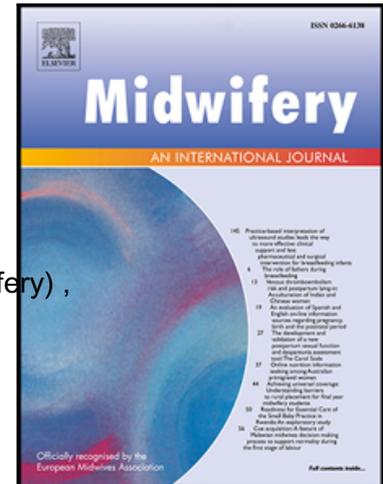


# Accepted Manuscript

Safety first: Factors affecting preceptor midwives experiences of competency assessment failure among midwifery students

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PII: S0266-6138(19)30062-2  
DOI: <https://doi.org/10.1016/j.midw.2019.03.012>  
Reference: YMIDW 2441



To appear in: *Midwifery*

Received date: 7 August 2018  
Revised date: 14 March 2019  
Accepted date: 17 March 2019

Please cite this article as: Carmel Bradshaw RN, RM, RNT, DPSM, MSc, PG Dip Education (Midwifery) ,  
Dr Judith Pettigrew PhD, MA, BSc OT, Dip OT , Dr Mary Fitzpatrick BBS, GDE, M.CIPD, MBS, PH.D, SFSEDA ,  
Safety first: Factors affecting preceptor midwives experiences of competency assessment failure  
among midwifery students, *Midwifery* (2019), doi: <https://doi.org/10.1016/j.midw.2019.03.012>

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**Title**

“No one wants to fail anybody but...”

Factors affecting preceptor midwives experiences of competency assessment failure among midwifery students

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1 Conflict of interest: None declared

2 Ethical approval: Ethical approval received for this study from Ethics Committee, HSE Mid West (covering University Maternity Hospital, Limerick) and from Ethics Committee, University Hospital, Waterford (covering University Maternity Hospital, Waterford, South Tipperary General Hospital and St Luke’s University Maternity Unit, Kilkenny) in Feb 2016.

3 Funding Sources: This research did not receive any specific grant from funding agencies in the public, commercial or not –for-profit sector.

**Acknowledgements**

Thank you to the preceptor midwives who participated in this study and provided a comprehensive picture of their experiences of assessment of midwifery students in clinical practice. Thanks too to those who recruited preceptors to the study and to the Directors of Midwifery who granted access to the participants.

## **Safety first: Factors affecting preceptor midwives experiences of competency assessment failure among midwifery students**

### **Abstract**

**Background:** Assessment of clinical practice is a core component of midwifery education. Clinical assessment is challenging and affected by a number of factors. Preceptor midwives are reported to be reluctant to fail students in clinical assessments. This is worrying as preceptor midwives are gatekeepers to the profession of midwifery and need to ensure midwifery students are safe and competent practitioners of midwifery on completion of their programmes.

**Methods:** This qualitative descriptive study explores preceptor midwives experiences of clinical assessment of midwifery students in four maternity units in the Republic of Ireland. Following ethical approval, twenty-nine preceptor midwives were interviewed. Content analysis was used to analyse the data and two themes with associated subthemes identified.

**Findings: Competency assessment in practice** was supported by a robust, clearly delineated process, considered vital to ensure effective and fair assessment of midwifery students. The process in place had many advantages but attracted some criticism too, most notably language, documentation and lack of continuity of the preceptor. The **challenges** of clinical assessment were multifaceted but the most pressing concern was dealing with students who were struggling in practice where the outcome of an assessment was potentially a fail. Preceptor midwives expressed reluctance to fail students but balanced this with ensuring safety for women and their babies. A number of other challenges hampered decisions in clinical assessments. These included the confidence of the preceptor, juggling the competing demands of clinical practice with effective assessment in an increasingly complex and fiscally challenging environment, operationalising the competency assessment process and the emotional toll associated with failing a student.

**Conclusion:** Preceptors' primary focus is on ensuring that graduate midwives are safe and competent practitioners and it is this which guides their decision making on the outcome of clinical assessments. However, more support is required for the onerous responsibility of

clinical assessment, particularly for less experienced midwives but also when failure of clinical assessment is a potential outcome. Preceptorship needs to be valued more at a strategic level.

