A rating code to be used as a guide in grade determination for clinical practice in the medical and surgical nursing course of a specific basic collegiate program

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A RATING SCALE TO BE USED AS A GUIDE IN GRADE DETERMINATION FOR CLINICAL PRACTICE IN THE MEDICAL AND SURGICAL NURSING COURSE OF A SPECIFIC BASIC COLLEGIATE PROGRAM

BY

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CHAPTER I

INTRODUCTION

STATEMENT OF THE PROBLEM

In this study the problem investigated was whether or not a rating scale based on clinical practice objectives would provide a reliable and valid method of grade determination for clinical performance in the medical and surgical nursing course of a specific basic collegiate program.

PURPOSES OF THE PROBLEM

The central purpose of the problem was as follows:

To develop a rating scale which would provide a reliable and valid method of determining a grade for clinical practice.

The contributory purpose of the problem was as follows:

To develop a rating scale which would be practical to use in terms of the time and effort required on the part of the instructors.

The concomitant purposes of the problem were as follows:

To aid the instructors in giving objectively based clinical practice grades to the students.

To aid the instructors in estimating the degree of student progress as the scale is periodically re-used on the same students.
To aid the instructors in their guidance function with the students.

To aid the instructors in their advisory role with parents or guardians of the students.

To aid the instructors in their role as interpreters of student achievement to the administrator of the program.

To aid the students in the assumption of increased self-evaluative abilities.

JUSTIFICATION OF THE PROBLEM

Difficult as the objective grading of theoretical work has been, the objective grading of practical performance in a clinical area has presented nursing educators with a problem of even greater magnitude.

This latter statement is particularly applicable to the educators in collegiate nursing programs for it is in the clinical areas of these programs that academic credit is increasingly being allocated for such practice. Therefore, as is true of most every other laboratory course in the college, a performance grade must be submitted for each student who practices in the clinical laboratory.

In view of the need for action implied in the above paragraph, it was felt that a study could well be justified if it were to be directed toward the establishment of at least one reliable and valid method of arriving at a grade for clinical performance.
Although the tool which was constructed in this study to aid instructors in the determination of a grade for clinical practice can only be used in the specific school for which it was devised, it was hoped that the method underlying the construction of the tool would be basically sound enough so that it could be adapted to any clinical area in any type of nursing school--provided someone were willing to rewrite the scale to comply with the needs of the area in question.¹

The author felt, therefore, that it was possible that this study could serve a useful purpose to any nurse educator involved with the grading of student performance in a clinical situation.

ASSUMPTIONS UNDERLYING THE STUDY

In order to meet the purposes of this study, the following basic assumptions were formulated:

Wherever the word "education" is used or implied in this study, its meaning is to be thought of in terms of the adjustment aim. The use of the word in this sense has been widely accepted by most nurse educators as well as by many leaders in the field of general education.²

¹Due to the fact that the evaluating tool which was developed in this study was based on the clinical practice objectives as set forth for a specific class of students in a specific program and in a specific clinical area, it could hardly be used with success in any other program.

²Committee on Curriculum of the National League of Nursing Education, A Curriculum Guide for Schools of Nursing, p. 17.
The measurement of the educative process can best be done in terms of the changes in behavior which have been effected. According to Tyler,\(^3\) this statement is one of the basic underlying assumptions involved in evaluation of any kind.

The extent to which changes in behavior are obvious can only be evaluated in terms of the objectives which have been set up in relation to the expected outcomes involved in the specific learning situation.\(^4\) Therefore, a rating scale which is based on the objectives of a specific clinical service should provide a worthwhile means of determining the degree of student behavioral change which has been achieved.

Since the objectives of any specific course—clinical or theoretical—relate to the past experiences of students as well as to the anticipated future experiences of students, it is obvious that a rating device based on such objectives can only be used with maximum effectiveness in the area for which it is devised. Hence, it was assumed that any comments pertinent to the scale which was developed in this study apply only to its use in the specific clinical area where the problem was investigated.

**SCOPE OF THE STUDY**

This study was limited in scope to the one basic collegiate school of nursing for which the rating scale was developed, used, and evaluated.

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\(^4\) Ibid., p. 496.
LIMITATIONS OF THE STUDY

Certain factors beyond the control of the author operated to make this study imperfect. These limitations were as follows:

1. Instructor bias and subjectivity could not be completely eliminated from the ratings which the students received.

2. The instructors who used the scale varied widely in their experience with clinical supervision of students. Therefore, the use to which the scale was put varied more than would have been the case had the instructors undergone more similar past experiences.

3. The author could not personally use the rating scale on the students. Therefore, it was possible that the opportunity to make certain observations was missed.

4. Semantic problems arose since the scale contained detailed descriptions of behavior.

5. Only one form of an evaluation device was explored in this study.

6. The rating scale was evaluated on the basis of having been used on one small sampling of students on one occasion. The results might have been different had a larger sampling been used and had the scale been tried a number of times.

PREVIEW OF METHODOLOGY

The method used to investigate the problem involved the following activities:

1. The refinement and reformulation of a set of clinical practice objectives.
2. A study of anecdotal records kept on students.

3. A review of the philosophy and aims of the school where the study was done.

4. The construction, the implementation, and the evaluation of the tool.

5. The holding of conferences with the instructors who used the tool.

6. The formation of two sets of questionnaires—one for the students and one for the instructors.
CHAPTER II

PHILOSOPHY UNDERLYING THE STUDY

When one decides to undertake a particular study to the exclusion of all other studies, it seems that he must have certain beliefs about the subject area to be investigated as well as personal reasons for choosing to explore it.

This author was aware of the above two influences and thought that it was important to discuss them so that all readers would be aware of the philosophical orientation basic to the problem of this study.

In respect to the grading process in general, it was felt that the system of letters and numbers should be abolished. The author would prefer to eliminate the competitive element which is associated with such practices, and substitute in its place, a genuinely motivated interest in learning which would serve as the students' sole operational springboard.

It was believed that grading as it is commonly employed is an unrealistic and artificial device which serves to widen the gap between the educational institution and the society in which it functions. When a student leaves the protected school environment, he never again receives a letter grade or a percentile grade for performance. There would be more of a thread of continuity, therefore, if evaluation in the schools was based on group approval or group disapproval rather than on teacher
constructed grades—whose only stimulus value is reward or punishment.

Strongly as the author felt about how evaluation should be determined, it is well known that the above process had received much criticism—even in the few progressive schools where it has been employed. Since this technique is still in its transitional and experimental state, it was felt that nurse educators could hardly be expected to inculcate it en masse.

It appeared, then, that grading would continue to be a required function of instructors for a long time and if this was to be, it was believed that these grades should be determined in as objective a manner as was possible. It was further felt that this was particularly important when clinical behavior needed to be evaluated, since both patient safety and the assurance of student continuation in the program could be at stake.

It was because such definite opinions about evaluation existed that this study was initiated. Also, since the author plans to teach in a program where the clinical grading of students will be a part of the job, a personal reason for developing a valid and reliable method for determining a grade was present.

With the above attitude, then, this study was undertaken. Eager as the author was to develop an evaluative tool
which would be of practical use, it was realized that the tool might not prove its worth when it was actually tested. However, basic to the approach of the study was the internalizing of the feeling which Michel de Montaigne\(^1\) portrayed in the following thought:

"Whoever goes in search of anything must reach this point: Either to say that he has found it, or that it is not to be found or that he is still upon the quest."

---

\(^1\)"Apology for Raimond de Sebonde," *The Essays of Michel de Montaigne.*
CHAPTER III

THEORETICAL FRAMEWORK OF THE STUDY
REVIEW OF THE LITERATURE

In order to relate this study to the past and present material available on the subject of clinical evaluation of student performance, the author surveyed the following sources: The American Journal of Nursing since 1930, Nursing Outlook since 1953, Nursing Research since 1952, Master and Doctoral dissertations since 1946, and a representative variety of textbooks—both in the realm of nursing education and general education. A synthesis of the information found in these sources follows.

In relation to the author's specific interest in developing a method based on clinical practice objectives whereby a reliable and valid grade could be ascertained for such practice, nothing was found in the literature which indicated that this sort of activity had ever before been attempted. However, Lucus¹ implied in her thesis that perhaps a project such as the present writer desired to undertake was

needed, when she made the following two statements in the conclusion of her study:

1. "The variable interpretation of grades and the lack of uniformity in grading provoked dissatisfaction among student nurses and contributed to the problems of the instructors."  

2. "The existing evaluation procedure and tools presented difficulties in making adequate appraisals of the student's performance."

The remainder of the literature found which was at least partially related to the topic of this study revolved around such subjects as the general concepts of evaluation, the use and abuse of rating devices, and the importance of self-evaluative techniques. A summary of this material follows.

