



The influence of a preceptor–student ‘Daily Feedback Tool’ on clinical feedback practices in nursing education: A qualitative study



Louise Allen ^{a,*}, Elizabeth Molloy ^b

^a Federation University, Gippsland Campus, 1670 Lardner's Track, Lardner, Victoria 3821, Australia

^b Faculty of Medicine, Nursing and Health Sciences, Monash University, Clayton, Victoria 3168, Australia

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ABSTRACT

Background: Feedback in clinical education is essential for the development of competent nurses. When the process is enacted well, it offers measured performance against standards required by the nursing health profession, promoting learning and behavioural change. Despite this, health literature describes numerous barriers to effective feedback processes.

Objective: A qualitative descriptive design was used to determine whether the introduction of a Daily Feedback Tool addressing some of the barriers to effective feedback, influenced nursing students and clinical supervisors (preceptors) experiences in nursing clinical education.

Method: A total of eight semi-structured focus groups related to student and preceptors reported experiences were completed comprising of preceptor and student groups independently. The data was analysed using aspects of grounded theory including purposive sampling and system analysis informing the subsequent stages of data collection.

Results: Participants reported that the introduction of the Daily Feedback Tool overcame some of the reported barriers, particularly relating to the frequency of feedback occasions, and the traditionally didactic, teacher-led feedback conversations.

Conclusion: The Daily Feedback Tool was reported to influence the development of trusting preceptor–student relationships which gave the learner agency to seek feedback promoting learning and overall performance.

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1. Introduction

Key elements for effective feedback for health students' performances during clinical placement identified in both nursing and other health education literature include: promotion of self-evaluative skills, clarification of good performance related to expected standards, formation of action plans and goals for further skill achievement, promotion of teacher and peer dialogue around learning, and motivation for students to learn promoting self-confidence and clinical competence through correction or reinforcement of clinical performance (Boud and Molloy, 2013; Nichol and Macfarlane-Dick, 2006; Rose and Best, 2005; Plakht et al., 2013; Kertis, 2007). Omission of these factors can result in students failing to recognise performance strengths and deficits, potentially resulting in substandard clinical skill development (Eva et al., 2012). The aim of this research is to explore any influence of introducing a Daily Feedback Tool (DFT), informed by empirical studies, on nursing students and preceptors' experiences of feedback in the clinical setting. It is predicted that the results of this study may be helpful in aiding

further development of a structured feedback tool and accompanying education programs for students and preceptors.

2. Background

Key barriers to effective feedback practices include inadequate amount of feedback, substandard feedback processes and a lack of communication between preceptors and students (Boud and Molloy, 2013; Middleton, 2007; Fernando et al., 2008; Henderson et al., 2006; Dunn and Hansford, 1997; Molloy, 2009; Molloy and Clarke, 2005; Sender-Liberman et al., 2005). The tendency for supervisors to deliver monologues in verbal feedback was seen to restrict students' opportunities to exercise their self-evaluative capacities (Molloy, 2009). In other studies, students reported receiving predominantly negative feedback, opposing preceptor's reports of reluctance in providing negative feedback for fear of upsetting learners and reducing motivation (Clynes, 2008; Elicigil & Sari, 2007; Webb and Shakespeare, 2008).

Despite these issues, both students and preceptors describe the value of feedback as a necessary commodity for learning. (Elicigil and Sari, 2007, 2008; Plakht et al., 2013; Webb and Shakespeare, 2008). These findings, justify the need for improving the feedback process in nursing clinical education informing the development of a DFT.

* Corresponding author.

E-mail addresses: l.allen@federation.edu.au (L. Allen), elizabeth.molloy@monash.edu (E. Molloy).

3. Aims and Objectives

The aim of this study was to determine whether the introduction of a DFT addressing some reported barriers to effective feedback, would influence the feedback process in undergraduate nursing clinical education.

4. Methods

This paper forms part of a larger mixed methods study, employing a comparative design (pre and post intervention analysis). The purpose of this paper is to report on analysis of the qualitative data from participants who experienced the DFT process (Creswell, 2007; Lingard et al., 2008).

