professional goals. Torres et al.wrote:

> Erikson's theory has eight psychosocial stages, with movement from one stage to the next creating a change in our identity. Stages have a cumulative relationship or influence on each other stage. Two polarized attributes are part of each stage. One can emerge from a stage feeling positive about his or her personal and social capacities or with a sense of self that may become debilitating later in life. (p.10)

A potential example of dissonance in a student's experience of being appraised in the clinical setting would be the Erikson's stage of trust versus basic mistrust. If a student senses her or his clinical experience is influenced by a negative or positive relationship with the instructor, it could potentially alter performance outcomes. Amanda recounts an example of the trust versus mistrust issue when she describes how different instructors impact how a student is evaluated:

> Every instructor is different . . . and it takes pretty much to the end to figure out . . . how they look into things and how they judge and evaluate . . . but I think they grade our care plans 'pass/fail' each week and through that you can kind of see how they, I mean, if you do well on your care plan and they say that you pass that week, you pretty much know that you're doing what they want you to do.

Charles added how the student experiences the personality of the instructor contributes to how they positively or negatively resolve the basic trust versus mistrust between the student and the instructor. He explains how this feeling of not being able to trust could interfere with successful fulfillment of clinical objectives: "Well, there's, of course, slight differences based on the personality of the teacher, but for the most part . . . most of the guidelines are kind of similar to each other."

Female and male participants interviewed for this study described CPA methods used as they attempted to make sense of their clinical practicum experience. Implementing a clinical log

was a primary method that allowed for reflection of each student's experience who participated in the study. As voiced by the students, the weekly self-evaluation was a means of sharing their clinical experiences through the lens of the learner. Participant variation regarding how the instructor evaluated the clinical log was described: Some professors would glance to observe if the students were performing their weekly reviews and others would diligently read the writings and make notations. Most students revealed that the clinical log was a means of sharing what objectives were met in the absence of the professor.

The female and male study participants described ideals reminiscent of Belenky et al. (1985) theory regarding women's ways of knowing. Although works by Belenky et al. disclosed results associated with women's studies, the utilization of the clinical log demonstrates the student learning experience through the lens of both male and female participants. To review information in Chapter 2, Belenky et al. wrote results of a study performed with 135 women who were asked about their ways of "thinking about thinking" and about themselves as knowers. Belenky et al. identified five ways of knowing, including silence, the voice of others, the inner voice, the voice of reason, and integration of the voices. The clinical log, in which the student reflects on how they make sense of their practical experiences, provides a weekly demonstration of integration of what was learned. Jenna points out how the weekly self-evaluation allowed individuals to develop their own ideas and emotions allowing for personal development of one's own mind and personhood:

> It's good . . . self-criticism, and what-not so I think it's a good way to learn . . . you can just go through . . . and it makes you feel good to go through and be like, 'Oh, I remembered to do that' . . . it just kind of keeps you on track with knowing, um, like 'provide information to family members', I didn't write anything there so it's like, next

> time I need to engage the family members more than what I did. And so you just reflect on your day and what you've done.

The nursing profession involves listening to others for the provision of care to patients as well as within the instructor/ student relationship. Gilligan (1982) considered the male and female voice in describing how morality demonstrates itself through the lens of care based upon increased understanding of others. How students perceive nursing faculty expectations through their individual developmental level influences their experience with the CPA process. Jim described how the experience with the instructor could influence learning:

> It depends on how the clinical instructor addresses . . . handles the evaluation as well. Because there's a very upfront way of 'you did this wrong, you did this wrong, you did this wrong and this is why I gave you this grade', instead of 'you really did this well, I saw that you kind of struggled with this; maybe we need to work on this in clinical.'

Jim's voicing how the instructor can present opportunities for performance improvement demonstrated how the expression of ideas that were perceived as caring are more accepted by those hearing the message.

Learning Theory Aspects. The nine female and male study participants were enrolled in a baccalaureate nursing program in one of the two Midwest, four-year universities included in this study. Experiential learning models set the stage for discussion regarding the experiences that an individual has lived, and how those opportunities enrich the acquisition and application of knowledge in an educational setting (Dewey, 1938; Kolb 1984). Kolb (1984) expanded on this ideal in his model created out of four elements, including concrete experience, observation and reflection, the formation of abstract concepts, and testing in new situations. Kolb explained that

experiential learning can begin at any one of the four points as approached from the perspective of a continuous spiral.

Kolb (1984) revealed that, as a result of our individual past life experiences, in combination with the demands of the present environment most people develop learning styles that emphasize certain abilities over others. Influenced by Dewey (1938), Kolb described these influences in this way:

> Experience does not go on simply inside a person. It does go on there, for it influences the formation of attitudes of desire and purpose. But this is not the whole of the story. Every genuine experience has an active side, which changes in some degree the objective conditions under which experiences are had. The difference between civilization and savagery, to take an example on a large scale, if found in the degree in which previous experiences have changed the objective conditions under which subsequent experiences take place. The existence of roads, of means of rapid movement and transportation, tools, implements, furniture, electric light and power, are illustrations. Destroy the external conditions of present civilized experience, and for a time our experience would relapse into that of barbaric peoples. (p. 39)

Through the lens of a 47-year-old female and mother of three from Africa, Aban revealed how her life experiences transferred and transformed her way of thinking and learning in the nursing program. She remarked how her experience as a person who had given birth, and subsequently raised three children, assisted with her transference of learning the obstetric and pediatric components of the nursing program. Conversely, Aban offered how her memories of the perception of mental health in Africa were transformed in the United States as her experiences in the nursing program changed her way of thinking and learning about this disease.

Aban asserted,

> I fell in love with them. I realized that, oh, indeed, it is a disease. It is so much uncontrollable; this is somebody that has depression, whatever you call it. You know, you are not going to say it's his fault or her fault, there's no fault. It is a disease that needs to be addressed, that needs to be seen as a nurse. That you have to be this patient's advocate, you have to be there for the person. So that really transformed me, I was really transformed in mental health. And that changed my perspective.

