Introduction

Monitoring progress, managing feedback and making assessment decisions are interrelated activities that are integral to the continuous assessment of practice. These activities are central to and essential in helping students learn through their practice to develop clinical competence. Using the continuous assessment process enables us to monitor progress continually and give feedback informally and constantly as we work with the learner – even over one working shift, feedback is an activity that occurs many times. There are, however, specific times when formal feedback should be given based on a more detailed examination of progress. As discussed in Chapter 6, when we conduct pre-scheduled and preplanned ‘formal’ formative and summative assessments, we have time and opportunities to discuss progress with the student, formally give feedback and make assessment decisions based on the analysis of assessment evidence. The assessor is in a ‘unique position in being able to provide precise feedback to individual students on all aspects of practical professional development’ (Stengelhofen 1993:153). However, if assessment is to be a true learning process, the student should be an equal partner in these
activities – progress is monitored jointly through the formative assessment process set up, and the student participates actively during feedback and assessment decision-making sessions. It is important that these activities occur, not only to maintain the integrity of the assessment process itself but also to meet the rights of the student as a learner. Torrance and Pryor (1998) believe that assessment is only truly formative if it involves the student directly in self-assessment.

Managing feedback

‘Managing feedback’ is used in this chapter to signify the activity of holding constructive discussions with the student about clinical experiences that the student and the assessor have been involved in. Feedback can take place informally as the assessor works alongside the student, or more formally during pre-arranged feedback sessions. Rowntree (1987:24) considers that this essential learning activity is the ‘life-blood of learning’. There is research evidence which suggests that this ‘life-blood’ is not well sustained – feedback is either not done well or as frequently as needed, or worse still, not at all (Neary 2000, Fish and Twinn 1997, Bedford et al 1993). Bedford et al (1993:107) quoted one assessor on assessment feedback:

... I shy away from having to give criticism anyway. I’ll always go to great lengths not to give criticism, so I’m not a good assessor from that point of view as I’ll always highlight the positive aspects and I’ll tend ... not to go into too many details if a student isn’t doing terribly well in certain areas.

As noted in Chapter 6, it is knowledge of the results of performance provided by detailed factual constructive feedback that enables students ‘to monitor strengths and weaknesses of their performances, so that aspects associated with success or high quality can be recognized and reinforced, and unsatisfactory aspects can be modified or improved’ (Sadler 1989:120). Feedback therefore contributes directly to learning through the process of formative assessment.

Constructive feedback has an impact not only on the teaching/learning process but also gives messages to students about their effectiveness and worth – their self-esteem (Gipps 1994). Feedback, therefore, has an indirect effect on learning by how the academic self-esteem of the student is affected. Coopersmith (1967 in Gipps 1994:132) defined self-esteem as:

the evaluation which the individual makes and customarily maintains with regard to himself – it expresses an attitude of approval or disapproval and indicates the extent to which an individual believes himself to be capable, significant, successful and worthy.

A major determinant of self-esteem is feedback from significant others. Consequently, students look to and, indeed, expect and welcome constructive feedback from significant others such as their teachers and assessors (Neary 2000, Phillips et al 2000, Gipps 1994, Bedford et al 1993). Other authors found that students view good clinical experiences to include receiving constructive feedback (Kotzabassaki et al 1997, Bedford et al 1993, Neville and French 1991). What we know about
the effects of assessment on motivation tells us that students give up trying if they do not see themselves as capable of success. If they feel relatively worthless and ineffectual they will reduce their effort or give up altogether when work is difficult (Child 1997). On the other hand, people who hold positive self-perceptions usually try harder and persist longer when faced with difficult or challenging tasks.

There are therefore many challenges for the assessor on how to manage feedback so that it has a positive impact on learning, and more importantly, on the self-esteem of the student. Some detailed suggestions of how this may be done are made in Chapter 6.

**Monitoring progress**

Monitoring the progress of students is an essential part of the continuous assessment process. Progress can be monitored most accurately if the mentorship is stable. The same assessor is better placed for keeping abreast of the clinical activities the student has had and will therefore know the amount of learning the student has achieved and how the competence of the student is developing. Monitoring progress is an ongoing assessment activity and takes place throughout the duration of the student’s placement. Monitoring in this context, and not ‘policing’, is viewed as a
process to help student learning, development and progression. We need to keep track of whether the student is developing competence and achieving the statutory competencies for professional practice. We therefore need to consider carefully what the student is learning, the clinical activities the student has been participating in and how further learning can be facilitated. When monitoring the progress of the student it is important to consider the prior clinical experiences of the student, the competencies and learning outcomes that the student needs to achieve during the placement and the stage of training the student is at. Curriculum documents will frequently state the expected level of performance at a specified stage of training.

When monitoring progress, the role and responsibilities of the assessor centre around answering these key questions:

- What has the student done and learned so far? How will I know?
- Is the student having any difficulties? How will I know?
- What can be done to facilitate further learning and development?

To obtain answers to these questions, the assessment activities shown in Figure 7.2 are suggested.

**Observation of practice for developing levels of competence**

In Chapter 4 there is a detailed discussion of how observation may be used as a method of assessment to obtain direct evidence of the ability to perform care activities. When monitoring the progress of students during observation of their practice, the assessor needs to gather evidence of:

- continuing safe and accurate performance of care activities with increasing speed and dexterity as the student has more clinical experiences and gains confidence
- the development in the level of a student’s competence between the outset of a placement and its conclusion (Bedford et al 1993).

What we know about the nature of expertise tells us that there are well-defined characteristics, across domains, that differentiate the performances of experts from
As proficiency develops, knowledge becomes increasingly integrated, new forms of cognitive skills emerge, access to knowledge is swift, and the efficiency of performance is heightened.

Glaser puts forward the case that, with growing proficiency, the changes in a person’s cognitive ability and psychomotor performance can define criteria by which competence can be assessed. The Dreyfus model (in Benner 1984) considers that, in the acquisition and development of a skill, a learner passes through five levels of proficiency: novice, advanced beginner, competent, proficient and expert. As a learner passes through these levels, there are corresponding changes in three general aspects of performance. First, there is a move away from reliance on rules and principles to the use of past experience to guide practice. Secondly, the learner begins to see a situation less and less as a combination of equally relevant bits but more and more as a complete whole in which only certain parts are relevant. Thirdly, the learner becomes an involved performer and engages in the situation.

Benner (1984) and Benner et al (1996) applied the Dreyfus model to the study of skills acquisition in the practice of qualified nurses. They are careful in stating that skills in the nursing context refer exclusively to skilled nursing interventions and clinical judgement skills in actual clinical situations and not to psychomotor skills or to other skills learnt in the laboratory setting. For the purposes of this discussion, a summary of the performance characteristics from the work of Benner (1984) and Benner et al (1996) at the levels of development of the novice, advanced beginner and competent will be made here. Although these characteristics are derived from the performance of qualified nurses, it is my view that they can be extrapolated to the developing performance of pre-registration students. Following this exposition, the characteristics of the knowledge base with increasing proficiency described by Glaser (1990) are summarized.

The novice

- Nursing students enter a new clinical area as novices with no experience of the situations in which they are expected to perform.
- They must be given rules and explicit detailed instructions to guide their performance; procedural lists are important for successful performance.
- They focus on getting individual tasks done; novices generally do not see beyond the task at hand and may not recognize underlying problems of the patient.
- They have little understanding of how to use classroom-acquired theory to guide practice.