This research was conducted in the acute general medical and surgical wards of a rural hospital located in Victoria, Australia. Ethical approval was granted for this study by the Human Research Ethics Committee of Monash University (CF11/2985–2011001684), and the participating rural hospital Ethics Committee. Participation in this project was voluntary; the main researcher held no position of influence over participants and informed written consent was obtained from all participants. The audio transcript was coded and recorded verbatim to ensure participant anonymity and an audit trail was generated to document theoretical, methodical and analytical choices to increase credibility and rigour (Liamputtong, 2009).

Undergraduate nursing students from Monash University ($n = 10$) at second or third year level participating in clinical education for at least two weeks were purposively selected to ensure students had previous exposure to clinical education and feedback processes. Limiting participants to the one educational facility, promoted consistency in the way in which students were orientated to clinical education and the feedback process. Purposive sampling of Registered nurses ($n = 14$) with equal or greater than one year's post graduate experience and who had been educated on effective feedback processes, ensured that participants had some clinical supervision experience to draw upon.

4.1. Data Collection

Preceptors from the medical and surgical wards and second and third year nursing students were invited to attend separate 60 minute focus groups held by the main researcher to ensure consistency of data collection. These four focus group interviews were conducted before the DFT intervention using semi-structured and open ended interview questions regarding 'typical' feedback practice in nursing clinical education informed from the literature. The participants in two settings, medical and surgical wards, were exposed to the DFT for two weeks and interviewed post intervention in the same composition as the pre-tool implementation four focus groups to seek their experiences of the DFT (refer to Table 1).

This study involved a responsive relationship between all sets of data whereby results influenced the next phase of research supporting a grounded theory approach.

4.2. Data Analysis

The focus groups were audio taped and transcribed verbatim. Researchers LA and EM coded transcripts independently and arrived at an analytical framework. LA completed analysis of the remaining data set using the framework, and a final meeting was held with co-researcher EM to ensure that the coding process represented the emerging data adequately.

Processes of open, axial and selective coding were employed, consistent with grounded theory linking ideas and concepts based on participants' reality and investigation of humanistic experiences (Creswell, 2007; Lingard et al., 2008; Liamputtong, 2009). All lines of transcripts

Table 1
Research phases.

Phase	Activity	Participants
1. DFT development	Informed from the literature review and analysis of published feedback models in health professions literature (Allen, 2014).	Research team as DFT designers
2. Pre-tool implementation data collection	Audio recorded qualitative semi-structured focus groups	Preceptors and students as independent groups
3. Tool implementation	Introduction of the DFT to the clinical setting across two wards: Surgical ward and medical ward. Orientation of the process and objectives of the DFT. Students were asked to approach their preceptors with the DFT to initiate feedback. The completed copy of the DFT afforded reflection of feedback episodes for students.	Collaborative approach by both students and preceptors
4. Post-tool implementation	Audio recorded qualitative semi-structured focus groups.	Preceptors and students as independent groups

were numbered to aid identification of quotes and commonalities. This open coding allowed information to be broken down, enabling the researcher to look at 'bits of information, by dissecting and labelling it' (Liamputtong, 2009). Axial coding ensured elaboration of each code by asking questions such as; 'when, where, why, who and how?' to gain deeper understanding of each category leading to theory generation (Corbin and Strauss, 2008). Finally selective coding refined the theory by identifying core categories. Themes were designated the same code with greatest explanatory relevance and grouped into categories. This substantiated the theory grounded in the data as the study involved a responsive relationship between all sets of data where the results influenced the next phase of research (Creswell, 2007). This process provided insight to relationships between themes amongst the student nurse and preceptor groups. The key theme of insurance of the 'formation of a trusting student-preceptor relationship' became significant in influencing feedback encounters.

5. Results

5.1. Pre-intervention (Traditional Feedback Processes)

This phase was designed to generate a reference point to determine whether the introduction of the DFT would influence feedback experiences for nursing students and preceptors. The following themes about 'traditional' or typical feedback practices emerged.

5.1.1. Feedback Is Valued

Both students and preceptor groups reported that feedback improves performance through identification of deficits and strategies for changing practice.

"If you don't get feedback you can walk away from something not knowing if you did it right". (Student, G1, L33)

"It is [feedback] to make them aware of areas needing improvement", Preceptor, FG 4, L9.

