



**Exploring nurse educators' perceptions of objective structured
clinical evaluation as summative assessment for students'
clinical competence**

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DECLARATION

I declare that the dissertation with the title: Exploring nurse educators' perception of Objective Structured Clinical Evaluation as summative assessment for students' clinical competence is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Segomotso Sophie Maruping

Date

DEDICATION

I dedicate this dissertation to the following images of the creator, our God:

My late husband Bakaile Clement Maruping.

My family for their care, understanding and willingness to support me during my long journey through this study experiences.

My mother, Kediemetse Betty Mohulatsi who taught me the value of education and perseverance.

To Moitshepi and Ontlametse for their patience, support and sacrifices. "Mummy" could not have accomplished this dissertation without your understanding, and for that I am eternally grateful.

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ABSTRACT

Key concepts: Perception, Nurse educator, OSCE, Summative assessment, Clinical competence.

The purpose of this study was to explore nurse educators' perception of Objective Structured Clinical Evaluation (OSCE) as summative assessment for students' clinical competence ,with the aim of recommending alternatives to the current situation.

The rationale behind the study is that the researcher became aware of concerns raised by nurse educators regarding the appropriateness of OSCE as summative assessment of students clinical competence and differences of opinion on the matter. An explorative, descriptive, contextual, qualitative research design was chosen. The sample included nurse educators actively involved in OSCE as summative assessment of nursing students in the provincial nursing college for at least 5 years or more. Data was collected by means of two (2) focus group interview sessions with fourteen (14) participants. During data analysis it became clear that data saturation had not been reached and a third focus group interview was conducted with seven (7) participants from the original sample who were available. The focus of the interviews was to explore participants' perception of Objective Structured Clinical Evaluation as summative assessment for students' clinical competence.

The data was independently analyzed by the researcher as well as an independent co-coder according to the principles for content analysis as described by Creswell (2008:251). Three (3) themes and nine (9) sub-themes emerged from the data collected from participants. The first theme described the value of OSCE as summative assessment method for students' clinical competence. Theme two described the obstacles in using OSCE as summative assessment for students' clinical competence. Theme three described the suggested alternatives. The collected data was discussed and integrated with relevant national and international literature to culminate in three (3) conclusive statements. The conclusive statements served as basis for recommending alternatives to the nursing educators and managers in order to enhance the value of OSCE as summative assessment for students' clinical competence.

OPSOMMING

Sleutelwoorde: Persepsie, Verpleegdosent, OGKE, Summatiewe Assessering, Kliniese vaardigheid.

Die doel van hierdie studie was om die persepsies van verpleegdosente rakende die Objektiewe Gestruktureerde Kliniese Evaluasie (OGKE) as summatiewe assessering van die kliniese vaardigheid van verpleegstudente te verken met die doelwit om alternatiewe voor te stel vir die huidige situasie.

Die rasionaal vir die studie is dat die navorser bewus geword het van voorbehoude onder verpleegdosente oor die toepaslikheid van OGKE as summatiewe assessering vir kliniese vaardigheid en van verskille in opinie oor die saak. 'n Verkennende, beskrywende, kontekstuele, kwalitatiewe navorsingsontwerp is gekies vir die navorsing. Die steekproef het bestaan uit verpleegdosente wat aktief betrokke is by OGKE as summatiewe assessering van verpleegstudente by die provinsiale verpleegkollege vir ten minste vyf jaar of langer. Data is versamel met behulp van twee (2) fokusgroep onderhoudsessies met veertien (14) deelnemers. Gedurende data-analise het dit egter duidelik geword dat datasaturasie nie bereik is nie. Gevolglik is 'n derde fokusgroep onderhoud gevoer met sewe (7) beskikbare deelnemers uit die oorspronklike steekproef. Die fokus van die onderhoude was om die deelnemers se persepsies rakende Objektiewe Gestruktureerde Kliniese Evaluasie as summatiewe assessering van kliniese vaardigheid te ondersoek.

Die data is onafhanklik geanaliseer deur die navorser en 'n onafhanklike medekodeerder aan die hand van die beginsels vir inhoudsanalise soos beskryf deur Creswell (2008:251). Drie (3) temas en nege (9) subtemas het duidelik geword uit die data wat van deelnemers ingesamel is. Die eerste tema beskryf die waarde van OGKE as summatiewe assesseringsmetode vir kliniese vaardigheid. Tema twee beskryf die hindernisse in die gebruik van OGKE as summatiewe assessering vir kliniese vaardigheid. Tema drie beskryf die voorgestelde alternatiewe. Die ingesamelde data is bespreek en geïntegreer met die relevante nasionale en internasionale literatuur, en dit het uitgeloop op drie (3) samevattende stellings. Die samevattende stellings het as basis gedien vir die voorstelling van alternatiewe aan die verpleegdosente en verpleegbestuur om sodoende die waarde van OGKE as summatiewe assessering vir kliniese vaardigheid te verryk.

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CHAPTER 1

AN OVERVIEW OF THE STUDY

This chapter provides an overview of the study by offering an introduction, the background and rationale for the study, the problem statement, followed by the objectives and the researcher's paradigmatic perspective. In addition, the chapter offers a short discussion of the research design and methods and the ethical and rigor aspects to ensure the study's trustworthiness. The chapter is concluded with the chapter outline for the rest of the study and a summary.

1.1 INTRODUCTION

Assessment for clinical competence poses challenges to nursing colleges in South Africa due to the ever increasing number of students per intake. The use of the Objective Structured Clinical Evaluation (OSCE) as summative assessment seems to gain popularity due to its ability to accommodate large groups of students in a relatively short period of time.

OSCE as an assessment method is increasingly being used in nursing education institutions and is geared to assess clinical competence in relation to knowledge, skills and attitude, either at a particular stage of a course or at the end of the course (Meyer & Van Niekerk, 2008:94). Although the use of OSCE is gaining popularity in nursing, its appropriateness as summative clinical assessment is questioned by some nurse educators, particularly with regard to its adequacy for comprehensive assessment i.e knowledge, skills and attitude and the complex skills required of a reflective practitioner (Redfern *et al.*, 2002:60; Chabeli, 2001a:86).

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

The assessment of the clinical competence of nursing students is imperative for client safety, for monitoring student progress, motivating students and assessment of achievement. Competence involves not only observable behavior, but also unobservable attributes, including judgemental ability and personal dispositions (Redfern *et al.*, 2002:53). However, the traditional methods used for the assessment of clinical competence were problematic because of their supposed subjectivity and complexity. This has been replaced by the OSCE (Furlong *et al.*, 2005:388). Since its development as an assessment strategy for medical education in the 1970s, OSCE has gained acceptance as a benchmark for clinical competence assessment, and it has since been adopted by other health related professions, such as occupational therapy, physiotherapy, radiotherapy and nursing (Kurz *et al.*, 2009:186).

According to Chabeli (2001a:85), the main objective of the OSCE is to assess students' transfer of classroom and laboratory learning experience into simulated clinical practice. The OSCE is an approach to the assessment of clinical competence in which different components of competence are assessed in a well planned and structured way, with special attention to objectivity (Mitchell *et al.*, 2009:398). The candidate is allocated to a specific task per station for a set amount of time per task/station and then moved on to the next task/station. The number of stations used depends on aspects such as the availability of resources i.e assessors, equipment and availability of space to set up stations. Usually, five (5) to ten (10) stations are prepared for an assessment. Large numbers of candidates can be assessed according to a structured checklist in a relatively short period of time; a feasible and attractive option for nursing educational institutions that have to address the limitations of the traditional methods of assessment for clinical competence.

Researchers site the following advantages of OSCE:

Standardized clinical assessment, strengthened by the involvement of clinical practitioners (Furlong *et al.*, 2005:388).

It helps nursing students to determine their own weaknesses and enables educators to organize additional teaching sessions if required (Meyer & Van Niekerk, 2008:949).

It is appropriate for use with large number of students, despite the extensive preparation involved in executing it (Byrne & Smyth, 2008:284).

According to Rushforth (2007:489) OSCE has the potential to make a very effective and meaningful contribution to “fitness for practice” assessment.

Literature indicates concerns regarding the appropriateness of OSCE as summative assessment for students’ clinical competence as follows:

Although an important advantage of OSCE is its ability to provide a standardized clinical assessment, it is this advantage that prevents it from accommodating the myriad cultural, economic and sociopolitical contents that exist within the larger clinical nursing context (Mitchell *et al.*, 2009:402).

The level of competence in critical thinking as assessed by an OSCE is unlikely to fully reflect the nursing student’s ability to competently apply critical thinking in the real-life clinical setting (Mitchell *et al.*, 2009:402).

Byrne and Smyth (2008:284) state that OSCEs are costly to execute in terms of manpower, resources and time elements and require careful planning to be successful.

OSCEs are not suitable for assessing all aspects of clinical competence (Furlong *et al.*, 2005:357; Byrne & Smith, 2008:284).

OSCEs seem to be unable to reproduce a real life clinical environment. The aspects that are assessable in an OSCE may not be sufficient to confirm that the nurse is in fact a caring nurse. Thus, the assessment of complex and essentially subjective constructs such as caring, empathy and other interpersonal skills are vulnerable to findings of low validity, and this makes assessment based on an OSCE questionable (Redfern *et al.*, 2002:62; Mitchell *et al.*, 2009:402).