### **Highlights**

Reluctance to fail midwifery students in clinical practice by preceptor midwives is always outweighed by concerns for safety of practice.

Failure of clinical practice assessments in midwifery are affected by a multiplicity of factors, many unrelated to student performance. These factors include the increasing complexity of maternity settings, compounded by staff shortages, challenges in operationalising assessment processes and the emotional costs associated with failing a student.

Failing a clinical assessment is stressful for both the student and the preceptor midwife and appropriate support needs to be provided to all involved.

Preceptorship needs to be valued more particularly from a strategic perspective to recognise preceptors' responsibilities as gatekeepers to the profession of midwifery.

### **Key words**

Failure, Clinical assessment, Competency assessment, Midwifery, Preceptors, Assessors, Safe practice.

### **Introduction**

The aim of any midwifery programme is to ensure that at registration the graduate midwife is a safe and competent practitioner of midwifery and can provide care to women and their babies in a variety of settings, including antenatal, intrapartum, postnatal and neonatal care. Midwifery students are prepared for practice in a number of different ways internationally. In the Republic of Ireland (ROI.) , students can access midwifery programmes directly and complete the four year BSc Midwifery Degree. Alternatively, registered general nurses can complete a shortened midwifery programme, the Higher Diploma in Midwifery, which is 18 months in duration. The standards and requirements for both midwifery programmes are prescribed by the Nursing and Midwifery Board of Ireland (NMBI) (An Bord Altranais 2005,

2007, NMBI 2016) and are reflective of international standards for midwifery education programmes (ICM 2010). It is the responsibility of the Higher Education Institutes (HEIs) offering midwifery programmes to ensure these standards are met.

Midwifery is a practice based profession and it is through exposure, participation and assessment of clinical practice that midwifery students are prepared for safe and competent practice on completion of their programmes. Theoretical input is provided by the HEIs but the clinical practice requirements, which constitute at least 50% of midwifery programmes, are facilitated within the maternity services.

Prior to the transfer of midwifery education to HEIs in the Republic of Ireland in 2006, the midwifery student had been supported and supervised in their clinical practice by midwives. The responsibility of summative assessment however, rested with the clinical midwifery manager (CMM) and the School of Midwifery situated within the maternity unit.

In preparation for the introduction of direct entry to midwifery in 2006, the role of the midwife extended to the summative assessment of the student. To facilitate this change, a number of supports were put in place nationally. Clinical Placement Coordinators in Midwifery (CPCs) were employed and Midwifery Practice Development Units (MPDUs) established within the maternity services to support both students and midwives as recommended by the Dept. of Health and Children (2004). Teaching and assessment programmes were provided by the HEIs and the MPDU on the use of a new competency assessment framework to prepare midwives to act as preceptors of midwifery students in clinical practice. Preceptor is the term used by the NMBI to describe this assessment role but other regulatory bodies e.g. the Nursing and Midwifery Council (NMC 2009) in the UK use the term mentor to describe the same role. A preceptor is defined as a registered midwife who has been specially prepared to guide and direct student learning during clinical placement, and assumes the role of supervisor and assessor of students achievement of clinical learning outcomes and competence (NMBI, 2016). The key role of the preceptor as a gatekeeper to the midwifery profession is acknowledged internationally (NMBI 2016., NMC 2009., Fitzgerald et al. 2010). A competency assessment process agreed between the HEIs and the maternity services was implemented locally. Each student was allocated a named primary preceptor during placement in a clinical area, usually for a minimum of four weeks

where a competency assessment is expected to be completed. The preceptor is expected to support and supervise the student in collaboration with her midwifery colleagues and is responsible for the summative assessment, facilitated by a competency assessment process. An associate preceptor, prepared as above is also assigned to each student and takes responsibility for the student in the absence of the primary preceptor

Assessment of the student is enabled by a series of interviews over the placement, an initial, midpoint and final interview, ideally facilitated by the named primary preceptor or associate preceptor. If a student fails a clinical assessment, a repeat assessment is facilitated and the student cannot progress on the programme until successful repeat of the clinical assessment. If the repeat assessment is failed, the student may be asked to exit the programme.