5.1.2. Reported Enablers to Effective Feedback

Preceptors reported that one of the hallmarks of effective feedback is a learner who seeks feedback, and actively searches for cues to help build a picture of their performance. In contrast, students reported that productive feedback was reliant on preceptors instigating feedback

episodes. These conflicting attitudes suggest that upfront communication relating to feedback purpose and process may be key for success.

It [feedback] is better when it is unexpected and the preceptor initiates it", (Student, FG1, L13)

"when the student initiates feedback, it is easier to give the areas if any that need to be improved". (Preceptor, FG4, L129)

5.1.3. Reported Barriers for Effective Feedback

i) Limited opportunities for feedback

Both student and preceptor groups reported that provision of patient care limited available time for feedback.

Student FG1, L42 reported: *"The preceptor was too busy with the patient workload"*

Preceptor FG3, L66 reported: *"(a barrier to giving feedback)...trying to manage a patient load and give the student opportunities to practice and have discussion"*.

ii) Inconsistency in preceptor judgements and expertise as a preceptor

Both student and preceptor groups reported that lack of continuity in the learner–preceptor relationship was a key barrier to effective feedback.

Student FG1, L52 reported: (inconsistent preceptors), *"Not feeling that you can put yourself forward to do more things because the preceptor doesn't know you"*.

Preceptor FG3, L60 reported: (the written assessment) *"is difficult to fill out if you have not worked with the student much"*.

iii) Poor preceptor–student relationships

Both preceptor and student groups reported that poor preceptor–student relationships were a barrier to effective feedback processes.

Student FG2, L103 reported: *"We couldn't approach or discuss our concerns, feelings or experiences with the preceptor"*.

Preceptor FG3, L27 reported: *"when I had to give feedback, we both had a discussion of what was needed to be improved allowing the student to reflect on how they thought they were going"*.

5.2. Post-intervention (The Influence of the Introduction of the DFT)

The post-DFT implementation focus groups revealed that the DFT was not implemented in the surgical ward despite the same orientation workshop for both learner and preceptor parties and the provision of the tool itself. Data collected from surgical and medical ward areas were therefore analysed and reported separately and contrasted with the aim to distinguish any differences between the groups. In the surgical ward preceptors did not initiate the tool and students did not feel comfortable to initiate the process, despite being primed in the same way as students on the medical ward. These findings highlighted significant differences in students not feeling able to approach preceptors in this setting.

As the DFT was not implemented in the surgical ward, whether the DFT had any influence on the preceptors reported experiences remains unknown. To investigate factors that may have inhibited uptake of the DFT, an additional question was added to the semi-structured interview *"why didn't you use the DFT?"*

5.2.1. Enhancing the Feedback Process

i) Frequency and amount of feedback episodes

Student FG5, L3 from medical ward (DFT implementation group) reported receipt of more feedback, and FG6, L107 *"There was a lot more... the preceptors gave us feedback every shift"* and *"It (the DFT) made sure*

that you got feedback because at the end of the day you could say 'can we do the feedback sheet now?' Students from the surgical ward (no uptake of DFT group) described a lack of feedback episodes, FG6, L88 "I got some feedback through the day, but I would have liked a summary at the end of the day".

Preceptors from medical ward reported that the DFT increased episodes of feedback, FG6, L88 *"It made me remember to give feedback"*.

ii) Collaborative approach to feedback

A student from the medical ward reported that the DFT emboldened them to initiate and seek feedback. FG 8, L8, *"It made me seek feedback whereas before I would have been happy to receive it when I got it but this time I sometimes initiated it. It made me partially responsible to improve my own performance"*.

A preceptor from the surgical ward reported that initiation of the feedback process is reliant upon the student. FG8, L8 *"If the students didn't initiate it (feedback) I didn't use it (the tool). It's up to the students to initiate it"*.