Constance reported experiences reflective of the thoughts of Freire (1993). Freire focused on students being active participants in their learning as opposed to what he described as the "banking" of information from the teacher to the student. Freire explained this ideal in stating that "they will not gain this liberation by chance but through the praxis of their quest for it, through their recognition of the necessity to fight for it" (p. 45). Constance reported that in her experience, the current clinical course practice does not allow for an exchange and assimilation of information but instead leaves the student and faculty with a list of "little tasks" to independently assess as "met" or "unmet" until the time of the formative or summative evaluation. As a suggested solution, Constance offered this example of how nursing instructors could enhance the clinical experience:

> If the instructors . . . instructed . . . this Socratic Method with their students . . . I think they would learn infinitesimally more in clinical if they sat down with, you know, if they were right there with us and saying okay, now what would you do now and why and . . . what makes you think that way? And why do you think the doctor is doing this?

Evaluation Tool Analysis

In Chapter 4, the evaluation tools employed at both Universities were examined. The tool at the private university is based upon an adaptation of the Bondy Scale (1983), which is comprised of five major categories, divided into subcategories, that each student is then assigned a number from the scale. The five categories are criterion-referenced, behavioral objectives incorporated within the following sub headings: nursing modalities, critical thinking, management, leadership, and therapeutic relationship. The clinical course is separate from the theory component of the curriculum with a passing grade of A, B, or C assigned.

The evaluation tool at the public university consisted of five major parameters that addressed behaviors such as critical thinking, safety, communication, professionalism, and leadership. A list of subtopics under each of the major behaviors specifically addresses the objectives' expectations. In areas that are indicated with an asterisk as critical elements, must obtain a “meets” or “exceeds”. The other two measurements utilized in the tool are those of “does not meet” and “not observed.” If a student does not meet the expectations of the clinical component of the course, he or she will fail the course, regardless of how the individual performed in the didactic portion.

Both of these forms of clinical evaluation reflected what was found in the literature review that from the late 1990s to the present, clinical appraisal methods reflect primarily the criterion-referenced tool based upon program-established objectives as well as an application of theory to practice. Additionally, these tools reflect evidence of evaluation of critical thinking, problem solving, and decision-making (Goldenberg & Dietrich, 2002; White, 2003). Participants share opportunities to contribute to the evaluation process in the formative and summative phases.

However, Cox (2000) cautioned "that intimate work relationship provides the opportunity for transferring not only practical knowledge and skills on the important cases . . . but also the expected professional behavior; therefore, flaws in performance should be dealt with on the spot" (p. 52). Student interviews affirmed that even when formal weekly or midterm reviews of expectations were not performed, faculty shared "on the spot" flaws in performance so opportunities for improvement were available prior to the summative, or final evaluation. Amber stated,

> They said that if there was a problem, that they would let you know. It's not like they would wait until the last week and then tell you you were going to fail. So if you're doing okay, you don't want to hear anything, but if they have a problem, they'll address it before then.

Within a dynamic learning environment, efforts were made to utilize criterion-referenced, behavioral objectives to assess student performance in the clinical setting. Heady (2000) reinforced that assessment must consistently measure what is identified as important for students to learn, over a period of time, to demonstrate consistency and reinforce student understanding. Heady also stressed the utilization of multiple types of assessment to demonstrate continuous improvement that reflects what is actually being measured. The methods of evaluation employed by both nursing programs in this study reflect this thought using not only the tool itself but also the addition of other forms of assessment of student learning, such as care plans and presentations. However, there is another school of thought that the educational community, including those who are not teaching faculty, should be involved with the assessment process which is not as clearly evident as part of the evaluation process.

What is evident in both nursing programs is the formative- or feedback-type of evaluation that demonstrates the student being informed of progressively meeting objectives prior to course completion, by either formal or informal means. One student explained formative feedback in this way:

> They're pretty much evaluating us all throughout the course; it's just the end where we see all the results, but like I said, if they see somebody like, you know, you need to work on this; they'll tell you . . . if that's the case.

Additionally, this study noted that one program ascertained the clinical grade based upon an adaptation of the Bondy Scale (1983) with the determination of an A, B, or C grade and the other the pass/fail option. Although there has been discussion that the pass/fail option did not always motivate the students to perform to their highest level, or give them a sense of accomplishment for their perceived hard work for nothing more than a passing grade, students did relate more insight into this assumption.

Neither evaluation tool employed by the private or public university demonstrated use of formal input other than that of the student and the instructor. However, students did note that at times when group work was a part of the evaluation, peers did evaluate the contribution that each gave to the project, which in turn, was considered by the instructor in assigning the individual student grade. One student revealed this practice as follows:

> When we do projects . . . we always do peer review and that always counts for at least one or two points . . . and many times we do a lot of group things and maybe sometimes somebody doesn't want to pull their weight and if you . . . get a bad grade, it's not going to be your fault so they always make us do a peer review . . . makes me nervous because you don't want to give them a bad grade in case you get paired up again . . .

A last thought I would like to consider in addressing the evaluation tool is that of how the clinical appraisal process works in congruence with the theory component of the nursing program. As discussed in Chapter 2, Howard-Hamilton (2007) expressed McEwen's ideals in explaining why integration of theory to practice should be evident in the decisions and practices that administrators make every day. Rationale for supporting the integration of theory into practice is that it provides a theoretical basis for knowledge, expertise, and practice that serves as a foundation for a profession. Theory lays the foundation for a mutual way of knowing and understanding what is communicated and understood among student affairs professionals; thereby, serving as a common language within a given community of those involved in the educational process.

However, interviews of participants from the two universities did not overwhelmingly support evidence of students identifying the connection of theory to practice in the clinical appraisal process. One student, Jim, explains the sense of this connection in saying,

> We have a lecture course and then we have a clinical course, and so the lecture course is going over what we are addressing in clinical . . . you can have people who do amazing in the lecture course, but then in the clinical course, they have no clue what they're doing . . . it's really showing that, that knowledge and . . . the book knowledge and being able to apply it in the actual hospital.

Conversely, the other eight participants voiced much of the same as quoted per Brittany when she voiced, "We're expected to take care of patients . . . meds, documentation, we're just doing as much as we can . . . if we take initiative." The majority of the female and male voices revealed they were aware that their clinical focus would change from that of fundamental

provision of basic care to that of pediatrics, obstetrics, or psychiatric focus, but none mentioned a direct link of the practical to the theoretical focus.

Analysis of Themes

The Impact of an Absent Instructor. Discussed within this theme was the sense that close instructor supervision experienced in the first semester of clinicals by students at both universities was soon replaced by decreased visibility in the following semesters. Therefore, participants expressed a desire to have some form of communication that would potentially lessen the chance of the CPA process being subjective on the part of the instructor while providing a platform for sharing information between the student and the professor in the absence of direct supervision. To address this concern, Mahara (1998) stated, "The teacher-evaluator and formative-summative dualism is challenged on the basis that its primary purpose is to maintain power differentials that impoverish teacher-student relationships" (p. 1,340).