This qualitative study sought to determine the experiences of preceptor midwives, who had been engaged in the support, supervision and assessment of midwifery students using a prescribed competency assessment framework in four maternity units in the Republic of Ireland. Specifically, this paper focuses on the challenges preceptor midwives experience with students who struggle with assessment in practice, sometimes resulting in failure of clinical assessment.

## **Background**

The safety of mothers and babies has always been a priority of the providers of maternity services. An evaluation of undergraduate nursing and midwifery programmes in Ireland (Dept. of Health, 2012) acknowledge this, noting that the wellbeing of the mother and her baby/ies overrules all other considerations in clinical practice and this is reiterated by the NMBI (2016), NHS (2016) and the RCM (2014). This focus on safety has been accentuated by tragic outcomes, which have highlighted deficits in maternity care nationally (Corcoran et al. 2015., HIQUA 2013., HIQUA 2015.) and internationally (King 2016., Kirkup 2015).

Consequently, midwifery care has been scrutinised and concerns raised in relation to safe practice and the primacy of safety in maternity care is a focus of the recently published National Maternity Strategy (Dept. of Health 2015).

In addition to this critique of care, there is a well-documented increase in women presenting for care in pregnancy with pre-existing comorbidities which impact on their care (McKeating et al 2015., Denny and Dunne 2010.), a rise in the age of women having their first babies (Biro et al 2012., Luke and Brown 2007.) and increased interventions including a spiralling caesarean section rate noted in the Western World. This has occurred in the context of an economic downturn that had implications globally, and in Ireland specifically resulted in significant reductions to funding within the health services. A moratorium on recruitment to maternity services was put in place from 2009 (Health Services Executive 2009) which although formally rescinded in 2016 has not yet resulted in a full complement of midwives employed within maternity services. Incentives encouraging early retirement among senior midwives from 2009-2012 were a further blow to denuded staffing levels and to skill mix.

In addition to this crowded context, preceptor midwives were coping with the introduction of a direct entry undergraduate degree programme to midwifery and a shortened post registration midwifery programme (reduced from a two year to an 18 month programme as directed by the Dept. of Health & Children (2004)). This necessitated orientation of preceptor midwives to the use of a new competency assessment framework and process, whilst assessing students to ensure safe and competent practice of midwifery.

The literature highlights issues that nurse and midwife preceptors face when assessing students (Hunt et al. 2016, Bradshaw et al. 2013, Cassidy et al. 2012, Bradshaw et al. 2012, Butler et al. 2011, Heffernan 2009., Rutkowski 2007., Duffy 2004., Dolan 2003, ) in clinical practice from both student and assessor perspective. Challenges identified include dealing with the competing demands of clinical practice, managing the time requirements of assessment, lack of continuity for the preceptor assigned to the student, the confidence and competence of the preceptor and making sense of complex documentation and language in clinical assessment documentation.

An often reported finding, suggests that nurses and midwives struggle particularly with failing students undertaking clinical assessments (Duffy 2004, Duffy 2013, Cassidy et al. 2017) and a myriad of reasons are postulated for this including some of the challenges noted above. A systematic review which sought to examine what is known about "failure to

fail” in clinical assessment of undergraduate nursing programmes (Hughes et al. 2016), found that there is substance to this suggestion .. However, there is limited literature available to illuminate this issue from a midwifery perspective. This paper seeks to understand the complexities of dealing with a “failing” or “failed” student from the perspective of preceptor midwives in the context described earlier.

## Methodology

A qualitative descriptive design was used. Such a design is merited when the researchers are motivated by discovery and understanding of a phenomenon, a process or the perspectives of the people involved (Caelli et al. 2003, Merriam 1998). In depth understanding of the experiences are sought, but with initial emphasis on literal description as described by Sandelowski (2010) followed by analysis and interpretation of the meaning participants attribute to their experience.