Preceptors from the medical ward reported that the DFT motivated students to seek feedback, and enhanced learner reflection. FG8, L8 *"I found after the first few days, the students became more proactive about areas that they wanted to get feedback in and would then initiate the process"*. FG7, L39 *They initiated the review of their own performance making it very easy for me. I could then agree with their self-assessment or reassure them that they were correct and give them some tips for better performances or reinforce how they were going"*.

iii) Feedback aimed at improving performance

A student from the medical ward reported that the feedback process motivated better performance. FG5, L11 *"I received a lot more (feedback) and at the time I did it which helped me to improve on what I had just done so next time I could do it better and it helped me to remember"*.

A student from the surgical ward reported, FG5, L42 *"There was no opportunity for me to discuss my expectations. This made me lose all of my confidence and I didn't want to come back"*.

A preceptor from the medical ward reported that the DFT enhanced clinical performance. FG7, L33, *"I think the tool motivated the student to push themselves in more aspects of nursing rather than waiting for me to initiate learning opportunities"*.

iv) Enhancement of preceptor–student relationships

Both preceptor and students from the medical ward described that they felt valued and preceptor–student relationships were enhanced.

Student FG5, L55 reported *"I felt more like a colleague rather than just a student and the preceptors wanted to help us"* and *"I felt more comfortable discussing my performance and the preceptor seemed to care about helping me improve"*.

Preceptor FG7, L62 reported *"I think the students like the fact that their opinion counts. I think it makes the feedback process a lot more comfortable as the negative things to improve are more sharing of information and advice of what to try rather than a list"*.

A student from surgical ward reported poor communication regarding placement expectations, objectives and goal setting. FG6, L98 *"When the expectations are not discussed it makes it very difficult to know what is expected of you"*.

5.2.2. Repetition and Tokenism

A preceptor from the medical ward commented that the process of the DFT was at times repetitive and tokenistic in nature. FG7, L16 *"Sometimes the only feedback to be given for that day had already been discussed and then could be repetitive"*.

6. Discussion

This exploratory study has identified that the introduction of a DFT appeared to have a positive impact on feedback process within a clinical environment for both students (learners) and preceptors (teachers). It became evident that the introduction of the DFT in the medical ward acted as a 'fire lighter' igniting the feedback process. Once the feedback fire became a self-sustaining glow, indicated by the comfort and ease of the feedback process between the student and preceptor, the ignition of the DFT was no longer required to initiate every feedback process. However, it has also become apparent, that without the presence of key features within the clinical environment required for fuelling for the fire such as; buy in from leadership, engagement by both participants, and significantly, the formation of a trusting student–preceptor relationship, the introduction of the DFT may have little impact on feedback processes for learners and/or teachers.

The findings indicate that there was a significant difference in the learning culture between the two clinical wards studied, resulting in notably different descriptions of feedback experiences. Dadgaran et al. (2013) identified that a positive ward culture, positive attitude to student learning needs, and most importantly, the development of good student–preceptor relationships, were important in students' learning.

Although it was anticipated that the DFT was to be initiated by the student, the data strongly suggested that students needed a sense of trust to be established, before they were prepared to take 'risks' in soliciting feedback.

There is emerging literature on the impact of trust on students' ability to seek and use feedback (Cox and Ewan, 1998; McAllister et al., 1997). Carless (2013) advocates that without the formation of trust between the teacher and learner, the uptake of feedback is seriously constrained, and that trusting relationships are facilitated when there are repeated opportunities for interaction.

On the medical ward, preceptors initiated the use of the DFT, and students commented that preceptors on this rotation were empathetic, approachable and engaged in their learning. Students viewed these qualities as different to experiences of feedback on prior clinical placement rotations. Once a trusting relationship is formed, these students may be more likely to exercise self-evaluation and self-regulation, which can reduce the 'all seeing, all knowing, all telling' expectation that some preceptors find stressful (Bearman et al., 2012).

The potential for the introduction of a simple framework, such as the DFT, to embolden students to seek and use information within an educational context demands more attention in research. In this project, the DFT gave students the authority to seek feedback, knowing that the preceptors were expecting them to seek performance critique. This 'seeming permission' encouraged the students to shift from the status of a passive recipient to an empowered seeker of information (Molloy, 2009).

Early conversations of goals and expectations that were afforded by the DFT between students and preceptors became a reference point for performance measurement (Bearman et al., 2012). Not only did this aid in student–preceptor relationship formation, but the responsibility for advancing performance is handed over to the student which also encouraged self-regulation of practice.