The advanced beginner

- The advanced beginner can demonstrate marginally acceptable performance.
- As a result of prior experiences, they are able to identify the recurring components of situations but are unable yet to sort out what is most important.
They cannot order information into a meaningful whole.
Their concern for good care is almost exclusively related to physical and technological support and to completing all the ordered treatment and procedures.

Competent nurses have:

- Increased clinical understanding and are able to focus on the clinical condition and management and less on getting tasks done
- Increased technical skill – performance is more fluid and coordinated and they can predict the outcomes of their performance
- More accuracy at judging the difficulty of a task
- Increased ability to handle busy complex situations and they can make decisions and solve problems
- Improved time management skills
- Improved organizational ability – they can prioritize care and manage care for several patients
- Increased awareness of the appropriateness of their actions and are able to ask questions about what they have to do.

Knowledge base

Glaser (1990) notes that as competence in a domain grows, the person displays a knowledge base that is increasingly coherent and useful. The characteristics underpinning these descriptors are described briefly here.

The coherence of knowledge
The beginner’s knowledge is spotty with superficial understanding: only fragments of information can be accessed for use. Knowledge consists of isolated definitions and superficial understandings.

As competence develops, elements of knowledge are integrated with past organizations of knowledge so that information becomes increasingly interconnected and structured: knowledge gets retrieved in larger units from memory. Proficient individuals are able to access ‘chunks’ rather than fragments of information from memory.

Usable knowledge
Novices generally possess theoretical knowledge without knowing the conditions where that knowledge applies and how it can be used most effectively. More proficient individuals are able to assess the relevance of their knowledge and thus access relevant knowledge to inform practice. Proficient individuals are able to make inferences based on interrelated information. Experts and novices may be equally competent at recalling specific items of information but only the more experienced are able to relate these to the conditions of practice and the goals of solving a problem.
Criteria for assessing development in the novice, advanced beginner and competent levels of performance

The following criteria for assessing the development in the level of a student’s competence are based upon, and extended from the work of Benner et al (1996), Glaser (1990) and Benner (1984). When using these criteria to assess the level of performance and monitor progress, it is important to remember that the change from the novice level to competent level is incremental (Benner et al 1996) and on a continuum. The criteria below have been developed to reflect this.

Novice level

These conditions of practice of the novice along the following continuum can be used as the criteria to monitor the progress of novice level practice.

**Conditions of practice**

- Requires very detailed and explicit instructions.
- Requires less detailed and explicit instructions.
- Requires some detailed and explicit instructions.
- Performs some activities with few prompts.
- Performs activities \((a, b, c)\) in a fully integrated way.
- Leads activities \((u, v, w)\) with few prompts.
- Beginning to assess, plan and implement care.
- Within level of practice, responds appropriately in situations requiring urgency.

It is important for each clinical area to identify which activities the student is expected to be able to achieve competence in. The reader is directed to the discussion of ‘competence’ in Chapter 3.

**Knowledge**

- Has a grasp of theory underpinning most practices.
- Beginning to make connections between chunks of theory.
- Can explain rationale underpinning some practices.
- Can discuss pertinent research underpinning some practices.

Advanced beginner level

These conditions of practice of the advanced beginner along the following continuum can be used as the criteria to monitor the progress of advanced beginner level practice.

**Conditions of practice**

- Performs activities with few prompts.
- Performs activities \((d, e, f)\) in a fully integrated way.
- Leads activities \((x, y, z)\) with few prompts.
- Beginning to prioritize care.
- Able to assess, plan and implement care.
● Beginning to evaluate effectiveness of care.
● Beginning to involve clients in their care.
● Within level of practice, responds appropriately in situations requiring urgency.

It is important for each clinical area to identify which activities the student is expected to be able to achieve competence.

Knowledge
● Can explain rationale underpinning practice.
● Able to make connections between more complex chunks of theory.
● Can discuss pertinent research underpinning practice.
● Beginning to implement evidence-based practice.

Competent level
These conditions of practice of the competent practitioner along the following continuum can be used as the criteria to monitor the progress of competent level practice.

Conditions of practice
● Performs activities (g, h, i) in a fully integrated way, without prompting
● Able to assess, plan and implement care.
● Able to prioritize care.
● Able to evaluate effectiveness of care and make changes to care plans.
● Able to plan, prioritize and manage care for a group of clients within a time span.
● Actively involves clients in their care.
● Is organized and efficient.
● Within level of practice, responds appropriately in situations requiring urgency.

Knowledge
● Critiques evidence-based research and its implementation.
● Able to make connections between complex chunks of theory.

During the early stages of a pre-registration programme, a student who is new to a clinical area is likely to start practice at the novice level but may achieve competent practice in some aspects of care by the end of the placement. The rate of progression is dependent on many factors, such as opportunities for practice and debriefing and reflection with the assessor, the prior experience of the student, the student as a learner and so on. In each new clinical area the ‘junior’ student may perform at novice level for a longer period before advancing. The ‘senior’ student who may have been to similar clinical areas, however, would be able to, and indeed would be expected to move more rapidly to advanced beginner and competent level practice. The assessor is reminded that it is a requirement of pre-registration education to prepare students to be able to apply knowledge, understanding and skills to perform to the standards required in employment when registered (UKCC 1999) and
Monitoring Progress, Managing Feedback and Making Assessment Decisions

practice is safe and effective (NMC 2005). It is suggested here that the ability to perform at the competent level is the required level to enable the student to achieve the requirements of statutory training, and to enable them to make the transition to registered practitioner. The criteria for assessing competent level practice should thus be used when monitoring the progress and assessing the practice of students who are at the stage of being prepared for professional practice, e.g. in the last 6 months of training. In its report *Fitness for Practice*, the UKCC (1999) recommends that all students should undertake a period of supervised clinical practice of at least 3 months towards the end of the pre-registration programme. This period of consolidation is intended to assist the student to make the transition to registered practitioner.

When monitoring the progress and assessing the practice of students, it is also important to consider the amount and level of supervision/support required by the student as well as the amount and level of participation in care you expect of the student. When students are at the novice level, they should initially observe care followed by participating and assisting in giving care. When giving care, they should be supervised closely and be supported. Students at the novice level, as discussed above, will require detailed and explicit instructions initially and may not be able to explain the rationale underpinning practice. As they learn and progress in their practice, less prompting is required for practised activities and they should be able to explain the rationale underpinning these practices.

As students progress, they should be encouraged to participate more actively. This should include the joint planning of activities. They should also be allowed to lead those activities they are confident in performing. The transition from novice level practice to advanced beginner level is on a continuum. The amount of supervision required starts to decrease and assessors may be able to ‘let go’ as they learn to trust the performance of the students. From performance that requires to be prompted because it lacks completeness, performance starts to become smooth and complete as students start to internalize the performance of activities. Prompting is generally not required. The rationale underpinning practice is understood.

As students move from advanced beginner level practice to competent level practice, the amount of supervision required becomes minimal, with indirect supervision only required towards the end of the training programme. Students should be taking an active role in giving care. They should be able to plan all practised activities and be leading most of them. They become organized and efficient and can carry out their own workload without having to be reminded of what to do.