Based upon this thought, Mahara (1998) offered instead the concept of the fourth generation evaluation, described as constructivism, where the student is not only involved in the formative phase of the evaluation but also actively contributes to the summative part. Mahara also suggested that the teacher-evaluator not be two dichotomous entities, but that evaluation should be a part of the teaching process. Students voiced their thoughts within Chapter 5 as to how they sense they are a part of the evaluation process throughout the span of each clinical experience. This is especially important given the limited time for direct teacher-student clinical site contact.

Students reported how they were able to communicate their experiences in their weekly clinical logs and cited examples of instructors acknowledging they were not fully aware of the participants' experiences until noted in the journals. Participants at the private university also

noted the opportunity for formal formative and summative feedback per one-to-one discussions with their respective clinical instructors. Although the public university students did not report that there was opportunity for formal sharing of performance, they did admit that when the instructor was able to be present with the student, on-the-spot performance feedback was provided.

Pugh (1992) posits that feedback verifies correct or incorrect student behavior. Pugh further asserts that the display of written comments, versus the verbal sharing of information between the instructor and the student, better illustrates what is needed to meet the desired outcome. She added that student self-evaluation is an opportunity for "inner conversations" that will add another dimension to the learning process, and that timely feedback from the instructor is important, particularly given the lack of availability of the instructor within the clinical setting. Pugh continues in saying that giving explicit feedback facilitates learning through the analysis of the learner's performance and the provision of ways to improve.

All Instructors are Different. Feedback, especially within the context of positive information sharing between the instructor and the student, was continued in the writings of Ovando (1994) as he explored the use of constructive feedback as a way to enhance teaching and learning. Ovando argued that students learn more from teachers who emphasize praise and encouragement, versus criticism and punishment, in rewarding student behaviors. Jim reported his experiences with these two different approaches in saying, "I've had more of the 'I've seen you struggle with this' or 'you did really well at this, you need to keep that up' kind of thing, than the in your face, 'you did this wrong,' which I appreciate." Jim also revealed how some instructors are different from others in their approach to facilitating student learning in noting,

> Some instructors tend to be a little more over your shoulder and want to be with you every time that you're doing something, so it just depends, I would say, I personally enjoy my instructors who really let me go and kind of let me experience things on my own as far as like being with the client and so forth. I know that they're looking over me because they've looked at my paperwork before I go in there.

Loving (1993) spoke to his study of student perception of learning described above by Jim and reinforced results that "experimentation is often thwarted by the threat of evaluation; the student may perceive that experimentation resulting in failure will result in an unfavorable evaluation, decreasing his or her self-competence perception" (p. 420). Therefore, Loving proffers that "if viewed through a learning context lens by both faculty and students, evaluation episodes could conceivably be considered as supportive, corrective feedback" (1993, p. 420).

The concept of the instructor being perceived as a threat to the student and therefore, interfering with the learning process, was discussed earlier in a study by Fencl and Scheel (2005). Fencl and Scheel suggested that as opposed to the instructor utilizing the evaluation process as a perceived method of threatening a student to perform as expected, the instructor should assist the student in believing in their own abilities, or self-efficacy, as seen through meeting objectives for the course. As noted earlier in the literature review, Fencl and Scheel asserted that "self-efficacy is not a static attribute, but is affected by a person's experience and is postulated to change according to the four sources of emotional arousal, vicarious learning, performance accomplishment, and social persuasion" (p. 20).

Bandura (1997) explained this more by comparing the concepts of self-efficacy versus self-esteem; whereas, self-efficacy is concerned with the capability of an individual, self-esteem is more associated with self-worth. Therefore, the student experiencing the instructor as a threat

could have negative thoughts that undermine his or her performance. As opposed to the student who is unable to perform due to thoughts of inadequacy, individuals with a sense of efficacy are able "to apply what they know consistently, persistently, and skillfully especially, when things are not going well" (Bandura, 1997, p. 223). Therefore, as illustrated through the stories of the participants that comprise this theme, the outcome of a students' appraisal could be dependent upon how an individual perceives the instructor.

Input into the Clinical Evaluation Process. Heady (2000) asserted that instructors should utilize multiple types of assessments to demonstrate continuous improvement reflecting what is actually being measured. Furthermore, she asserted that the educational community, including those who are not teaching faculty, should be involved with the assessment process. This assertion was tested in a question posed to the participants of this study, which resulted in one of the thickest responses.

Most students were not hesitant to offer their unwavering opinions to the question as to whether others, outside their clinical instructor, be involved in their CPA. The answers centered around the supposition that the possible individuals involved in the student appraisal could be student peers, the nurses on the units where they are doing their clinical experience, or the patients for whom they provided care. Of those three possibilities, participants agreed that the individual who would potentially have the most insight, aside from the clinical instructor, would be the nurse.

The response that the nurse would potentially be the best individual to have insight into the student's performance is not surprising, given the participants has already identified another major theme to be that of "the impact of an absent instructor." Amanda noted,

> I think we work very closely with the nurses . . . especially in the ICU [intensive care unit] . . . I think it would be nice to know the nurses' input because our clinical instructor is not always with us . . . the nurse is more with you than . . . your clinical instructor so I think their input would be valuable . . . and they know what could help you improve.

The only concern about the nurses' involvement in the appraisal process was that there could be some personality issues or the sense that the student was an imposition in the nurse's very busy day. The recognition that the novice student takes longer to perform a skill, especially one not performed often or for the first time, is many times perceived as an inconvenience to the nurse who needs to accompany the learner. Benner (1984) expressed the major implication here is that the novice nurse needs assistance with setting priorities in providing patient care. She stated,

> They [novice nurses] operate on general guidelines and are only beginning to perceive recurrent meaningful patterns in their clinical practice . . . their nursing care of patients needs to be backed up by nurses who have reached at least the competent level of skill and performance. (pp. 24-25)

Participants were not consistent in their opinions about including the patient in the appraisal process. Jenna explained, "Patients, when they hear you're a student, they get a little nervous" and others sensed that the client would not be able to ascertain if the learner had performed procedures that met objectives or were just happy to have had the personal contact associated with the care provided.