In respect to the topic of evaluation in general, numerous articles were available. Indeed, since 1930, nursing publications have reported many meetings, workshops, and conventions in which papers were presented and where discussions were held which were pertinent to this problem.  

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2 Ibid., p. 104.
3 Ibid.
4 A good example of such a conference was the one held in November of 1950 which was sponsored by the Department of Measurement and Guidance of the National League of Nursing Education. (Nursing educators representing eight census areas were present as well as noted speakers from both nursing education and general education.)
material related to evaluation in this overall sense ranged from specific writings in which the details of one evaluative procedure as implemented in one school of nursing were presented to articles of a more general nature—such as those in which the modification of certain examinations such as the National League For Nursing Pre-Nursing and Guidance Examination, the National League for Nursing Achievement Tests in Professional Nursing, the National League For Nursing Graduate Nurse Qualifying Examination, and the National League For Nursing State Board Test Pool Examination were presented.

Other typical examples of the variety of topics covered in the evaluation area in general could be found in an article written by Symonds and in an article written by Smith. In the publication by Symonds\(^5\) specific factors (such as the "halo" effect) which contribute to variation in the judgment of another person were discussed. On the other hand, Smith,\(^6\) in her article, explained how one faculty evaluation committee was formed and how this committee successfully produced results by working under the philosophy that "evaluation measures what can be done and how it can be done" as well as what has already been done.


Aside from the literature which portrayed miscellaneous topics related to evaluation, there were many articles which contained information on one specific form of evaluation—rating scales. Considered as a whole, most of these articles seemed to be rather negatively oriented.

As early as 1934, Eickman, after a study of scales used by a representative number of schools stated the following disadvantages which were inherent in the use of such scales:

1. The terms used were too "inclusive" or too "vague."
2. There was too much dependence on the memory of the evaluator.
3. There was too much of a tendency for personal reactions to enter into the evaluation.

Then in 1950, Jamison wrote an article about scales which involved the use of check lists. Two difficulties which she mentioned had to do with (1) the problem of making the check list all-inclusive without sacrificing its practical usefulness and (2) the tendency in human nature which makes


one feel that a quality should be rated if it appears on a list, regardless of the ability of the rater to judge that particular trait.

Also, in 1950, Hunter⁹ and others stated that they felt that a change was needed in the way they were evaluating students, since there was such an unfavorable response to the "trait" method of judging them. It was believed that such terms as were used in the descriptions tended to "label" the students unfairly and it was also found that sometimes the students felt that the examples substantiating their behavior were rather nebulous and groundless.

Two years later, an article by Frederick¹⁰ and others appeared in which an evaluation project involving the use of a rating scale was described. Among the points stressed were these two: (1) in order to avoid carelessness, the scale should be as concise as possible; and (2) comparisons made by the evaluators should only be drawn between people who have had similar experiences.

During this past year--1957--Symonds¹¹ expressed the


following feelings concerning the use of rating devices when he said "evaluation in terms of ratings had administrative values but the value to the student is dubious."

In addition to the material already discussed relative to articles on evaluation in general and relative to contributions in regard to rating scales, the literature also contained a number of articles pertinent to the self-evaluation area.

Sefford\textsuperscript{12} described how resentful she felt as a student when she was handed an evaluation which she considered to be unfair. She then compared this experience with one she underwent as a graduate student in which she was encouraged to write her own objectives for patient care, following which she evaluated the same objectives. She further stated that she felt freer to discuss her reactions in this latter experience since they were derived from her own observations.

Beland\textsuperscript{13} presented a project which was undertaken at Wayne University, School of Nursing, in which a group of basic students were assisted in the formulation of objectives


for one of their courses. Periodically, they were allowed to alter these objectives as they felt the need to do so. Eventually, an overall evaluation conference was held with the instructor at which time both the teacher and the student estimated the progress which had been achieved.

Another process whereby students were also helped to do self-evaluation was presented by Ingmire. Each student was asked to keep a daily record of her work in which she described her satisfactions and dissatisfactions. Then, when the time came, she prepared a written evaluation which was compiled from the weekly summaries. The final report which was written was based on anecdotal notes which the instructor had kept as well as on the student-kept record. As a joint effort, both student and instructor composed the final report.

In summary, the literature contained much information pertinent to evaluation concepts in general as well as many articles which gave emphasis to the use of two specific techniques--the rating scale and the self-evaluative record. The most concrete work seems to have been achieved in the area of the national test services; the least concrete work seems to have been accomplished in the area of clinical evaluation of performance.

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BASES OF HYPOTHESIS

The hypothesis for this study was chosen after a comprehensive study of the literature pertinent to the subject. The hypothesis was based on the author's past experience with the grading of students in the clinical nursing laboratory.

Since the literature which was reviewed—whether authored by nurse educators or general educators—stressed the importance of evaluating performance on the basis of the achievement of objectives, it was concluded that if a grade could be determined on the same basis, this grade would be more solidly grounded than if it were determined through the use of some other criterion.

Since objectives which are truly operational are applicable only to the course for which they are constructed, it was further concluded that if the study were to have any concrete meaning, it would have to be confined to one specific course in one specific nursing school.

STATEMENT OF HYPOTHESIS

In view of the above comments, the hypothesis for this study was formulated as follows:

A rating scale based on clinical practice objectives will provide a reliable and valid method of determining a grade for clinical practice in the medical-surgical nursing course of a specific basic collegiate program.
CHAPTER IV

METHODOLOGY

SELECTION AND DESCRIPTION OF THE METHOD FOLLOWED FOR

THE COLLECTION OF DATA

The selection of the method used in the collection of data was based on the belief that this method was the most suitable one for testing the hypothesis of this study. The actual methodology used can best be described under the following subheadings: (1) The Construction of the Tool; (2) The Implementation of the Tool; and (3) The Evaluation of the Tool.

THE CONSTRUCTION OF THE TOOL

In the construction of this tool, the following four phases of work were undertaken: (1) the refining and the reformulating of those clinical practice objectives around which the tool was devised; (2) the developing of the rating scale for the determination of clinical grades; (3) the writing of the direction sheet to preface the rating scale; and (4) the devising of the form to be used for the written comments pertinent to clinical practice. The description of each of these phases follows.

1. REFINEMENT AND REFORMULATION OF OBJECTIVES

It was decided that the best way of arriving at a
grade for clinical practice was to base this grade on the achievement of the clinical practice objectives under which the students were performing. As early as 1940, this principle was considered sound, for in that year Crist\textsuperscript{1} said:

"Evaluation can only be done when objectives and purposes of the learning activity is known. We must know exactly what it is that we are attempting to measure before we can select appropriate techniques that will give us accurate appraisals of student progress."

Also, as recently as 1952, Heidgerken\textsuperscript{2} wrote:

"Evaluation devices should be planned and developed and used to determine if objectives have been attained."

Since objectives were used as the pivotal point of the study, it seemed imperative that they meet those criteria which both nurse and general educators have recognized as being essential to all good objectives. Therefore, each of the clinical practice objectives were appraised in terms of the following principles:

1. Were the objectives briefly stated? (Brown\textsuperscript{3} considers this point to be particularly crucial when objectives are used in conjunction with evaluation.)

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\textsuperscript{1}Crist, Alice, "Measuring Student Achievement," \textit{American Journal of Nursing}, 40: 805, July, 1940.

\textsuperscript{2}Heidgerken, Loretta, \textit{Teaching in Schools of Nursing}, p. 255.

\textsuperscript{3}Brown, Amy Frances, \textit{Clinical Instruction}, p. 393.
2. Were the objectives few in number? (According to Tyler, it is better to have a few well stated objectives than a multitude of repetitious and wordy objectives.)

3. Were the objectives clearly stated in terms which could be evaluated directly?

4. Were the objectives stated in terms of the behavioral changes expected of the learners?

5. Were the objectives grouped for purposes of clarity?

6. Were the objectives achievable during the time allotted for the clinical experience?

7. Were the objectives related to the "ability level" of the student?

8. Were the objectives so stated that they were neither too specific nor too detailed?

9. Were the objectives consistent with the stated philosophy of the school?

10. The author goes on to say that this characteristic allows for "flexibility and adaptability by teacher and student."


7 Heidgerken, op. cit., p. 255.

8 Ibid., p. 254.

9 Ibid.

10 Ibid., p. 255. The author goes on to say that this characteristic allows for "flexibility and adaptability by teacher and student."

In respect to the clinical practice objectives which were studied, four of the above criteria were unquestionably met--those criteria being #4, #6, #7, and #9. However, a few changes had to be made in some of the other objectives before the remainder of the criteria could be met. A description of how the changes were made follows the listing of the clinical practice objectives below.

Prior to their refinement and reformulation, the clinical practice objectives for the medical-surgical nursing course were stated as follows:

1. To develop the skill necessary to give complete physical care to selected medical and surgical patients.

2. To develop the ability to recognize and report significant emotional, spiritual, social, and economic components of illness and to be able to meet the elementary needs of patients in these areas.