**Discussion with the student**

Talking, questioning and listening are crucial to assessment (Phillips et al 2000) and they can be used as instruments for ongoing review of the student’s progress. There is a discussion of how questioning can be used to facilitate and assess student learning during clinical practice in Chapter 4. As the assessor and student work together, inviting the student to suggest how best to carry out care in clinical situations in which the student has been involved previously will give the assessor opportunities to consider what the student has learnt from similar past care giving experiences. It will also provide the assessor with information about the student’s ongoing achievement. Whenever you spend time with your student in care activities, utilize every opportunity for discussions, using what is going on in front of you as
the focus. What the student is able to articulate will indicate the amount of progress made. Subsequent discussion and questioning to explore further the quantity and quality of learning, and any difficulties the student may be having with performing particular care activities, will add to this source of evidence of student progression. In putting forward the case for using ‘dialogue in assessment’, Bedford et al (1993:136) note that through ‘discussion about a particular event, students can demonstrate the knowledge, understanding and values that have informed their actions in the clinical area on a given occasion’. This enables the assessor to ascertain the understanding and the values held by the student about care given. There is further discussion of using dialogue as a vehicle for pre-activity discussion and post-event reflection in Chapter 9.

Progress reviews should also include student self-assessment and constructive feedback from the assessor. When engaging in self-assessment, students may need help in looking at themselves as they are, to judge realistically what they could become, while at the same time helping them to hold in mind the vision of how they would like to be, perhaps modelled on observations of more experienced practitioners. One aim of self-assessment should be to shift the focus from ‘how good am I?’ to ‘how can I get better?’ (Mattheos et al 2004).

Assessors should not assume that students are able to self-assess independently (Maloney et al 1997). Boud (1992) contends that self-assessment skills need to be facilitated. On the other hand, students are aware of the standards against which to measure themselves. Woolliscroft et al (1993) suggest that accurate professional self-assessment requires individuals to be realistic about how their performance would be judged by others using valid performance-monitoring tools. Self-assessment schedules like the one devised by Woolliscroft et al (1993) can be of great value as they appear to prompt students to apply ideas to their own practice and reflect on their learning. Such schedules can be given to students prior to clinical activities and meeting sessions to discuss progress. Students can then use them to assess their own performance immediately after the clinical activity. The schedule used by Woolliscroft et al (1993) is modified and adapted for nursing and midwifery and reproduced here in Box 7.1.

Such self-assessment schedules, if used throughout the placement, will help students make specific judgements about their own performance and monitor their own progress in a range of clinical activities. Those clinical activities, specified in the learning contract and assessment plan (see Chapter 6), could be the topics for self-assessment schedules.

The crucial role of constructive feedback for learning is discussed at some length in Chapter 6. Feedback sessions should be designed to help students grow in their clinical skills and professional competence. Beginning level students have been found to be anxious about their ability to perform basic clinical skills (Robertson et al 1997). They often fail to focus on the patient/client as they have to concentrate their attention on developing clinical skills. Robertson et al (1997) suggest that feedback for these students should be designed to prompt them to think of the client holistically and to build self-confidence to enable the shift of focus to the patient/client. Advanced level students, on the other hand, may feel confident about their clinical skills but anxious about becoming a fully-fledged professional in the near future (Robertson et al 1997). These students would benefit from feedback designed to promote the growth of professionalism and confidence in their professional personae to enable them to make the transition to registered practitioner.
Examination of the student’s portfolio

In *Fitness for Practice* (UKCC 1999) recommendation 14 states:

The use of a portfolio of practice experience should be extended to demonstrate a student’s fitness for practice and provide evidence of rational decision making and clinical judgement.
More recently, the NMC (NMC 2006) states that students are expected to maintain an ongoing achievement record (student passport), including comments from assessors. This must be passed from one placement to the next to enable judgements to be made on the student’s progress.

In 1993, Bedford et al found that there was much diversity about the contents of portfolios of pre-registration students and how they were used for the assessment of practice. It would appear that the same degree and amount of ambiguity still exists (Phillips et al 2000, Gerrish et al 1997).

The following principles should guide the development of the student’s portfolio (ENB 1997, UKCC 1999, NMC 2006). There should be:

1. Cumulative information about the student’s achievement of outcomes and learning through reflection, demonstrating the interrelationship of theory and practice
2. Cumulative information about the outcomes of assessment of both theory and practice
3. Evidence of rational decision-making and clinical judgement
4. A record of issues raised in discussion, including causes for concern between the assessor, the student and the personal/named lecturer as part of the formative process of development
5. A collection of the action plans or learning contracts agreed between assessors, the student and the personal/named lecturer
6. Information on key issues from the student’s experience which will inform the preparation for subsequent clinical experience. These key issues should stem from student self-assessment and constructive feedback from the assessor.

Recording evidence

The use of different methods of assessment in order to gain a comprehensive picture of the skills, knowledge, attributes and attitudes (see Chapter 4) will clearly produce a fairly big range and different kinds of evidence. If several methods are used on a day-to-day basis, how can we possibly keep track of all the evidence that is produced? Even over 1 week there will be more evidence than either the learner or assessor can remember. Memory is also dangerously selective (Jones 1995). So, unless we can record this evidence on a fairly frequent basis, we can lose track of the quantity and quality of learning achieved. Now, try Activity 7.1.

Activity 7.1

Consider the types of learners in your area. How do they make ongoing records of evidence of what they achieve?

Those of you who have worked alongside NVQ (national vocational qualification) candidates will have seen these learners recording details of achievement in what is known as an evidence log. Figure 7.3 is an example of the evidence log of a student learning to administer medication on the ward. This example of an evidence log compiled by a learner indicates the occasions and types of medications administered and the aspects learned. It also shows the progress the learner made. These evidence
logs are usually filed with other documented evidence of learning in a portfolio. The maintenance of evidence of learning in this format will enable sufficient information of a student’s ongoing achievement in practice to be available to assessors so that professional practice requirements are addressed (NMC 2006).

The assessor or co-assessor may also provide written evidence logs of learning. Figure 7.4 is an example of the evidence log kept by an assessor in the operating theatre. This evidence log shows the areas of difficulties experienced by the learner and the facilitation of further learning which led to progress and subsequent achievement of learning outcomes. It is of course not possible or feasible to compile evidence logs of every learning task, but crucial aspects of learning can be identified in each clinical area so that such logs of learning can be compiled. There should, however, be an accumulation of sufficient evidence for a valid assessment to be made on whether a student is competent at the point of registration (Fraser et al 1997).
Using the documented evidence to monitor progress

Phillips et al. (2000) found that portfolios are most often constructed as collections of evidence of practice – they provide evidence of the student’s repertoire of clinical activities. The portfolio can then be used by a range of people to consider the achievement of the student. This summative function of portfolios has come to assume greater importance than its formative function of facilitating learning and development. Phillips et al. (2000) warn that if the emphasis is on the portfolio’s summative function there is frequently no engagement in any discussion and critique of the written evidence – this limits and narrows the usefulness of portfolios as a source of learning. In any case, most portfolios do not tell us how well prepared the student is for practice. An examination of the evidence in the portfolio is therefore only one way of assessing and monitoring progress. The portfolio needs to be complemented by other ways of assessing practice.

