Clinical assessment and the benefit of the doubt: What is the doubt?

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KEY WORDS

Clinical education, assessment, competence, clinical supervisor preparation

ABSTRACT

Introduction
Clinical education and associated assessment is an important component of nurse education. A range of factors contribute to a culture that makes the assessment of clinical competence difficult. These factors are environmental, educational, cultural and linguistic diversity amongst students, student expectation, a diverse range of clinical education models. All of which contribute to the variable quality of the clinical education experience and the outcome of clinical assessment.

Aim
The term 'benefit of the doubt' is frequently heard in relation to the assessment process; and, despite the utilisation of a seemingly comprehensive competency framework to assess clinical learning for close to two decades, it seems that a concerning level of doubt persists. The aim of this paper is to examine the complex factors that impact on the quality of decisions around competence the decision by an assessor to assign a judgement of competent or not, and to explore the reasons that lead to doubt on the part of the assessor and to suggest some possible solutions.

Conclusion
It is suggested that what is needed going forward is a continued commitment on the part of government, the health sector, the tertiary education sector and the National Regulatory Authority to implement, value and extend the initiatives that are currently being developed to insure a viable and sustainable education and training culture for clinical supervisors in the future.

INTRODUCTION

Clinical education and the associated assessment is an important component of nurse education. The authors' experience of coordinating large clinical subjects in preregistration nursing courses combined with relevant literature has largely informed this discussion. The term 'benefit of the doubt' is frequently heard in relation to the assessment process; and, despite the utilisation of a seemingly comprehensive competency framework to guide and assess clinical learning for close to two decades, it seems that a concerning level of doubt persists.

AIM

The aims of this paper are to examine the complex factors that impact on the decisions making processes when determining competence, and to explore the reasons that lead to doubt on the part of the assessor. The main question being 'what is the doubt' and how it can be minimised.

A range of factors contribute to a culture that makes the assessment of clinical competence difficult; these factors are environmental, educational diversity, cultural and linguistic diversity, student expectation, a diverse range of clinical education models and clinical educator preparedness for the role.

ENVIRONMENT

The clinical learning environment has been aptly described as a highly complex space occurring at the intersection of health care and education; occupied by numerous health professionals and professional bodies, involving government and non-government employer agencies and multiple levels of authority (National Review of Nurse Education 2002).

Educational Diversity and Expectation

There has been an increase in enrolments across courses and institutions with the move from an elite to a mass education system. This has led to an unprecedented level of heterogeneity amongst the undergraduate student population in Australian universities; and, nursing has been at the forefront of that diversification.

Students' expectations of their educational experiences in nursing are shaped by at least three factors: educational diversity, cultural and linguistic diversity; and, expectations of the tertiary education experience (Deegan 2008).

Range of Entry Pathways

In recent years a number of initiatives have been introduced to improve access to the Bachelor of Nursing preregistration course. For example, provision for increasing the numbers of mature age students and a two-year accelerated program to assist enrolled nurses and graduates of other degree programs to progress to a registered nurse qualification. This has led to a diverse range of prior educational experiences.

This diversity often creates challenges for students, academic staff and clinical educators alike. The challenges for academics and clinical educators, are centred on the learning needs of these diverse groups in terms of readiness for the rigours and complexity of the preregistration curriculum; and, in particular the complexities of the clinical learning environment. Muldoon and Pendreigh (2003) found that, students in Bachelor of Nursing programs, struggle with tertiary and professional literacy requirements despite being highly motivated. These authors acknowledge that while lecturers are aware of these issues they do not always have the time and the expertise to address them effectively; only to have them resurface in the clinical environment where accuracy in written and verbal communication is paramount to both clinical learning and patient safety.