Peers were another area of ambivalence regarding input into the evaluation process. Participants recognized that peers were already part of the process in activities, such as presentations, that involved group participation. As noted in the voices of the students in Chapter 5, when responding to this question, there was a sense that peers were not able to always

provide objective appraisals of each other's work. Students asserted that in group work or presentations, where peer appraisal already occurs, classmates were not always honest in their grading of fellow team members. Students voiced concerns that there could be future retribution from a fellow classmate whom they may not grade favorably.

The Evaluation Process is a Formality. The study question regarding the sense that baccalaureate degree nursing students perceived the clinical evaluation appraisal process as a means of meeting personal and professional goals was answered primarily in the responses of the participants within this identified theme. The answer as seen through the lens of the nursing student was of great interest. As addressed earlier, historically the CPA process has been a long documented concern for faculty that has resulted in decades of research with the primary emphasis on the perceptions and attitudes of faculty. A multitude of literature exists addressing how a clinical instructor can most objectively evaluate a student's performance while simultaneously teaching in a dynamic learning environment. In response to this concern, most of the emphasis has been placed upon the development of different tools with the goal to create one that would lend itself to less instructor subjectivity.

Participant responses to this question revealed they found the utilization of the evaluation tool within the appraisal process to be a formality. What I discovered in the voices of the students was that what they learned from most was the dialogue shared between the learners and the instructor. Freire (1993) related that

> Authentic education is not carried on by 'A' *for* 'B' or by 'A' *about* 'B', but rather by 'A' *with* 'B' mediated by the world – a world which impresses and challenges both parties, giving rise to views or opinions about it. (p. 93)

In other words, performance appraisal also addresses the importance of development of critical thinking in the students, which means the learner needs exposure to activities reflective of Freire's (1993) thought that all be involved in the process of expressing ideas and opinions through mutual dialogue. The participants clarified that it was not the evaluation tool itself that led to this opportunity for learning, but when they could actually meet with their professor and digest what was meant by the words that comprised the objectives of the paper the student has been asked to comprehend. This is also reminiscent of what Freire described as critical thinking as a true dialogue existing in those engaged in the exploration of a topic when all are fully engaged in the discussion.

Connell (2002) revealed a view of the evaluation process from an epistemic perspective in that he discussed that to make the process meaningful, a shared justification system is desired. He stressed that all who are involved in the appraisal process should possess a mutual understanding of what is being measured and how the measurement occurs. The voices of the participants often reflected they do not fully comprehend what is being asked when they complete their self-evaluation with the appraisal tool. The students even go on to say that they sense the tool primarily serves the instructors and the associated program accreditation requirements.

CHAPTER 7

CONCLUSION

The purpose of this study was to focus on the perception and experience of the baccalaureate degree seeking nursing student undergoing the clinical evaluation appraisal process. The study involved participants who were in their senior year of a baccalaureate nursing program in the Midwestern part of the United States. Two nursing programs delivered within a private and public university provided the setting for the study. Chapter 4 provided information learned from semi-structured interviews with the nine study participants, and the evaluation tools that guide their learning in the clinical setting. Chapter 4 began by providing information that included demographic and other rich information surrounding their experience with the clinical evaluation process. The types of evaluation tools utilized by the two different universities closed out Chapter 4. Chapter 5 disclosed results of the stories heard from the students themselves. While listening to the nine participants, four emergent themes evolved including: (a) the impact of an absent instructor; (b) all instructors are different; (c) input into the clinical evaluation process; and (d) the evaluation process is a formality. Chapter 6 recounted literary discussion and interpretation of the findings associated with the study questions expressed through the results revealed in Chapters 4 and 5.

Chapter 7 provides implications for higher education in the clinical practice setting as they relate to the performance appraisal process including opportunities for additional research.

Recommendations for nursing programs to consider when developing evaluation tools and implementing the appraisal process are suggested. Additional thoughts for future research regarding the student undergoing the clinical evaluation process experience are provided. A conclusion of the study completes this chapter.

Implications for Higher Education

The theme that participants sensed the evaluation process to be a formality is a major concern for higher education. Alarmingly, students revealed how the CPA minimally affected their learning. Constance's statement that the evaluation tool "is a piece of paper I fill out and that if the instructor thinks that you are going to pass clinical, you met everything" and that "you'd have to kill someone [to not pass]" is of major importance for educators to hear and take action. Constance continues this concerning thought in saying "the meaningless sheet of paper is good because it gives the school something to hand over to Boards [accrediting body] . . . but as for my learning experience, I don't even know what's on it!"

Participant voices sharing experiences with clinical evaluation resonate with a common question: What is the purpose of the appraisal process and more specifically, what is the tool with which the process is implemented? Stories voiced by the nine senior baccalaureate nursing students voiced their sense of how the clinical evaluation process occurred, but not without some discrepancy for its existence. Some participants did report a correlation between the theory component of the program, and the objectives and behaviors found within the evaluation tool. Other participants voiced uncertainty as to what the words and measurements meant and found them to be enhanced by student and faculty interaction in combination with the evaluation tool.

Some students voice the evaluation tool was reviewed in great detail in the first semester and then made available online for future reference, and others voiced its availability online for

referral without further explanation. However, after the first semester of clinical, students consistently reported that they were expected to review and understand course requirements outlined in the evaluation tool, in subsequent semesters without the detail experienced in the first clinical experience.

Another theme threading through the voices is that not all participants were sure of how they were being evaluated or understood the meaning of the behaviors included on the evaluation tool. Some participants voiced a sense that one's evaluation was based upon a sense of how well the instructor "liked" or "trusted" the student. Many related the words on the tools to be "nonsensical" to the point of being developed for a purpose other than that of student learning.

Participants expressed ambivalence in their responses to, other than the clinical instructor, who should have input into his or her clinical evaluation appraisal. The majority of the respondents did not sense their peers or patients to be good sources of information as to whether or not clinical objectives were met. The only common thread was that peer evaluation was accepted in group presentations. However, given the theme that the instructor was not always present when students were providing patient care, the participants did voice acceptance that the nurse who worked with the student could have input.

The majority of the participants agreed that if they did not hear anything negative, or anything at all from their clinical instructor, the assumption was that they were performing as expected. Some cited examples of informal verbal reminders from professors in areas that needed improvement, but otherwise assumed standards were being met. Some students revealed they had not seen their instructors for up to eight weeks at a time and were not altogether sure how the instructor could perform an informed performance evaluation.