Potentially, portfolios are most useful for assessing theoretical understanding and intellectual capacities, such as the capacity to analyse critically the values and issues inherent in the context of the practice situations, leading to the construction of alternative ways to practise. Phillips et al. (2000: 110) suggest that good portfolio assessment must capture the following aspects of learning and development:

- critical analysis of the way things are currently done
- identification of the values inherent in current practice
- critical appraisal of the context of current practice
- imagination of alternative ways of practice
- imagination of alternative ways of promoting better care and core values
- envisioning strategies to make changes.

In my view, portfolios should be used as a process tool as well as a tool to measure achievements. When reviewing the progress of the student using the portfolio, the documentation within it needs to be considered in terms of:

1. what the student has learnt so far
2. what can be done to facilitate a greater depth and breadth of learning based on what is documented in the portfolio.

<table>
<thead>
<tr>
<th>Date</th>
<th>Clinical Activities and Teaching/Learning Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.10.98</td>
<td>Difficulty with scrub technique. Trolley setting met performance criteria. Asepsis and uses of equipment discussed using question and answer with prompting from observer. Discussed time for private study to review asepsis policy. Scrub poster and policy manual used to discuss equipment.</td>
</tr>
<tr>
<td>2.11.98</td>
<td>Difficulty with scrub technique. Trolley setting satisfactorily met performance criteria. Highlighted scrub technique as major problem. Further session to be instigated.</td>
</tr>
<tr>
<td>2.11.98</td>
<td>Practised scrub technique – applying gloves and gown.</td>
</tr>
<tr>
<td>4.11.98</td>
<td>Practised scrub technique and applying gloves and gown. Improvement made.</td>
</tr>
<tr>
<td>13.11.98</td>
<td>Demonstrating competent performance. All learning outcomes achieved.</td>
</tr>
</tbody>
</table>

Figure 7.4 Evidence log compiled by the assessor
The following steps may help you review progress using the portfolio evidence.

- Review the previous action plan or learning contract. Decide how far the activities planned have helped the student in participating in care delivery which has contributed to the achievement of the plan or contract.
- If an evidence log is kept, discuss the nature and amount of clinical experiences the student has participated in which have contributed to the achievement of statutory competencies. (The statutory competencies are usually contained in the student’s assessment forms obtainable from the higher education institution of the student.)
- If a learning journal is kept, help the student to analyse critically specific care experiences you have both shared so that the most important issues emerge in order to increase the depth and breath of learning. (See Chapters 4, 6 and 9 for guidelines on the facilitation and assessment of learning through reflection.)
- Ask questions to help the student explain the rationale behind care, thereby enabling the student to apply theory to practice.
- Help the student to consider how practice could change as a result of learning through the specific clinical experiences. Explore alternative practices and strategies with the student.

Discussion with other assessors

If it is not possible for the named assessor to work with the student on enough occasions to monitor the progress of students with validity and reliability, it is important and only fair to the student that the assessor seeks the views of other practitioners who have worked with the student. In the real world of the busyness of clinical practice, Phillips et al (2000) and Bedford et al (1993) found that assessors are unable to be with assessees for any length of time. These research teams recommend that assessment should be a team effort to obtain a stronger and wider evidence base on which formative and summative assessments may be made. Phillips et al (2000) further recommend the following actions as part of good assessment practice:

- assessment should include discussion that occurs as part of the working day
- evidence and issues should be contributed, where possible, by all members of the team, including the assessee
- this occasion may be during a handover, a ‘case’ conference or some other event.

When discussing the performance and ongoing achievement of students as part of the process of monitoring progress, it is important to consider whether the quality and quantity of clinical experiences the student has had are sufficient to help development and therefore progress. Knowledge of the length of the placement, and the stage of training the student is at, will assist assessors in deciding how much progression, within and across each of the levels (novice, advanced beginner, competent), can be expected.

Written records by other assessors will complement and strengthen records of evidence of learning kept by the student. An example of this is given in Figure 7.5.

These testimonies strengthen the evidence of learning provided in the log kept by the student as shown in Figure 7.6.
Assessment, supervision and support in clinical practice

Figure 7.5

Evidence log compiled by the assessor

11/09/03
I have observed Stacey undertake the preparation of an intramuscular injection. She was able to prepare the environment, understanding the importance of communicating effectively with the patient in a calm/relaxed environment. She understands the importance of informing the patient of what is being administered, offering support/reassurance.

Stacey was able to calculate the dosage of medication to be administered and drew the liquid into the syringe in a safe manner.

Stacey practised the process the administering the injection utilizing approved techniques.

11/09/03
Stacey attended a teaching session I conducted for the safe preparation and administration of depot intramuscular injections. Throughout the session Stacey demonstrated a sound knowledge of the procedure, asking appropriate questions and demonstrated correct techniques using simulation.

8/10/03
Stacey attended Clozaril Clinic. She gained an overview of the monitoring that takes place and helped with the physical observations. Stacey demonstrated an understanding of Clozapine and its effects through a question and answer session.

12/10/03
Stacy has assisted me in the administration of medication several times during her placement. She has adhered to policy guidelines ensuring safety at all times.

Making assessment decisions

Formative assessment – is the student progressing?

As discussed above, the assessment activities of working alongside the student and observing practice, discussion with the student and examination of the student’s portfolio, discussion with other assessors are done both informally and formally to monitor progress. During the formal sessions, which should be planned and timetabled (Phillips et al 2000), the assessor should formally review with the student the progress made and identify any difficulties at an earlier, rather than a later, stage of the placement. The number of formal progress review meetings you hold altogether during the student’s placement would be dependent on the length of the placement and the progress the student is making. There should be at least one formalized session (Bedford et al 1993). As a guide, try to hold a formal progress review session at least every 2 weeks. To decide whether the student is progressing, ask the following questions:

- Is the student achieving statutory competencies?
- Is there a demonstration of a growing level of skill and competence (see criteria in Figure 7.7)? An important point to remember is that the level of competence of newly qualified nurses and midwives can vary considerably as
Monitoring Progress, Managing Feedback and Making Assessment

Decisions

Figure 7.6

Evidence log compiled by a learner

06/09/03

I administered a depot injection using the Z track method and the safe procedure that I had previously demonstrated to my mentor.

The patient receiving the depot has the injection regularly therefore presented as quite calm and co-operative. Her mood was appropriate and she gave me good positive comments.

After the depot was given the patient stated that I had given the injection well and that I didn’t hurt her.

Reflection

I gave my first depot injection today. I felt relaxed when I got all of the equipment together as I could remember what I needed from previous practice sessions. The depot I had to give was 37.5 mg Risperidal consta. I felt a little unnerved about this injection as it is different from other depots, as you have to mix the solution that is injected. It is also pre-packed.

After preparing the injection I went and got the patient. The patient that the depot was for was a patient I spend a lot of time with. The patient gave me permission to give her the injection.

I felt nervous before and during giving the injection as I was scared of hurting the patient as the needle was big and the patient was very thin.

Afterwards the patient asked me if it was my first injection as she said I was very good and it didn’t hurt her. I was pleased about this but I was quite overwhelmed by the whole experience and felt a little upset.

I will be practising more depots by simulation and actually giving another three before the end of my placement to make me feel more at ease.

09/09/03

I administered a depot injection using a safe procedure which my mentor and I had discussed and practised within a simulation set up by my mentor.

After administrating the depot and safely disposing of all the equipment used my mentor and I assessed the procedure.