One of the dangers of introducing a model of framework such as the DFT into a clinical environment is that it can potentially become repetitive, as described in this study (Bearman and Ajjawi, 2013; Boud and Molloy, 2013).

Although the DFT was an evidence based framework, the results demonstrated that educator attitudes are key to whether these are used in practice (Rose and Best, 2005). For effective change to occur, parties must believe that the change is important, and they have the capacities to take on the new behaviours (Espleland and Baerheim, 2003). Despite the orientation to the DFT, students were not confident in initiating feedback until a trusting preceptor–student relationship was formed.

The study participants are depicted in stages of feedback engagement within the conceptual model (Fig. 1). Although it was anticipated that students would approach preceptors with the DFT to initiate feedback, until a trusting relationship was formed, initiation was reliant upon the preceptor (stage 1). As feedback episodes unfolded, ensuring both student and preceptor expectations, performance critique reinforcing or modifying performance, and target goals and strategies were discussed, students progressed to stage 2. Stage 2 revealed the development of preceptor–student relationship whereby feedback was initiated by preceptors or students. Throughout this stage, students developed some agency to seek feedback rather than being passive recipients. As the student developed confidence (in both their clinical practice and feedback practice) and the trusting relationship developed further, the student advanced to stage 3. Stage 3 describes the final stage whereby students actively sought feedback and were able to self-

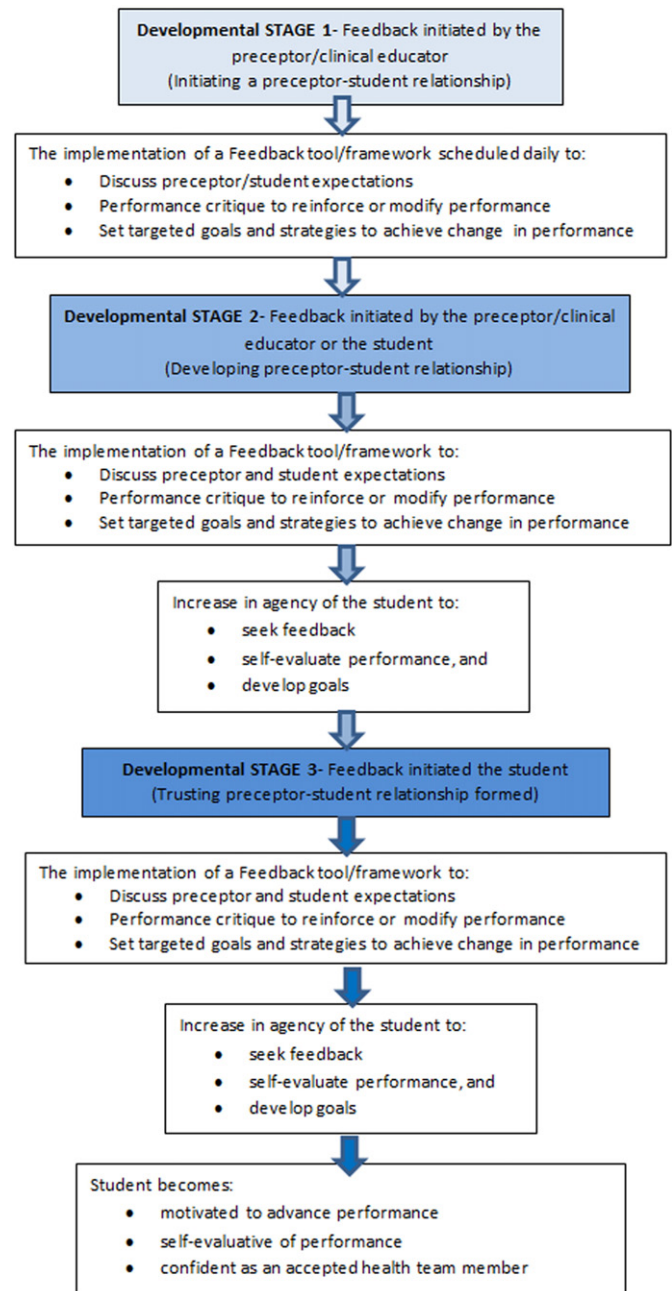


Fig. 1. Conceptual model describing feedback engagement patterns in nursing students' early clinical placements.

evaluate (either prompted or otherwise) as they became accepted as team members within the clinical environment.