OSCEs promote rote learning rather than competence in practice (Redfern *et al.*, 2002:62).

OSCEs seem to be appropriate for assessing medical students and other health related disciplines, but are questioned for its appropriateness for assessment of nursing skills, because nursing students are expected to demonstrate a caring virtue. They must therefore be able to define problems accurately, make the best choice from an array of possible alternative solutions, safely implement the care plans and evaluate the effectiveness of their actions (Mitchell *et al.*, 2009:402).

OSCEs tend to compartmentalize the student’s knowledge and skills by focusing on just one problem at a time rather than assessing the student’s holistic approach to the patient (Furlong *et al.*, 2005: 388).

OSCEs do not always need to be a summative assessment (Ward & Barrat, 2005:4; Major, 2005: 450).

The South African Nursing Council (Regulation R425) emphasizes meaningful integration of theory and practice and stressed the need for nurse educators to create meaningful learning opportunities in which the student can correlate theory and practice. The programme objectives as set out in R425 state clearly that on completion of the course of study, the nursing student should have the cognitive, psychomotor and affective skills to serve as a basis for effective practice. The concern with regard to the use of OSCE is its potential to reduce nursing practice to a mere set of tasks to be performed and its inability to take into account the interacting contextual factors that are common in the clinical environment (Mitchell *et al.*, 2009:402). SANC requires nurse educators to ensure that diplomandi from nursing colleges are professionally developed. This would mean that the students have had the stipulated numbers of hours of exposure to learning opportunities in a real-life clinical setting and are competent in rendering high quality comprehensive/holistic nursing care to the patient (Muller, 2009:7; Meyer & Van Niekerk, 2008:88). "Comprehensive nursing", according to SANC Nursing Act (Act no 33 of 2005), means nursing interventions that integrate and apply the scientific process of the full range of nursing. This includes general, community, obstetric and mental health nursing.

Comprehensive nursing should promote and maintain the health status of health care users in all contexts of health care delivery. Mitchell *et al.* (2009:398) state that the OSCE can be used most effectively to assess safe practice in terms of the performance of psychomotor skills, which then puts a question mark behind the other aspects of the role of nursing educators.

1.3 PROBLEM STATEMENT

Prior to 2003, the nursing college where this study was conducted implemented OSCE as clinical progress assessment for first level nursing students only based on the fact that OSCE is appropriate in assessing psychomotor skills rather than complex cognitive skills (Redfern *et al.*, 2002:62; Mitchell *et al.*, 2009:398). Students from the second to the fourth levels were assessed in the traditional manner. They had to perform nursing procedures on real-life patients in the clinical area where patients were cared for.

Due to the shortage of professional nurses in the province, the North West Provincial government mandated the nursing college to intensify the recruitment of students to be trained as nurses and increase the number of nursing students (North West Department of Health, 2002:21). Based on this mandate, the provincial nursing college increased their nursing student intake from one to two intakes per year, thus doubling the number of nursing students.

The increase in the number of nursing students, (from seventy five (75) per year to one hundred and fifty (150) per year) makes it impossible to continue with the traditional method for clinical summative assessment where each student has to conduct a total patient study on a real-life patient in a clinical facility. This resulted in an expansion of the OSCE as clinical assessment for progress of first year students only to the clinical assessment for progress purposes of all the year levels. This decision implies that the OSCE is used as assessment method for the summative clinical assessment (thus, clinical competence) for final year nursing students; transition from student status to the status as independent, professional nurse. The focus of this study is on whether the OSCE is an appropriate method to assess the final year nursing students' clinical competence for entering professional status.

As nurse educator at a provincial nursing college, the researcher became aware of a difference in opinion on this matter and concerns raised by nurse educators regarding the appropriateness of the OSCE as summative assessment for students' clinical competence. With this problem as basis, the researcher aim to search for answers to the following questions:

What are the perception of the nurse educators with regard to the use of OSCE as summative assessment for students' clinical competence?

What alternatives can they (nurse educators) suggest?

1.4 OBJECTIVES OF THE RESEARCH

Based on the questions above, the research objectives for this study are:

To explore and describe the perception of the nurse educators at the provincial nursing college with regard to OSCE as summative assessment for students' clinical competence.

To explore and suggest alternatives for the current summative assessment practice for clinical competence.

1.5 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective describes the manner in which the researcher views and explains the research material (De Vos, 2005:40). The following meta-theoretical, theoretical and methodological statements define the paradigmatic perspective within which the researcher conducted this research.

1.5.1 META-THEORETICAL ASSUMPTIONS

The meta-theoretical assumptions refer to the researcher's beliefs regarding man's origin and the world he lives in (Babbie & Mouton, 2001:13) and include assumptions regarding human beings, the environment, health and illness.

1.5.1.1 Human being

The Oxford Dictionary (2006:436) defines a human being as a person distinguished from other animals or as representing the human species. Within the context of this study, the researcher's view of human beings include the final year nursing students and the nurse educators as stakeholders involved in the OSCE as summative assessment for clinical competence.

1.5.1.2 Health

Nursing actions are aimed to prevent illness and promote and maintain the health of society. For the purpose of this study, health refers to the competence of the final year nursing student to function as an independent professional nurse practitioner. Illness as the opposite of health refers to incompetence.

1.5.1.3 Environment

The concept environment refers to the setting, surroundings or background where something happens (Oxford Advanced Learner's Dictionary (OALD), 2010:491). In this study environment refers to the simulated conditions created at a nursing college to represent the clinical environment of nursing practice for the purpose of assessing students' clinical competence.

1.5.1.4 Nursing

Nursing refers to the job or skill of caring for people who are sick or injured (OALD, 2010:1009). The South African Nursing Act (No.33 of 2005) defines nursing as a caring profession practiced by a person registered under section 31, maintaining nursing activities directed towards preserving the health status. In order to achieve the status of a registered nurse, the nursing student needs to demonstrate competence in order to function independently.

In this study, the focus is on whether the OSCE is appropriate to assess the clinical competence of the final year nursing student.

1.5.2 THEORETICAL ASSUMPTIONS

The theoretical assumptions of the study refer to the scientific knowledge on the research topic (Brink, 2006:22) and are thus testable. The theoretical assumptions of this research include the central theoretical statement, the conceptual definitions of core concepts applicable to this research and the central theoretical statement as focus point of this study.

1.5.2.1 Conceptual definitions

The following concepts are central to this research and are defined as follows within the context of this study.

- **Nurse Educator**

A nurse educator refers to a professional nurse with a qualification in nursing education (Reg. 118) and registered as such with SANC under section 31 of the Nursing Act (Act No 33 of 2005). The nurse educator acts as facilitator of the learning process and assessor of learning regarding the therapeutic regimen, the nursing environment and inter-professional relationship (Meyer & Van Niekerk, 2008:62). The nurse educator as facilitator and assessor of learning and clinical competence is a valuable source of information in this study.

- **Perception**

The concept perception refers to the way things are noticed, interpreted and understood (OALD, 2010:1087). This study aims to explore and describe the nurse educators' interpretation/understanding of OSCE as summative assessment of students' clinical competence. The fact that the nurse educators had a number of years experience regarding the matter under scrutiny implies that they must have some opinion of interest to the researcher.

- **Nursing student**

This term refers to a person studying at a university or college (OALD, 2010:1484). In this study, the nursing student refers to a final year student registered under Regulation 425 for the Diploma as Nurse (General, Psychiatric and Community) and Midwife (SANC, 1992:17) who should still be assessed for clinical competence by means of an OSCE.

- **Clinical Assessment**

Clinical assessment refers to the process of obtaining information regarding the standard of students' clinical performance, with the purpose of a valid appraisal of a student's knowledge, skills and attitudes (Bruce *et al.*, 2011:273) in order to ensure that the nursing students comply with the level of clinical competence needed to act as professional nurse practitioner.

- **Clinical competence**

Clinical competence refers to a wider, more holistic term that entails the knowledge, skills, values and attitude that a nursing student should demonstrate in a particular context (Bruce *et al.*, 2011:176). It includes behavioral aspects (knowledge, skills and attitude) and interpretative

aspects (critical thinking, clinical skills) and interactive/interpersonal skills to exercise clinical judgement (Bruce *et al.*, 2011:263-264).

- **Objective Structured Clinical Evaluation (OSCE)**

The concept Objective Structured Clinical Evaluation refers to a type of clinical assessment in a simulation laboratory, popular as a means of summative (or final) assessment of clinical competence at a particular stage of a course for promotional purposes, to complete a section of a course, or at the end of the course (Bruce *et al.*, 2011:279; Ward & Barratt, 2005:37).

The principle is that learners rotate through a number of stations (8-10). They spend a short period of time (5 or 10 minutes) at each station, during which they must perform a particular learning activity or clinical task (Ward & Barratt, 2005:37).

1.5.2.2 Central theoretical statement

Knowledge of the nurse educators' perception regarding the use of OSCE as summative assessment for students' clinical competence together with the integration of relevant literature should lead to a better understanding of the issue at hand and facilitate a change in the current practice.