I felt nervous because I didn’t want to hurt the patient and I didn’t know how the patient would react. I also observed that the patient presented as agitated. I used my communication skills to reassure her and make her feel at ease with the injection procedure. I also overcame my fears by communicating with the patient and with reassuring her I reassured myself. My mentor said my communication skills with the patient were excellent, taking into consideration the patient’s needs and concerns. I maintained the safety for the patient, myself and mentor throughout the procedure. This involved preparing the equipment in a safe environment, ensuring the medication was correct i.e. correct dose, within the expiry date, the correct medication for the right patient. The patient was then called to the treatment room as I felt this was a safe environment. The drug was administered using the Z track method. I had maintained the comfort and dignity of the patient.

Is performance consistent (Maloney et al 1997)?

Is there a demonstration of a growing understanding of the rationale underpinning practice?

this is dependent on the opportunities they have in training (NMC 2005). During formative assessments it is important to check that students are having learning opportunities to enable the achievement of competencies.
11/09/03

I have acted out a simulation exercise of a depot injection. This is an intramuscular injection. I was able to prepare the surroundings and equipment for the injection to take place. I was given support and told what to do beforehand. I understood the importance of communicating with the patient to make them feel safe and at ease with the injection procedure. Informing the patient of what is being administered is essential and support and reassurance was offered. I feel that I need more practice in calculating dosages of medication even though I calculated the correct dosage for the injection on this occasion.

I drew the medication into the syringe safely and then I practised the process of giving the injection using approved techniques that I was shown. I felt nervous before I gave the injection but doing it helped me gain confidence to do the procedure again. Support was given to me throughout the exercise which helped me a lot.

12/09/03

I administered medications under the supervision of a staff nurse. At the start of giving out medications I felt a little nervous but after being supported by the staff nurse, I felt a lot more confident. I feel that I need more practice in working out the correct dosages of medication which I will do.

14/09/03

When administering my third depot injection to a male patient the Z track method was used again. This was done in a safe way that was demonstrated to my mentor previously.

I felt more at ease in giving this injection as at this stage I had given two injections before this one. I also felt that I had built up a rapport with the patient I was giving the injection to.

My mentor was quite happy with the way I gave the depot injection, stating that I am quite competent in administering depot injections.

I was pleased with the way my mentor guided me through the procedure of depot injections safely. This gave me more confidence to give the injection and let me know that I was doing the procedure correctly.

I was glad that my mentor gave me time to reflect on each depot I administered as it helped me to pick out points in the procedure that I did well, not so well and things I could have done differently.

18/10/03

I attended clozaril clinic in psychiatric outpatients. Clozaril is a drug used to treat schizophrenia but it can cause quite severe side effects such as making the heart beat to fast and decreasing the white blood cells. This is why the patients that take clozaril get monitored every week. In the clinic the patient gets weighed, blood pressure and pulse taken and blood is taken from them. The patient gets asked from a check list what side effects they have from the drug. The blood taken from the patient gets sent to clozaril monitoring service who check the blood and make sure that that the patient is okay to continue to take the clozaril.

I found working in clozaril clinic different to working on the ward. The clozaril nurse doesn’t seem to get to spend much time with the patients only getting the chance to ask the patient what side effects they have.

My role in the clinic was to take the patient’s blood pressure and pulse. The patient couldn’t really talk about anything confidential to the clozaril nurse as the phlebotomist was there. I enjoyed it in the clinic and I am going to read up on clozaril as more and more patients are being treated by it and I will be using it as a trained nurse in the near future.

Figure 7.6 cont’d
| LEVEL 1 | Competence Achieved | Close supervision required  
Participates and assists in care  
Performs with few prompts  
Can explain the rationale underpinning practice  
 | Competence NOT Achieved | Direct supervision required  
Has difficulty participating and assisting in care  
Requires detailed and explicit instructions  
Cannot explain the rationale underpinning practice  
 | LEVEL 2 | Competence Achieved | Minimal supervision required  
Active participation in care  
Beginning to prioritize care  
Planning most activities and leading some  
Performance is smooth and complete  
Does not require prompting  
Can explain rationale underpinning practice and discuss pertinent research  
 | Competence NOT Achieved | Close supervision required  
Participates and assists in care  
Performance lacks completeness  
Requires to be prompted  
Cannot explain rationale underpinning practice  
 | LEVEL 3 | Competence Achieved | Indirect supervision required  
Active participation in care  
Planning all activities and leading most  
Does not require prompting  
Is organized and efficient  
Is able to prioritize care  
Critiques evidence-based practice and its implementation  
 | Competence NOT Achieved | Close supervision required  
Participates and assists in care only  
Requires prompting  
Unable to organize care  
Does not consider evidence-based practice  

Figure 7.7 - Criteria for assessing the achievement of clinical competence
- Is there a demonstration of development of the attitudes and values appropriate to professional practice?
- Is there a demonstration of a developing ability to engage in evidence-based and reflective practice?

It is important for assessors to remember that many factors can affect a student’s progress and to explore reasons for the student’s difficulties. Phillips et al (2000) made the point that any judgement of a student’s capabilities must take into account the circumstances in which that student is performing.

Summative assessment – should the student be passed?

All assessments involve complex decision-making as ‘assessors ... weigh evidence which will enable them to judge “on the balance of probabilities” or “beyond reasonable doubt”’ (Gonczi 1994:33). When weighing assessment evidence of competence or incompetence, assessors must have sufficient evidence to reach a defensible conclusion which is ‘responsible, reasonable and respectable’, whereas ‘beyond reasonable doubt’ demands a greater burden of proof (Ilott and Murphy1999:89). Here, assessors will be expected to substantiate the assessment decision of either a ‘pass’ or a ‘fail’ grade.

The summative assessment is done at the end of the placement. A final meeting/discussion session should be arranged to take place during the last week of the student’s placement, preferably on the last day. Additional time should be allocated to review and analyse fully the evidence of competence. The following questions may assist in helping you judge and analyse evidence to establish whether there is sufficient assessment evidence to confer competence. Assessors should be careful that responses to these questions are not made on the ‘relative strength of student articulation of their unobserved practice’ (While 1994:102).

1. Has the student achieved the statutory competencies?

Examine the student’s assessment forms, which contain the statutory competencies. Statutory competencies have been set at the point of registration such that the student is able to fulfil the requirements of the practitioner as laid down by the statutory professional body. In order to prepare the student to practise safely and effectively so that, on registration, the student can assume the responsibilities and accountability for practice as a professional such as a nurse or a midwife, all competencies for that placement must be achieved in order to pass.

In recommending the use of the competence-based approach for pre-registration nursing and midwifery education, the NMC (2004a, 2004b) requires students, on qualification, to be able to practise safely and effectively without the need for direct supervision. If these training requirements are to be realized, only competent or not competent judgements can be made. Wolf (1995:22) states that in competence-based assessment ‘either the person has consistently demonstrated workplace performance which meets the specified standards [in the competencies] or they are not yet able to do so’. Using the pre-specified levels of supervision and practice (see Chapter 6), and conditions of practice discussed earlier in this chapter, criteria are put forward to make ‘competent’ or ‘not competent’ decisions in Figure 7.7. Levels 1, 2 and 3 correspond to students during years one, two and three of the pre-registration programme, respectively.
Is there sufficient performance evidence to confer competent practice? Performance evidence would have been gathered by the assessor throughout the period of supervised practice or generated from the testimonies provided by other members of the team.