M. A. Chambers (1998) stated, “To be a ‘knowledgeable doer,’ the clinical nurse must be able to demonstrate credibility in both theoretical knowledge and practical skills” (p. 206). A voiced concern by faculty was how to meet this lofty goal objectively while assuring the public that nursing program graduates are deemed eligible to meet examination board standards and criteria. M. A. Chambers (1998) defined the concept of reflective practice as a way for the student to reinforce to the instructor what has been learned by way of reviewing and analyzing what has been experienced in the clinical setting, thereby demonstrating the student's practical competence.

Recommendations for Higher Education

The first recommendation is that a mechanism be put into place that would stress to the nursing student the importance of the clinical evaluation process. As addressed in one of the primary themes, and again within the implications for higher education, it is alarming that students voice the evaluation tool to be nothing more “than a meaningless piece of paper” and that one would “need to kill someone” to fail the course. The researcher would recommend that in addition to the detailed explanation of the evaluation tool that is initially presented to novice students, instructors should continue to reinforce the importance of meeting the objectives with each subsequent clinical experience. Student voices are sharing the sense that if there is less time taken to emphasize the expectations of the behaviors within the evaluation tool as they progress with subsequent clinical courses, then the expectations must also be dwindling. Within each clinical course, activities must take place that reinforce the need for novice and expert students to recognize the negative impact of what can and will occur if desired behaviors are not met.

An example of how this could occur is through deliberate simulation activities prior to each clinical experience. Students have already identified the comfort of practicing activities in a simulated environment that is safe for the practitioner as well as the patient because a fateful error in care can readily be rectified and the opportunity for learning a better plan of action can be learned. What could be added to that experience would be to illustrate on the course evaluation tool how errors in the simulation setting would impact the student performance evaluation should those untoward behaviors occur in the actual clinical setting.

Secondly, there should be a goal to develop a clinical evaluation tool or process that would lend itself to be evident of verbalized mutual understanding of expected behavior in the clinical setting. The process should incorporate an instrument that posses a mutual goal of simplicity and a recognizable link to nursing practice. Students could be a part of creating the evaluation process, including the instrument designed for that purpose. Of the literature reviewed in Chapter 2, there was no evidence of this practice. The majority of literature to date reflects faculty angst in looking to create the ideal tool for a fair and objective student clinical evaluation. However, there were none relating how the student would or could be involved in the process.

Next, the researcher recommends that the evaluation tool be presented to students in a setting that relates consistent verbalization of the behaviors expected within the practice setting and allows opportunity for dialogue between the faculty and students. As the participants related, each semester brought new expectations and objectives to the evaluation process by way of either the course content or the practice setting. However, no participants related a consistent method in the evaluation process for each semester.

Continuing the idea of a consistent method of delivery of clinical evaluation expectations is the recommendation that faculty, including adjunct and full-time, be involved in training at the beginning of each course regarding implementation of the clinical evaluation process. This would include the mentoring of new faculty. All involved in training would collectively discuss and plan how to reinforce student objectives expected for that semester. Included in this discussion would be methods of how faculty would deliver course expectations to the students in an informative manner and perceived as caring regarding student success in meeting course objectives. Ideally, the manner of delivery of the CPA would result in the student leaving the process with a sense of caring regardless of the outcome (Duke, 1996; Hanson & Smith, 1996; Pellicer, 2003).

Another recommendation would be that a clear explanation of the correlation between the evaluation tool with what learned in theory be made at the onset of each clinical course (Howard-Hamilton, 2007). As revealed earlier, a student voiced that her evaluation is based upon "nonsensical" words, or her personality, which is not a desirable inference to hear. The detailed explanation would then be followed by examples in instructor practice. Although an instructor would like to think they are not exhibiting signs of student bias, there are opportunities where this can occur. Consistency in student evaluation, based upon clearly identified objectives, is imperative.

Regarding the implication that participants do not hear anything negative or at all from their clinical instructor for a large period of time within a given clinical rotation, the researcher recommends a course of action that would avoid a potentially wrong assumption by the student that they were performing as expected. Formal, planned meetings between the student and the professor at established times throughout the clinical course are recommended. Some

participants cited examples of formal meetings with clinical instructors where the student and instructor would come prepared to clarify expectations based on clinical performance and what behaviors should be continued and those that needed to be changed. A discourse between the student and instructor would specify what should be changed and how. Planned meetings would also eliminate the stories expressed by some students that they had not seen their instructors for up to eight weeks at a time and were not altogether sure how the instructor could perform an informed performance evaluation.

Based upon M. A. Chambers' (1998) proposed concept of reflective practice as a method for the students to reinforce and demonstrate their practical competence, I recommend some method of this skill be implemented within the clinical evaluation process. Aban implied a form of reflective practice through journaling her clinical experiences. She voiced, "I use [evaluation] tools to write in journal and they [instructors] guide me." Aban also revealed reflection of application of theory to practice in simulation activities in the practical lab setting. She points out that "simulation allows you to be yourself" while practicing provision of patient care "where you actually bring out what you think is the best of you" without fear of making a mistake and "get someone's feedback" and "you know where to change."

Therefore, the use of journaling that is not unilateral, but provides timely feedback to students is a practice that the researcher recommends be a part of the evaluation process. This activity would allow open dialogue between the student and instructor in a timely manner while promoting reflective thinking in applying theory to practice (Goldenberg & Dietrich, 2002; White, 2003). Simulation is another reflective type of activity that can be practiced prior to, during, and at the end of a clinical experience. Simulation, either through the use of mechanically, programmed mannequins or computer assisted patient scenarios, provides a non-

threatening platform that promotes reflective activity in a safe learning environment not only for the student, but also the patient. Simulation activities would also allow students the opportunity to demonstrate select skills in a non-threatening environment – including skills that are not always readily available in the skilled practice setting or could be missed due to the absence of the instructor.

A last recommendation for education is to add another voice to the student clinical evaluation. As noted earlier, Heady (2000) emphasizes that instructors should utilize multiple types of assessments to demonstrate continuous improvement that reflects what is actually being measured; this includes those that are a part of the educational community who are not teaching faculty. Upon hearing stories that after the first clinical semester there is limited instructor availability, the researcher recommends that the staff nurse who works alongside the student in the delivery of patient care should have a part in the evaluation process. Student inquiry supports that if individuals, aside from the clinical instructor, were involved in the evaluation process, there would be comfort in that person being the staff nurse who accompanied them on a given day in the health care setting.