1.5.3 METHODOLOGICAL ASSUMPTIONS

According to Creswell (1998:77) a researcher's methodological assumptions refer to how the researcher conceptualizes the entire research process. In other words, it is the researcher's view on what "good research" entails. The researcher views "good" research as a scientific process (Brink, 2006:3) that validates and refines existing knowledge and generates new knowledge with the purpose to initiate change and improve the current situation (Burns & Grove, 2009:3).

1.6 RESEARCH DESIGN AND METHODS

The research design refers to the manner in which the research process is structured and planned (Babbie & Mouton, 2001:72) to achieve the set objectives. The research methods include the specific choice of methods selected for sampling, data collection and data analysis to comply with the principles for ethical and trustworthy research.

1.6.1 RESEARCH DESIGN

The design for this study is a qualitative approach that is exploratory, descriptive and contextual (limited to a specific provincial nursing college with two campuses).

The qualitative researcher's emphasis is on detailed description and understanding the phenomenon within the appropriate context (Babbie & Mouton, 2001:279). A qualitative approach is appropriate for the purpose of exploring and understanding the meaning individuals or groups ascribe to a social or human problem (Burn & Grove, 2009: 23; Creswell, 2009:19).

1.6.2 RESEARCH METHODS

The following methods, appropriate for a qualitative design, will be employed to reach the objectives set for this study.

1.6.2.1 Sampling

Sampling includes decisions regarding the study population, the sample and the process employed to select a representative sample from the population.

- **Population**

The concept population refers to all the elements (individual, objects or substances) that meet certain criteria for inclusion in a given universe (Burns & Grove, 2009:345; Meyer *et al.*, 2009:378; Brink, 2006:123). The target population in this study consisted of all the nurse educators at the two campuses of the provincial nursing college who are actively involved in assessing the final year nursing students registered for the Diploma that leads to registration as Nurse (General, Psychiatric and Community) and Midwife (R425), for clinical competence by using the OSCE.

- **Sample**

A sample is a subset of the population that is selected for a particular study (Burns & Grove, 2009:23). In this study a sample refers to the process followed by the researcher to select a smaller group (sample) that is representative of the criteria of the identified population of interest in order to obtain information relevant to the phenomenon under study (Brink, 2006:124).

For this study, the sample included all nurse educators from the two campuses of the provincial nursing college who comply with the selection criteria and voluntarily agree to participate in the study (see detailed description in chapter 2).

- **Sampling process**

A purposive, voluntary sampling process was used to select participants who have first-hand experience (Brink, 2006:124; Polit & Beck, 2006:264) of using the OSCE as summative assessment for students' clinical competence. The advantage of this sampling is that it allows the researcher to select the sample based on the criteria that the nurse educators are knowledgeable regarding the phenomena being studied. They are information rich cases (Brink, 2006:123; Burns & Grove, 2009:35). A detailed description of the sampling process follows in chapter 2.

1.6.2.2 Data Collection

The data collection refers to the process through which information is collected from the research participants. For this study, the researcher was interested in the nurse educators' perception on OSCE as summative assessment for students' clinical competence. Data collection was planned to take place by means of focus group interviews, appropriate for qualitative research designs (Creswell 2009:177; Polit & Beck, 2006:290).

The focus group technique involves a moderator who facilitates a small group discussion between the selected participants (nurse educators) with regard to the topic, in this case the OSCE as summative assessment for students' clinical competence.

The focus group interview was chosen for data collection because of the following reasons:

The focus group interview is a means to better understand how people feel or think about an issue, product or service (Greeff, 2005:299).

Focus groups are convenient for a first hand observation of the process of people discussing issues with their friends (Babbie, 2007:309).

The focus group interview is an appropriate choice for collection of data in this study due to its climate of sharing between the participants and the amount and rich data it generate at a low cost (Babbie, 2007:309; Gubrium & Holstein, 2002:141). A detailed description of the focus group process follows in chapter 2.

1.6.2.3 Data analysis

According to Creswell (2009:133) and Burns & Grove (2009:337), qualitative data analysis is primarily an inductive process of organizing data into categories and identifying patterns (relationships) between the categories as primary basis for reporting results.

For this study, content analysis was independently done by the researcher and an independent co-coder experienced in qualitative data analysis. The raw data (audio-taped focus group interviews, as well as the verbatim transcriptions of the audio-taped focus group interviews) were given to a co-coder who independently analyzed the data by using Tech's eight steps as guideline (Creswell, 2008:238).

After the independent analysis of the raw data, the researcher and the co-coder met to compare their findings and reach consensus. The process of data analysis is described in detail in chapter 2.

1.7 TRUSTWORTHINESS

The concept trustworthiness refers to the measures taken by the researcher to ensure that the findings of the study are of scientific value and reflects the viewpoints of the participants in an accurate and honest manner, and not those of the researcher (Babbie & Mouton, 2001:276-277.) The researcher ensured that the four criteria for establishing trustworthiness of qualitative data (credibility, dependability, confirmability and transferability) were maintained throughout the study. A detailed description of the measures taken by the researcher follows in chapter 2.

1.8 ETHICAL CONSIDERATIONS

Ethics refer to the moral principles a researcher must comply with (Strydom, 2005:57). It includes good manners (Babbie, 2007:62) towards all stakeholders and respect for the human rights of the participants.

The researcher obtained **ethical approval (NWU-00051-11-A1)** from the ethical committee of North-West University: Potchefstroom Campus to commence with the study as part of a postgraduate qualification.

Thereafter, the researcher obtained **permission** to conduct the study from the

The Department of Health, Policy, Planning, Evaluation and Monitoring: North-West Province; Management of the two campuses of the provincial nursing college.

After the Provincial Government had approved the study at the two campuses of the Provincial Nursing College, arrangements were made with the study population.

Voluntary, **informed consent** was obtained from the selected participants in written format (Burns & Grove, 2009:190) after the details of the study was explained to them. This included the purpose, the nature and procedure of research and the expected roles of the participants and the researcher (Creswell, 2008:238), as well as the measures in place to ensure confidentiality, anonymity, protection from harm and the benefits of participation (Brink, 2006: 33).

The researcher committed to conducting this study in an **honest and professional manner**, to be sensitive towards the participants' rights and the intellectual property of other researchers (Babbie, 2007:62-78).

1.9 CHAPTER OUTLAY

The report on this study is structured as follows:

Chapter 1: Overview of the study

Chapter 2: Research methodology

Chapter 3: Research Results

Chapter 4: Evaluation of the study, limitations and recommendations

1.10 SUMMARY

Chapter 1 dealt with the background of and rationale for the study, the research questions and objectives, the research design and methodology, as well as the considerations for trustworthiness and ethical considerations. Chapter 2 will deal with a detailed description of the research methodology as applied in this study.

CHAPTER 2

RESEARCH METHODOLOGY

Chapter 1 dealt with an overview of this study, which included the background, problem statement, the objectives, the paradigmatic perspective, as well as a brief orientation of the research methodology to be applied in this study.

Chapter 2 entails a detailed description of the research design, research methodology, as well as measures taken to ensure trustworthiness of the research and ethical issues related to the quality of the research.

2.1 RESEARCH DESIGN AND METHODS

The research design refers to the overall plan for addressing a research question, including specifications for enhancing the study's integrity (Polit & Beck, 2006:508). Burns and Grove (2009:696) refer to the "blueprint" or plan to conduct a study that maximizes control over factors that could interfere with the validity of the findings. The research method is described in terms of a plan to conduct the specific steps of the study and includes a detailed description of the population.

2.1.1 RESEARCH DESIGN

The chosen design for this study is exploratory, descriptive and contextual (limited to a specific Provincial Nursing College with two campuses), which is congruent with a qualitative approach to research. The selection of a research design is based on the nature of the research problem because the research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove, 2009:218; Creswell, 2003:3). The components of the chosen design with the explanation are discussed as follows:

- **Qualitative research**

A qualitative approach is useful for exploring and understanding a central phenomenon (Creswell, 2008:641). Creswell (2003:175), as well as Polit and Beck (2006:210) identify the following key features to qualitative research that are applicable to this study:

The focus is on participants' perception and experiences, which is in line with the objectives of this study;

The researcher is the key figure. In this study the researcher actually gathered the information personally after having established good rapport with the participants, and did not rely on questionnaires or other instruments developed by other researchers for data collection;

The researcher was intensively involved in the whole research process; the decision maker in sampling, preparation and implementation of data collection, data analysis and report writing;

A qualitative design tends to be flexible, hence the researcher was able to adjust the plans and processes to achieve the goal;

The researcher, in co-operation with an independent co-coder, analyzed the collected data and organized it into themes that cut across different data sources.

- **Explorative research**

The exploratory approach is useful for disclosing existing problems in a real setting and is designed to shed light on the various ways in which a phenomenon is manifested, as well as on the underlying processes. In this case the exploration looks at nurse educators' perception of OSCE as summative assessment of students' clinical competence and aims to come with recommendations in this regard (Polit & Beck, 2006:21; Burns & Grove, 2009:359). The focus group interview was chosen for data collection in this study because it is one of the relevant methods available to explore this matter. The topic generated much discussion (Polit & Beck, 2006:292). The explorative nature of the study enabled the researcher to gain insight about the perception of nurse educators' regarding OSCE as summative assessment for students' clinical competence and to hear suggestions for alternatives to change the current practice.