3. To develop the ability to recognize and accurately report significant symptoms and/or changes in patients conditions.

4. To develop the skill necessary for the adequate physical and emotional preparation of the patient for diagnostic studies.

12 The author received permission from the school in which the study was done to make any changes in the objectives which would make them more usable with the rating scale, provided she did not alter the basic intention of the objectives.
5. To develop the ability to effectively care for patients in the various age groups inclusive of the young adult to the aged person.

6. To develop the ability to effectively care for patients with the most common communicable diseases.

7. To develop the ability to apply the principles of medical and surgical asepsis when performing nursing care which requires this skill.

8. To develop skill in the execution of pre-operative and post-operative nursing care measures on patients with the usual medical-surgical conditions.

9. To develop the ability to interpret and carry out orders in respect to the proper calculation, dosage, preparation, action, and administration of medications as well as to develop the ability to recognize and intelligently report symptoms which suggest ineffective drug action.

10. To develop the ability to interpret information about drugs on the patient's level and to answer questions concerning the relative use and abuse of self medication.

11. To develop the ability to assist doctors with the basic diagnostic treatments used with medical-surgical patients.

12. To develop the ability to interpret progress notes and laboratory reports in relation to the administration of planned nursing care.
13. To develop the ability to recognize and report common medical and surgical emergencies and to be able to perform the initial emergency care required.

14. To develop the ability to organize reasonably difficult nursing assignments within a definite time span.

15. To develop the capacity to adjust in such a way to changes and problems in nursing assignments that the ability to function is not impaired.

16. To develop the ability to analyze relatively complex nursing problems with the ability to recognize and initiate solutions to these problems.

17. To develop the beginning skills in communicative techniques to such an extent that patient teaching on an elementary level can be accomplished.

18. To develop the ability to recognize when patient referral and subsequent post hospital care is essential and to be able to initiate the preliminary steps necessary for this action.

The activities which were undertaken in the changing of the objectives involved four considerations.

Since there were eighteen clinical practice objectives, this number failed to meet the brevity criterion. It was also felt that the rating scale would not be simple and easy to use if all of these objectives were incorporated in it. Therefore, an attempt was made to dovetail those objectives which overlapped in terms of meaning. Thus, in
a number of instances, one objective was reconstructed from two or more objectives. For example, it was possible to take the four objectives which were concerned with the act of "reporting" and make one objective which read: "To aid the student in developing the ability to report and record observations which are pertinent to the welfare of patients." This same procedure was followed with the five objectives which were related to the ability to "recognize," the twelve objectives which were related to the ability to "execute" or "carry out" something, the three objectives which were related to the act of "interpreting" and the two objectives which were related to some "teaching" aspect. Synthesizing in this manner, it was possible to reduce the seventeen objectives to ten objectives.\textsuperscript{13}

Thought was also given to the stating of the objectives in as brief a form as possible and in such a way that specificity was avoided.\textsuperscript{14}

\textsuperscript{13}Objectives #2, #3, #9 and #13 contained the "reporting" concept; objectives #2, #3, #9, #13, #16, and #18 contained the "recognizing" concept; objectives #1, #2, #4, #5, #6, #8, #9, #11, #13, #16, #17 and #18 contained the "executing" concept; objectives #9, #10, and #12 contained the "interpreting" concept; and #10 and #17 contained the "teaching" concept.

\textsuperscript{14}The author tried to eliminate such an objective as #9 where the ability to interpret, to execute, to recognize, and to report were all part of one objective.
Consideration was given to the stating of the objectives in terms which could be directly evaluated. In order to do this, many of the qualifying words were removed from the original objectives and the verbs used in each objective were carefully selected.\textsuperscript{15} It was further decided that some of the activities which were specified in the objectives might better be used in the actual descriptions of behavior which would appear on the rating scale. For example, since the "teaching" aspect of nursing care is a part of the total needs of the patient, this aspect was included in objectives which were concerned with the identification and the fulfillment of patient need, rather than being retained as separate entities as had been done in the original list of objectives. This same analysis was given to the other objectives too, so that the revised set of objectives did not include separate statements pertaining to age groups, communicable diseases, pre-operative and post-operative care, drugs, diagnostic treatments, aseptic technique, and emergency measures. All of these concepts were either stated or implied in the more generally worded objectives or they were

\textsuperscript{15} Such adjectives as "intelligently" and "elementary" were removed from the objectives since these words suggest a variety of meaning to people. In respect to the choice of verbs in the revised objectives, a dictionary and Roget's Thesaurus were consulted for each one so that the verb which had the commonest and most generally accepted meaning to the majority of people was selected wherever possible.
used in the examples of certain levels of performance which were written into the categories found on the rating scale.

The final step taken in regard to the objectives was that of grouping them for purposes of clarity. In order to do this, they were arranged according to the order in which the students would usually carry them out. Thus the objective concerned with the ability to "interpret" and "analyze" clinical data was placed first-followed by the "reasoning out of principles" objective, the "identifying" of patient need objective, the "fulfillment" of the need objective, the "execution" of the assignment objective, and the "reporting" and "recording" objective. Since the remaining objectives were basic to all nursing performance, such as the one which implies the ability to "communicate," they were randomly placed at the end of the list.

Even after the above activities had been done in respect to the refining and the reformulating of the objectives, some of them were rewritten a number of times before they met the approval of the author and the chief instructor in the medical surgical course where the objectives were to be used. However, the ten objectives listed on the following page were the ones finally accepted, and it was those ten that formed the basis for the rating scale.
The revised clinical practice objectives for the medical-surgical nursing course were stated as follows:

1. To assist the student in developing the ability to interpret and analyze data on clinical charts in the light of possible implications for nursing care.

2. To assist the student in developing the ability to reason out the application of principles.

3. To assist the student in developing the ability to identify the physical, emotional, spiritual, social, and teaching needs of patients.

4. To assist the student in developing the ability to organize assignments to such a degree that the plan includes provision for the meeting of the physical, emotional, spiritual, social, and teaching needs of patients.

5. To assist the student in developing the ability to execute nursing care assignments to such a degree that adjustments can be made when circumstances arise which interfere with the original plan of performance.

6. To assist the student in developing the ability to report and record observations which are pertinent to the welfare of patients.

7. To assist the student in developing that degree of interpersonal sensitivity which is necessary to the establishment and maintenance of rapport with the various levels of co-workers.
8. To assist the student in developing skills in communicative techniques.

9. To assist the student in developing that degree of insight necessary to the evaluation of personal strengths and weaknesses in relation to nursing activities performed.

10. To assist the student in developing that degree of insight necessary to the evaluation of self in terms of personal and group progress.

2. DEVELOPMENT OF THE RATING SCALE

After weighing the advantages and disadvantages of the use of rating scales in the sphere of evaluation, it was decided that this device could justifiably be employed. The writings of various experts in the testing and measurement field led to the confirmation of this decision. In respect to the use of scales for this purpose Bradfield and Merdock say:

"Rating scales find their greatest use in areas where measurement must rely largely on observational methods."

That evaluation of clinical performance must necessarily arise from observations made by instructional personnel is a well known fact; therefore, the construction of a scale as

the chief tool for this study seemed to be an appropriate device to utilize.

Once it was determined that the use of a scale could be justified, a decision had to be reached concerning the number of categories which would appear under each of the ten objectives. The literature indicated that scales vary widely in this area. Bradfield\textsuperscript{17} says:

"The number of categories or sub-divisions optimum for a scale is indeterminate--the principle to be followed in designing a rating scale is that the number of scale intervals should approximate the number of clearly discernable differences in the dimensions being appraised."

Also, pertinent to this subject, Gerberich and others\textsuperscript{18} have this to say:

"Distinctive features may range from only a few to a large number--depending on the complexity of the skill performance and the degree of analysis desired in evaluation."

Based on the above comments, the author decided to use three categories in the scale since it was felt that this number would lend itself to the writing of clearly distinct levels

\textsuperscript{17} Ibid., p. 58.

of performance without overlap.  

The next step involved the choosing of the three words which would head the levels. It was decided to use the words "outstanding," "acceptable," and "unsatisfactory" because it was felt that these terms were less ambiguous and less suggestive than were such words as "excellent," "average," and "poor."  

Next came the actual writing of the descriptions of behavior pertinent to each of the three levels of performance. In accord with a principle advocated by Furst that "records of the characteristics of individuals who have engaged in the particular job or activity be studied"--the author reviewed the anecdotal records which had been kept on two previous classes of students in the same program basic

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19 Another factor leading to this decision came about as a result of a study of anecdotal records kept on a group of nursing students. All of the recorded incidents of behavior could easily be classified into one of three levels of achievement, but when five or seven levels were considered, it seemed that the behavioral incidents could be placed in at least two levels, due to the lack of distinctness in the levels.  