Ethical approval was granted from the relevant ethics committees to undertake the study. Access to the maternity units was provided by the relevant Directors of Midwifery and the study was advertised using posters in each of the four units. Purposive sampling was used to avail of accessible participants, but also allows selection of those whose qualities or experiences are required for the study (Parahoo 2014). Twenty-nine preceptors from the four units were recruited, all of whom were qualified longer than six months and had experience of being a preceptor on at least one occasion. The use of CPCs and CMMs to assist recruitment within the four units, referred to as gatekeepers to the research setting by Holloway and Wheeler (2010), helped to reduce preceptor midwives potentially feeling pressurised into participating by virtue of the position of the researcher within the organisation. Participants who had indicated their willingness to be interviewed by the gatekeepers were contacted by text only once by the researcher, and were not pursued if no response to the text was received. Semi structured interviews were carried out by the lead author , twenty seven of these were face to face in a venue of participants choosing, and two by telephone at the request of the participants.

The range of midwifery experience varied from eight months to over thirty years and the length of interview ranged between 22 minutes to 55 minutes. Some of the midwives interviewed had dual qualifications in nursing and midwifery, whilst others were direct entry

midwives. The interviews were guided using pre-determined questions, reflecting the relevant published literature as suggested by Miles et al. (2014).

The semi-structured nature of the interviews as recommended by Sandelowski (2000) ensured that the relevant information was requested of each participant but avoided limiting responses and encouraged preceptors to discuss concerns specific to them. All of the interviews were audio recorded and transcribed. Confidentiality of the participant was addressed by allocating a numerical identifier to each transcript. Only the interviewing author had access to identifying details of the participants.

The data were analysed using Burnard's framework for content analysis (2011) consisting of coding and categorisation resulting in the ordering and organising of the material into themes and associated subthemes. This was performed by the lead author initially, (Initials to be inserted), the themes and sub themes then reviewed and agreed by the other authors (Initials to be inserted).

### Findings

Two themes, relevant to the complexities of dealing with a "failing" or "failed" student from the perspective of preceptor midwives were identified from the data (Table 1).

<b>Table 1 Findings from the preceptor midwives</b>	
<b>Themes</b>	<b>Sub themes</b>
<b>Competency assessment in practice</b>	<b>Documentation and language</b> <b>Process</b> <b>Continuity of preceptors</b>
<b>Challenges</b>	<b>Students not making the grade</b> <b>Confidence and competence of preceptors</b> <b>Meeting the competing demands</b>

### Competency assessment in practice

A competency assessment process that was clearly delineated was vital to ensure robust assessment of midwifery students, particularly when dealing with students challenged in clinical practice.

The inclusion of the mandated interviews in the process ensured that time was set aside for the assessment process and to ensure there was a mechanism for explicit feedback for the student

*“The interviews give you time, you know to talk to the student, to identify any needs she might have and where she might be failing”* Pre 1

*“The middle interview is so important, because there is no point bringing up something at the end unless it has been highlighted in the middle. That’s not fair to the student or the midwife”* Pre 29

Notwithstanding the acknowledgement of the process in place, there was some critique of the documentation and language within the clinical assessment tool and this became more apparent when a student was struggling in clinical assessment. Many found both the document and the language difficult to navigate but this was less pronounced in those preceptors who had used the documentation themselves as students. A senior preceptor midwife who had used the document for over 10 years remarked on the language

*“The language is not the easiest, but I am doing it so long now, I am familiar with it”* Pre 18

However, another participant who has been a preceptor for many years noted that her experience of using the documentation had not helped

*“I hate that book. It’s not user friendly, in all of the years I have been doing it, it has only got a small bit easier. If it could be written in proper English that a midwife without a degree could understand. If it was more related to practice it would be easier to identify to the student what they were doing wrong and how to get it right and prevent a failure of clinical assessment.”* Pre 25

There were challenges too in the operationalisation of the process, including the time commitment required but most notably in facilitating continuity of preceptor. Every

preceptor interviewed referred to the adverse effect that lack of continuity of preceptor had on the process and ultimately on the assessment of the student.

*“The process is good, even excellent if you have the continuity but you need to have that continuity”* Pre 22

*“Continuity, that’s one of the main things because you know from that first interview the level they started at, you can see whether they are progressing or not, tell them what they need to do and whether or not they pass their competency”* Pre 14

### **Challenges**

There were a number of challenges identified by participants in relation to the clinical assessment of midwifery students. All the participants spoke of their experience of dealing with students who struggled in clinical practice where the outcome of an assessment was a likely or actual fail. This was affected by a multiplicity of factors including meeting the competing demands of practice and coming to terms with the consequences of an assessment outcome, sometimes exacerbated by the competency assessment process. Discussion was dominated by preceptors’ unwillingness to fail students’ competencies whilst at the same time endeavouring to ensure safe practice within midwifery.