- **Descriptive research**

Burns and Grove (2009:696) define descriptive research as the type of research that provides an accurate portrayal or account of the characteristics of a particular event or individual/group in a real situation. In this study the researcher engaged in an explorative conversation with nurse educators in order for them to express their perception about the use of OSCE for assessing clinical competence of nursing students (Creswell, 2008:51). Based on the nurse educators' descriptions, the researcher was able to integrate the collected data with the findings of national and international literature and describe the results as the findings of the study (see chapter 3 of this report).

- **Contextual research**

Qualitative research is context bound (Mouton & Marais, 1996:133; Burns & Grove, 2009:54). The qualitative researcher aims to understand and describe events within the concrete, natural context in which they occur. This research took place in a specific Provincial Nursing College where participants of this study are actively involved in using the OSCE as summative assessment of students' clinical competence.

The chosen research methods are congruent with the research design and are described as follows:

2.1.2 RESEARCH METHODS

Research methods refer to the steps, procedures and strategies for gathering and analyzing data in a research investigation (Polit & Beck, 2006:21). The research methods applied in this study are described with regard to sampling, data collection and data analysis to ensure that the data is trustworthy and ethically sound.

2.1.2.1 SAMPLING

Sampling is a process of selecting a portion or sample from the population that is considered to be representative of the target population (Strydom, 2005:203).

The sampling process includes a description of the population, the sampling method and the sample size as applicable to the study.

- **Population**

Population refers to all the elements (individual, objects or substances) that meet certain criteria for inclusion in a given universe (Burns & Grove, 2009:345; Meyer *et al.*, 2009:378; Brink, 2006: 23). The qualitative nature of this study implies a population with first hand information and knowledge on the issue under study, namely those nurse educators who are actively involved in the use of OSCE as summative clinical assessment method for clinical competence of nursing students.

A total of twenty (20) participants (ten (10) participants per campus) were identified as target population for this study (N=20).

- **Sample**

According to Creswell (2008:152) a sample is a subgroup of the target population, and in this study it will be a selected group of nurse educators from the two campuses of a Nursing College in the North West Province involved with using OSCE for summative assessment of students' clinical competence.

For this study a voluntary purposive sampling method was chosen to select a sample from the target population, which implies a selection from a target population with a purpose in mind. The researcher intentionally selects individuals who comply with specific criteria (Burns & Grove, 2009:344; Creswell, 2008: 214; Brink, 2006:133).

The criteria for inclusion in the sample were:

Registration with SANC (South African Nursing Council) as nurse educators;

Active involvement for at least 5 years or more in OSCE as summative assessment of nursing students registered for the Diploma as Nurse (General, Psychiatric and Community) and Midwife (R425) (SANC, 1992:17) for clinical competence;

Availability and willingness to voluntarily participate in the study, signing of the informed consent form and agreement to the use of audio recording during the interview (see Annexure D).

- **Sample Size**

According to Burns and Grove (2009:361), Creswell (2008:217) and Polit and Beck (2006:273) sample size in qualitative studies is usually determined by informational needs. The guiding principle is data saturation (sampling to the point at which no new information is obtained and redundancy is achieved). For this study the focus was on the quality of information obtained from the nurse educators.

The sample size for this study was fourteen (n=14) nurse educators. Only seven (7) out of the possible ten (10) participants per campus were available and willing to participate in the research.

2.2 DATA COLLECTION

Data was collected from nurse educators who were selected as part of the sample from the target population. They are considered as representative of the study population and who complied with the selection criteria by means of focus group interviews, appropriate to qualitative research.

Although a pilot study is not normally done in qualitative research, the researcher did a test run on five (5) nurse educators who were part of the target population, but were not available on the day the focus groups were conducted. The aim was to “test” the researcher’s interview skills and to ensure that the central questions are clearly understood and will produce responses of interest to the researcher (Brink, 2006:166; Strydom & Delport, 2005:331).

Data were collected by means of focus group interviews. The participants' responses were integrated with findings from studies on this topic reported in national and international literature.

2.2.1 FOCUS GROUP INTERVIEW

According to Krueger (cited by Kingry *et al.*, 1990:124) a focus group is “a carefully planned discussion designed for a group of four to twelve participants, to obtain perceptions on a defined area of interest in a permissive, none threatening environment”. The group will give a sense of “safety in numbers” to those who are anxious (Burns & Grove, 2009:513; Polit and Beck, 2006:292).

The focus group interview was the preferred method for data collection in this study because the group dynamics and the climate of sharing information (views and experiences) assisted nurse educators to freely express and clarify their perceptions about the use of OSCE in ways less likely to occur in a one-to-one interview. Using focus groups made it possible to come closer to the perceptions of nurse educators in a specific Provincial Nursing College (Gubrium & Holstein 2002:142). The focus group's potential to generate large amounts of data, flexibility as data collection technique and its low cost (Gubrium & Holstein 2002:141; Babbie, 2007:309) served as motivation to use it as data method. In preparation for data collection the researcher ensured the following:

Permission was obtained from the management of the nursing college to conduct the study based on the approval from the research committee of the Department of Health North West Province (Addendum B2) and the Ethical Committee of the North-West University, Potchefstroom Campus (Addendum A).

The focus group interviews were arranged by means of written communication (See Addendum D1) with the potential participants who complied with the set criteria.

Participants who volunteered for the study were notified regarding the date, time and venue two weeks before the actual date of the focus group interview.

Voluntary, informed consent was obtained from the participants (Addendum D2).

A quiet, suitable place was selected for conducting the interview. The researcher chose an office free from distractions and that is conducive to free communication. A notebook and pen, drinking water and glasses were available for use by the participants.

A voice recorder in good working condition to record the proceedings for verbatim transcription purposes to ease the data analysis process.

The researcher appointed a second facilitator to assist the researcher during the sessions with managing the audio recording and helping with field notes of the session.

Focus group interviews were held at both campuses for the convenience of the participants.

Before the actual interview started, the researcher welcomed the participants and explained the following:

The purpose and objectives of the study.

The participants' right to voluntary participation and right to withdraw from the group without any pressure.

The measures in place to protect the anonymity of the participants and confidentiality of the information shared in the group.

The audiotaping of the proceedings to ease the analysis process.

The role of the second facilitator.

Participants were given an opportunity to decide on participation by signing the informed consent form (Addendum D2).

During the interview the researcher encouraged the participants to talk and ensured a free flow of communication by using the communication techniques described by Greeff (2005:289) (minimal verbal response, paraphrasing, clarification, reflection, probing, encouragement and summary).

Two central questions were posed to the participants for discussion:

Describe your perception as nurse educator with regard to the use of OSCE as summative assessment for students' clinical competence?

What alternatives can you suggest?

The central questions were followed by probing questions to clarify meanings and stimulate thoughts for the enrichment of data.

The researcher used non-verbal communication to demonstrate attentive listening, interest, reassurance and encouragement. The non-verbal techniques that were used included maintaining an open posture, eye contact, sitting up with no barriers between the participant and the researcher, nodding of the head and smiling. The duration of the focus group interviews was about 45 minutes.

In this study three focus group interviews were conducted. One focus group was conducted per campus comprising of seven (7) nurse educators, each meeting the criteria. A third focus group was scheduled for only one campus with the intention to confirm the collected data and the researcher's interpretation of it and to probe for more information to enrich the already collected data. (See Addendum E).

For the third focus group interview, the researcher appointed an independent, skilled interviewer and qualitative researcher to conduct the focus group interview. The researcher briefed the interviewer prior to the session regarding the background and purpose of the study. At the start of the session, the researcher gave feedback on the previous two sessions and the findings for confirmation purposes, as well as the purpose of the third session to the participants (See Addendum E). The researcher acted as assistant during this session by handling the voice recorder and making field notes.

Field notes (Addendum F) were written immediately in order not to forget crucial aspects of interview. According to Creswell (2003:181), Polit & Beck (2006:307) and Polit *et al.* (2004:642) field notes represent the observer's efforts to record information and also to synthesize and understand the data. In this study the researcher watched out for body language and flow of discussion. The field notes comprised of two kinds of notes:

Descriptive notes (or observational notes): A description of the physical setting, accounts of particular events that occurred and activities that took place during the interview. According to Stommel and Wills (2004:286) observational notes are attempts to describe people, events, or interactions that adhere to observable details.

Reflective notes: These are a record of personal thoughts such as “speculation of incidents, feelings, problems, ideas, hunches, impressions and prejudices encountered during an interview” (Botma *et al.*, 2010:219).

Demographic information: These are written information about the time, place and date to describe the physical setting where the interview took place.

The field notes were typed, marked and attached to the transcription of each focus group interview.

Creswell (2008:648) describes transcription as the process of converting audiotape recordings and/or field notes into text data to ease the process of data analysis. Data from the audio recording of the focus group interviews was transcribed. The researcher made verbatim transcriptions prior to data analysis.