Has the student reached the required level? You may wish to review the section on ‘Criteria for assessing development in the novice, advanced beginner and competent levels of performance’. Related to this is discriminating power. When making the final decision to pass or fail the student, consider carefully whether your assessment has identified the correct standard to be achieved and the correct level of ability of the student for the stage of the training. In its consultation on *Fitness to Practise* the NMC (2005) proposed to identify a specific point, or points, in a programme where competence should be confirmed at the stated standard.

2. Does the assessment evidence achieve validity of assessment?
Examine the student’s portfolio. Has the learner engaged in a sufficient number and range of care situations for you to be confident that validity has been achieved? Does the student have ‘the ability to actually care for patients?’ (Gerrish et al 1997:70). Remember that the narrower the base of evidence for the inference of competence, the less generalizable it will be to the performance of other tasks. The reader is referred to Chapter 5 for a discussion of validity.

3. Does the assessment evidence achieve reliability of assessment?
Examine the student’s portfolio. Has the learner engaged in a sufficient number and range of care situations for you to be confident that reliability has been achieved? The amount of evidence must be sufficient to ensure consistent performance to the standard required across a range of situations. To ensure reliability, evidence is needed of repeated performances or we may be able to draw upon a number of different sources of evidence. It is dubious that a single correct performance is sufficient to confer competence for assessment purposes (Gonczi et al 1993). Maatsch et al (1987 in Gonczi et al 1993) considered that assessments on five to seven cases were required for the casualty physician to achieve general competence.

4. Is there a demonstration of a sound understanding of the rationale underpinning each competency?
Knowledge and understanding underpin competent practice. Students must be able to demonstrate that they understand the rationale for care activities. It is likely that the assessor will have assessed the student’s understanding through the use of questioning throughout the period of formative assessment. This may require to be supplemented through further questioning when assessment evidence is being reviewed and analysed. Additionally, at Level 2, can the student discuss pertinent research underpinning evidence-based practice? and at Level 3, can the student discuss and critique pertinent research underpinning evidence-based practice?

5. Is the student developing the attitudes and values appropriate to professional practice?
The assessment of attitudes and values is not easy. Although several methods of assessment can be used to ‘assess’ the attitudes and values of another (see Chapter 4), it nonetheless leaves this crucial aspect of competent professional practice open to
personal biases and subjectiveness. It also stands in danger of not being assessed at all (Fraser 2000, Bedford et al 1993).

Many would agree with Goffman (1959, in Hodges 2003:1137) when he said that ‘... the “true” or “real” attitudes, beliefs and emotions of the individual can be ascertained only indirectly through his avowals or through what appears to be involuntary expressive behaviour’. A tool termed the ‘professional behaviours inventory’ to assess pre-specified behaviours expected of a professional exhibiting the accepted conduct of practitioner is proposed in Chapter 3. These behaviours are assumed to be underpinned by the attitudes, values and beliefs of the person. The use of such a tool is likely to assist the assessor in being more objective.

**Managing some assessment problems**

**Students experiencing problems learning during clinical practice**

Although ‘poor’ students were found to be typically in the minority, the issue is nonetheless an important one as these students are a ‘cause for concern’ (Bedford et al 1993). Any student who is either not progressing or failing to meet the required standard needs identification by assessment systems so that opportunities can be provided for the student to improve. It is suggested here that the use of the assessment activities to monitor progress as discussed above will help the assessor identify those students who require extra help and support. Maloney et al (1997) provide some criteria for recognizing these students early. They remind us that although some of these behaviours are exhibited by many students at some time during clinical practice, the student who is either not progressing or failing exhibits these behaviours to such a degree and extent that learning is interrupted. These behaviours are listed here:

- is inconsistent in meeting the required level of competence for expected stage of training
- is inconsistent in clinical performance
- does not respond appropriately to constructive feedback
- appears unable to make changes in response to constructive feedback — therefore clinical skills do not improve
- exhibits poor preparation and organizational skills
- has limited interactional and poor communication skills
- may experience continual poor health, feel depressed, angry, uncommitted, withdrawn, sad, emotionally labile, tired or listless.

How can the assessor manage the situation when a student is either not progressing or failing? In Chapter 2 there is a discussion of the professional responsibility and accountability of the assessor in these situations. It is acknowledged here that people are generally reluctant to pass negative judgements on fellow workers. Assessors also experience the handling of the assessment of weak students as great challenges, both professionally and personally (Ilott and Murphy 1999, Bedford et al 1993).
But the implications of poor students ‘slipping through the net’ to become registered practitioners are grave if the situation is not managed appropriately as a minority of incompetent professionals can do untold damage. Appropriate management, I believe, includes using ‘intelligence, sensitivity, understanding and insight’ when dealing with these students, as suggested by Maloney et al (1997). It is reiterated here that the use of the strategy of triangulation to collect assessment evidence (see Chapter 4) will increase the confidence of the assessor when dealing with these students. Although the following plan of action is offered, the assessor should be clear of the policy laid down by the higher education institution of the student for dealing with these situations so that the correct procedure is followed:

- Concern is documented in the assessment forms at an early stage, and certainly no later than the point at which formative mid-placement assessment takes place (Bedford et al 1993). The nature of the problem should be carefully, clearly and explicitly documented. The written word gives a visual record of problems and actions taken.
- Discuss the situation with the senior practitioner with overall responsibility for student learning. Following this, inform the student’s personal teacher and/or the clinical link lecturer (ENB 1997). Support from the higher education institution is essential in these situations. Assessors in Duffy’s (2004) study found that more support from education staff and colleagues was required when they were supporting ‘weak’ students.
- It is important to establish clear and open communication between the student, assessor and the higher education institution.
- Arrange to have a meeting with the student as soon as possible. Explain the reason for the meeting to the student.
- Consider and discuss the evidence which has led to concern. Give honest unambiguous feedback (Ilott and Murphy 1999). Maloney et al (1997:204) found that some students reacted positively and were relieved when their shortcomings were openly discussed with them, saying: ‘It’s so good not to pretend, now I feel I can say I don’t know and extend my learning and increase my clinical skills’.
- Make sure the student understands the nature of the problems – has the student heard accurately what you are saying? The most difficult cases are those students who are clearly not succeeding but do not recognize this. Duffy (2004) found that many students who were failing lacked insight of their weak areas of practice and therefore, did not perceive any necessity for extra support. Supportive measures were then ineffective as they were not recognized as such. Students should thus be provided with the opportunity to give their own perception of their performance. Help students identify what they already know and what they need to focus on in order to learn and overcome their weaknesses. Help students identify resources they can utilize to improve knowledge and skills.
- Jointly, draw up a targeted detailed action plan. Where action plans were negotiated and monitored through reviews, Gleason (1984 in Ilott and Murphy 1999) found that 70% of students improved their grades. The good, honest, clear formative assessment motivated the students.
  - Provide a clear and unambiguous assessment plan (see Chapter 6) to retrieve the situation
- Set deadlines and make sure the student understands these
- Make arrangements to work closely with the student
- Arrangements should also be made for the student to work with other assessors so that testimonies can be provided: this will increase the validity and reliability of the assessment. Furthermore, students have the right to be protected from unfair or biased assessment and should not be failed until they are judged by another assessor (Gomez et al 1998).
- Make arrangements to conduct a progress review in 1 week. If, despite remedial action, there is little or no improvement, make arrangements for the clinical link lecturer to be present at a tripartite meeting to discuss the situation and develop another action plan.
- A weekly progress review is advisable for as long as the student’s difficulties persist.
- It is also important to keep careful notes of all discussions: there may come a time when you have to use these as evidence that you may have pointed out the same things again and again and that the student has repeatedly failed to meet the goals you have set. It is important to remember that the report will be scrutinized by the examination board of the higher education institution. It therefore needs to be clear, accurate and well evidenced. Where students have appealed against ‘fail’ decisions, I have known instances when the fail decision has been overthrown by the examination board due to poor documentation and lack of substantive written evidence against the fail grade. Likewise, Fraser et al (1997) found that where there is insufficient assessment evidence, the benefit of the doubt will be in the student’s favour.

