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Moving on from the pilot. (The Sligo experience)

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Good afternoon, Madam President, colleagues, it gives me great pleasure to have the opportunity to share with you this afternoon our experiences in Sligo since the pilot project. This will be a practical presentation outlining how we moved on since the pilot project in developing a clinical assessment competency tool for the assessment of clinical competence for the BNS programme. I am no expert, but I have a firm belief in sharing all our expertise in developing innovative ways to assess clinical competence. I am sure you are all aware there are many different approaches to the development of an assessment tool and every local curriculum steering group will have found or are in the process of finding the right approach for them. So, I will share with you our experiences of embracing this challenge.

This presentation will take the following format:

- A short introduction placing the project in context
- An outline of the Sligo experience
- An exploration of the process involved in developing a clinical assessment tool
- The assessment tool, its layout , content, and rationale for particular decisions
- A brief discussion on the assessment process
- Issues for further discussion - a local context perspective
- Questions and answers.

Introduction:

Following the completion of An Bord Altranais pilot project in December 2000 in Sligo on the assessment of clinical competence, we submitted our report to An Bord Altranais with the recommendations that have already been eluded to by my colleague Ms. Catherine Griffin. However I would like to re-emphasise two recommendations from our report, that has particular reference for this presentation. The pilot study participants made reference to the need for:

- A staff development programme to enable clinical staff to fully embrace the educational changes with confidence in particular in relation to the proposed new assessment strategy
- The immediate establishment of a strategy group to commence the development of an assessment tool, which would take cognisance of the local context and the recommendations of the pilot project.

The pilot study findings were presented at St. Angela's College and NUI, Galway curriculum steering group, and following this, we established a working group who had the remit to develop the assessment tool.

The following documentation and reports further reinforced the need for the immediate commencement of this work, and facilitated discussion with regards to the work involved.

An Bord Altranais, (2000), Requirements and Standards for Nurse Registration Education Programmes. I am sure you are all familiar with this document, however for the purpose of this presentation I would like to draw your attention to the following sections.

Section 2.2, pgs, 14-17, provides an introduction to competency based assessment and introduces the 5 domains of competence which are inclusive of the performance criteria in respect of each domain plus the indicators. I would respectfully suggest that 50% of the assessment tool is already written within this section.

Could I please draw your attention to section 3, pg.44-50 "Standards for the approval of Third Level Institutions, Health Care Institutions and Educational Programmes leading to Registration" 3.2.2.10, P.48, which refers to quality assurance in relation to:

- Evidence of continuing professional development of all practice staff
- Availability of mechanisms for student support, supervision and assessment
- Availability of mechanisms for educational and clinical audit

The Nurse Education Forum Report, in particular Chapters 5, "The curriculum Regulation and Design". In this chapter the Forum makes reference to the Assessment of Clinical Competence by concluding "the resultant domains of competence should provide clearer goals for planning the outcomes of the educational programme" (Government of Ireland 2000,p 61).

Furthermore, in Chapter 6, "The Curriculum – Learning the Practice of Nursing" the Forum recognises that the issue with regard to the preparation of clinical staff is crucial. The following quote illustrates " The Forum recognises that this issue is crucial to the integrity of the degree programme and to the successful development of nursing education" (Government of Ireland 2000, p.68).

The Forum report makes further reference to the integral role of reflection on practice by suggesting " Clinical learning is enhanced when students are enabled to reflect on their experiences of the clinical practice setting" (Government of Ireland 2000, p.71). These recommendations were central to our deliberations in the development of the assessment tool, the educational audit tool and the continued development of our preceptorship programme.

The Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais, 2000). This revised edition of the code makes specific reference to nursing competence, for example " In determining his/ her scope of practice the nurse or midwife must make a judgement as to whether he/she is competent to carry out a particular role or function. The nurse or midwife must take measures to develop and maintain the competence necessary for professional practice".

Finally, we worked with the BNS draft curriculum, St. Angela's and NUI, Galway. In our deliberation during the development of this innovative curriculum we all agreed that the clinical modules be awarded "Euro Cats" credits in line with the theoretical modules. This decision further reinforced our beliefs in the central role of clinical practice in the BNS Programme. However, it also meant that the way practice was assessed would need to be rigorous enough to defend the decision to award a credit rating on the successful completion of a clinical placement.

It was with these reports and documents in mind that we commenced our deliberations, and the challenging task of developing an assessment tool for the assessment of clinical competence and hence moving on from the pilot.

The Sligo experience: A local context perspective.

