



Original research

Facilitating peer based learning through summative assessment – An adaptation of the Objective Structured Clinical Assessment tool for the blended learning environment

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ABSTRACT

Adapting a course from face to face to blended delivery necessitates that assessments are modified accordingly. In Australia the Objective Structured Clinical Assessment tool, as a derivative from the Objective Structured Clinical Examination, has been used in the face-to-face delivery mode as a formative or summative assessment tool in medicine and nursing since 1990. The Objective Structured Clinical Assessment has been used at Charles Darwin University to assess nursing students' simulated clinical skills prior to the commencement of their clinical placements since 2008. Although the majority of the course is delivered online, students attend a one-week intensive clinical simulation block yearly, prior to attending clinical placements. Initially, the Objective Structured Clinical Assessment was introduced as a lecturer assessed summative assessment, over time it was adapted to better suit the blended learning environment. The modification of the tool from an academic to peer assessed assessment tool, was based on the empirical literature, student feedback and a cross-sectional, qualitative study exploring academics' perceptions of the Objective Structured Clinical Assessment (Bouchoucha et al., 2013a, b). This paper presents an overview of the process leading to the successful adaptation of the Objective Structured Clinical Assessment to suit the requirements of a preregistration nursing course delivered through blended learning. This is significant as many universities are moving their curriculum to fully online or blended delivery, yet little attention has been paid to adapting the assessment of simulated clinical skills. The aim is to identify the benefits and drawbacks of using the peer assessed Objective Structured Clinical Assessment and share recommendations for successful implementation.

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1. Introduction

The Objective Structured Clinical Assessment (OSCA) is used in simulated clinical teaching settings to assess students' clinical skills. The OSCA was derived from the Objective Structured Clinical Examination (OSCE) tool and introduced in Australia in 1990 (Bujack et al., 1991a,b; Major, 2005). The traditional OSCE was based on a simulated patient and consisted of a multi station setup (Kurz et al., 2009). Students rotated through each station, within a pre-determined timeframe, carrying out various procedures or answering set questions (Harden and Gleeson, 1979). Bujack et al. (1991a,b) adapted the OSCE to reflect the nature of nursing rather

than medical practice in 1991. The adaptation became known as the Macarthur OSCA. Since then the OSCA has been further adapted and deemed effective in assessing nursing students competencies (East et al., 2014). This paper traces the introduction and adaptation of the OSCA tool to better suit a preregistration nursing course delivered through blended learning.

2. Background

In 1997 Charles Darwin University (CDU) externalised the delivery of its undergraduate nursing degree and by 2008 most of the course was delivered online. Many CDU students complete the theory component of their course as external students. The only face to face component of their course is three Simulation Blocks (SB). During the SB, clinical skills, unable to be taught online are demonstrated by staff, and then practiced by students. At the end of

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the SB students are expected to pass a certain number of OSCAs. The OSCAs are summative and must be passed before students can proceed to their clinical practicum.

In courses delivered by internal mode, students are on site and have access to clinical laboratories throughout the semester. Internal students, therefore, have the benefit of being able to practice their simulated clinical skills over an extended period of time. The skills internal students have learned and practiced, are then assessed at the end of the semester. In contrast, CDU nursing students are not able to practice learned skills over the course of a semester. Clinical skills are taught and assessed within a condensed timeframe during the SBs.

The SBs cover most of the skills nursing students will potentially be exposed to during their clinical placements (e.g., complex dressing; intramuscular injection). These skills are determined by the scope of practice document for the corresponding year level. Time is dedicated to the demonstration and practice of most skills, in addition to the assessment of selected clinical skills as determined by the nursing faculty. It is important to stress that in the face-to-face delivery mode assessment usually occurs after the students have had several weeks to practice skills. The transition to an online reliant course incorporating the SB model meant that practice time was condensed to 24–48 h and it constituted a major change to the intention of traditional clinical skills assessment tools.

In late 2008, two OSCA assessments per SB were introduced. In first and second year both these assessments were carried out by academic staff. In third year, however, one assessment was predetermined and known to the students and assessed by academic staff, whilst the second was randomly chosen out of a pool of four skills and peer-assessed. These skills included blood transfusion administration, setting up and connecting patient controlled analgesia, central venous catheter dressing and tracheostomy dressing change. Positive feedback from the third-year peer OSCAs from both staff and students resulted in the peer OSCA being introduced into the second-year SBs in 2011, and in 2013 they were successfully extended to the first-year SBs.