If, despite the actions and opportunities provided for the student to improve, development does not occur and standards are not achieved, failure decisions can be made fairly and on the basis of a fully documented evidence base.

Managing the situation when a student has to be failed

There comes a time when you may have to fail a student. It is important that failure does not come as a surprise to the student. Correct use of formative assessment processes, including feedback, would have indicated to the student those aspects of learning which were consistently not achieved. Before making this critical fail decision, you must have followed the plan of action outlined above for helping the student who is not progressing. These situations are demanding and sensitive to handle. Notwithstanding that, assessors have professional responsibilities and accountability to make sound and accurate assessment decisions which include failing students who have not met the standards of training. The legal and ethical issues surrounding not failing a student who has not met the training standards and is unsafe to practise are discussed in Chapter 2. Suffice here to remind ourselves by asking the following question: Would I want such a nurse or midwife or doctor to look after me or a relative or a friend of mine? Bedford et al (1993) say that considerable skill and confidence are required to manage these situations effectively. I would also suggest that the assessor requires the courage and strength to fail a student – a conviction that a just assessment decision has been made will vest the assessor with this courage. This conviction will ensue if assessment processes to ensure fair assessments are followed. The assessor, then, will have no fear that there will be
reprisals for failing a student. However, it is important to remember that it is as wrong to ‘fail to fail’ as it is to fail unjustly (Ilott and Murphy 1999).

Consider the scenario shown in Activity 7.2. How would you deal with it?

**Activity 7.2**

Staff Nurse Mark Bradshaw is the named assessor to a student called Mary who has struggled considerably to achieve the required standard in three of the competency statements. He has been reviewing progress with her weekly. She is now approaching the end of the placement and has not achieved the required standard and, in Mark’s opinion, should be failed. A fellow registered nurse who has also worked with Mary argues strongly that Mary’s practice is up to standard and she should be passed. What should Mark do?

The decision to fail a student is never an easy one to make (Stuart 2002, Lankshear 1990). When another assessor disagrees with your decision, it becomes even more tricky. The starting point is perhaps to consider both sets of assessment evidence objectively – Are both of you using the same criteria for assessment, so that assessment evidence is reliable? Therefore, evidence of achievement or non-achievement is based on the same criteria. The next question you may wish to consider is the validity of the assessment – e.g. Have both of you been assessing what you should be assessing? Has too much or too little been expected of the student? Other aspects of validity will also need to be considered (see Chapter 5).

Assuming that individual personal biases are not implicated and feasibility (see Chapter 5) within the assessment process has received due attention, and you still cannot agree with each other, as the named assessor you may wish to take the following action(s):

- arrange a meeting with your senior nurse/midwife with overall responsibility for student learning to discuss the situation
- arrange a meeting with your clinical link teacher or the student’s personal teacher to discuss the situation
- arrange a joint meeting with your senior nurse/midwife and clinical link teacher to discuss the situation.

The final point to remember is that, as the named assessor, you are responsible for making the final assessment decision and are accountable for passing or failing the student at the end of the period of practice placement. The grade you award should reflect the student’s standard of practice in the latter part of the placement.

**Student reactions to being failed and how to manage them**

Failing students may react in a number of ways (Gomez et al 1998). These behaviours need to be recognized for what they are, i.e. the student’s reactions to the news of failure and not a personal vendetta against the assessor. Gomez et al (1998:420) recommend giving extra time to these situations, as the student needs time to ‘grieve the loss of what was, perhaps, a dream’. Students need time to process the information and should not feel rushed. Assessors should listen attentively, show concern and provide the appropriate support.
Students may respond with *denial* – their own perception of their competence contradicts that of the assessor. They may also deny situations where their performance was observed to have been unsafe or the attitude they exhibited was inappropriate. They may make excuses for their behaviours. The conversation needs to be steered to learning outcomes not being met.

The denial and/or anger (see below) may also be demonstrated in other ways, such as making attempts to undermine the assessor’s judgement by soliciting the views of other team members behind the back of the assessor (Duffy 2004). The assessor will need to deal with these instances firmly without causing disharmony in the team. It may be useful to remember that as the named assessor, your professional statutory body, such as the Nursing and Midwifery Council in the case of nurses and midwives, has invested you with the responsibility and accountability for making assessment decisions. As such you are invested with the authority to make assessment decisions as you see fit.

Students may respond with *anger and aggression* – they may become abusive and accusing, e.g. making accusations of biases against their personal characteristics. If the assessor suspects that this situation could arise, it may be wise to have the presence of a third person, such as the personal teacher of the student. The anger should not be taken personally. Provide guidance about feelings and focus on anger as part of the loss.

Anger and/or denial could also be in the form of blaming others by deflecting responsibility for failure onto the staff such as saying that failure was caused by personality clashes between themselves and the staff (Duffy 2004).

Some students may attempt to bargain for a passing grade. The assessor needs to stand firm and remain focused on the results.

As the reality of the loss is recognized, students may respond with *sadness* – they may cry over the loss of the right to carry on with the training. For mature students with families, losing the right to train is also likely to mean loss of income. Allow them to cry before going on to discuss the reasons for the failure.

Some students may be quite relieved. A career as a nurse or midwife or physiotherapist may not be what they want but they may not have the courage to make that decision.

Failure may be a positive experience for some students. Some learn from the experience and go on to achieve success. Maloney et al (1997) give an example of a student who learned from failure – failure for her was positive (Case study 7.1).

---

**CASE STUDY 7.1**

Learning from the Experience of Failure (Reproduced with the permission of Nelson Thornes Ltd from *Facilitating Learning in Clinical Settings*, McAllister et al, ISBN 0 7487 3316 7, first published in 1997)

A university medical lecturer was surprised when approached at a social function by a confident young woman, who had recently been making her name in art design. She thanked him for helping her to make ‘the most important decision of her life!’ To his
Failure, however, is not a positive experience for many students. For some, it is a devastating experience and can appear to be a scar carried for life. In his study of the kinds of failure people remembered, Cannon (2002) found that, with few exceptions, each experience of failure was still recalled with feelings of anger and sadness. He concluded that failures are ‘anxiety-raising experiences [which] are simply difficult to delete from memory’ (p.76). This painful situation may be averted if lack of progress is determined early and appropriate support and help put in place. The reader is directed to the work of Maloney et al (1997) for a more comprehensive discussion of students who are either not progressing or failing.