Based upon the findings from this study, the following recommendations have emerged as essential implications for feedback within nursing clinical education (Fig. 2).

7. Rigour

This research was designed to adhere to the four components of rigour in qualitative research; credibility, transferability, dependability and confirmability (Creswell, 2007). Credibility was achieved through maintaining an audit trail, utilisation of audio recording of focus group interviews, purposeful sampling of participants for their knowledge, characteristics and experiences, and engagement of additional experienced researchers (Liamputtong, 2009; Carpenter and Suto, 2008; Letts et al., 2007; Roberts and Traynor, 2006). This approach elicited actual experiences from the participants excluding preconceived ideas from the researcher (Heath and Cowley, 2004). Transferability was achieved by ensuring that the research design and methodology was described in enough detail to be applied to other groups and settings (Letts et al., 2007). Dependability was demonstrated by the audit trail of the data collection process and transcription verbatim of direct quotes for further analysis. Concepts were then grouped and labelled into themes as they developed for further exploration using grounded theory approaches (Carpenter and Suto, 2008; Liamputtong, 2009; Scott, 2004). Furthermore, ongoing discussions with co-researcher (EM) ensured that the coding process presented emergent themes adequately. Confirmability was satisfied through the audit trail, literature review and participant selection (Padgett, 2008). By using the concept mapping process (Rosas and Kane, 2012) it was possible to look for relationships between themes, uncovering additional insights to help clarify the influence of the DFT on participants' experiences of feedback.

8. Limitations

This study explored the perceptions and experiences of nursing students and preceptors from a small sample from one educational and one health organisation. Whilst this was a deliberate intention to ensure consistency of educational processes, the data may not reflect perceptions or experiences from other educational or health facilities. A larger study involving multiple institutions and larger sample size is recommended to further investigate the emergent patterns described in this study. Additionally, an observational study design is recommended to investigate how the DFT-mediated discussions compared to traditional preceptor-led feedback encounters.

9. Conclusion

The data suggest that the process of feedback in clinical education between nursing students and preceptors is a complex one, and is

- I. *Provide orientation and education to preceptors and students relating to effective feedback processes*
- II. *Educate both students and preceptors in the use of the feedback tool*
- III. *Schedule daily feedback using the tool (at least in the early stages of education- scaffolding for habit and to enhance the formation of a trusting preceptor- student relationship)*
- IV. *Facilitate the formation of a trusting preceptor-student relationship by ensuring that the preceptor and student work together consistently*
- V. *Promote a collaborative approach to feedback episodes*

Fig. 2. Essential implications for feedback within nursing clinical education.

contingent on key factors such as time, culture of the institution and the attitudes learners and educators. This research suggests that some barriers to effective feedback can be overcome with the implementation of a tool such as the DFT to cultivate productive feedback habits. Key outcomes of the DFT included a more collaborative approach to feedback which in turn helped to develop a trusting student-preceptor relationship (and vice versa); emboldening a 'lower status participant' such as the student to gain status as an information seeker in the workplace environment; and an increase in the agency of the learner to self-evaluate. Both learners and preceptors reported that the scheduled daily feedback increased the amount of feedback compared to their 'traditional feedback' practices.

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Appendix 1

THE DAILY FEEDBACK TOOL

Date:

Student Name:

List three things that you have done well and, why?

(Example: Communication skills- The way in which you approached and explained to the patient that you were about to take blood was in a language and a manner that put the patient at ease)

- 1.
- 2.
- 3.

List three things that need improving/modifying, and why?

(Example: When taking blood the equipment needed was out of reach which made it awkward and dangerous as you had a sharp in your hand)

- 1.
- 2.
- 3.

Ways in which to reinforce or improve on performance.

(Example: Tomorrow you will have another opportunity to take blood, I would like you to practice setting up the equipment so it is within reach. We will aim to provide you with many opportunities to become confident with this skill)

Student signature:

Preceptor signature:

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