Recommendations for Research

Literature reviewed for the study reflects numerous accounts of studies pertaining to the CPA process. Most of what has been studied since the early 1900s reflects the voice of the faculty with few writings sharing the student's experience. Therefore, I recommend continued studies occur from the perspective of the student. In addition to studies that reflect those of the student, I would also like to note that the study conducted by this researcher, as well as one mentioned most recently by Reynolds (2005) were conducted in the Midwest. Therefore, I

recommend future studies occur within more purposefully selected geographical areas of the United States in the Northern, Southern, Eastern, and Western extremes.

Also noted in this study is that there is a long history of a low number of minorities in the nursing community. As stated earlier, Cabrera et al. (1999) asserts, "Academic ability, parental encouragement, perceptions of prejudice, academic performance, goal commitment, and institutional commitment explain 56% of the variance in African Americans' decision to persist in college" (p. 140) compared to a 39% variance in Whites. Therefore, in agreement with Cabrera et al., I recommend that further research be conducted on institutional policies and practices that address student needs in varied minority groups. This is especially important given the majority of nurses who are of European ethnicity are decreasingly reflecting the population of the United States who seek health care. As the demand for nurses continues to increase (United States Department of Labor, 2009), careful attention needs to be given to recruit and retain minority students and faculty into post-secondary nursing education programs (Ortiz & Rhoads, 2000). Furthermore, based upon the challenges voiced by Aban regarding learning in an environment foreign to her own, I recommend that more study be done as to the experiences of international students during the clinical evaluation process.

For this study, I purposely chose baccalaureate nursing students as my attention was first drawn to a study performed by someone utilizing baccalaureate nursing programs, but also because my personal experience and bias has been with primarily practical and associate of science nursing programs. Therefore, I recommend extending this study to the other entry level nursing programs, such as practical and associate degree nursing to test for such various differences in perspectives.

Self-efficacy was discussed in this study through the writings of Bandura (1997) and Fencl and Scheel (2005). They define self-efficacy as an individual's way of succeeding in any given situation separate from one's self-esteem. In this way, they sense that self-efficacy serves as a primary predictor of student retention and thereby, achievement of goals. Their belief is that the learning strategies utilized in instructing a student impacts their self-efficacy and the course climate. However, review of the literature did not reveal studies that test this hypothesis as it relates to the student experiencing the clinical evaluation appraisal process.

Limitations of the Study

Limitations of this study begin with participants being from two universities located within the same geographical areas in the Midwestern part of the United States. Two primary differences existed between the two institutions. One difference was that one was public and the other private. The other primary difference was that one nursing program included the clinical and theory components as one course, with the practicum section designated a pass/fail option, and the other separately assigned grades. However, reflective of the replicated study mentioned at the beginning of this study, the geographical limitations are still evident. The study conducted by Reynolds (2005) that took place at three colleges of nursing were a mix of private and public and were located in the Midwest. Although the colleges where Reynolds conducted her study were not inclusive of the same two colleges where I performed my study, the proximity of the two Midwest states was close.

Nine semi-structured interviews were conducted with six females and three males. Although the participant majority of the female gender reflects the population attending nursing programs, the small number of male voices could affect the outcome of the study. The majority of those who participated in the study were in their 20s with one the age of 47. Eight were of

European ethnicity and one African. Although the private university does pride itself in global outreach and hosts a number of students from other countries, the nature of nursing programs lends to the limitation that is identified in the low number of minorities who enroll in this area of study. Other limitations included the limited amount of time that was afforded to spend with each participant, including that of direct observation within the clinical setting and actually seeing how they lived the experience.

Finally, in regards to the number of participants, I would like to discuss the original intent of my research to be a case study at a single, private institution to one that ultimately included student interviews from two institutions. Based upon my initial desire to hear the voices of at least eight nursing students of varying demographics, and the realization that four participants desired to relate their stories at the private university, led to my pursuit of another four-year nursing program to contribute to the study. The first, private college offering a baccalaureate degree nursing program did offer me the depth for which I was searching in the variety of students who volunteered to reveal their experiences. Those four students were comprised of two males and two females and were in their senior year. The two White males were in their 20s. One of the females was 22 and of White ethnicity and the other was 47 and of African ethnicity. Although I was warned of the noted hesitation of the woman from Africa to openly speak to many faculty and students associated with the program, I was pleasantly surprised by her candor with me. She offered one of the richest interviews associated with the study. However, I did sense the need to expand the number of participants to assure the goal of reaching the point of saturation of data obtained.

Therefore, I met with the nursing director of another four-year university that was public in nature, discussed the purpose of the study, and the desire to hear the voices of the senior

baccalaureate degree nursing students at that college. The director allowed me the opportunity to speak with the senior class to present my study and request their desire to reveal their experiences of the clinical appraisal process through their lens. Five students volunteered to participate. I was able to obtain another male voice in his 20s as well as four female voices in their 20s, all of White ethnicity. What I did discover was that between the two colleges, I was able to attain the point of saturation as to the experiences each had to relate regarding the evaluation process. What I did not achieve was variety that is more ethnic.

Personal limitations included the time allotted for the study, the structure and schedule of the programs' semesters and courses that would lend availability of the students, and the time allowed for me to conduct the semi-structured interviews. Another personal limitation was that I have not had personal experience with development or instruction within a baccalaureate nursing program or a four-year institution. Aside from two years spent as a graduate assistant in a two-year nursing program at a four-year university, my primary focus to date has been with that of practical and associate degree nursing programs at a two-year community college. In addition, my personal identity with the White, female culture could influence my way of questioning those of other ethnicities and genders, in that I would not be able to draw upon personal experience to guide deeper questioning.

Conclusion

In this study, the researcher examined the perception and experience of the baccalaureate degree seeking nursing student undergoing the clinical evaluation appraisal process. The researcher examined: (a) the experience of a baccalaureate degree nursing student undergoing the process of clinical evaluation appraisal; and (b) baccalaureate degree nursing student perception of the clinical evaluation appraisal process as a means of meeting personal and professional

goals. An interview protocol comprised of 27 questions guided the researcher in examining the essence of each participant as they experienced the evaluation process.

As mentioned earlier in the study, the national need for RNs is projected to increase 22.2% by the year 2018 (United States Department of Labor, 2009). The importance for nursing faculty to understand and implement the clinical evaluation process through the lens of the student is an important part of meeting this need while facilitating learning. How students experience the process is even more important in the ultimate goal of providing an increased number of potential graduates of the baccalaureate of science in nursing program through the opportunity to persist, graduate, and possess the knowledge necessary to take and successfully pass the licensing examination.