2.2.2 LITERATURE

After the analysis of the data obtained from the focus group interviews, national and international literature on the topic was explored. The findings from studies reported in literature were integrated with the data from the focus group interviews. The results are described in detail in chapter 3.

2.3 DATA ANALYSIS

According to Creswell (2003:133) and Botma *et al.* (2010:221), qualitative data analysis is primarily an inductive process of organizing data into categories and identifying patterns (relationships) among the categories. Polit and Beck (2006:498) describe it as the systematic organization and synthesis of research data.

Two analysts analyzed the transcribed focus group interviews in order to ensure trustworthiness, namely the researcher and an independent co-coder who is skilled in the analysis of qualitative data. Each analyst followed an independent process of content analysis.

On completion of the individual data analysis, the analysts met to compare and discuss their findings until consensus was achieved.

Creswell (2008:251-252) recommends the steps developed by Tesch for qualitative data analysis, but also states that there is no definite procedure to follow.

The following four (4) principles serve as guide for the analysis of qualitative data:

Verbal data should be *transcribed* in text;

The transcribed data should be *organized* in smaller meaningful units according to similarities and should then be coded;

The organized data should be re-read and *reduced* to a smaller number of themes and related sub-themes;

The organized and reduced data should be *described*.

The following process was followed in this study for the analysis of the data:

The focus group interviews were transcribed word by word;

All the transcriptions were read carefully and ideas were jotted down as they come to mind;

Concepts and sentences were used as units of analysis;

Transcripts were read again and the spoken words / concepts and sentences of note were underlined;

The related concepts were grouped (organized) together as possible themes;

The most descriptive wording was used for formulating themes;

The list of themes was reduced by re-grouping concepts that relate to each other in as few themes and sub-themes as possible, without losing focus of the study's objectives and aim;

Three (3) themes were finalized and arranged in a logical sequence:

- The value of OSCE as summative assessment method for students' clinical competence;
- Obstacles in using OSCE as summative assessment for students' clinical competence;
- Alternatives suggested for changing the current practice.

- The underlined concepts and sentences (verbatim quotes from the transcript) were used as illustration and support for the description of the findings and its integration with national and international literature (see chapter 3).

2.4 RIGOR

Lincoln and Guba (1985:298) “translated” the criteria for validity and reliability to strategies and criteria applicable in qualitative research. This gave rise to the concept of trustworthiness, defined as a process followed by the researcher to persuade his or her audience (including self) that the findings of an inquiry are worth taking note of. The criteria currently thought of as the “gold standard” for qualitative researchers are those outlined by Lincoln and Guba (1985:301). The researcher included the descriptions of Krefting (1991:220), Polit and Beck (2006:332) as well as Babbie and Mouton (2001:277) as guideline in the application of these strategies and criteria to ensure the trustworthiness of this study. These measures include strategies for credibility, dependability, confirmability and transferability.

The measures taken to ensure the trustworthiness of this research are tabled in Table 2.1.

Table 2.1: Measures taken to ensure trustworthiness

STRATEGY	CRITERIA	APPLICATION IN THIS STUDY
<p>Credibility</p> <p>Are the findings believable and a reflection of reality?</p>	<p>-prolonged engagement</p> <p>-persistent observation</p> <p>-interview technique</p> <p>-triangulation</p> <p>-verification</p>	<ul style="list-style-type: none"> • Good rapport/trusting relationship between the facilitator and participants was ensured before the start of the focus group interviews; • The researcher was familiar with the context; • Sufficient time given for each focus group interview; • Data sources included focus group interviews, field notes, national and international literature on the topic; • The researcher did an informal pilot study to test the clarity of the questions asked during the focus group interviews; • Two interviewers, two data analysts, data and the interpretation confirmed by participants; • The researcher used thick description of methodology and findings, which are accompanied by verbatim quotes.
<p>Transferability</p> <p>Can the findings be transferred to other settings?</p>	<p>-Sample selection</p> <p>-Audit trail</p>	<ul style="list-style-type: none"> • Study is contextual in nature, aims to change a context specific practice; • Purposive sampling used: participants (nurse educators) with first hand experience and who meet the set criteria were used; • Thick description of research methods and processes of data is supplied. • Aspects of this study may have application value in other contexts.
<p>Dependability</p> <p>Are the findings consistent? Can the findings be subjected to inquiry audit?</p>	<p>-Peer examination</p> <p>-triangulation</p>	<ul style="list-style-type: none"> • Central questions posed to all participants; • Research plan, method and implementation checked by study leader and supported by literature; • An independent interviewer acted as the facilitator of third focus group to confirm previously collected data and probe for more information to enrich

		the data.
Confirmability Are the findings objective, accurate, relevant and has meaning?	-audit trial -reflexivity	<ul style="list-style-type: none">• A second facilitator experienced in qualitative data analysis used as co-coder;• There was consensus between researcher and a co-coder regarding the interpretation of data and findings;• Data from focus groups were confirmed and uncertainties clarified with participants in the third focus group;• Audio recorded focus group interviews, transcribed verbatim, field note and all records available for audit;• Findings supported from literature;• Data saturation ensured.

2.5 ETHICAL CONSIDERATIONS

Ethics is the branch of philosophy that deals with morality (Burns & Grove, 2009:61). Ethical considerations are critical where research involves human participants. Failure to comply with the ethical codes and principles undermines the scientific process and the trustworthiness of the study (Brink, 2006:30).

The following ethical considerations were maintained by the measures described below since the study involves human participants:

- **Ethical approval**

The study received ethical approval from The Ethical Committee of North-West University, Potchefstroom Campus; certificate number NWU-00051-11-A1 (Addendum A) on the basis of the submission and approval of the research proposal and a recommendation from the Research Committee of the School of Nursing Science, North-West University, Potchefstroom Campus.

- **Permission to conduct the study**

Permission to conduct the study at the provincial nursing college was requested in writing and supported by the approval from the Ethical Committee from the NWU from the:

Directorate of Policy, Planning, Research, Monitoring and Evaluation, Department of Health: North West Province (Addendum B);

Management of the two campuses of the Provincial Nursing College: North West Province (Addendum C).

- **Informed consent (Addendum D)**

The researcher adhered to the principle of informed consent from the participants by providing a consent form written format. Participants signed an informed consent form after the researcher explained the particulars of participation in detail. Potential participants were invited and given time to decide on participation. Participation was voluntary and could be stopped at any time

without any consequences. Although participation had no immediate and direct benefit for the participants, the results should contribute to a change in the current practice of assessing students' clinical competence.

Participants' **basic human rights** were honored and protected by considering the following rights:

- Right to self-determination: respect for participants' decision to participate or withdraw from the study;
- Right to privacy: focus group interviews took place in a private room. Interviews were audio recorded with the permission of participants;
- Right to anonymity and confidentiality: no names were attached to responses from participants; results are reported as aggregate; raw data are accessible only to researchers directly involved in study, findings were confirmed with participants before publication.

2.6 SUMMARY

Chapter 2 entailed a detailed description of the research design, research methodology, as well as measures taken to ensure trustworthiness of the research and ethical issues related to this research study. Chapter 3 reports the results of this study.

CHAPTER 3

RESULTS

Chapter two dealt with a detailed description of the research design, research methodology, as well as measures taken to ensure trustworthiness and to address ethical issues related to the quality of the research. This chapter describes the results of the study and integrates these with national and international literature, supported by quotations from the study participants.

3.1 INTRODUCTION

The purpose of this study is to explore nurse educators' perception of Objective Structured Clinical Evaluation (OSCE) as summative assessment for students' clinical competence with the aim to recommend alternatives to the current situation.

The following questions served as basis for the data collection:

Describe your perception as nurse educator with regard to the use of OSCE as summative assessment for students' clinical competence?

What alternatives can you suggest?

Data was collected by means of two (2) focus group interview sessions that tested the perceptions of fourteen (14) participants. The sessions were facilitated by the researcher. Participants are all nurse educators from the provincial nursing college and are actively involved in the summative assessment of the nursing students enrolled for the Diploma leading to registration with the South African Nursing Council as Nurse (General, Psychiatric and Community) and Midwife (R425).

During data analysis it became clear that data saturation had not been reached and as a consequence a third focus group interview was arranged with a twofold purpose: to confirm the data (and its interpretation) collected previously and to explore the topic further in order to enrich the data. This focus group interview was conducted by an independent facilitator who has extensive experience in qualitative research. Seven (7) of the original fourteen (14) participants were available and gave voluntary consent to partake in the third focus group. The researcher acted as assistant during this session.

3.2 THEMES

The data from all three focus group interviews were independently analyzed by the researcher as well as an independent co-coder according to the principles for content analysis as described by Creswell (2008:251).

Three (3) themes and associated sub-themes emerged from the collected data. The themes and sub-themes are tabled in table 3.1 and consequently described and integrated with national and international literature to culminate in conclusive statements.