Three of the preceptor midwives referred to the fact that they themselves were nurses or in a caring profession and

*“Failing students is against our nature”* Pre 10, Pre 11, Pre19.

Less experienced participants acknowledged the difficulties they faced because of their limited experience and a junior preceptor midwife spoke of failing a student who had a number of complex problems

*“I felt I wasn’t qualified enough to look after the student, I made it clear it was outside my scope of practice. I am angry because it shouldn’t have been left to me, it should have been a more senior midwife”* Pre 22.

Failing a student in a competency assessment had emotional consequences for the preceptor and the student but some of the preceptor midwives felt that the responsibility of the fail did not rest with them as an individual which helped

*“You know there will be tears. One of the most stressful things I have ever had to endure in my whole career. I found it absolutely awful. The student she was lovely but she did not have the knowledge and the skills, no matter what I did”* Pre 18.

*“It’s not a case of you failing a student off your own bat, there is communication and discussion with other, it is a team effort”* Pre 26.

Assessing a student was acknowledged as time consuming, failing a student even more so.

*“It’s so understaffed and you are under so much pressure that sometimes you think I will just get on with it,(passing a student) because if I report these issues it will just open a can of worms and I am already hours behind my work as it is”* Pre 23.

Notwithstanding, the hesitancy expressed about failing students in clinical assessment, many participants spoke of the importance of ensuring that midwifery students could provide safe midwifery care to women and their babies.

*“I had been thinking for about a week “Oh my God I can’t pass this student and what am I going to do, a failure is going to affect her training. I have to pass her”... and then I thought, I have to think about the women and the service, I can’t pass her. I cannot live with that, it would be less stress but it is not the right thing to do”* Pre 6.

Participants often personalised the issue when considering students struggling to meet the appropriate level and keeping the focus on safety helped

*“When I am making my decision, I ask myself would I leave this student alone with my labouring sister and if I won’t, the student has to fail”* Pre 24.

A number of factors could affect decision-making skills when deciding assessment outcomes, most notably lack of continuity with the student

*“I ended up doing a final interview for someone who is now qualified. I think in hindsight I shouldn't have agreed to it. I did pass her based on working with her for about two days, that isn't enough practice to make an assessment”* Pre 6.

The confidence of the preceptor midwife was an important element in the assessment process and this was more often noted by participants who were newly qualified

*“I was not a good preceptor to that student, through my own insecurities. I was newly qualified and there was bit of fear there, fear for my own registration, fear that I wouldn't get it right”* Pre 11

Another dominant issue related to meeting the competing demands of clinical practice whilst facilitating support, supervision and assessment of midwifery students.

*“Trying to give the woman your time, trying to get all your workload done, your paperwork done and then teaching a student in between all that, following doctors in between and assessing a student on top of all of that, it's just so hard “* Pre 13

Preceptor midwives, juggling the many facets of their workload, were often angry and disillusioned about the lack of support they received

*“There is no allowance made for us having a student midwife and preceptoring with the same workload. Large or small, it still falls on your shoulders, it's tiring and draining. I would love to see somebody care for the preceptors”* Pre 10

## **Discussion**

This study explored preceptor midwives experiences of engagement in the support, supervision and assessment of midwifery students using a prescribed competency assessment framework in four maternity units in the Republic of Ireland. Preceptor midwives spoke of the many challenges associated with clinical assessment in practice, given the busy, complex and fiscally challenging environments preceptor midwives work within. The most dominant concern for the participants was dealing with students struggling with clinical assessment, sometime resulting in failure of clinical assessment.

In this study preceptor midwives reported reluctance to fail midwifery students for a variety of reasons. This is supported by nursing literature (Duffy 2004, Duffy 2013, Cassidy et al. 2017). However despite their misgivings, predominantly associated with the emotional consequences for both the student and themselves, most of the preceptors considered it to be unethical to fail “to fail”. Participants attributed this to the overarching need to ensure safe practice for women and their babies, a factor considered the cornerstone of midwifery practice and one which has been the focus of critique in several recent reports investigating failures within maternity services (Corcoran et al. 2015.,HIQUA 2013.,HIQUA 2015.,King 2016., Kirkup 2015).