A strategy Plan was decided which included:

An information meeting took place at the beginning of March 2001. The following staff were invited to attend:

- Directors of Nursing and

- Chief Nursing Officers from
- Community Nursing
- General Nursing
- Learning Disability Nursing
- Mental Health Nursing and
- Care of the Elderly
- Third level College Head of Nursing Department & representatives
- School of Nursing staff
- Director of the Nursing and Midwifery Planning Unit (NWHB)
- Nursing Practice Development Co-ordinator.

At this meeting, we discussed and recalled the recommendations from the Sligo pilot project on the assessment of clinical competence, chapter 6 of the Educational Forum Report, the BNS draft curriculum and the other reports and documentation I mentioned in the introduction to this paper. This informative meeting provided an opportunity for free exchange of ideas with regard to the implementation issues associated with this educational change. The following was agreed at this meeting:

- Agreement on resources and provision of support from managers
- The Sligo working group to be established with the following membership:
- CNM1 and CNM2 from each discipline i.e. General Nursing, Learning Disability Nursing, Mental Health Nursing and Care of the Elderly.
- Clinical Placement Co-ordinators from General Nursing, Learning Disability nursing, and Mental Health Nursing,
- Nurse Tutors from General, Learning Disability and Mental Health Schools
- Public Health Nurses
- Representative from the Nursing Department, St. Angela's Third level College.
- A co-ordinator for the group was agreed, and I am indebted to my colleague Ms. Maura McGettrick who took on this role with enthusiasm.

I was chairperson of the group.

The working group had the following terms of reference:

- Develop a clinical assessment tool to assess the domains of competence for the 4year degree programme.
- Develop a educational clinical audit tool,
- Develop the existing preceptorship programme
- Outline a communication strategy to disseminate general information for all staff on this approach to the assessment of clinical competence.

The following commitments and time frame was agreed:

The members of the working group would need to meet for a total of approximately 14 days, plus days working on the objectives in between the agreed meetings. The agreed meetings were as follows - 1 day per week for the month of April and 1 day per fortnight for the months of May and June. There were no meetings in July and August, and we will reconvene for one day per week in September to reflect on feedback and to make any amendments prior to submission with the full curriculum document to An Bord Altranais for validation.

Developing a clinical assessment tool, the process

The working group came together for our first meeting on April the 5th. We had 14 members representing the professional groups already mentioned. It was agreed to meet as outlined above and to achieve our objectives within the time frame. The terms of reference were agreed, as we felt that the infrastructures concerning staff development and the implementation of educational audit were essential and should be developed simultaneously, and be prepared for implementation to support the proposed assessment strategy.

Engagement with the literature:

The group engaged with the literature concerning competency assessment, preceptorship, and educational audit for the first two meetings. This proved very useful and facilitated an appreciation of the issues for all involved in this process and ultimately resulted in the group working together with minimum facilitation. The following text were found to be helpful by the members of the working group, please see (appendix 1) for full reference and recommended reading.

The working group divided into two sub-groups:

Group 1 - To design a clinical assessment tool for assessment of the domains of competence, to include the development of critical elements to enable the performance criteria to be enacted.

Group 2 - To develop an educational clinical audit tool and develop a preceptorship programme for the educational preparation of staff.

All of the above to be developed while taking cognisance of the local context and of national developments, while at the same time continuing to liaise with the curriculum steering group, St. Angela's College and NUI, Galway.

The Assessment Tool / Learning Log.

Each completed booklet, for 1st, 2nd, 3rd, and 4th years respectively is comprised of:

- An introduction, which is taken from Requirements and Standards for Nurse Registration Education Programmes (An Bord Altranais 2000),
- Glossary of terms, the working group felt this was important as some of the terminology would be new to clinical and educational staff as well as the students. The following is an example of some of the terms included in the glossary:
- Critical elements
- Learning log
- Learning plan / action plan
- Reflective time
- Verifier

- Please see (appendix 2) for a glossary of these terms.

Taxonomy of Levels

There is a lot of debate in the literature concerning levels, a report (by ENB & The Open University 2001) suggests there is very little agreement about criteria for any level of practice beyond "basic safe practice". One important question for many people is how does practice relate to academic levels? Lecturers are probably interested in practical competence, theoretical knowledge and understanding. This involves collecting a lot of evidence, using such tools as a learning log. However, preceptors who are assessing students may start with a view of what a 'normal' student nurse or midwife should or should not be. They may be less concerned with making connections between types of knowledge and levels of practice; than with whether a student behaves like a nurse. Therefore when two groups like this try to collaborate, both sides may feel uneasy, even though they want to collaborate they are coming from different perspectives.

There is a real opportunity for beneficial discussion in such circumstances. Nevertheless when these discussions do occur, people usually focus more on getting some assessment documentation in place than on open debate that would lead to documentation suiting the range of interests (ENB and The Open University 2001). Herein lies the challenge in developing assessment documentation that will satisfy all interests, and I don't claim that the documentation that we have developed has solved this issue. However I would like to suggest, that through research and sharing of experience we can go somewhere in solving these dilemmas.