The skill assessed in the peer OSCA is not known to the students and chosen out of four predetermined skills. The student does not know until they walk into the assessment room which skill they will be assessed on. Not knowing which skills is being assessed acts as an incentive to practice all four skills and allows for better utilisation of the time spent in practice session which in turn has an impact on skill retention. Bond et al. (2007) showed that the best predictor of competent performance is repetitive, deliberate practice. It can however lead to students practicing non-assessed skills less.

Preparing students for the peer assessment is essential (Garner et al., 2010; Rush et al., 2012; Topping, 2009). Successful preparation will decrease the chances of issues arising during the process. Preparation should include information regarding professional obligations and assertiveness training. Staff also need to model how to provide useful constructive feedback. Students would then practice the OSCA procedure before the actual assessment. Practicing the OSCA procedure allows students to feel more comfortable with the process. Providing an assessment guide could also increase students confidence and decrease the risk of poor interrater reliability, although completely removing the risks of discrepancies between assessors might prove extremely challenging and near impossible (East et al., 2014).

Despite the OSCA having been shown to be one of the most adequate clinical skills assessment formats, there are some drawbacks to its use. One of these drawbacks is the potential for discrepancies in administration of the tool. Standardised and consistent administration of the OSCA is essential to decrease the

risk of interrater discrepancies (Bouchoucha et al., 2013b; Najjar et al., 2016). Being a labour intensive assessment modality has also been cited as a drawback to its use (Baid, 2011; Chenot et al., 2007). Utilising students as assessors would overcome some of the associated drawbacks, as well as ensuring students are equipped with lifelong skills. These skills, often referred to by Universities as graduate attributes, such as team work, problem solving skills or communication, are essential attributes for successful employment (Kember et al., 2016). Although Chenot et al. (2007) found that students can have mixed feelings about assessing each other, most students accept the ratings given by their peers, and feel confident that they are able to accurately rate their peers.

Li et al. (2010) listed the benefits of peer assessment for the assessor and assessee as constructive reflection, increased time on task, attention to crucial elements of quality work and greater sense of accountability and responsibility. In addition to these benefits, Topping (2009) argued that peer assessment results in improvements in the effectiveness and quality of learning for both the assessor and the assessee. Casey et al. (2011) found that students generally enjoyed the process and that peer assessment facilitated and enhanced student learning. Furthermore, van Dulmen et al. (2014) demonstrated that peer assessment is an effective method to improve guideline knowledge and guideline, consistent clinical reasoning.

Despite the benefits widely described in the literature (Li et al., 2010; Topping, 2009; Casey et al., 2011; van Dulmen et al., 2014), there was an initial reluctance amongst lecturing staff at CDU to implement peer assessment for first year students. It took several years for peer OSCAs to be accepted as a first-year assessment mode. Falchikov and Goldfinch (2000) found that there was no course level difference in peer-teacher marking correspondence, challenging the perception that peer assessment should be reserved to more senior students, Rush et al. (2012) also documented the successful implementation of peer assessed clinical skills in the first year of study, and identified improvements in the learning of skills, teamwork, communication and the ability to give and receive constructive feedback. Furthermore, Hodgson et al. (2014) suggested that if more educators adopted peer assessment to improve student learning in first year, it would be likely that teacher guidance could be incrementally withdrawn in subsequent years.

Lecturer assessed OSCAs have been found to be stressful for students (Bouchoucha et al., 2013a; Furlong et al., 2005). Excessive stress has the potential to negatively affect performance (Arora et al., 2010). This is mostly investigated in the literature in surgical practitioners and trainees (Arora et al., 2010) with the impact of stress on the performance of psychomotor skills in simulated nursing settings seldom studied. The peer assessed OSCA is not as stressful as the traditional OSCA for the students, which in turn has the potential to improve performance. This position is supported by McKenna and French (2011) who found that students are less anxious performing a skill in front of their peers than lecturers, and can better interact and communicate with peer assessors. Additionally, peer assessment motivates students to practice and improves their ability to critically appraise the performance of peers (Topping, 2009). Another benefit described by Li et al. (2010) is the ability for students to gain greater insight into the assessment process as they need to familiarise themselves with the standards/assessors tool prior to assessing their peers.

While many benefits of peer assessment are described in the literature, there are also some perceived drawbacks. Some of the arguments used for not using peer assessment include that the students do not have the expertise to assess each other, do not know what constitute good work, can collude with each other, lack experience or give invalid marks and create an increased workload

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