20 For example, the word "average" is commonly equated with "mediocrity," and most students consider this to denote an undesirable level of performance. The word "satisfactory" seems to imply a much pleasanter meaning and is generally better accepted by the student.  

to this study. These records were divided into three groups, depending on whether the student's performance had been considered "outstanding," "acceptable" or "unsatisfactory."

Then, from each stack of records, examples of actual performance were extracted so that a list of the behavioral activities which had led to student placement in each category was furnished. From these examples, many of the typical behavior patterns written for each level of the scale had their origin. The author felt justified in basing the behavioral descriptions on actual clinical performance as it had been carried out by students in the past because it was a way of composing categorical comments which gave direct evidence of behavior which actually occurred in a given clinical situation. In at least one respect, this approach made the scale acceptable, for Tyler\(^{22}\) has said that "judged by the principle that a record should describe accurately all significant reactions that actually take place, most rating scales are unsatisfactory." Further support was found in the writing of Sand\(^{23}\) who says:

"The need to show changes of behavior in clinical practice points to the need for developing precise descriptive phrases about how students work......further assistance may come as more detailed description is developed for the behavioral aspects of the objectives."

\(^{22}\)Tyler, Ralph, "Elements of Diagnosis," The Thirty Fourth Yearbook of the National Society for the Study of Education. p. 118.

\(^{23}\)Sand, Ole, Curriculum Study in Basic Nursing Education, p. 146.
It was felt that the rating scale described in this study embodied the thoughts common to the above two quotations.

The last decision which was made relative to the development of the scale was that of assigning a grade range of ninety-five or ninety percent for each objective which was achieved in an "outstanding" manner, a grade range of eighty-five, eighty, seventy-five or seventy percent for each objective which was achieved in an "acceptable" manner and a grade range of sixty-five, sixty, or fifty-five percent for each objective which was achieved in an "unsatisfactory" manner.24

A range of grades was offered for each level rather than a single grade because since only three scale intervals were used, it would be possible that a given student's behavior could be very highly "acceptable" (therefore, of the eighty-five percent caliber) and yet not be quite good enough to be judged "outstanding."

The widest grade span was allowed in the "acceptable" scale interval because it was assumed that the majority of students would be placed in this level. This allowance was substantiated by the literature, for Bradfield25 says:

24 The first two grades (sixty-five and sixty percent) in the "unsatisfactory" level of the scale are considered passing grades in terms of overall University policy. However, it was felt that if clinical performance were rated this low, the student should not be continued in the program.

"Scales which are characterized by unequal intervals have both a psychological and a statistical basis. Since it is more difficult to make valid distinctions among a large group called the average than among the extremes, one can compensate by spreading the middle intervals and constraining the ends."

The four steps described above were basic to the actual development of the rating scale. In order to make the scale as easy to use as possible, it was mimeographed on standard sized filing paper and arranged in the style and form which is presented on the following twenty-two pages.
A GUIDE TO BE USED IN THE GRADE DETERMINATION OF STUDENT CLINICAL PERFORMANCE IN THE MEDICAL-SURGICAL NURSING COURSE
I. **OBJECTIVE:**

To assist the student in developing the ability to interpret and analyze data on clinical charts in the light of possible implications for nursing care.

**OUTSTANDING**

(95-90)

The student shows evidence of having done thorough and extensive background study on all assigned patients, regardless of the complexity of the problems involved. The student is able to analyze the differences between the textbook description of illness and the patient's illness. The student is able to relate laboratory reports and orders on the chart to the patient's condition. Following a study of the chart and textbook, the student is able to interpret what the patient needs in respect to necessary nursing care. (Example—if the student notes that in the past, the patient has been quite susceptible to respiratory infections, the student is able to reason out that during the post-operative period extra precautions should be observed—such as the protection of the patient from drafts and the screening of visitors.

**ACCEPTABLE**

(85-80-75-70)

The student shows a generally adequate understanding of the background chart material, but the comparison with the textbook picture may be scant or incomplete—particularly when the patient presents a complex problem. The student may
have trouble interpreting and relating special reports and orders on the chart to the patient--particularly when these reports and orders do not follow the usual pattern. The student is able to interpret material he has studied in the light of analyzing outstanding nursing needs, but the student may miss the implications for meeting the more insidious needs of the patient. (Example--the student may not reason out that the patient needs teaching prior to undergoing surgery on the genitourinary system when it is known that the patient drinks only two to three glasses of fluid daily.)

**UNSATISFACTORY**

(65-60-55)

The student shows an inadequate understanding of the background chart material on patients who present even simple problems. The student does a limited amount of textbook study and he is unable to compare and interpret the book work with the clinical picture which the patient presents. When the student attempts to relate the textbook work to the needs of the patient, his concepts are scant and incomplete.
II. OBJECTIVE:

To assist the student in developing the ability to reason out the application of principles.

OUTSTANDING

(95-90)

The student shows an exceptional understanding of all principles and he is able to draw sound and logical conclusions when he is confronted with situations which require special adaptations. (Example—when the student has a sterile dressing to do, he knows that either gloves or instruments can be used and he is able to reason out the differences in technique which are pertinent to each method.)

ACCEPTABLE

(85-80-75-70)

The student demonstrates an adequate understanding of principles, but he may not be able to reason out the appropriate action when he is faced with a situation which is more unusual than the normal. (Example—if the student is doing a catherization, he recognizes at once when a section of the sterile towel becomes contaminated, but he may not know how to adapt his activities during the rest of the procedure to work around this imposed limitation.)

UNSATISFACTORY

(65-60-55)

The student shows limited understanding of even basic underlying principles. (Example—in respect to drug administration
principles, the student may prepare the wrong dosage of a drug and may consistently display calculation difficulties.) The student is unable to reason out even simple adaptations in relation to patient needs. (Example--if the student is going to apply a hot water bottle over a wet dressing, he may not reason out that the temperature of the hot water bottle should be less than would be normally acceptable.)
III. **OBJECTIVE:**

To assist the student in developing the ability to identify the physical, emotional, spiritual, social, and teaching needs of patients.

**OUTSTANDING**

(95-90)

The student is able to identify all of the factors which constitute total nursing care, even when these factors involve more than the commonly encountered needs of the patient. (Example--the student recognizes that a patient who has a condition which causes him to react untowardly to even the average degrees of heat and cold should be bathed in tepid water.) The student recognizes when the less obvious needs of the patient are not being met and he is aware of the measures which may remedy this situation. (Example--the student may suggest the use of a footboard for a patient who continuously slides down in bed, even though the patient does not have a condition which ordinarily is associated with the use of such a board.)

**ACCEPTABLE**

(85-80-75-70)

The student is able to identify most of the obvious factors which constitute the total care concept, but he may not recognize the more insidious needs of the patient. (Example--the student recognizes that the colostomy patient needs to be taught self-care, but he may not see that this same patient...
needs to have a follow-up visit at home by some nursing agency.) The student is able to recognize when the more obvious patient needs are not being met, but he has difficulty with isolating the less obvious needs. (Example--the student may recognize that an alcoholic patient needs assistance from Alcoholic Anonymous but he may not be aware of how to initiate this assistance.)

UNSATISFACTORY

(65-60-55)

The student is seldom able to identify even the most glaring factors which make up total care. (Example--The student often does not recognize the need to observe such basic safety factors as putting cribsides up, attaching signal lights, and having sufficient help when assisting a handicapped patient.) The student is seldom able to recognize when the needs of the patient are being neglected even in the simpler nursing situations. (Example--the student may not recognize that the diabetic patient has needs which require consideration beyond the immediate hospital period.)
IV. OBJECTIVE:

To assist the student in developing the ability to organize assignments to such a degree that the plan includes provision for the meeting of the physical, emotional, spiritual, social, and teaching needs of patients.

OUTSTANDING
(95-90)

The student plans care systematically in even the most difficult nursing situations. The student carefully thinks through the needs of the patient before commencing care and he allows adequate time to complete the assignment. (Example--if the student knows that the patient needs to be taught about the diet, he will plan time for a question period as well as a teaching period by judiciously economizing on some other activity.)

ACCEPTABLE
(85-80-75-70)

The student is able to plan patient care effectively in the usual situation, but he may not show a consciousness of the time factor when some additional patient need has to be met. (Example--if the student knows that he has to assist the doctor with a lumbar puncture sometime during the morning, he may neglect to take advantage of the free moments he has to gather the necessary equipment, with the result that the assignment may not be completed on time.)
The student is consistently unable to do ordinary simple planning for patient care. He often does not complete his assignment on time, regardless of whether or not an additional patient need arises which needs attention.
V. **OBJECTIVE:**

To assist the student in developing the ability to execute nursing care assignments to such a degree that adjustments can be made when circumstances arise which interfere with the original plan of performance.