Consequently, the significance of replicating this study conducted by Reynolds (2005) at other baccalaureate nursing programs located within the Midwest offered more students the opportunity to voice their experiences with the clinical evaluation process. Furthermore, more student voices combined in answering if the clinical evaluation process assists in meeting their personal and professional goals. This phenomenological study also examined the minimally explored area of how the student perceives the clinical evaluation process versus the large number of studies already available sharing instructor perceptions.

The four common themes identified and expressed through the voices of the participants in Chapter 5 assisted in answering the questions that were posited for this study. The experience of a baccalaureate degree nursing student undergoing the clinical evaluation appraisal process was expressed through the diverse participant voices through identification of four emergent themes that included: (a) the impact of an absent instructor; (b) all instructors are different; (c) input into clinical evaluation process; and (d) the evaluation process is a formality. Research of

cognitive and noncognitive variables of the evaluation process explored by French et al. (2005) reinforced how the factor of student motivation impacts success.

French et al. (2005) examined student success and persistence including both cognitive and noncognitive variables. Cognitive variables included those of high school rank, university cumulative grade point average, and SAT scores. Noncognitive variables included institution involvement and academic motivation.

Findings from the study of French et al. (2005) suggested that programs that promote retention focus on academic achievement. Increased motivation contributes to the student continuing in the major of choice; therefore, an atmosphere that contributes to satisfactorily meeting objectives on the CPA, including how to improve upon those not mastered, would be more desirable to student success. Conversely, instructors who repeatedly focus on unsatisfactory student behaviors do not contribute to successful student learning behaviors. Jim reinforces this ideal in saying,

> I would say it depends on how the clinical instructor addresses that [behaviors that a student needs to work on], if that makes sense . . . how the instructor handles the evaluation . . . there's a very upfront way of 'you did this wrong, you did this wrong, you did this wrong and this is why I gave you this grade' instead of 'you really did this well . . . I saw that you kind of struggled with this . . . maybe we need to work on this in clinical'. . . which I appreciate.

Regarding examination of the baccalaureate degree nursing student perception of the clinical evaluation appraisal process as a means of meeting personal and professional goals, participants expressed that dialogue with the instructor contributed most to successful

completion of their goals. Amanda spoke to this in her statement regarding student use of the evaluation tool:

> And a lot of people don't take it seriously, they just write, "M", "M", "M", "M" [indicating meets objective] all the way down, but I really think everyone needs to take the time to read what it says and really think about do I really meet that criteria . . . You need to have a little direction [from the instructor] as far as what they are looking for.

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APPENDIX A: RECRUITMENT LETTER TO POTENTIAL PARTICIPANTS

Dear Nursing Student:

As a doctoral candidate in the Educational Leadership, and Administration Foundations Department at Indiana State University, I am conducting a qualitative study for the purpose of gaining a rich understanding of the experience of baccalaureate degree seeking nursing students undergoing the process of clinical evaluation appraisal. This study will be conducted during the summer and fall 2009 and potentially spring 2010 semesters and will serve as my doctoral dissertation.

Results of the study will be shared in an academic setting as a part of my dissertation defense and could be presented to nursing faculty for the purpose of improving the clinical evaluation appraisal process; however, information that can identify you individually will not be available to anyone outside the study. Information obtained from the study could potentially be used in any way thought best for publication or education. Any information used for publication will not identify you individually.

I sincerely hope that you will agree to participate in this study. Your participation would include being interviewed three times ranging from thirty minutes to an hour each time. I will ask you questions about the clinical evaluation process at your college, and your feelings and experiences about this process. I would like to digitally record the interviews for the purpose of capturing an accurate, verbatim transcript for analysis. The tapes will not be heard by anyone outside the study unless I have you sign a separate permission form allowing me to use them. The recording will be destroyed three years post study completion.

No anticipated risks are expected to be incurred as a result of your participation in this study.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of use of a pseudonym (false name). Your actual name will not be in any of the information obtained from this study or in any of the study reports. As is the practice with all identifying information, the list that shows which pseudonym goes with your name will be destroyed three years after completion of the study.

If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer. There is no

penalty if you withdraw from the study, and you will not lose any benefits to which you are otherwise entitled.

If you have any questions about this study or your rights as a participant, please contact me at (812) 429-1496 (office) or per e-mail at jmccutch@ivytech.edu. If you are willing to participate and understand what I am asking of you, please sign and return this form to me in the self-addressed stamped envelope provided with this letter by July 15 or sooner, if able.

Respectfully,

Judith A. McCutchan, MSN, RN

_____

Participant's Printed Name

_____

Participant's Signature

APPENDIX B: NURSING STUDENT DEMOGRAPHIC QUESTIONNAIRE

1.	**GENDER:**	A.	Male
		B.	Female
2.	**AGE:**	A.	18-22 years
		B.	23-30years
		C.	31-40 years
		D.	41-50 years
		E.	51 years or over
3.	**ETHNICITY/**	A.	Caucasian/White
	RACE DATA:	B.	African American/Black
		C.	Pacific Islander/Asian
		D.	Hispanic
		E.	Other (please specify)

_____

4. **EDUCATIONAL LEVEL:**

A. Classified as Junior in nursing program
B. Classified as Senior in nursing program
C. Classified as neither a Junior or Senior in nursing program

APPENDIX C: CONSENT TO PARTICIPATE IN RESEARCH FORM

CONSENT TO PARTICIPATE IN RESEARCH

Title of Study:
The Experience of Baccalaureate Degree Seeking Nursing Students Undergoing the Process of Clinical Evaluation Appraisal

You are invited to participate in a research study conducted by Judith A. McCutchan, who is a doctoral student from the Educational Leadership, Administration, and Foundations Department at Indiana State University. Ms. McCutchan is conducting this study for her doctoral dissertation. Dr. Kandace G. Hinton is her faculty sponsor for this project.

Your participation in this study is entirely voluntary. You should read the information below and ask questions about anything you do not understand, before deciding whether or not to participate. You are being asked to participate in this study because you are a student in the Baccalaureate of Science in nursing program at University of Evansville.

- **PURPOSE OF THE STUDY**

The purpose of the study is to focus on the perception or experience of the nursing student undergoing the clinical performance appraisal (CPA).