However, there are a myriad of factors which affected preceptor midwives ability to make an informed decision on the outcome of an assessment in this study. The time consuming nature of assessment (Moran and Banks 2016) competed with the demands of care provision,(Bradshaw et al 2013) compounded by complex language and documentation (Fraser 2000, Hanley and Higgins 2005,) and limited continuity of preceptors ( Bradshaw et al. 2013), all impacted on the participants decision on whether to pass or fail a student in clinical assessment.

There were several references to the preceptor role as gatekeepers to the profession as identified by the NMBI (2016). Participants referred to their ethical obligation to promote safety (Earle-Foley et al. 2012) and protect women and their babies from unsafe practice. However, most participants considered it from a more personal perspective, which helped them to make their decision in relation to a pass or fail of an assessment. This was similar to the findings of Hunt et al (2016 p. 82) which suggest a model for assessment decision beginning with the question “Would I let this student look after me “. Similarly, participants in this study based their assessment decisions on whether or not the student could be trusted to look after themselves or a family member. This personalisation was perceived as a mechanism to promote safety in practice addressing their gatekeeper role, but also helped consolidate decisions on outcome of assessment.

There was recognition that failing a student in a clinical practice assessment had significant implications for the student and emotional consequences for the student and preceptor midwife. Preceptor midwives abhorred the notion of failing a student, attributed in some

instances to being dissonant to their professional and personal philosophy. This finding is supported by Luhanga et al. (2008) and Kennedy and Chesser–Smyth (2017) with reference to nurse preceptors. Participants in this study referred to the philosophy of midwifery as one of education and empowerment (NMBI 2015a, ICM 2005) and therefore incongruent with failing a student.

The more inexperienced preceptors attributed their unwillingness to fail students in clinical assessment to lack of confidence in their own abilities as referenced by Timmins et al (2017). If the situation was compounded by other challenges e.g. special needs of a student, the junior preceptor was further impeded in her decision-making ability. Reduction of barriers to entering nursing and midwifery programmes and improving access will result in more students requiring specialist support in clinical assessment, and support for the preceptors will need to be considered in tandem. The NMC (2008) stipulate that appointment to the role of preceptor should only be when the midwife is qualified a minimum of six months and had the opportunity to consolidate their own practice before being expected to guide others. The NMBI (2016) provide less prescriptive guidance but do state the preceptor should be experienced in midwifery practice. The Scope of Nursing and Midwifery Practice Framework (NMBI 2015b) can also provide support and guidance to preceptor midwives when confronted with challenges outside their competence or expertise.

Preceptor midwives in this study considered themselves a lynchpin for students in clinical practice, evidenced too by Moran and Banks (2016). The preceptor role is often referred to as central to midwifery students' experience of clinical practice and assessment (Hughes and Fraser 2011, Bradshaw et al 2013), and by regulatory bodies such as the NMBI and the NMC in the UK. This study does not detract from this assertion, but queries the promotion and support of this role from a strategic perspective. This is evidenced by reference to factors that influence the quality of clinical assessment, in an environment where there are many competing demands made of preceptor midwives and operational challenges associated with the competency assessment process. These include maximising continuity of preceptor midwives and recognition of the time required to complete comprehensive assessment of the competencies at the prescribed level. These findings are supported by previous research particularly in the nursing context (Hunt et al 2016, Cassidy et al.2012,

Bradshaw et al. 2012, Butler et al. 2011, Heffernan 2009, Rutkowski 2007, Duffy 2004, Dolan 2003), ) and in the midwifery setting (Moran and Banks 2016, Bradshaw et al. 2013).

Assessment in clinical practice is time consuming (Moran and Banks, 2016, Morrow et al. 2016) and requires protected time to facilitate the process (NMC 2008), incorporating space for reflection on practice by preceptor and student. Continuity of preceptor midwife was considered vital and was the most frequent challenge to deciding outcome of assessment in this study. Consideration needs to be given to a mechanism to facilitate continuity of preceptor and student midwife. If this is not feasible, consideration needs to be given to how best support a student working within a team of midwives to ensure a fair and informed clinical assessment.