**OUTSTANDING**

(95-90)

The student carries out the assignment on a consistently high level of performance, regardless of how challenging or how complex the nursing situation may be. The student does "first things first" even when this involves a complete change in the original plan of care. (Example--if a patient receives some bad news, the student realizes that it is more important at that time to listen to the patient than to concentrate on finishing the bath.) The motions of the student are purposeful and waste steps and waste efforts are kept to a minimum. The student performs with overall effectiveness in an emergency situation. (Example--if the patient suddenly develops respiratory distress, the student raises the head of the bed, signals for assistance, and remains with the patient.)

**ACCEPTABLE**

(85-80-75-70)

The student may have difficulty with the execution of an assignment if circumstances arise which substantially interfere with the original plan of care--this difficulty may be
particularly obvious when it comes to deciding "first things first." (Example--if a broncoscopy is suddenly ordered in the middle of the morning's routine, the student rushes to finish the bath rather than to spend the time preparing the patient emotionally for this test.) The student tends to waste steps and motions when he feels rushed. The student performs the proper emergency measures in the commonly encountered situations. (Example--if someone faints, the student acts effectively.) In a more complex situation, however, the student may not carry through on all of the necessary measures. (Example--if a patient starts to hemorrhage, the student may rush for help rather than remain with the patient.)

**UNSATISFACTORY**

(65-60-55)

The student is unable to execute even the simpler nursing assignments. The student becomes quite erratic and functionless in stress situations which require a change of plans for care. The student wastes steps and motions whether under stress or not--may often be seen wandering about in an aimless manner on the nursing unit. The student usually does not perform effectively in even the most obvious emergency situation. (Example--if an unconscious patient begins to choke on a formula being given by gavage, the student does not clamp the tube to stop the solution from flowing.)
VI. OBJECTIVE:

To assist the student in developing the ability to report and record observations which are pertinent to the welfare of patients.

OUTSTANDING
(95-90)

The student promptly reports to the proper person whenever the least obvious or least expected (but significant) symptoms arise in relation to the assigned patients. The student's charting is always pertinent, inclusive, and well expressed, regardless of how involved the patient situation may be.

ACCEPTABLE
(85-80-75-70)

The student reports the more outstanding changes in patients' conditions, but may not report those changes which are less obvious. The student's charting is pertinent for the usual patient situation but it may be incomplete if the nursing situation is such that numerous aspects of care need to be recorded. (Example—-if the student is commenting on an immediate post-operative patient, he may leave out important observations.) The student may not express statements with clarity nor judiciously use medical terminology.
The student often does not report the more obvious changes in patients' conditions unless he is specifically told to look for certain symptoms. The student's charting contains extraneous comments and is usually incomplete. Charting may also tend to be poorly organized and awkwardly expressed.
VII. **OBJECTIVE:**

To assist the student in developing that degree of interpersonal sensitivity which is necessary to the establishment and maintenance of rapport with the various levels of co-workers.

**OUTSTANDING**

(95-90)

The student shows an exceptional understanding and consideration of co-workers. The student is alert to the need of assisting co-workers when the occasion arises and he always acts in a professional but friendly manner with them. The student uses good judgment and diplomacy when responding to a situation which could easily arouse antagonistic behavior in others. (Example--if the student sees an aide who is about to perform some aspect of patient care which would be of harm, the student might offer to assist her and thus show by action the correct procedure, rather than by a verbal reprimand.)

**ACCEPTABLE**

(85-80-75-70)

The student is courteous with co-workers and he shows an appreciation of their role although he may not consistently assist them when he is free to do so. The student usually acts in a professional manner with co-workers but he may err in the direction of being too familiar or too formal when
confronted with an awkward or unusual situation. (Example— if the student is told by an authority figure to do something which violates a principle, he may become quite indignant and offer sharp comments rather than handle the situation more diplomatically and with understanding of the other person's viewpoint.)

UNSATISFACTORY
(65-60-55)

The student shows an inconsistency in his relationships with co-workers. He may not often assist others or he may become so involved with the work of others that his own responsibilities are neglected. The student has much difficulty establishing a satisfactory professional relationship with co-workers, he may be either very casual and unassuming with them or he is openly critical of their behavior. The student shows little evidence of ability to interact effectively with co-workers.
VIII. **OBJECTIVE:**

To assist the student in developing skills in communicative techniques.

**OUTSTANDING**

(95-90)

The student establishes a good therapeutic communicative relationship in even the most trying patient situations. (Example--the student effectively handles the situation of caring for a patient of the opposite sex who is known on a dating basis.) In respect to the need of the patient, the student has the skill to encourage either socialization or verbalization with the patient. In even the more difficult nursing situations, such as during a pelvic examination, the student has the facility for making the patient feel at ease. Regardless of the circumstances, the student shows evidence of being more concerned with the patient than with the activity which the patient is undergoing.

**ACCEPTABLE**

(85-80-75-70)

The student establishes a satisfactory relationship with the usual patient but he may have problems in this area when he is confronted with a more difficult patient, such as one who is crying and depressed. The student is usually able to assist the patient with the verbalization of worries, but he may not show as much consciousness of the patient's feelings.
when concentrating on his own activities. (Example—when the student is teaching the patient he may be so concerned with the process itself that he may not talk on the patient's level nor present material in comprehensible amounts.) The student makes the patient feel emotionally comfortable if the activity involving the patient is not new to the student; otherwise, the student may show more concern for himself than the patient. (Example—if the student is assisting the doctor for the first time with some procedure, he may not reassure the patient because of being so concerned with what is expected of him by the doctor.)

UNSATISFACTORY
(65-60-55)

The student has marked difficulty in relating to the patient with even a minimum of problems. The student gives the impression of being too unconcerned with their problems or he may tend to become so identified with their problems that he cannot function with effectiveness. The student may be able to encourage socialization but he may have difficulty with encouraging verbalization. Because of an insincere, hesitant, abrupt, or insecure approach, the student is not usually successful at assisting the patient to feel at ease in a nursing situation.
IX. **OBJECTIVE:**

To assist the student in developing that degree of insight necessary to the evaluation of personal strengths and weaknesses in relation to nursing activities performed.

**OUTSTANDING**

(95-90)

The student is fully aware of his strengths and weaknesses and can evaluate these in a realistic manner. If he is in doubt in the nursing situation, he will always seek the necessary information or ask for the instructor's assistance before proceeding with the activity. The student knows his limitations and acts accordingly. The student seeks and graciously accepts suggestions for improvement. The student is consistently able to evaluate himself with an increased degree of proficiency as time progresses.

**ACCEPTABLE**

(85-80=75-70)

The student has difficulty analyzing his strengths and weaknesses—he may tend to overemphasize or underemphasize certain traits out of proportion to their reality. The student usually asks questions when he is in doubt, but he may not always ask the proper person. (Example—the student may confer with a classmate rather than with the instructor.) Occasionally, the student may commence an activity without recognizing the need for the instructor's assistance until
the problem becomes quite difficult to handle. The student accepts suggestions for improvement in the proper spirit. An increased ability to evaluate self is obvious as time progresses.

**UNSATISFACTORY**

(65-60-55) The student is unable to realistically weigh his strengths and weaknesses. The student seldom recognizes the need for supervision and often proceeds with a nursing activity without an adequate understanding of the activity or what is needed to carry out the activity. The student may accept criticism but may not be aware of its significance. The student shows little or no growth in the area of gaining insight relative to self-evaluation as time progresses.
X. **OBJECTIVE:**

To assist the student in developing that degree of insight necessary to the evaluation of self in terms of personal and group progress.

**OUTSTANDING**

(95-90)

The student shows consistent, steady self-progress from one experience to the next. The quality of nursing care given is of a continuously improved nature, even when the student is assigned to patients who present very special problems. In general, the student performs well with a minimum of instructor guidance. Whether under direct supervision or not, the student always assumes adequate responsibility for his assignment and can be relied upon to give quality care, regardless of any poor example which may be seen in the environment. The student progresses very well in relation to the rest of the group and often exceeds group development in certain areas.

**ACCEPTABLE**

(85-80-75-70)

In general, the student shows progress in relation to self and he performs nursing care on higher levels as more experience is gained. The student may occasionally repeat a similar error in a situation which is new and where the problem is a complex one; however, he displays the ability to profit from past mistakes and with the average amount of
instructor guidance, he is able to function more and more adequately. Whether under direct supervision or not, the student is consistent in the quality of nursing care given; however, he may be swayed by poor example in the environment if the circumstances are very unusual. The student progresses satisfactorily in terms of group development although he may need encouragement to keep showing improvement in areas which may have always been above the average achievement. (Example—if the student had always done better than was expected of him in communicative skills, he should continue on a higher plane in this area, even if at the time he is still doing better than the rest of the group.)