Failure to fail

Having to fail a student causes many of us considerable anguish. At the other end of the continuum is the abuse of the power to fail, using it as a tool to exert control and punish ‘difficult’ or unpopular students (Wolf 1995). This complex problem of ‘failure to fail’ is not new and appears to be a continuing challenge for assessors of students on professional courses. In the health professions, ‘failure to fail’ is reported in literature relating to assessment from the fields of social work (Brandon and Davis 1979), medicine (Green 1991), nursing and midwifery (Duffy 2004, Fraser et al 1997, White et al 1994, Bedford et al 1993, Lankshear 1990) and occupational therapy (Ilott and Murphy 1997). The teaching profession has the same problem (Hawe 2003). References are made to assessors giving students the benefit of the doubt in marginal situations instead of awarding a fail when it was clearly warranted. What is also of concern is that students are aware that they can get round weak areas of practice. A student in White et al’s study (1994:103) said that ‘it is virtually impossible to fail the practical part of the course’.

Why do assessors find it difficult to assign a fail grade? There are no straightforward answers and it would appear that professional and strong affective and personal overtones/factors influence assessors’ decision-making process when confronted with having to make a fail decision. From a review of some of the literature relating to assessment in professional education I attempt to give a summary of the main reasons for not failing students.

- Lankshear (1990) found that staff were loath to fail students knowing that awarding a fail meant additional work for them plus having to deal with the rancour of the student.
- Ilott and Murphy (1997) explored the affective responses of assessors in fail scenarios in occupational therapy courses in the UK. Feelings reported included anxiety, guilt, distress, self-doubt, regret and relief. For some of the
assessors, the emotions were so strong that a pass grade was awarded over a fail. While the failure to fail seemed the less stressful option, it often engendered its own degree of guilt and shame in the assessor.

- Ilott and Murphy (1997) also commented on the acute sense of personal failure felt by assessors when students failed, thus construing the assessment process as a reflection of their personal and/or professional worth.
- A personal dilemma for many assessors is that of feeling that failing a student is incongruent with being a health care professional whose central role is to ‘care’ and nurture (Duffy 2004, Fraser et al 1997, Ilott and Murphy 1997, Stengelhofen 1993).
- Many studies reporting the assessment of pre-registration nursing and midwifery students in the UK show that where mentors lacked confidence in assessing, had poor preparation for their role, do not know the student very well or where they did not have sufficient assessment evidence, the benefit of the doubt was more likely to be given (Duffy 2004, Fraser et al 1997, Bedford et al 1993).
- Students manipulate assessors or the system to avoid failure (Duffy 2004, Fraser et al 1997, White et al 1994).
- Duffy (2004) also found that mentors need more support from colleagues and education staff to fail incompetent students. In a study of undergraduate and postgraduate professional training, Green (1991) found that assessors lacked support from colleagues, managers and lecturing staff when making fail decisions, with some practice teachers even experiencing considerable pressure to pass students.
- It is difficult to fail students in their third year as assessors do not want to be responsible for ending students’ careers so late in a programme (Duffy 2004, Phillips et al 2000). Equally difficult is failing first year students as there is the held notion that problems will resolve as students progress through the course (Duffy 2004).

An awareness of those factors that contribute to ‘failure to fail’ may be a first step to understanding why we experience difficulties when dealing with a failing student, and may thus end up passing a student when a fail is clearly warranted. It may also help us to identify the support we need when dealing with these difficult situations.

**Conclusion**

When working with learners it is important to be able to indicate to them the progress they are making. Progress during clinical practice needs to be carefully tracked and feedback given so that learners may be able to learn and develop further. A discussion of the four assessment activities – working alongside the student and observing practice for development in the level of the student’s competence, discussion with the student, examination of the student’s portfolio and discussion with other assessors – shows how they can be used to monitor the progress of learners. Based upon what we know about the nature of expertise (Benner et al 1996, Glaser 1990, Benner 1984), a model that outlines the performance characteristics of novice, advanced beginner and competent practice is proposed here to monitor and assist with progression during clinical practice.
Monitoring progress is not about policing the learner. It is very much about finding out the quality and quantity of learning which has taken place and any difficulties the learner may be experiencing so that further assessment activities can be discussed and planned to further learning and development. It is inevitable that there will be instances when learners do not succeed: for these learners, early identification of difficulties and taking the appropriate action may reduce the trauma of failure for them.

If progress is carefully tracked through the four assessment activities discussed here, and done throughout the student’s placement, it becomes much easier to make assessment decisions that are also more likely to be based on a valid and reliable evidence base, which means that students have a fairer deal. It also makes the task of making assessment decisions easier for the assessor – easier, as it is never easy to make fail decisions. Assigning a fail grade is something that is rarely done lightly or without misgivings. It is a formidable responsibility. Passing a student is an equally formidable responsibility. However, do we also assign a pass grade lightly and without misgivings too? I end this chapter by leaving you to ponder this question.

Key points for reflection

When monitoring progress, the role and responsibilities of the assessor centre around answering these key questions:

1. What has the student done and learned so far? How will I know?
2. Is the student having any difficulties? How will I know?
3. What can be done to facilitate further learning and development?

Answers to these questions may be obtained through the use of the assessment activities in Figure 7.2:

The period of formative assessment allows the assessor to monitor progress. Answers to the following questions will enable the assessor to decide whether there is progress:

1. Is the student achieving statutory competencies?
2. Is there a demonstration of a growing level of skill and competence (see criteria in Figure 7.7)?
3. Is performance consistent?
4. Is there a demonstration of a growing understanding of the rationale underpinning practice?
5. Is there a demonstration of development of the attitudes and values appropriate to professional practice?
6. Is there a demonstration of a developing ability to engage in evidence-based and reflective practice?

The occasion of summative assessment centres around making a ‘pass’ or ‘fail’ decision. Answers to the following questions will enable the assessor to decide whether the student should be passed:

1. Has the student achieved the statutory competencies?
2. Does the assessment evidence achieve validity and reliability of assessment?
3. Is there a demonstration of a sound understanding of the rationale underpinning each competency?
4. Is the student developing the attitudes and values appropriate to professional practice?

Students who are either not progressing or failing to meet the required standard needs identification by assessment systems so that opportunities can be provided for the student to improve. The following behaviours could be indicative of this:

1. inconsistency in meeting the required level of competence for expected stage of training
2. inconsistency in clinical performance
3. does not respond appropriately to constructive feedback
4. inability to make changes in response to constructive feedback – therefore clinical skills do not improve
5. exhibits poor preparation and organizational skills
6. has limited interactional and poor communication skills
7. may experience continual poor health, feel depressed, angry, uncommitted, withdrawn, sad, emotionally labile, tired or listless.

The following actions should be taken:

1. document concerns
2. discuss the situation with a senior practitioner and the higher education institution
3. discuss concerns with the student
4. make sure the student understands the problems
5. jointly, draw up a targeted detailed action plan.

A ‘fail’ decision should not come as a surprise to the student. Students may react with denial, anger, aggression, sadness or may try to bargain for a pass. The assessor is invested with the responsibility and accountability for making assessment decisions. Assigning a fail grade is something that is rarely done lightly or without misgivings. It is a formidable responsibility. Passing a student is an equally formidable responsibility.

References


Green C (1991) Identification of the responsibilities and perceptions of the training task held by workforce supervisors of those training within the caring professions. Project 551 prepared for the Further Education Unit, Anglia Polytechnic.


Hodges B (2003) OSCE! Variations on a theme by Harden. Medical Education. 37, 1134–1140.


Nursing and Midwifery Council (2004a) Standards of proficiency for pre-registration


