EVALUATING CLINICAL LEARNING EXPERIENCES*

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Abstract

In this study the aim was to conduct a formative evaluation of the implementation of clinical education in the Diploma of Applied Science (Nursing) program at Armidale College of Advanced Education. This program was one of several to commence in New South Wales in 1985 as part of the general transfer of nurse education to the tertiary sector throughout Australia.

The intention was to identify those factors, both intended and unintended, which influence the implementation of clinical education in an innovative program, according to the perceptions of students, clinical educators, registered nurses, a participant observer and other stakeholders in areas where clinical education is undertaken.

As the intention of this evaluative study was to portray all facets of the clinical education component of the program to enable judgements and decisions to be made, and because of the importance of the environment where clinical education takes place an illuminative, naturalistic approach to evaluation was adopted. The findings demonstrated the importance of thorough preparation for clinical education and the establishment of trust and good channels of communication between all participants prior to, during and following clinical education practicums, in order to maximise learning opportunities.

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*Data for this paper were obtained from Malko, K. 1989 The Evaluation of Clinical Education in Nursing, unpublished M.Ed thesis.

Introduction

The purpose of the study reported in this paper was to conduct a formative evaluation of the implementation of clinical education in the Diploma of Applied Science (Nursing) at Armidale College of Advanced Education. This was to be achieved through an identification of those factors which influence the implementation of this component of the program, according to the perceptions of students, clinical educators, registered nurses, a participant observer and other people in areas where clinical experience practicums are conducted.

Findings from this study were presented to interested parties or stake holders,
and decisions were subsequently made regarding the future of this component of
this program. The stake holders to whom the results of the evaluation were
presented included lecturers and clinical educators of the program, members of
the curriculum development committee for the program, students and nursing
representatives from the agencies being used for clinical placements.

The aim of the curriculum was identified as being to produce graduates who are
academically and experientially prepared to assume responsibility for
competent, individualised nursing care at beginning practitioner level. In
order to achieve this aim the students were provided with clinical learning
opportunities in patient care settings which would facilitate the application
of theoretical concepts and skills from all areas of the program.

The reason for the need to demonstrate the development of professional
competencies in students is related to a demand for the implementers of the
curriculum to be accountable to produce competent practitioners. Over a number
of years considerable disquiet had been expressed in a questioning of the
ability of these programs to produce competent practitioners because students
spend less time in clinical areas than they did in traditional hospital based
programs.

Furthermore, because of this limited time in clinical settings it is essential
to ensure that clinical education experiences which facilitate the maximisation
of learning and development are undertaken, in order to meet the goal of the
program. Therefore, because the perceived success or lack of success of the
implementation of this program would depend largely on the extent to which
graduates would develop and subsequently exhibit what are considered to be
appropriate and necessary values and competencies in clinical settings, the
development of these attributes and the assessment of student performance
needed to be evaluated. Additionally, because the learning milieu plays a role
in the development of these values and competencies, its evaluation was
considered to be necessary.

A number of studies (Kratz, 1979; Mackay, 1981 Lonsdale et al, 1982 and
McArtur et al, 1983) indicate that the clinical education milieu is a
significant determinant of nursing performance. Features of this clinical
education milieu which warrant analysis in an evaluative study were identified
as including the selection of appropriate learning environments, the on-campus
clinical laboratory, pre and post clinical conferences, the role of the
clinical educator and the assessment of student performance.

Problems Associated with Clinical Assessment

A review of the literature indicates that the process of assessing and
recording students' clinical performances, or the attainment of competencies,
is a widely discussed and vexing problem. According to del Bueno (1977, 21),
successfully implementing it is similar to achieving peace in the world. Wood
(1972, 1982) and Woolley (1977) have provided informative historical overviews
focused on assessing student performances within clinical settings and have
discussed various proposals put forward for the assessment of nursing students.
However, basic problems which they identify are perennial and therefore need
addressing. Central to these is the fact that student assessment is undertaken
in an environment that is everchanging. 'These changes of milieu, staff and
clients present both positive and negative learning elements and they complicate... (assessment)... significantly' (Wood, 1982, 12), resulting in a situation where a format developed for one program and area may not be usable in another program or area.