From a Sligo perspective, we decided on Steiner and Bell's (1979) taxonomy of experiential learning to guide the development of the competency assessment tool. The rationale for choosing this model was that it seemed to satisfy both groups from clinical and educational perspectives. We had also utilized this taxonomy in the past when we developed an introductory learning package for the first year students on the Registration/ Diploma programme. Staff were therefore familiar with the theoretical principles underpinning this model.

The Experiential Taxonomy (Steiner and Bell 1979)

- **Exposure** - The student will have observed a competent practitioner carry out aspects of care. The student will be able to discuss with the practitioner why and how certain aspects of care were carried out.
- **Identification** - The student now shows the ability to participate in the delivery of care under supervision on a more sustained basis. Demonstrates a wish to acquire further information and is able to analyse and interpret information.
- **Internalisation** - The student is able to explain the rationale for nursing action. Requires less supervision while caring for a group of patients/ clients and is able to transfer knowledge to new situations.
- **Participation** - The student is able to participate under close supervision of a competent practitioner in carrying out aspects of care having demonstrated knowledge by analysis of care participated in previously.
- **Dissemination** - The student can now, assess, plan implement and evaluate care for a group of patients/ clients under minimal supervision of a competent practitioner. The student can advise others, and shows an ability to teach junior colleagues and shows an ability to manage care delivered by junior colleagues.

Please refer to (appendix 3) for details of the application of the taxonomy, as adapted from Quinn (1980).

To facilitate the application of this taxonomy we are utilizing the nursing process in the learning log.

Domains of Competency:

Not all of the performance criteria are assessed in year 1, for example –

Domain 4, "Organisation and management of care".

Performance Criteria - Effectively manages the nursing care of clients/ groups/ communities.

This performance criteria has 5 indicators, but we are only assessing 3 in the first year. As we thought, for example, the indicator which requires the student to provide evidence with regard to utilizing methods to demonstrate quality assurance and quality management might be more easily assessed in the third year/ fourth year. However, this is a local working group interpretation and it is important to recognise that students will develop at different rates and will have unique experiences.

Learning log/ Collecting the evidence:

This consists of the 5 domains of competence, the performance criteria and indicators, all of which are in the Requirements and Standards for Nurse Registration Education Programmes (An Bord Altranais 2000). The critical elements were what the working group needed to agree upon and working with the curriculum, the Standards document, the agreed taxonomy, and the nursing process the group identified the critical elements for each domain and for each year of the programme.

Critical elements are a set of simple discrete, observable behaviours that are mandatory for the designated skill at the targeted level of practice. They represent principles that are essential to ascribe competence performance (Lenberg1999).

This aspect of the development of the assessment tool put the greatest demands on the working group, but on hindsight having invested time with the literature and engaged in open debate throughout the process helped reduce the trauma and facilitated progression. The learning log has two columns, one to indicate achievement of the competence and one for the preceptor's signature. Following each domain in the learning log, there is a sheet titled "Reflective notes / Evidence". This sheet is blank to allow the student to reflect upon practice and to provide the evidence to take to assessment. We are suggesting that the student has ½ day per week protected reflective time as indicated in the Educational Forum report (Government of Ireland 2000).

I would like to share with you an example of the application of the taxonomy and the nursing process using one domain for Years 1,2,3, and 4 respectively. We will demonstrate the acquisition of the levels of knowledge of theory and practice as the student progresses from first year to fourth year.

Please refer to (appendix 4) for examples of learning log and reflective notes.

The Learning Plan (Action Plan):

The learning plan (action plan) serves as a guide for the student with regard to their development. The student's needs are met by discussion with the preceptors with regards to what competencies are to be achieved in the respective placement and a learning plan is agreed accordingly. The action plan is only instigated should a difficulty arise and the student is not achieving their objectives.

Student's responsibility throughout the process

The student must actively engage in the process, as this is the key to success. It is therefore the student's responsibility to negotiate opportunities for learning and then to provide the necessary

evidence. Maximum of 100% attendance is expected of the student in the clinical placement. However, 80% attendance is the minimum acceptable prior to the assessment. Special circumstances will be taken into consideration in line with the agreed policies regarding attendance as outlined in the curriculum document and agreed by all partners. The student must attend a full shift in accordance with the clinical areas roster and any deviation from this must be negotiated with the preceptor / associate preceptor / ward manager.

Responsibility of Preceptor and the Student:

The student must receive an orientation to the placement during the first week of the placement. The student will work with a preceptor or an associate preceptor to develop the expected competencies for the duration of the clinical placement. The preceptor must have successfully completed the preceptorship course. The preceptor in consultation with the student can review and change the learning plan at any time throughout the clinical placement.