UNSATISFACTORY
(65-60-55)

From one experience to the next, the student shows limited self-improvement. There is little or no improvement seen in the quality of nursing care given even in a similar or related situation. Although there may be some improvement seen in a repeated, simple situation, the student needs almost complete instructor direction when more complex problems are presented. The student often repeats similar types of errors and he does not seem to profit from corrections given him on past mistakes. The student is easily influenced by poor example in the environment and if he is not under direct supervision, the quality of care given is questionable. The
student has displayed little progress in respect to overall group development even when he is compared to the slower members of the group. The student has much difficulty evaluating himself in terms of the group; he often feels that he is doing "as well as" or "better than" the rest of his classmates.
3. DEVELOPMENT OF THE FORM TO BE USED FOR THE WRITTEN
COMMENTS PERTINENT TO CLINICAL PERFORMANCE

Another phase which was involved in the construction of the tool was the devising of an evaluation form on which written comments pertinent to the student's achievement in the clinical area could be recorded. This form also contains space for the clinical practice grade which was determined on the basis of the rating scale. Since the clinical practice objectives were so crucial to the rating scale itself, it was felt that they should also appear on this form. The form was set up so that there was space allowed opposite each objective for the instructor to comment on the extent to which the student had fulfilled each objective. This form is reproduced on the following three pages.
UNIVERSITY OF VERMONT
School of Nursing

EVALUATION OF STUDENT CLINICAL PERFORMANCE IN
MEDICAL-SURGICAL NURSING

GRADE

NAME____________________ CLASS OF__________ DATE__________

OBJECTIVES TO BE MET:

1. To assist the student in developing the ability to interpret and analyze data on clinical charts in the light of possible implications for nursing care.

2. To assist the student in developing the ability to reason out the application of principles.

3. To assist the student in developing the ability to identify the physical, emotional, spiritual, social and teaching needs of patients.

4. To assist the student in developing the ability to organize assignments to such a degree that the plan includes provision for the meeting of the physical, emotional, spiritual, social and teaching needs of patients.

COMMENTS:
STUDENT EVALUATION, Cont.

NAME ____________________________ 

5. To assist the student in developing the ability to execute nursing care assignments to such a degree that adjustments can be made when circumstances arise which interfere with the original plan of performance.

6. To assist the student in developing the ability to report and record observations which are pertinent to the welfare of patients.

7. To assist the student in developing that degree of interpersonal sensitivity which is necessary to the establishment and maintenance of rapport with the various levels of coworkers.

8. To assist the student in developing skills in communicative techniques.
9. To assist the student in developing that degree of insight necessary to the evaluation of personal strengths and weaknesses in relation to nursing activities performed.

10. To assist the student in developing that degree of insight necessary to the evaluation of self in terms of personal and group progress.

OTHER COMMENTS:

STUDENT COMMENTS:

CONFERENCE COMMENTS:

SUMMARY COMMENTS:
4. DEVELOPMENT OF THE SHEET OF DIRECTIONS

The last phase pertinent to the construction of the tool was the composing of a sheet of directions to accompany the use of the rating scale and the evaluation form for written comments. This was done so that all of the instructors who used the forms could do so in as consistent a manner as possible. The direction sheets as they were set up are reproduced on the following pages.
BACKGROUND INFORMATION AND SUGGESTIONS PERTINENT TO THE USE OF THE FOLLOWING FORMS:

1. "A Guide to be Used in the Grade Determination of Student Clinical Performance in the Medical-Surgical Nursing Course"

2. "Evaluation of Student Clinical Performance in Medical-Surgical Nursing"
I. PURPOSE OF THE GUIDE:

To provide as objective and as constant a base as possible for the evaluation of student performance in respect to determining a grade and in respect to the writing of evaluative comments.

II. USE OF THE GUIDE:

Following a review and study of the anecdotal notes kept on a student, each of the ten areas on the Guide should be read in an effort to determine which description of behavior in each category is most consistent with the student's level. (For example, in respect to meeting Objective #2, the student's performance might be consistent with that described under the "Outstanding" column, while in respect to Objective #4, the student's performance might be more in accord with that described under the "Acceptable" column). However, incidents of behavior on the student's anecdotal record should provide the only basis upon which the student is placed in the various categories.

III. DETERMINATION OF THE GRADE:

Once it is decided which of the three descriptions under each objective best characterizes a given student, a grade is chosen for each area judged. In order to establish an over-all grade, an average of all the grades from each area is obtained. (For example, if a student received a
grade of 80% for meeting objectives #1, 3, 6, and 8; a grade of 70% for meeting objectives #2, 5, 9, and 10; a grade of 90% for meeting objective #7 and a grade of 65% for meeting objective #4, the over-all grade for clinical practice would be 76%.

If the instructor does not feel that it is possible to grade a student in the area of a certain objective, (due perhaps to the student's lack of experience with a situation in which this ability would ordinarily be judged), then only those areas in which a grade could be justified are averaged. Since all ten objectives are weighted equally, there is no penalty on the student's grade if all areas are not used.

Because it is very possible that within a given description of behavior, a student may vary from being very highly "acceptable," (85%), to being just barely "acceptable," (70%), a range of from two to four grades is offered for each of the three categories under each objective. The instructor, therefore, needs to choose the one grade for each area which seems to best represent the caliber of the student's performance.

IV. WRITING THE EVALUATION:

Once a grade has been determined, general comments based on anecdotal notations relative to the achievement of each of the objectives evaluated should be made on the form called, "Evaluation of the student's Clinical Performance in
Medical-Surgical Nursing." (Some examples of actual student behavior might be included to illustrate certain statements).

The "Other Comments" section of the form may be used for recording any statements which cannot be written elsewhere, such as comments on grooming problems, health problems, etc.

The "Student Comments" section of the form should be used by the student to express his reaction to the evaluation and his plans for future improvement. Any other comments would also be acceptable.

The "Conference Note" section of the form should be used by the evaluator to comment on the nature of the conference which was held with the student.

The "Summary Comments" section of the form may be used to make overall general statements.
IMPLEMENTATION OF THE TOOL

Involved in the process of implementing this tool was the selection of the area in which to test it and the orientation of the instructors and students who were to participate in its use.

The tool was tested in the medical-surgical nursing course of the basic collegiate program for which it was designed. The four instructors and the thirty-five students who used it were also involved in this specific course.

During the time this device was being constructed, the chief instructor in the medical-surgical area was consulted frequently and agreement was mutually reached on all major points relative to the scale and its use. One general meeting was held with the four instructors in the medical-surgical course. At this time, the author described the purpose of the study, explained the construction of the scale, reviewed the form which was to be used for the written evaluations, and discussed the role which each of them was to play as student evaluators. An explanation of how the instructors were to assist with the reliability and validity test of the scale was also given as well as a request for their cooperation in answering a questionnaire relative to the scale. It was further agreed that the instructors would orient the students to this tool and its use since the author did not have any contact with the students during the writing of the study.
EVALUATION OF THE TOOL

In order to evaluate this tool, two validity tests and one reliability test were performed. In addition, two sets of questionnaires, one for the instructors and one for the students, were used.

Description of Validity Tests

In order to ascertain to what extent the grades which were determined by the use of the scale agreed with some other measure of clinical ability, the following activity was undertaken. Prior to using the scale, two instructors were asked to agree on the ranking of all students into two equal groups: one group would contain those students who were considered to be "high" in clinical performance; the other group would contain those students who were considered to be "low" in clinical performance. Following the determination of grades based on the use of the scale, the students were again placed into two equal groups, depending on whether or not they received "high" or "low" grades. The phi coefficient of correlation was then calculated for the two sets of rankings.

The second test for validity was carried out by comparing and correlating the clinical practice grade derived by the use of the scale with the grade received for theoretical classroom instruction. According to an article written by
Potts,\textsuperscript{26} the correlation between the theoretical and the clinical ability should be a high one.

\textbf{Description of Reliability Test}

In order to find out to what extent the rating scale could give similar results when used on the same students by different instructors, the following activity was undertaken. Two of the instructors used the rating scale to determine a grade for the same four students—one of whom was an "outstanding" student; two of whom were "acceptable" students; and one of whom was an "unsatisfactory" student. The grades which were calculated by the two instructors for the same students were then compared and rank order correlation figures were obtained.

\textbf{Description of Instructor Questionnaire}

In order to find out how the instructors reacted to the use of the rating scale and the use of the form for the written evaluation of student progress, a questionnaire composed of six open-ended questions was devised and used.\textsuperscript{27}

\begin{flushright}
\footnotesize
\textsuperscript{26} Potts, Edith, "She Can't Learn Anatomy, But---, American Journal of Nursing, 33:888-891, September, 1933. (The correlation between the theoretical and clinical grades in this study was 0.834.)