Cultural and Linguistic Diversity

The internationalisation of tertiary education is not a new phenomenon. However, with increasing trends in globalisation in recent years has led to increased demand from international students participating in university courses in Australia (Marginson et al 2011); and despite the recent downturn in numbers of international students there has been a 1.4% increase in the tertiary sector in 2010 (Rosenberg 2011). In this context students who are deemed most at risk are international students, who gain entry into the accelerated nursing program through the recognition of a previous undergraduate degree qualification in another discipline. Quite often a discipline quite disparate from nursing; where basic science and human bioscience are not part of the curriculum. Compounding this, international students in general face complex challenges associated with unfamiliar approaches to education, as many of them are familiar with didactic approaches to teaching; and, rote learning versus more independent problem solving approaches encouraged in Australian universities (O'Neill and Cullingford 2005).

In addition to these adjustments, international students are faced with the need to adapt to cultural and social differences (Baker and Hawkins 2006). Students of nursing are particularly affected by communication and cultural adaptation processes as they apply to the learning encounter. This is because the compulsory clinical education component of nurse education brings them face to face with the daily workings of the health care system and the culture of nursing in Australia (Kilstoff and Baker 2006), thus making the assessment of theoretical, interactional and procedural knowledge difficult in the clinical environment.

Models of Clinical Education

Models of clinical education range from preceptorship, mentorship, or clinician led supervision models to the clinical teacher led model. The latter sometimes referred to as clinical supervisor, or clinical educator; can be either a university or hospital employee. In turn, each clinical venue will have a particular preference in terms of the clinical education model to be utilised to support students on placement. A major factor in deciding this model includes the partnership arrangements between the health care facility and university; but more importantly, the skill mix of the nursing staff available at the health care facility to participate in clinical supervision.

Preceptor/mentorship

The preceptor/mentor is a registered nurse (clinician) who is employed by the clinical venue. The preceptor/mentorship model is generally a 1:1 arrangement with support from a heath care facility education coordinator, and or, a university based academic. However, the demands placed on mentors by an increasingly demanding patient load and limited resources make assessment in practice problematic, given the one-on-one teaching for each skill and incorporating the knowledge base with holistic care (Bonreuf and Haigh 2010 p.198). Having to balance the assessment process with care delivery and, associated duties means that the continuity of the student assessment process is often interrupted, and not viewed as a priority. Adding to this complexity, McCarthy and Murphy (2007) found that the majority of preceptors are inexperienced and do not fully comprehend the student assessment process. They revealed many preceptors focus on the student's practical skills rather than focussing on the holistic care of patients. McCarthy and Murphy concluded the preparation of preceptors was inadequate given the complexity of the clinical assessment process.

The Clinical Teacher/Educator Model

The clinical teacher model means an educator is employed by the university on a casual basis and deployed to the clinical venue with responsibility for supervising the clinical learning and assessment of up to eight students at a given time. This model although seemingly sound from an educational perspective has some serious limitations from the point of view of familiarity with the clinical environment; and, in some cases with the clinical speciality that makes up the student's learning space.

The alternative clinical teacher model which seems to work well from the perspective of the provision of a quality student learning experience is the one, where the supervising clinical teacher is appointed by the health care facility, to work exclusively with nursing students, from various universities without the added responsibility of a patient load. Thus the focus is on the achievement of a quality learning experience within a setting; which although, unfamiliar to the student, is very familiar to the educator.

Preparation of Clinical Educators

In considering the range of clinical education models there are several factors that make a standard model of preparation and, ongoing performance review of educators difficult to plan and implement. Firstly, at the national and international level there seems to be no consensus on minimum qualifications or required experience for clinical educators (Salminen et.al. 2010). As Younge et al (2008) point out that role of the preceptor in the clinical environment does not have professional standards for clinical teaching, with Kaviani and Stillwell (2000) recommending the inclusion of career path competencies. In Australia whilst universities do have some formal preclinical preparation such as professional development workshops for clinical educators; being either, preceptors, or clinical teachers; the duration and content varies and there are numerous barriers to their attendance. Firstly, workshops need to have a generic focus due to the diverse range of clinical education models, and specific requirements of clinical venues. Consequently, workshop attendees are frequently exposed to content that is not always pertinent to them. Secondly, there are financial considerations for nurses to attend these workshops. For example, if the supervisor is a casual employee of the university, they may be in other casual or part-time employment when the workshop is scheduled, which makes attendance not possible. Similarly, if a preceptor, clinical supervisor is provided by the clinical venue, the financial costs to the university to have the staff member released are substantial. Similarly, as universities face budgetary constraints, they are often not in the position to provide an increased reimbursement to the clinical venue, and in turn the clinical venue cannot release the staff member due to the ongoing staffing shortages in nursing. Thus the competing demands of concurrent employment, budgetary and staffing constraints in both sectors all contribute to low levels of attendance at clinical educator workshops.