Interviews between Student and Preceptor

The first interview takes place early in the first week of the placement and will involve the preceptor and the student in agreeing the domains of competence that will be achieved in the placement. The learning plan will be discussed and agreed at this stage.

The midway meeting is at the ½ way point in the placement. At this stage the preceptor and the student discuss the student's progress. If there is a difficulty this is discussed and a learning plan (action plan) is negotiated. If the preceptor or student foresees a difficulty prior to this interview the link lecturer / verifier will be invited to attend. We felt this was important, as developing an action plan at the end of the placement would not have the same beneficial effect as identifying any problems early and supporting the student to work through them. On the other hand the student may also have difficulties in accessing appropriate practice or accessing the preceptor. This can form the basis of the interview and again appropriate action will be agreed. The student's attendance record is reviewed and evaluated on an ongoing basis.

The third and final interview, during which the assessment is completed, takes place during the last week of the clinical placement. However if the student's attendance is less than 80% - then the assessment does not take place, and the interview / assessment does not proceed. The placement must then be repeated. The verifier will be present at the assessment.

Appeals procedures

These are locally agreed, in line with the third level college requirements and will be included in the supporting documentation with the curriculum. This information will also be freely available to the student on commencement of the educational programme.

The assessment

- Who does the assessment, and who should be present?

The preceptor, from the clinical placement carries out the assessment. However, the preceptor must have completed a preceptorship course, which must include a teaching and assessing component. Present at the assessment will be the preceptor, the student and the verifier.

- When should the assessment take place?

The assessment should take place in the last week of the student's clinical placement. The student should be notified in advance of the assessment in order to give them adequate time to prepare.

- Where should the assessment take place?

The assessment should take place on the clinical area, where there is privacy and where interruptions will be at a minimum.

- How long should the assessment take?

During the pilot project the interviews for assessment took approx. 20 minutes per student. However if there are difficulties the assessment may last longer. Sufficient time must be set aside for the assessment, and for the interviews with the student.

- What is the student's responsibility in preparation for the assessment?

The student must have attended the clinical placement for the required amount of allocated time. They must keep a personal record of their attendance. They must have completed their learning log and provided evidence through their reflective notes that they have achieved competence in the relevant domain for their stage in the educational programme. They must have their learning log signed appropriately by the preceptor and other qualified staff.

- Checking the evidence from the students learning log.

The assessment is based on the evidence from the student's learning log and on discussion with the student. The assessment outcomes are based on the evidence.

- Criteria that must be met prior to the student been considered for assessment?

As discussed, 80% minimal attendance, completion of their learning log and the provision of evidence to support their assessment.

- Assessment outcomes, learning plan/ action plan.

If the evidence is not available for the preceptor to sign off on any aspect of the domain of competence, then the student and the assessor agree a learning plan (action plan) to be taken to the next placement. The assessment of clinical competence is a continuous process.

Finally, before I conclude I would like to share a sentiment from the ENB (2000) report, "the role of the student can be an uncomfortable one. They have a lot to loose, and their performance is under surveillance for what it shows about their skill, their competence, their knowledge (or ignorance) and their character. When they first begin in an unfamiliar practice placement, they are likely to feel particularly incompetent and ignorant: they don't know who is who, what the routines are, or what they are supposed to be doing. It is not surprising therefore that most interviewees use terms such as "scary", "frightening", "terrified" or "anxious" in describing their first days in clinical practice"

I am sure we can all identify with these feelings, and we can all recall vividly our first clinical placements, I know I can, and it had a lot of similarity to what I have just described. I am sure you would all agree with me that any innovations in nurse education that can reduce the actual or potential traumas for students is to be embraced and developed as the profession moves forward with these exciting yet, challenging changes.

Conclusion:

- Issues for further discussion, a local context perspective. Please refer to (appendix 5)
- Communication strategy, for the local context. Please refer to (appendix 6)

Acknowledgements:

I would like to take this opportunity to thank, Ms. Ann-Marie Ryan, Chief Education Officer An Bord Altranais for offering me the opportunity to share our experiences with you. I am indebted to Ms. Catherine Griffin for her support during the pilot and for ongoing discussion on the issues. To all my colleagues in Sligo, the Director of Nursing, Ms. Martina Healy, and other Senior Health Board personnel for their personal support during the pilot, and for their ongoing support since the pilot. In particular, I want to thank the working group members and the co-ordinator of the group they have been "bricks" of support even though they thought they were going mad, and I was mad, and we all thought that we were all mad at times!!

Thank you all, very much for your courteous attention.