\textsuperscript{27} For a sample of the instructor questionnaire form, see Appendix A.
\end{flushright}
Description of Student Questionnaire

In order to find out how the students reacted to their clinical practice evaluations, a questionnaire composed of five open-ended questions was devised and used.  

PROCUREMENT OF THE DATA

The data for this study were procured from an exhaustive literature survey, from a study of student records, from a study of the University bulletin in which the nursing school was located, from the development and use of the rating scale, from the development and use of the form for written comments on student achievement, from the responses obtained on two sets of questionnaires, from the reliability and validity tests used on the rating scale, and from the conferences held with the instructors in the program for which the scale was devised.

28 For a sample of the student questionnaire form, see Appendix B.
CHAPTER V

PRESENTATION AND ANALYSIS OF THE DATA

This chapter is devoted to an analysis of the data collected in this study. The results of the validity and reliability tests will be presented as well as the results of the instructor and the student questionnaires.

VALIDITY OF THE SCALE

The validity of this scale was tested in two ways. Prior to its use, two instructors, working together, divided the thirty-four students into two groups. One group consisted of those seventeen students whose clinical performance was considered to be of "high" caliber; the other group consisted of those seventeen students whose clinical performance was considered to be of "low" caliber.

Following the determination of a grade based on the use of the rating scale, the same students were again divided into two groups—one group consisted of those seventeen students who received a "high" grade for clinical performance; the other group consisted of those seventeen students who received a "low" grade for clinical performance.

Table 1 illustrates the results of those two ratings.
TABLE 1

Instructors' Grouping of Students into "High" and "Low" Ability Groups as Compared to the Same Grouping Based on Clinical Practice Grades Determined by the Use of the Rating Scale

<table>
<thead>
<tr>
<th>Instructors' Grouping</th>
<th>low ability group</th>
<th>high ability group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating Scale Grouping</td>
<td>high ability group</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>low ability group</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>17</td>
<td>34</td>
</tr>
</tbody>
</table>

This table shows that perfect agreement was found to exist between the two groupings. A phi coefficient of correlation of .31 or over would be statistically significant for this size sample. The phi coefficient of correlation for these two measures is 1. This is highly significant, indicating that the rating scale did measure what it was set up to measure.

The second test for validity involved the comparison between clinical practice grades which had been determined through the use of the rating scale and the grades which had been achieved for the theoretical part of the medical-surgical course.

Table 2 illustrates the results of that comparison.
TABLE 2

A Comparison of Point Differences Between Grades Received for Clinical Practice and Grades Received for Theoretical Work

<table>
<thead>
<tr>
<th>Point Difference</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Students</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

This table shows that there was a difference of five points or less between the theoretical and practical grades of nearly seventy-five percent of the total class of thirty-four students. This closeness of grades further indicated that the rating scale was valid.

RELIABILITY OF THE SCALE

Through the use of the rating scale two instructors graded the same four students—one of whom was considered by them to be an "outstanding" student; two of whom were considered by them to be "acceptable" students; and one of whom was considered by them to be an "unsatisfactory" student.

Table 3 illustrates the results of those gradings.
TABLE 3
A Comparison of the Grades Given to
Same Four Students by Two Instructors
Who Used the Rating Scale to Determine
the Grades

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>Grades Given by Instructor A</th>
<th>Grades Given by Instructor B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outstanding Student</td>
<td>Acceptable Student</td>
</tr>
<tr>
<td>#1</td>
<td>88</td>
<td>75</td>
</tr>
<tr>
<td>#2</td>
<td>90</td>
<td>74</td>
</tr>
<tr>
<td>#3</td>
<td>89</td>
<td>77</td>
</tr>
<tr>
<td>#4</td>
<td>90</td>
<td>78</td>
</tr>
<tr>
<td>#5</td>
<td>89</td>
<td>80</td>
</tr>
<tr>
<td>#6</td>
<td>92</td>
<td>76</td>
</tr>
<tr>
<td>#7</td>
<td>88</td>
<td>83</td>
</tr>
<tr>
<td>#8</td>
<td>90</td>
<td>83</td>
</tr>
<tr>
<td>#9</td>
<td>90</td>
<td>80</td>
</tr>
<tr>
<td>#10</td>
<td>91</td>
<td>85</td>
</tr>
</tbody>
</table>
Based on Spearman's rank correlation coefficient, the correlation figures for each of the four ratings were as follows:

Student I ---- .766
Student II ---- .879
Student III ---- -.700
Student IV ---- .815

Except for Student III, those correlations were highly significant, since a figure of .564 would be statistically significant for this size sample.\(^1\) It seemed, therefore, that the rating scale was proven to have consistency between raters on the basis of this test.

INSTRUCTOR QUESTIONNAIRE DATA

In order to determine the degree to which the rating scale met its contributory and concomitant purposes\(^2\) and in order to obtain the overall reactions of the instructors to its use, a questionnaire for instructors using the scale was devised. The findings were as follows:

1. All of the instructors indicated that the direction sheet pertaining to the use of the rating scale was beneficial. Most of them further stated that such a sheet would be particularly helpful in the orientation of new faculty members.

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\(^1\) It is possible that this negative correlation was the result of instructor disagreement over the interpretation of the anecdotal record of this student.

\(^2\) To review the purposes of this study, see pages 1 and 2.
2. All but one of the instructors felt that the rating scale was practical to use in terms of the personal effort expended and the time it took to determine the grades.

3. With the exception of two objectives, all of the instructors indicated that the descriptions of behavior were so stated that they were helpful in deciding where to place the students. However, all but one of the instructors felt that there was overlap in meaning between objective #4 and objective #5.

4. All of the instructors felt that the use of the rating scale for grade determination would assist them in their guidance function with the students.

5. All of the instructors indicated that it would be easier to confer with parents and guardians about student standing after using the scale, since they felt that the scale provided them with a more objective method of pointing out the grounds for specific evaluative comments.

6. All but one of the instructors felt that the use of the rating scale would lead to easier interpretation of student standing to the administrator of the program.

7. All of the instructors indicated that, in general, the rating scale aided them in arriving at objectively based grades. However, the following qualifying statements were offered:

   (1) "It is difficult to attach a grade to behavior which may not always be consistent."

To review these two objectives, see pages 41 and 43.
(2) "It is hard at best to be objective—I would prefer to have
a system whereby the student is
said to be either satisfactory
or unsatisfactory, without the
necessity of giving a grade—but since a numerical grade has
to be given for practice, the
scale is very useful for this
purpose."

(3) "Although the scale appears to be
a more objective method, I wonder
if it doesn't merely categorize
our existing subjectivity."

8. None of the instructors were satisfied with
the way in which the grade was calculated.
They felt that certain objectives should be
more heavily weighted than others. They
also indicated that they would prefer the
grade interval in the "unsatisfactory" level
to be the same as the University's range—
that is, below sixty per cent.

9. All of the instructors felt that with some
revision the guide was worth using again.

In addition to the above summary, there were some
other isolated comments which seemed to have definite impli-
cations in regard to the rating scale. Those comments em-
obody the following thoughts:

1. "The rating scale is only as good as
the people who use it; it could be a
poor tool in the hands of some people."

2. "Anecdotal records tend to be written
with an eye toward the later use of the
rating scale."

3. "Some of the behavioral descriptions
seemed a bit ideal—particularly for those
students in the first semester of the
Medical-Surgical course."

4. "Some of the anecdotal notes were not written
as objectively as they should have been."
5. "The scale is somewhat inflexible—it tends to set one's thinking toward a particular goal."

6. "There is too wide a spread of grades in the 'acceptable' area."

7. "Much more time should be spent in preparing people who could excel in evaluation and guidance, since these functions are such an important part of the nurse's education."

In respect to the use of the form for the written evaluative comments, all of the instructors were favorably impressed. However, the following suggestions were offered concerning its possible improvement:

1. "More space should be allowed for the 'Student Comments' section of the form."

2. "The form is bulky which makes it rather inconvenient for permanent filing."

On the basis of the information obtained from the instructor questionnaire, it appeared that the rating scale adequately met those purposes for which it was constructed.

STUDENT QUESTIONNAIRE DATA

In order to determine how the thirty-four students felt who were evaluated on the basis of the rating scale, a questionnaire was devised. The findings were as follows:

1. All of the students indicated that they liked being evaluated on the basis of specifically stated objectives. Typical comments were:
(1) "Specifically stated objectives set up a clear picture for you to see. By being evaluated according to these objectives I feel that one can obtain a greater insight into one's self and how they are doing."

(2) "I felt that it was the only way in which an accurate evaluation could be made since the objectives were such that they covered the entire performance of the semester."

2. Ninety-five percent of the students stated that they felt that the way in which their grade had been determined was a fair one. Typical thoughts were:

(1) "I realize that to determine a grade for such intangibles as 'attitudes' and 'abilities' is very difficult and often of questionable reliability. I think, therefore, that the method of breaking up the clinical work into sections and then rating the student on each section comes as close as possible to an accurate analysis."