Competence Defined

Assessing clinical competence is a complex process and competency is generally affected by an individual's perception and understanding of what competency is (Rutkowski 2007). Demonstrating generic skills can be challenging for the student who is often distracted by the presence of the patient when learning how to perform a new skill. Being faced with two distinct aspects of patient care can affect the students ability to do both well (Borneuf and Haigh 2010). Benner (1984), one of the most influential scholars in nursing, has defined clinical competency as the ability to perform tasks with the desirable outcomes under varied circumstances of the real world. In Australia clinical competence for assessment purposes is guided by the Australian Nursing and Midwifery Competency Framework. The ANMC Framework relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base and accountability for practice. In addition, there is generally a Subject Outline indicating the clinical skill and associated knowledge that students need to demonstrate and articulate in order to be successful in completing a given clinical subject. However, despite this there seems to be a persistent dichotomous relationship between observable motor skill and the acquisition of skills in communication, critical thinking, critical decision making and other generic skills, with many educators struggling to articulate problems with student behaviours referring to them as 'grey areas' or just 'difficult to pinpoint' and consequently giving the student 'the benefit of the doubt; despite the fact that the achievement of such skills are incorporated in the ANMC Competency Framework and associated codes.

Challenging behaviours are often viewed as the most difficult to deal with in the context of assessment. According to Luhanga et al (2008, p.258) a challenging student is one who has: difficulty learning, easily distracted, attitude problems as in defensive behaviour and lack of motivation to learn resulting in frequent repetitive mistakes and failure to implement basic safety measures such as asepsis, resulting in potential danger to patients. Lahunga et al concluded that students may not always be receiving adequate knowledge skill preparation at the university level. Conversely, Duffy (2003) found that a student would only be failed when 'unsafe' practice was demonstrated. This is in keeping with the findings of McCarthy et al (2007) that educators were only concerned with safe practice and not with the knowledge and behaviours and attitudes necessary to support it. Whilst the focus of any clinical placement is for the student is to optimise clinical learning opportunity, the flip side of the coin, seems to be the point at where learning is separated from competency. It was noted by Duffy that assessors repeatedly gave the student the 'benefit of the doubt'.

The question here becomes: What is the doubt? It will be argued that at least two possible explanations exist for the persistence of this indecision. Firstly, assessors are not adequately prepared and experience stress caused by demands of managing the many dimensions of the role; frequently being expected to act as student counsellor, teacher, role model, nurse clinician and liaison person between health provider and the university (Duke 1996). Secondly, that the clinical learning environment is complex and variable and frequently supervisors struggle to combine the vicissitudes of a large complex clinical nursing role with the role of educator.

DISCUSSION

The exploration of this topic has raised a complex mix of educational, political, service, financial issues, all of which contribute amongst other things to inadequate preparation and support for clinical educators; which, in turn make assessment of competence in the clinical learning environment difficult to achieve with a high degree of confidence. What is needed then is a practical and sustainable solution to a complex and persistent challenge. The design of the Australian National Competency Standards for the Registered Nurse (ANRA 1990) coincided with the transfer of undergraduate nurse education to the tertiary sector following generations of training under the apprenticeship system. The domains of the National Competency Standards for the Registered Nurse are intended to guide the assessment of student progress and achievement in applying theory to practice (ANMC 2006). However, there seems to be a persistent disconnect between the intent of the framework and the manner in which it is used, if at all, to guide learning and assessment. What was neglected from the outset was a national coordinated approach to the preparation of clinical educators to fit the new national competency model.