- **PROCEDURES**

If you volunteer to participate in this study, I will ask you to do the following:

1. I will ask you to take part in 3 tasks over the course of a total of approximately 2 hours of time.
2. Anticipated tasks include: (1) explanation of study by the researcher, (2) answering questions about your experience with the clinical performance appraisal process; and (3) assisting with verification and validation of what transcribed from your responses.
3. Interview will be digitally recorded. The digital recorder will be placed in an inconspicuous area that allows for accurate recording of what the participant wishes to share with the researcher.

- **POTENTIAL RISKS AND DISCOMFORTS**

It is expected that any risks or inconveniences will be minor, and I believe that they are not likely to happen. There is little likelihood of any physical risk as a result of participation in this research project. Interview participants are not asked to perform any tasks as a part of interview protocol that could result in physical harm. Participants will be asked to provide information

about their experiences with the clinical performance appraisal process and demographic data (e.g. age, gender, race, ethnicity, educational level).

- **POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

There are no direct benefits to the participant by participating in this study.

- **PAYMENT FOR PARTICIPATION**

You will not receive any payment or other compensation for participation in this study. There is also no cost to you for participation.

- **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of use of a pseudonym to allow Ms. McCutchan and Dr. Hinton know who you are. I will not use your name in any of the information I get from this study or in any of the research reports. Three years after completion of the study, I will destroy the list that shows which pseudonym goes with your name.

Information that can identify you individually will not be released to anyone outside the study. Ms. McCutchan will, however, use the information collected in her dissertation and other publications. I also may use any information that I get from this study in any way I think is best for publication or education. Any information I use for publication will not identify you individually.

The audiotapes that I make will not be heard by anyone outside the study unless I have you sign a separate permission form allowing me to use them. The tapes will be destroyed three years after the end of the study. Given the results of the study will be shared with the faculty at your school, and the nature of the study, there exists the possibility that an instructor from your program might identify you even with the use of a pseudonym. However, while sharing the results of the study, every effort will be taken to avoid the potential for identification.

- **PARTICIPATION AND WITHDRAWAL**

You can choose whether or not to be in this study. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer. There is no penalty if you withdraw from the study, and you will not lose any benefits to which you are otherwise entitled.

- **IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact:

Ms. Judith A. McCutchan
Principal Investigator
School of Health Sciences
Ivy Tech Community College
3501 First Avenue
Evansville, IN 47710
812-429-1496
jmccutch@ivytech.edu

Dr. Kandace G. Hinton
Assistant Professor
Department of Educational Leadership,
Administration, and Foundations
Indiana State University
Terre Haute, IN 47809
812-237-2900
kghinton@indstate.edu

- **RIGHTS OF RESEARCH SUBJECTS**

If you have any questions about your rights as a research subject, you may contact the Indiana State University Institutional Review Board (IRB) by mail at Indiana State University, Office of Sponsored Programs, Terre Haute, IN 47809, by phone at (812) 237-8217, or e-mail the IRB at irb@indstate.edu. You will be given the opportunity to discuss any questions about your rights as a research subject with a member of the IRB. The IRB is an independent committee composed of members of the University community, as well as lay members of the community not connected with ISU. The IRB has reviewed and approved this study.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____

Printed Name of Subject

_____ _____

Signature of Subject Date

Indiana State University

Institutional Review Board

APPROVED

IRB Number:

_____

Approval:

_____

Expiration Date:

_____

APPENDIX D: INTERVIEW PROTOCOL

1. Tell me about the procedure for clinical evaluation at your college.
2. Does it involve more than your actual performance in the clinical area?
3. How does your clinical evaluation impact your course grade?
4. How were you oriented to the clinical evaluation process?
5. How could this orientation be improved?
6. Walk me through the process for clinical evaluation at your college.
7. Does it involve more than your actual performance in the clinical area?
8. How does your clinical evaluation impact your course grade?
9. How were you oriented to the clinical evaluation process?
10. How could this orientation be improved?
11. What is the process for evaluating your own clinical performance?
12. Is this an ongoing process throughout the clinical experience, or a reflective exercise at the conclusion of the clinical experience?
13. How do you feel when you write your clinical self-evaluation?
14. Do you feel your self-evaluation adequately and accurately reflects your performance?
15. Tell me about your experiences with the clinical evaluation process.
16. What is it like to be a nursing student undergoing the clinical evaluation process?
17. How do you think your clinical instructor makes decisions regarding your clinical performance?
18. How do you feel when you review your clinical evaluation?
19. Does your clinical evaluation adequately and accurately reflect your performance?
20. Tell me about an instance where you and your instructor had differing opinions regarding the evaluation of your clinical performance.
21. How did you handle this situation of differing opinions of your clinical performance?
22. Do you think other people should have input into your evaluation (e.g., clients, their families, your peers, nursing staff)?
23. If not, why? If so, how would this work?
24. How do you think you have changed personally or professionally as the result of the clinical evaluation procedure?
25. What advice regarding the clinical evaluation process would you offer a new student who is preparing for his/her first day of clinical?
26. What recommendations do you have for improvement in the clinical evaluation procedure at your college?
27. How might this process work?

APPENDIX E: TRANSCRIPTIONIST(S) CONFIDENTIALITY AGREEMENT

I agree to type transcripts of digitally-recorded interviews obtained for the purpose of research in a study being conducted by Judith A McCutchan, MSN, RN. I understand that this research is being conducted as partial fulfillment of a dissertation requirement through Indiana State University.

I recognize the importance of maintaining the confidentiality of the research participants, and I agree that I will not disclose information from the interview tapes to anyone other than the researcher. I will contact the researcher, Judith A McCutchan, with any questions that I may have in reference to the tapes or their contents.

_____ _____

Signature of Typist Date

APPENDIX F: PEER DEBRIEFER LETTER

Dear Colleague:

I am approaching the final stages of conducting a research study for the partial fulfillment of completing a Doctorate of Philosophy degree in Educational Leadership, Administration, and Foundations at Indiana State University. The focus of my study is to explore the perception or experience of the baccalaureate nursing student undergoing clinical evaluation.

Attached you will find my study, which takes the reader from the statement of the problem on to the findings of the study. What I would like to request of you is a review of the attached document and provision of feedback regarding the accuracy of how my initial questions and interpretations speak to one another as well as search for any biases or areas that need more reinforcement of the findings.

Thank you in advance for your valued time in assisting me with this important part of the study. Please let me know if any clarification is needed by contacting me at 812-429-1496 or jmccutch@ivytech.edu.

Sincerely,

Judith A. McCutchan, MSN, RN