(2) "Since separate objectives were used for different aspects of our work, it gave us a fair chance to make up for low marks in any weak areas."

3. All of the students felt that it was advantageous to know where they placed in respect to each of the three levels of performance on the scale. A representative statement was:

"The honest opinion of instructors is always of value. I find it beneficial to know 'where' and 'why' as well as 'what'."

4. All but one of the students felt that the evaluation they had received would contribute to their improvement in the clinical area. Typical thoughts were:
(1) "I feel that this evaluation will help me to understand exactly where I need the most improvement and it has also made me feel freer to ask for advice in specific ways to improve."

(2) "We now know our strengths and weaknesses and can work from there. We know exactly the areas we need work in and, therefore, should be able to improve our clinical performance."

5. All of the students made favorable comments pertinent to the periodic reuse of this method of evaluation. Typical statements were:

(1) "It is difficult to appraise yourself objectively and frequent evaluations aid in improvement before problems develop."

(2) "The use of a consistent form is of great help in looking back and evaluating present work on the basis of past work."

(3) "It is an eye opener and a good reminder to yourself."

In addition to the above summary, other comments which carried certain implications had to do with the desire of the students to experience more frequent evaluative conferences; to be made more acutely aware of problem areas at the time of their occurrence; to play a more active role in the evaluative process; and to have the opportunity to discuss and study the objectives and the rating scale previous to their use.
On the basis of the information obtained on the student questionnaire, it appeared that the rating scale met the one purpose which was primarily student oriented--"to aid the students in the assumption of increased self-evaluative abilities."
CHAPTER VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

The primary purpose of this study was to develop a valid and reliable rating scale, based on clinical practice objectives, which could be used in the determination of grades for clinical performance in the medical-surgical nursing course of a specific basic collegiate program. Other purposes of this study were to devise a scale which would:

1. be practical to use;
2. be as objective a measuring tool as possible;
3. assist in the estimation of student growth;
4. help in the interpretation of progress to students, parents and administrators;
5. aid the student in the assumption of self-evaluative activities.

The writing of this study was justified on the premise that since academic credit was frequently being allocated for clinical practice, a method for determining a grade for such practice seemed mandatory. It was further felt that if this method were a reliable and valid one, it would serve its purpose to an even greater degree.

An exhaustive literature survey revealed that there was abundant material which pertained to most of the general areas involved in testing. However, information relative to
the evaluation of clinical performance was scarce and of a non-specific nature.

Prior to the construction of the scale, the medical-surgical clinical practice objectives of the program for which the scale was devised were refined and reformulated, since the behavioral descriptions in the scale were ultimately based on these objectives.

The scale itself consisted of three behavioral descriptions— one which contained typical examples of behavior which might be exhibited by an "outstanding" student; one which contained typical examples of behavior which might be exhibited by an "acceptable" student; and one which contained typical examples of behavior which might be exhibited by an "unsatisfactory" student. Three such descriptions were written for all ten clinical practice objectives so that the instructor, following a review of anecdotal records, could decide to what degree the student had achieved each of these objectives.

A range of grades was established for each of the three levels of performance, from which the instructor was to choose that grade which was assigned to the level which contained the behavioral description which was most consistent with the student's actual performance. The overall grade for clinical practice was to be obtained by averaging whatever objectives were evaluated.
Following the construction of the scale, an evaluation form was devised on which the clinical practice grade could be recorded as well as comments pertinent to actual student performance.

A direction sheet was also written so that all of the instructors who used the scale and the evaluation form would be aware of their purposes and how they were to be employed.

When the scale was evaluated, the two tests for validity and the one test for reliability revealed positive and significant correlations to the degree that the scale could be considered to have met both of these criteria satisfactorily.

Two sets of questionnaires—one student oriented and one instructor oriented—revealed that the secondary purposes of the study had also been met. On the whole, both groups were favorably impressed with the tool and were willing that, with some revision, it be used again.

CONCLUSIONS

On the basis of this study, the following conclusions seemed justified:

1. The rating scale provided a valid and reliable method of determining a grade for clinical practice.

2. The rating scale was practical to use from the time and effort standpoint.
3. The use of the rating scale reduced trial and error activities in the determination of the grade for clinical practice.

4. The rating scale when reused will aid instructors in the estimation of student progress.

5. The rating scale helped the instructors in their guidance function with students.

6. The rating scale assisted the instructors in their advisory role with parents and guardians of students.

7. The rating scale aided the instructors in their role as interpreter of student achievement to the administrator of the program.

8. The rating scale could assist the student in the assumption of increased self-evaluative abilities.

9. The form for written evaluative comments provided a systematic, concise method for the recording of the grade and pertinent comments.

10. The sheet of directions will prove useful in the orientation of newly appointed faculty members.

RECOMMENDATIONS

On the basis of this study, the following recommendations are offered:

1. That this rating scale, following revisions pertinent to overlapping behavioral descriptions and grade range figures, be used and evaluated again in the same program with the same class of students.
2. That this rating scale be used in the same program with other classes of students.

3. That this rating scale be reviewed periodically by the students as a step toward their eventual complete self-evaluation.

4. That a rating scale constructed in the same manner but based on another school's clinical practice objectives in medical-surgical nursing be developed so that a comparative study could be done.

5. That the behavioral descriptions in this rating scale be further studied in an attempt to reduce the semantic barriers present.

6. That continuous effort be expended toward the more objective recording of anecdotal notations.

7. That continuous study and subsequent revision of clinical practice objectives be undertaken.

8. That continuous study be made of the various factors which contribute to bias in the area of student evaluation in the clinical field.

9. That more research be done in an attempt to discover other methods of determining grades for clinical performance.

10. That efforts be directed toward the encouragement of nurse educators to specialize in the realm of evaluation.
BIBLIOGRAPHY
BIBLIOGRAPHY


Potts, Edith Margaret, "She Can't Learn Anatomy, But ____," American Journal of Nursing, 33: 888-891, September, 1933.


APPENDIX A

INSTRUCTOR QUESTIONNAIRE PERTINENT TO THE USE OF THE TOOL
Questionnaire Devised for the Instructors in the Medical-Surgical Clinical Area of a Specific Basic Collegiate Program Where the Form—"A Guide to be Used in the Grade Determination of Student Clinical Performance in the Medical-Surgical Nursing Course" was Used.

DIRECTIONS: Answer the following questions on the blank sheets of paper provided. Please be as specific as possible by giving the reason behind your responses.

QUESTIONS PERTINENT TO THE GUIDE:

1. Was the direction sheet which accompanied the guide of help to you?

2. Was the guide practical to use in terms of time and effort required on your part?

3. Were the descriptions of behavior so stated that they were of assistance in helping you decide into which grade category a given student should be placed?

4. Were you satisfied with the method used to arrive at a grade for clinical practice?

5. Do you think that the use of this guide in the determination of grades will assist you to more effectively carry out:
   
   1. your function as a guidance person with the student?
   
   2. your function as a counselor with parents or guardians of students?
   
   3. your function as an interpreter of student standing to the administrator of the program?
   
6. Did you feel any differently about holding an evaluation conference with the student after having used this guide to arrive at a clinical practice grade as contrasted to the methods you may have used previously to determine such a grade?

7. Did you feel that this method of grade determination allowed you to arrive at as objectively a calculated grade as is possible?
8. Is this scale worth using again for the same purpose?

9. Please state your overall reaction to the guide as well as any suggestions for its improvement.

QUESTIONS PERTINENT TO THE WRITTEN EVALUATION FORM

1. Did you feel that the form was so constructed that it served its purpose adequately? Enough space for written comments? Convenient to work with?

2. Did you feel that your evaluations tended to be more objectively and fairly written when the same criterion (clinical practice objectives) was used with all students?

3. Please state your overall reaction to the usefulness of the form as well as any suggestions for its improvement.
APPENDIX B

STUDENT QUESTIONNAIRE PERTINENT TO THE
USE OF THE TOOL
Questionnaire Devised for the Students in the Medical-Surgical Clinical Area of a Specific Basic Collegiate Program Where the Form—"A Guide to be Used in the Grade Determination of Student Clinical Performance in the Medical-Surgical Nursing Course"—was used.

DIRECTIONS:
Answer the following questions in the spaces provided below. If additional space is needed, the back of the sheet may be used. Please be as specific as possible in your responses.

1. How did you feel about being evaluated on the basis of specifically stated objectives?

2. Did you feel that the way in which your grade was determined was a fair one?

3. Did it upset you to know where you stood in relation to each of the three categories for each objective which appeared on the scale?

4. What effect do you think the evaluation you have just received will have on your clinical performance during the remainder of this course?

5. Do you think that the periodic reuse of this method of evaluation will help you to better appraise yourself in terms of strengths and weaknesses?