Table 3.1: Themes and sub-themes

THEMES	SUB-THEMES
<p>Theme 1: The value of OSCE as summative assessment method for students' clinical competence:</p>	<p>1.1 Assessor influence</p> <p>1.2 Theory/practice gap</p> <p>1.3 Assessment instruments</p> <p>1.4 Student matters</p> <p>1.5 "Patient" influence</p>
<p>Theme 2: Obstacles in using OSCE as summative assessment for students' clinical competence:</p>	<p>2.1 Human resources:</p> <ul style="list-style-type: none"> ➤ Assessor-student ratio ➤ Minimal number of stations <p>2.2 Financial constraints</p> <ul style="list-style-type: none"> ➤ Standardized patients ➤ Preceptors
<p>Theme 3: Alternatives suggested</p>	<p>3.1 Planning and organization:</p> <ul style="list-style-type: none"> ➤ Assessors and standardized patients ➤ Assessment tools <p>3.2 Innovative approaches:</p> <ul style="list-style-type: none"> ➤ OSCE over several days ➤ Variety of scenarios/procedures

3.2.1 THEME 1: THE VALUE OF OSCE AS SUMMATIVE ASSESSMENT METHOD FOR STUDENTS' CLINICAL COMPETENCE

The participants in this study were divided in their opinions regarding the value of OSCE as summative assessment for students' clinical competence. The participants of one focus group (F2) were initially very positive. It was only later that they indicated their concerns. The textbox below shows how respondents expressed their views. It offers their own descriptions of their views by means of direct quotes. The codes following the quotation indicate the focus group from which the quote was cited e. g **F1** focus group one (1), **F2** focus group two (2) and **F3** focus group number three (3).

“OSCE is able to reach students and thoroughly testing their understanding...we have not encountered any problems of bias or whatever negative aspect...” **(F2)**

“...it is objective...two examiners and moderators...” **(F2)**

“OSCE test the maturity of students...ready to face the professional field ”**(F2)**

“OSCE is good because of being structured it is consistent and you will never be biased, prejudice against students...all students will be subjected to same assessment, around the same time in the same environment. It is uniform.” **(F2)**

“...not time consuming where planning was done well in advance” **(F2)**

“...some preparations maybe built into an OSCE...can test many outcomes within time frames that are set” **(F2)**

International and national studies have highlighted the strengths of the OSCE. Literature offers the following strengths of OSCE that support the views of the participants of this study:

The OSCE has greater objectivity than in most other clinical assessment methods and increases the consistency of experience between students (Rushforth, 2007:483). It offers particular strengths in terms of assessor objectivity and parity for all nursing students (Nulty *et al.*, 2011:145) and can produce a positive student experience and satisfactorily develop clinical skills.

According to Hanley and Higgins (2005:272) and Chabeli (2001a:88), all three domains of nursing skill, namely cognitive, affective and psychomotor skills can be assessed if the OSCE is well planned.

A broader range of skills can be assessed in a safe and controlled environment (Walsh *et al.*, 2009:1586; Rushforth, 2007:483; Zaidi, 2006:726) and if more than one assessor is used per assessment task or OSCE station, it reduces the risk of assessor bias (Rushforth, 2007:483).

Nulty *et al.* (2011:145) describe the OSCE as follows: “[OSCE] can demonstrate procedural, professional and educational efficiency and effectiveness...’alignment’ of curricular components (teaching, learning and assessment) ...” These authors describe OSCEs as “intrinsically aligned and authentic and should also promote student engagement and achievement of desired learning outcomes”.

The participants of the first focus group (F1) did not share their colleagues’ positive views because according to them, the OSCE limits the assessment of competence. Only a limited number of clinical procedures are fit for an OSCE due to the time limit (10 minutes) in which the student must complete the assessment task (only portions of a procedure are used for assessment).

“The way we do our summative assessment is not good enough....there is something lacking and the OSCEs are not helping us at all.” (F1)

“...we cannot test someone’s competencies in ten minutes or whatever.” (F1; F3)

“OSCE does not allow for affective-, interpersonal-, reflective- and critical thinking skills as it would have on real patient.” (F1; F3)

“...simulation becomes difficult because of the type of mannequins (rigid) used for catheterization).” (F1)

These findings are supported by both national (Chabeli, 2001a:88) and international studies (Major, 2005:448; Redfern *et al.*, 2002:60; Love *et al.*, 1989:974) where the use of OSCE is questioned as summative assessment for students’ clinical competence.

The study by Alinier *et al.* (2005:360) endorse the perception of the participants in focus group 1 that the use of mannequins is only effective in some particular psychomotor skills. For instance,

catheterization poses problems. Alinier *et al.* (2005) recommend the use of high fidelity simulators instead of mannequins during OSCE (Intermediate to high fidelity simulation refers to a full-scale patient simulators with a full body-sized mannequin with realistic anatomical and interactive physiological features as would be expected in a human being).

Parker and Sheldon (in Major, 2005:448) support this study and the studies conducted by Redfern *et al.* (2002:60) and Chabeli (2001a:88). They all argue that passing an OSCE does not ensure a clinically competent nursing student, because the nursing student does not always possess the knowledge, skills and attitudes to be able to practice safely in the real-life situations. Mitchell *et al.* (2009:402) argue that the level of competence in critical thinking as assessed by an OSCE is unlikely to fully reflect the student's ability to competently apply critical thinking in a real life clinical setting. Joy and Nickless (2008:353) support the findings of the studies conducted by Redfern *et al.* (2002:62) and Chabeli (2001a:86) states that there is concern about the lack of emphasis on holistic care delivery and its limited transferability to practice.

The findings of this study are consistent with international studies. Mitchell *et al.* (2009:402) and Redfern *et al.* (2002:62) confirm the perceptions of the participants in focus group 1 by stating that a limitation of OSCE is its focus on the "basic" and technical skills rather than "complex" skills. Mitchell *et al.* (2009:402) argue that the level of competence in critical thinking as assessed by an OSCE is unlikely to fully reflect the student's ability to competently analyze complex patient situations, solving problems and communicating effectively with the patient and professionals from other health care disciplines.

The value of the OSCE is perceived as limited and challenged due to the fact that it is used as summative assessment method for students' clinical competence. The participants cited that certain procedures are too difficult to simulate and those who tried said that the simulation becomes unrealistic and meaningless. This finding is supported by Ward and Barratt (2005:2) who state that the assessment tasks at some stations may be overly complex and it becomes difficult to test those skills in a 10 minute time frame, while in another situation the content is too simple to accurately assess clinical competence.

Walsh *et al.* (2009:1592) emphasize that the design and intent of an OSCE should receive appropriate attention long before implementation. An OSCE should be properly planned and organized to achieve its goal. The review of literature by Rushforth (2007:482) on OSCE and its

implications for nursing education concludes that caution must be applied whenever there are situations where OSCE is relied upon as the sole means of clinical assessment. Rushforth (2007:482), Ward and Barratt (2005:4) and Major, (2005:450) share the viewpoint that OSCEs do not always need to be a summative assessment.

The participants of this study raised a number of issues that they felt may have an influence on the value of OSCE as summative assessment for students' clinical competence.

3.2.1.1 Sub-theme1.1: Assessor influence

The participants in this study are of the opinion that the attitude and behavior of the nurse educators who are the assessors during the OSCE may have an influence on the value of OSCE as summative assessment method for clinical competence. The following identified aspects are discussed and thereafter illustrated with verbatim quotes.

- **Lack of objectivity**

OSCE gained popularity in nursing because of its objectivity (Harden *et al.*,1975:475; Selby *et al.*, 1995:1188) and is widely used in Health Sciences to assess components of clinical competence in a well-planned and structured way (Nulty *et al.*,2011:145). In spite of this, the participants in this study stated that the assessor's objectivity is questionable and may influence the outcome of assessment. The participants cited that assessors are not always clear about the principles guiding the OSCE, they just blindly follow the assessment instrument. That may be due to the fact that the assessor is not always part of the planning and preparation of the environment, the assessment tasks, instruments and briefing of simulated clients. Other factors that contribute to assessors' lack of objectivity are the inappropriate student/assessor ratios. When there are too few assessors for the number of students to be assessed, it results in clinical assessment of nursing student that have not been done properly.

“...subjective in cases where the assessor say... okay I am looking at this specific, I can give” (F1; F3)

“...other assessors are lenient and others are strict” (F3)

“...lecturers are assessing the students based on their past performance...” (F3)

“At the end somebody that is not competent is rated to be competent” (F1; F3)

“...inserting a catheter in a doll...inject water and it does not run in, but we just take it as OK, it is done. You just take it that the person can do it and in the real situation they can't” (F3)

“...with a doll you overlook a lot of things...” (F3)

Support for this finding are found in the studies by Walsh *et al.* (2010:2808); Byrne and Smyth, (2008:284); Morley (2007:25) and Ross *et al.* (1988:46), who all argue that the assessment of clinical competence continues to be a matter of concern for nursing, because most clinical assessments methods rely on subjective judgements by clinical nurse educators and observations in the clinical situation. They further state that proper preparation for an OSCE increases assessors' confidence with regard to the use of the assessments tools and enhances objective assessment.

The participants stated that assessors are sometimes biased due to remarks made by colleagues (subject lecturer) that a particular student is good in practice or in theory. This finding is confirmed by Calman *et al.* (cited by Byrne & Smyth, 2008:284) who reports that student nurses are sometimes assessed during an OSCE by performing the same skills they were assessed on previously and those students run the risk of assessor bias.