Wood notes that because of the number of students that a clinical educator must accommodate simultaneously... assessment of an individual student's performance is inevitably based on a sample of the student's total experience' (1982, 12). She then draws attention to the fact that students undertaking clinical practicums are being assessed while that are still learning and stresses the need for this to be taken into account when assessments are being conducted.

The presence of an educator observing students perform changes the dynamics of a situation, causing students to act differently to normal, even influencing the interactions between students and patients (Jackson, 1983, 30). Having an educator present may cause students to suffer anxiety which can inhibit performance. Student anxiety is likely to be further increased if an instructor's procedures make students unsure about what they must do in order to pass or obtain a good result (Fowler and Heater, 1983, 403).

As previously stated, methods used to assess students in the clinical field predominantly involve direct human observation which 'exhibits inherent bias and subjectivity, and is a subjective process' (Wood, 1982, 11). According to Fowler and Heater (1983, 402) and Reilly and Oermann (1985, 306) educator variables such as past experiences, values, attitudes and pre-existing knowledge of students influence the assessment of students in relation to the behaviours noted and the way in which they are interpreted, contributing to low inter-rater reliability. Woolley noted that grades awarded may vary considerably from one assessor to another when observing the same procedure being performed (1977, 308).

Of further concern are the particular difficulties associated with assessing in the affective domain (Jackson, 1983, 30). Inadequate clarification of assessment criteria and failure to adequately prepare educators regarding the use of the tool are likely to increase subjectivity still further (Wysocki, 1980; Wood, 1982).

Several significant biases are common amongst observers. They include personal response tendency, halo effect and logical error (Craig, 1978, 27; Rezler and Stevens, 1978, 136-137). Personal response tendency relates to individual variations between assessors in which some are consistently too lenient, giving students the benefit of the doubt, or too severe, demanding compliance in every detail, while others see most behaviours as average. The tendency to take the middle of the road course is common (Spencer, 1985, 43), in some cases even to the point where students are never failed. Halo effect concerns the influence of good or bad general impressions on observations. When this occurs, a good overall impression of student performance makes an observer more likely to pass off an observation of an isolated ineffective behaviour as being unimportant or 'just one of those things' (Craig, 1978, 27). Logical error arises when observers are influenced by preconceived assumptions that certain things go together. Rezler and Stevens (1978, 136-137) see that these problems are most likely to occur when the behaviour is not easily observable, is not frequently discussed, is not clearly defined, involves the reactions of other people and
contains some socially desired characteristics. Awareness of these potential biases can assist in making observers more impartial.

In an attempt to overcome problems related to the subjective nature of performance assessment, Brozenec et al (1987 43-44) suggest a number of strategies which are summarised in the following points:

- Using criterion referenced instead of norm referenced tools;
- Using a variety of methods of assessment that are appropriate to learning objectives enabling better student assessment and identification of problem areas;
- Developing tools that measure behavioural objectives which reflect critical concepts of the curriculum;
- Avoiding the use of excessively lengthy evaluation tools;
- Decreasing the number of points on rating scales;
- Discussing and clarifying items on the assessment tools;
- Keeping anecdotal notes to facilitate recall at evaluation time;
- Involving other educators and ward staff in clinical observation and assessment;
- Incorporating self assessment by students;
- Counselling students and providing frequent feedback;
- Ensuring students are provided with appropriate situations to enable them to demonstrate clinical competence in key areas.

A number of authors have noted that while it is essential that the assessment process is as fair as possible, attaining total objectivity may not be possible. According to Wysocki (1980, 43)

the quest to eliminate subjectivity from the process is commendable but unrealistic. Better to accept that it exists, and make allowances, rather than delude ourselves that total objectivity has been achieved.