Preceptor midwives in this study discussed the support systems utilised when students were struggling with a competency assessment and Hunt et al. (2016) elaborate on the types of assistance required including emotional, evaluative, informational and instrumental support for preceptors. Support from colleagues and the CPCs were accessed by preceptors in this study, often to confirm or refute their own appraisals, particularly when their decisions were impacted on by not knowing the students. Support from CPCs was also recognised by nursing students in the study by Butler et al. (2009) and by midwifery students in the study by Bradshaw et al. (2013), both from an Irish context. Butler et al. (2009) reported that nurse preceptors perceived the CPCs as supports for nursing students more so than for themselves. This perception was not apparent in this study or in Kennedy and Chesser-Smyth (2017) study of nurse preceptors in Ireland, where CPCs were seen as support for students, preceptors and the assessment process overall, but particularly when students were identified as struggling in practice. Support from colleagues was particularly valued and for many participants reduced the onus of their own individual responsibility if a student failed their competency. A fail did not happen in isolation but with consensus and collaboration of the midwives who had worked with the student, a team effort. This was essential where continuity of preceptor had been limited as reported by many of the participants. This collegial approach in consultation with the CPCs also helped to detract from some of the emotional burden associated with failure of a student. This is likewise advocated by Cassidy et al (2017) to combat the assessment of the student being a "lone" affair. Unlike the findings of Hunt et al. (2016), preceptor midwives did not identify using

supports available outside of work to combat their distress with these difficult decisions. This may be in part accounted for by the network of support provided by their midwifery colleagues, often outside of work. Nevertheless, this does not detract from the turmoil these preceptors experienced which may have affected their personal lives

### **Recommendations and Implications for practice**

The preceptor midwives in this study considered what might help with the intricacies of facilitating effective assessment of clinical practice in busy complex care environments where the first priority is always the care of women and their babies.

- Mandatory updates of preceptorship education programmes with a focus on supporting preceptors when students are challenged with or are unsuccessful in competency assessment, suggested too by Kennedy and Chesser-Smyth (2017).
- A mechanism for feedback to preceptors needs to be implemented, advocated also by Moran and Banks (2016). Preceptors very rarely received feedback on their own effectiveness as preceptors, which affected their development and their confidence and competence in assessment of all students, but especially those who were struggling with clinical assessment.
- Incentivising the preceptor role would enhance the value of preceptorship and tangibly acknowledge the onerous responsibilities of safeguarding entry to the profession of midwifery. Inducements suggested included increased payment for preceptors, credits for continuing professional development, protected time for assessment and a reduction in caseload.

### **Limitations**

This study examined the experiences of preceptor midwives in four maternity units, all of which served as placements for midwifery students from one university in the Republic of Ireland. Confining the study was deliberate to ensure that participants were discussing their experiences of a defined competency assessment process and documentation in use in all of the units. The findings of the study do however, reflect other research findings internationally and may have resonance with providers of midwifery and nursing education

and practice. It also contributes to the limited research published from a midwifery perspective on this issue.

## **Conclusion**

Preceptorship need to be valued more to recognise their responsibilities as gatekeepers to the profession. Supports for preceptor midwives have been acknowledged, but the findings of this study indicate deficiencies resulting in lip service to the worth of preceptors.

As advocated by Hunt et al (2016), a more comprehensive examination of the supports required by preceptors who are charged with preparing midwives for the future is required. The perspectives of midwifery students who have failed clinical assessments also merit exploration as recommended by Hughes et al (2016).

Failing a student in clinical assessment is fraught with difficulties for preceptor midwives, compounded by extraneous factors which are outside their control included staffing deficits and increasing complexity of midwifery care. The emotional costs of failing students must be recognised and appropriate support and credit provided to preceptors who are balancing their responsibilities to students of midwifery but also to the profession to provide safe and effective midwifery care to future generations of women and their babies. Regardless of the difficulties associated with failing midwifery students, preceptor midwives prioritise safety of women and babies over any other consideration when undertaking clinical assessment.

## **Declaration of Interest**

This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sector.

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