Another concern is assessors' perception that when procedures are done on models or mannequins (simulation), they can be more lenient and that “mistakes” can be ignored because the situation is not real and it is assumed that the student is competent. This finding is supported by Redfern *et al.* (2002:63), who confirm that the measurement of clinical competence remains vulnerable to assessors' lack of objectivity and individual interpretation. According to Redfern *et al.* (2002:63) OSCE as simulated assessments can be subjected to subjective assessor ratings of student performance and so it is inadequate for assessing the complex skills required of a reflective practitioner.

- **Assessors unfamiliar with the subject content**

The inconsistencies in the assessment of clinical competence during OSCEs may be due to inadequate preparation of the assessors for the task at hand. This is revealed by the participants when they mention that they are only guided by the assessment instrument. The participants also raised their concern about the fact that due to the inappropriate student/assessor ratio (94 nursing students to a team of three or four nurse educators per year level) at their institutions, all nurse educators are compelled to act as assessors in the OSCE, irrespective of the subject or group that she/he teaches.

“...because you are not involved in that group neh, you will be allocating marks or ticking based on the marking guide” (F1; F3)

“...difficult with other procedures to use own discretion because you are not involved in that subject” (F1)

Byrne and Smyth (2008:288) support this finding, stating that the majority of assessors in their study prefer to assess the skills they are familiar with and had mastered themselves. If assessors are allowed to choose the skills they want to assess, the reliability of the assessment will be enhanced due to consistency and assessors will be able to use their own discretion and not follow the assessment tool blindly. Khattab & Rawlings (2008:756) support the findings of this study as they stated that both assessors and moderators need preparation for their roles, so adequate time must be allowed for staff development.

According to the Nursing Act (Act No 33 of 2005) "assessor" means a practitioner registered as such with the SANC who is responsible for the assessment of the nursing students' achievement of learning outcomes for the professional nurse education. According to Rushforth (2007:484) there is minimal debate in literature regarding who examiners should be, and whether qualifications, experience or training affects the reliability of OSCE.

- **Prejudice**

This occurs when the assessor's knowledge of a student's previous performance, preferences and overall impression, influences the rating he/she gives during assessment. The nurse educators assess the students already having in mind what type of a learner he or she is and then may overlook important aspects of the procedure that the student is not competent in.

“...I know how good or how bad this student is, I start the whole process with that in mind
“(F1; F3.)

Walsh *et al.* (2010:2807) found that some nurse educators are impressed by a nursing student on face value and they will allocate marks based on their impressions and not the student's performance. Ross *et al.* (1988:46) confirm the findings of this study. They report halo effects in rating the clinical competence of nursing students, which suggests that such ratings were primarily influenced by the interpersonal relationship between the nursing student and the assessors, rather than the actual performance of a skill.

Bruce *et al.* (2011:277) support these findings by stating that a nursing student who has made a positive impression on the assessor during previous encounters is likely to receive positive ratings during assessment.

- **Assessors' fatigue**

Participants identified assessor fatigue as a factor that may contribute negatively on the value of OSCE as summative assessment for the students' clinical competence. Depending on the number of the nursing students, the number of stations and the number of assessors, an OSCE is a tedious process that requires both students and assessors to be on high alert for a considerable period of time with only a fifteen (15) minute break for tea and a thirty (30) minute break for lunch.

The limited number of assessors implies that the same assessors are on duty at the same station, assessing the same assessment task for the whole OSCE process. The participants reported tiredness and loss of concentration as factors that may be either to the advantage of some and disadvantage of other nursing students and thus a threat for reliability.

The example illustrated by one participant was as follows: 94 nursing students need to complete four stations manned by two assessors per station. In order to complete the OSCE in one day, the stations are duplicated. This allows 8 students per round, 16 assessors and one organizer (17 nurse educators). Ten minutes per station is allowed with a 2 minute changing period between stations. Adding tea and lunch breaks, the total hours spent equals to \pm 11 hours.

“... student numbers...because in the morning if you have ninety four learners and they are supposed to do four procedures...” (F1; F2; F3)

“...in the morning you might be like awake as an assessor but imagine at eight o clock at night” (F1; F3)

“It is disadvantaging or advantaging some of the learners.” (F1; F3)

Byrne and Smyth (2008:288) suggest that an examiner should assess a maximum of four nursing students in a two hour period to prevent examiner fatigue. Brookes (2007:30) supports the findings of this study by reporting that due to time pressure, markers (nurse educators) may compromise the validity of the assessment.

Major (2005:447) concurs with the participants of this study by stating that if an OSCE is scheduled for the whole day, examiner fatigue should be expected. He further states that if an OSCE is scheduled for half a day it is more realistic for assessors and provides a good compromise between reliability through consistency and unreliability through fatigue.

3.2.1.2 Sub-theme 1.2: Theory-Practice Gap

The participants in this study reported that the use of the OSCE as summative assessment for students' clinical competence is challenged because of the following:

A number of the procedures that are taught in the nursing college are no longer relevant to the clinical practice. The skill of wound dressings is one example. Dressings are left on the wound for 5 to 7 days instead of being done daily. Exposure to wound dressings in real patients for clinical learning is diminishing.

Some students find it difficult to display the essential nursing skills (affective, interpersonal communication and caring skills like empathy) in a simulated scenario and then only focus on the clinical, psycho-motor skills.

Clinical summative assessment in the form of an OSCE is scheduled at the end of each year level for the major nursing subjects, to provide the final judgement as to whether or not the student has achieved the educational goals and to verify if the student's level of practice meets the minimum standards of safety and competence to practice as an independent, registered nurse as stipulated by the statutory body for nursing, the South African Nursing Council (SANC). According to the participants in this study, the use of an OSCE at their nursing college is not achieving this goal.

“...some procedures are fading out...special dressing...only opened after five days...sometimes discharged without even opening the wound...learners don't get the chance to see the progress of the wound' (F3)

“...our newly qualified professional nurses of late are not clinically competent...” (F1)

“We do not have enough resources to meet the number of our learners...sophisticated technology as substitute for real patient” (F2)

“...a person is very good in theory but when coming to practical most of them they get out, do education and management just to get away from the patient bedside because they cannot cope...the way we do summative assessment was not good enough” (F3)

Mitchell *et al.* (2009:402) quoted Mcgrath *et al.* (2006), citing that aspects that are applicable for an OSCE may not be sufficient to confirm that the nurse is in fact a caring nurse. Walsh *et al.* (2009:1585) define clinical competence as a psychological construct that includes aspects of cognitive, affective and psycho-motor skills such as critical thinking and problem solving skills. The incorporation of knowledge, values, beliefs and attitudes are vulnerable to findings of low validity and assessment via an OSCE is questionable. According to Kayihura and Mtshali (2010:104) one case presentation is not enough to assess the practical skill learned over a period of one year.

Kurz *et al.* (2009:187) are of the opinion that an OSCE is appropriate for assessing medical students and other disciplines, but they are not convinced that the OSCE is appropriate for assessing nursing skills. An OSCE does not reflect the reality of nursing, since nursing students

are expected to demonstrate a caring virtue and must therefore be able to define problems accurately, make the best choice from a range of possible alternative solutions, safely implement the care plans and evaluate the effectiveness of their actions. Nursing students need critical and reflective thinking skills to execute these tasks and need to be assessed (in real life situations) to be safe and competent practitioners.

According to Mitchell *et al.* (2009:402) and Furlong *et al.* (2005:388) the OSCE has the tendency to compartmentalize the students' knowledge and skills by focusing on just one problem at a time rather than assessing the students' holistic approach to the patient. They further reveal that an OSCE is unable to take into account the interacting contextual factors that are common in the clinical environment and this presents a major limitation with regard to its assessment of clinical competence.

The findings of the result of the study conducted by Ross *et al.* (1988:54) reveal that the participants perceived the OSCE to be less useful as a motivating factor for learning theory than for learning skills and they appeared undecided about the value of the OSCE as an assessment tool.

3.2.1.3 Sub-Theme 1.3: Assessment instrument/tools

Participants stated that the assessment instruments/tools used during the OSCE have a negative influence on the value of OSCE as summative assessment for students' clinical competence. The following concerns were raised:

Students memorize the assessment instrument exactly from A to Z. The nursing student will make sure to mention or perform the critical and important points, and if marked by an assessor who is a strict follower of the instrument tool they will pass. The participants question the students' competence and are not convinced that the students will be able to cope on their own.

The repeated use of the same assessment tasks/procedures and assessment instruments during OSCE encourage the memorization of the assessment instruments and the regurgitation of associated facts to ensure a pass mark.

Assessors who are too flexible or too rigid in the allocation of marks may be indicative of poor subject knowledge and/or clinical experience as support for decisions. This is increased because the criteria for mark allocation are not clearly defined.

Poor planning and organization of the OSCE lead to the discussion of assessment instruments on the morning of the clinical examination, including last minute changes to the instrument (like adding critical points), causing uncertainty and confusion to the assessors.