Blomquist (1985, 8-11) agrees with this view, and believes that the trend towards increasing subjectivity and validity in assessment is reductionistic and has resulted in a devaluation of the intuition and judgement which is necessary in a clinically competent nurse. She sees that while clear clinical objectives may assist in providing guidance for both student learning and assessment, it is important to not forget those aspects of clinical learning and competence which are not so easily identified. Her views are based upon Benner's (1982) model of skill acquisition which suggests that an individual passes through five levels of proficiency in the acquisition and development of skills. Benner (1982, 402) sees that these levels reflect changes in two aspects of performance.

One is a movement from reliance on abstract principles to the use of past, concrete experience as paradigms. The other is a change in the perception and understanding of a demand situation so that the situation is seen less as a compilation of equally relevant bits and more as a complete whole in which only certain parts are relevant.
These distinctions between levels of performance are similar to the two major dimensions of performance identified by del Bueno (1977, 21). They are 'doing the thing right', which indicates technical competence, and 'doing the right thing', or the application of prior knowledge and experiences to make judgements, set priorities and evaluate consequences of actions.

Methodology

Because of the nature of the research question, which was to investigate the factors, both intended and unintended, which influence the implementation of clinical education in this program, Parlett and Hamilton's (1972) Illuminative Evaluation using concepts of Guba and Lincoln's (1987) Naturalistic evaluation enquiry methods was seen to provide the most appropriate general approach to data gathering. Batchler's (1983) modified version of Stake's (1967) model of curriculum evaluation (figure 1) was used to provide a framework for the general categorisation of data collected and for the presentation of findings and decisions.

WHAT WAS INTENDED

WHAT WE NEEDED

PEOPLE, RESOURCES

TO BE USED IN

PROJECT, AS WELL

AS A DESCRIPTION

OF STUDENTS _________________

WHAT WE INTENDED

TO DO: PROCEDURES

TO BE USED TO

PRODUCE INTENDED

RESULTS ____________________

WHAT WE INTENDED

TO HAPPEN:

WHAT WAS INTENDED

TO HAPPEN AS A

RESULT OF THE

PROGRAM
RESOURCES

PROCESSES

RESULTS

WHAT HAPPENED

WHAT WE HAD:

ACTUAL

CHARACTERISTICS

OF STUDENTS, STAFF

AND RESOURCES

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WHAT WE ACTUALLY

DID DURING THE

IMPLEMENTATION OF

THE PROGRAM
WHAT ACTUALLY HAPPENED:
IMMEDIATE AND LONG TERM RESULTS OF THE PROGRAM

Figure 1: Batchler's Modified Version of Stake's (1967) Countenance Model.

Quantitative and qualitative methodologies were both used to define phenomena and collect data. Quantitative data were collected in a survey using close-ended items in questionnaires. Qualitative data were obtained using a combination of open-ended items in the questionnaire, anecdotal recordings, open ended interviews and participant-as-observer participant observation during each practicum.

There were a number of potential problem areas regarding data collection and processing. The unidirectional nature of the scale in the student questionnaire could have led to the "Halo effect" occurring with some students. This appeared to be the case with a small number of students who responded with the category "mostly" for all questions. This could have been a genuine response to individual questions, but also could have been due to a general feeling of satisfaction, and hence agreement across the board. This problem was anticipated. However, it was decided that the maintenance of a single directional scale would be more satisfactory, because randomisation had led to some confusion among students in one of the pilot studies, despite clear instructions.

The second area of concern related to the interviews. Although the evaluator guarded against leading respondents to answer in particular ways, it was felt that a number of comments were made primarily because the interviewer was also the co-ordinator of clinical education experiences. Respondents may have had a vested interest in getting a certain message across to the co-ordinator, who was seen to be in a position to make suggested changes. Similar concerns were felt by the evaluator in the participant observer role. It was felt, however, that having an evaluator who was closely involved with the program and who was known and trusted would contribute to the collection of a significant amount of data which would possibly not have been elicited by an outsider.