Hence, it seems that the theory practice gap persists with variable levels of collaboration between education providers and their health counterparts largely related to a lack of a structured cross sectoral communication strategy and an adequately funded quality approach to the education and training of clinical supervisors.

According to Richardson et al (2000) the learning that a student experiences in the clinical area is frequently only as good as the nurse that supervises them. Hence the personality, personal traits, interpersonal relationships skills as well as the competency and clinical decision making skills of the educator, influence the performance of quality self-efficacy. However, these personal and professional traits are frequently compromised by a range of factors for example Duke (1996) found even though educators were skilled at identifying student problems they were reluctant to make difficult evaluation decisions due to low self-esteem, role conflict and their ethic of caring. Kaviani and Baker (2000) found that the personal and professional development of preceptors, and in turn a positive partnership with university staff are vital in educating students. This was

supported by a Canadian study where Younge et al (2008) found that the quality of the experience of being a preceptor correlated with the level of support provided by the university academics; which goes beyond the initial workshop (McCarty and Higgins 2003).

Self-efficacy it is argued here can be promoted by formal education courses and teaching experiences, enabling the educator to bring about effective student learning by applying education theory, managing the learning environment, meeting goals and judging competencies.

Maddock (2009) noted that ,training involves honing of the mind for the purpose of someone other than the person; whereas, education is the exact opposite, in that it entails not dissociation, but utter integration of knowledge and the self, self-knowledge.(p.1). The focus then must be on formal education courses for supervisors that combine formal education and training, aimed at the development of professional mastery, self-efficacy and self-esteem and the utilisation of those attributes in the teaching and assessment process.

At present the Health Department of Victoria in partnership with Health Workforce Australia (HWA), have introduced a number of initiatives by way of funded projects; aimed at increasing capacity for clinical education. The projects are administered by the Victorian Clinical Placement Council (VCPC), through eleven Clinical Placement Networks (CPNs). The most relevant of these initiatives in the context of this paper is Clinical Supervision and Support Program. The Clinical Supervision and Support Program has a cross-sectoral multidisciplinary focus, aimed at the education and training of the clinical supervision workforce. The most innovative element of this initiative is the cross sectoral focus; with applications for funding requiring evidence of a collaborative commitment between public, private health care providers and education providers.

CONCLUSION

Many issues related to the difficulties associated with accurate assessment of competence have been identified. The key argument being that the current preparation of clinical educators is variable, leading to confusion around student teaching, assessment and management of the learning environment. The Clinical Supervision and Support Program can be regarded as significant catalysts for change around the strengthening of professional relationships at the organisational level, improving communication and collaboration between university academics and clinical placement providers; and, the development of formal teaching and assessment skills, self-efficacy and in turn improved self-esteem. However, what is needed going forward is a continued commitment on the part of government, the health sector, the tertiary education sector and the National Regulatory Authority to implement, value and extend the initiatives that are currently being developed to insure a viable and sustainable education and training culture for clinical supervisors in the future.

RECOMMENDATIONS

- Ongoing commitment by government, the tertiary education sector and health providers to sustain developments around supervisor training.

- The development of a universal generic formal qualification for all clinical educators within a competency framework.

- A strengthening of professional relationships at the organisational level with a view to improving communication and collaboration between university academics and clinicians.

- A requirement by course accreditation authorities that the plan, and annual budgetary allocation for the preparation and ongoing support of clinical educators be submitted as part of the curriculum approval process.

- A commitment on the part of education providers and the health sector to budgetary provision for the development of clinical educators.

- A reduced patient load for clinicians charged with a supervisory role.

- Active promotion of attitudinal change to the status of the clinical educator regardless of the terms or organisational basis of their employment that is be they employed by a hospital or university.

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