Findings

In relation to the category of Resources there were a range of responses which indicated that inadequate preparatory work had been undertaken. Although most
students felt that they had been adequately prepared for the first practicum on the whole, a number indicated that there were specific areas such as report writing, documentation, lifting techniques, drugs and equipment usage in which they felt they had received inadequate tuition. Students also felt that they had received inadequate and insufficient orientations to ward areas and to agencies in general.

Although the majority of students indicated that they could relate well to ward staff, there was a concern about the lack of knowledge of the ward staff regarding the program, the educational needs of students and their abilities. This was evident despite the fact that two liaison sessions were conducted at each venue prior to the first practicum. It became evident that many of the nurses who were working with the students had not attended due to the fact that they were on days-off or were too busy to be released from the ward to attend. This lack of knowledge appeared to contribute to hostility. When information was provided across a broad scale over the three week period, much of the questioning disappeared as did the hostility.

Considerable stress was felt by the clinical educators because of their inability to attend preparatory sessions or because of a breakdown in the system of rostering for supervision of students. This was also a major criticism noted by students and ward staff.

Despite the fact that all of the preparatory activities had been undertaken, such as the Clinical Experience Handbook and the orientation and liaison sessions, and a number of respondents commented on the positive nature of these, they were insufficient for the needs generated in the practicum.

In relation to the category of Processes similar themes arose as those in the resources category in that problems arose as a result of the inadequate preparation of individuals. The behaviour and attitudes of clinical educators were seen as a major influence on the practicum, as were the behaviour and attitudes of ward staff. Students seemed to be more willing to take responsibility and use their initiative when they felt secure in the knowledge that clinical educators and ward staff were supportive and readily available to assist them if required. The hostility on the part of ward staff particularly in the early stages, contributed to feelings of inadequacy in the students. Again, as a result of inadequate preparation and inappropriate student coverage the clinical educators were not able to carry out their activities sufficiently, creating considerable stress, particularly if they did not have previous experience in this role.

In relation to the category of Results the major findings related to the assessment of students. There seemed to be a general feeling of satisfaction among the students about their performance and this was echoed in the comments of educators, registered nurses and the participant observer. However, there was also general agreement that the assessment was excessive and in some cases unfair, with minimal inter-rater reliability. There was concern that there was too much emphasis on performance appraisal with too little attention being paid to the learning process. Of equal concern to the curriculum development team was the fact that all students were given a passing grade for each practicum, despite the fact that some students were not successful in initial assessments. The result of these findings was the formation of a sub committee to develop
new assessment instruments and associated guidelines for assessment techniques for educators.

Another finding was that good relationships developed during clinical practice among students, clinical educators, ward staff and patients. Although these could be attributed to better pre clinical preparation of students and clinical educators, increased two-way communications and the increased inclusion of ward staff in the education and assessment of students, there seemed also to be a greater general acceptance of the innovative program and its participants, simply because people were becoming more familiar with the program and thus, less threatened by it.

Conclusion

The findings of this study indicate that there is a need to conduct ongoing evaluations of the clinical education component of this program, due to the fact that the curriculum is undergoing constant refinements and also because of the everchanging clinical experience milieu. Although evaluations have been conducted of individual courses in this program a general evaluation of the whole program has not been undertaken. This could provide valuable information as it is designed to be an integrated curriculum, with the clinical education component building upon all other courses in the program.

Further studies could focus on the perceptions of graduates regarding the adequacy of the program in general and the clinical education component in particular for meeting their professional needs. Choice of areas of work by graduates could be investigated as could enrolment in post graduate programs. Finally, a research study could address the perceptions of nurse academics who have been involved in the transition of nurse education to the tertiary sector regarding changes which have taken place in the past, and those changes which they are experiencing currently because of the general alterations in the tertiary education sector throughout Australia.

References


* The methodology is reported here in general terms. Further details are available from the authors.