“...they [*students*] memorize the tool” (F1; F2; F3)

“...they memorize the tool and their competence is short term...temporary competence, because they forget easily afterwards”. (F1)

“...the tool categorize aspects under critical or important. Student memorize the critical aspects of the procedures, the student should fail but he will pass the critical point...” (F1; F2; F3)

“...not able to do the actual skill...will be telling you the theory of the skill” (F2)

“One student said to a patient “Okay, I have to ask if you have emptied the bladder because it is a critical point”.” (F3)

“...we need to test that tool before so that we can identify problems”. (F2; F 3)

“... the thing is, uhm... inter-rater reliability is done before the start of OSCE... then the tool will be corrected...” (F3)

“...identify problems before hand not on the day of the exam...” (F3)

“...beginning of the year the tools should be discussed and fine tuned...” (F3)

The literature on OSCE assessment tools identify the inclusion of essential criteria (critical points) as very important. However, this is not clear-cut, some skills could have many elements in each of the constructs that demonstrate safe practice (Zaidi, 2006:727). Nullty *et al.* (2011:146); Wilkinson and Frampton (2004:1115) suggest that global rating scales are more valid and reliable because they reflect holistic judgements. They further suggest that checklist style marking should be used during formative assessment because these can provide specific feedback and in turn reduce inter-rater-variability.

Ward and Barratt (2005:38) state that the OSCE organizer should send each assessor details of their role in the OSCE around four to six weeks before the examination to ensure proper planning and give examiners time to familiarize themselves with the area they will be examining.

Ward and Barratt (2005:38); Holland *et al.* (2010:467) further state that only after all examiners involved are clear and certain of the pass and fail criteria for each assessment task,

comprehensible and unambiguous that the proposed assessment task can be used in the OSCE. This confirms the participants' concerns that the tool must be tested long before use and not on the morning before the start of OSCE.

Rushforth's (2007:485) literature review on OSCE and its implications for nursing education argues that OSCE checklists were found insufficient to reveal whether students mastered the complex skills. Their review found evidence that OSCE tools undermine the assessors' expert clinical judgement (Rushforth, 2007:485). These findings confirm the participants' doubt regarding the ability of OSCE tools to assess clinical competence.

Zaidi (2006:727) reports that it is not possible to capture a student's level of clinical knowledge during OSCE. For instance, a nursing student who undertakes the task in a systematic and logical way and who exceeds the requirements of the tool in terms of the application of knowledge to the skill, could receive the same marks as another student who performs the task in a haphazard or average manner.

3.2.1.4 Sub-Theme 1.4: Student Matters

Participants raised a number of aspects pertaining to students' actions and reactions during an OSCE that may contribute to their perception regarding the value of the OSCE as summative assessment for students' clinical competence:

The students' focus is on passing the OSCE procedure, not on the demonstration of the comprehensive nursing care expected of the final year nursing student. As a consequence they memorize the tools, especially the critical points;

Some of the students fail to interact with the simulated patient/client, seemingly because they fail to "translate" the simulated situation to reality;

Students appear to be not sure of what they are doing;

Students become confused during OSCE because sometimes they do not understand the case scenarios, maybe due to a language or interpretation deficiency. The participants explained that students usually interact with their patients in the patient's language of choice or in the local language (Tswana), both during everyday practice and formative assessment. During the OSCE they are expected to interact in the language of tuition, English;

Student fatigue may have a negative impact on a student's performance. Due to the number of students that have be assessed during an OSCE, nursing students who are awaiting their assessment are kept separate from those who have completed their assessment. The implication is that some students have to wait the whole day for their turn.

The participants' responses are quoted verbatim in the text box:

“...OSCE in itself ... will definitely make them more anxious.”(F2; F 3)

“...they recite the tool, have programmed themselves and any disturbance they panic and then the whole thing goes out of hand... (F1)

“...our learners become so confused because of this thing of “you have already scrubbed”. (F2; F 3)

“ they don't regard this model as a real patient” (F3)

“Interaction...even though they are told to regard the doll as a real patient, in most cases that skill is not demonstrated” (F3)

“...the language issue in the formative...a Tswana patient, so the student feel relaxed interacting with the patient, knowing what to ask and she can explain...summative they are forced to speak English...” (F3)

“...learners have been waiting since eight o'clock in the morning and yoy are only going to be assessed at eight o' clock in the evening...” (F3)

The perception of the participants are on par with the report of a study conducted by Walsh *et al.* (2010:2807) who found that certain procedures are difficult to simulate and when a simulation is attempted, the simulation becomes unrealistic and meaningless, causing confusion for the student. Mcwilliam and Botwinski (2010:40) support the findings that the design and planning of the nursing OSCE is critical. Assessment tasks (e.g. case scenarios) that are not well-phrased or formulated or inadequately trained standardized patients contribute to student anxiety and may lead to poor performance of students.

The finding is confirmed by Rushforth (2007:483) who cites that students clearly find the OSCE process enormously stressful, which in turn affects their performance adversely. Brosnan and Evans (in Kayihura & Mtshali, 2010:106) echo that the OSCE is a stressful experience and requires considerable preparation effort by students and academic staff.

According to Alinier *et al.* (2005:367) the student briefing prior to the OSCE should be well-structured in order not to omit any details about the session, environment, equipment or patient simulator. They also state that it is very important to remind students that they should engage themselves in the scenarios in order to avoid misinterpretations and confusion.

Memorizing of the assessment tool by nursing students as cited by participants of all three focus groups, is viewed as a unique finding because no support could be found in literature.

3.2.1.5 Sub-theme 1.5: “Patient” Influence

The participants indicated that who the “patient” is during the OSCE may influence the outcome. Some of the participants indicated a preference for real patients or at least a live human being to act as patient (simulated patient/client or standardized patient) during OSCE. This issue was described as a dilemma, referring to the different advantages and disadvantages, as well as the possible consequences of each.

- Using a real patient allows flexibility (a measure of comprehensive care) because the student will be expected to perform the skill and at the same time attend to specific nursing skills, including interpersonal and caring skills. Using real patients hold the threat of violating their basic human rights, while a simulated patient will be subjected to so many nursing students for such a long period of time that it would result in patient fatigue.
- Participants also expressed their concern with regard to the performance of any invasive procedures on a live human being. In that case, a mannequin or simulator seemed to be a better option.

Participants reported that when a mannequin is used to simulate a patient, students tend to forget (or ignore) critical issues, for example asking whether the patient is comfortable before starting with the procedure. Some assessors also tend to overlook the “human” aspects essential in nursing care because the procedure is simulated.

According to participants a simulated client can guide the student by means of verbal (“patient” asking a question) or non-verbal messages (facial expression of discomfort), especially if the “patient” has either experience or knowledge of the issue at hand. In order to address this problem, the participants suggested well-trained standardized patients instead of students or workers as is the current practice.

“...we need real patients but because of the student numbers we cannot subject them to so many students” **(F2)**

“...real patients...must remember issues like rights of patients” **(F1)**

“...invasive procedures...models at the university that are like real people, they will tell you that sjoe, eina” **(F3)**

“We make use of nursing student from the college [as client]...that very same client is directing the student” **(F1)**

“We take workers or other staff members but not students” **(F2)**

“...with us we don't train them...we orientate them for a few minutes which is really not enough” **(F2)**

Mitchell *et al.* (2009:402) confirm the finding when they state that it is unlikely that when critical thinking skills such as problem solving, clinical reasoning and decision making is assessed by simulation, the assessment will reflect the students' ability to competently apply critical thinking in the real life clinical setting.

McWilliam and Botwinski (2010:40) support the findings of this study that the use of professional nurses as standardized patients could weaken the OSCE format, because nurses tend to provide more information than what is called for in a case scenario.

The suggestions made by the participants to exchange patients or simulated patients is reinforced by the following authors in their studies, Harden *et al.* (1975:451) suggest that in the case where a technique is being assessed, for example testing the visual fields, each examiner may have up to three patients so that each one is examined by only every third student.

McWilliam and Botwinski (2010:40) state that standardized patients reported that participating in the OSCE for an 8-hour day caused fatigue and confusion and this affected the way they handle interactions with students during the assessment.

The participants in this study acknowledge that good simulation is useful in preparing the students to reach professional maturity and also in avoiding inconvenience or discomfort to live people (real patient, standardized patient). Simulation technology is an educational tool that

provides students with opportunities to practice skills and apply theoretical knowledge in a realistic context (Alinier *et al.*, 2004:367).

According to McWilliam and Botwinski (2010:37) nursing students exposed to the standardized patients reported less anxiety, more positive experiences, and increased self-confidence than students taught using peers as patients. The participants in this study also acknowledge the use of simulation if used appropriately. They suggested the use of high fidelity simulators (as used by some health care institutions) and well-trained standardized patients in order to create an assessment environment as near as possible to reality.

Conclusive statement: Theme 1

The value of the OSCE as summative assessment for students' clinical competence is compromised by:

Inconsistent performance of both the assessors and the simulated patients, resulting in behavior and practices that may impact negatively on the outcome of the OSCE;

Poor planning and organization of the OSCE, resulting in the repetitive use of the same assessment tasks and instruments or last minute changes and poor preparation of stakeholders that give rise to confusion and poor efficiency.

3.2.2 THEME 2: OBSTACLES IN USING OSCE AS SUMMATIVE ASSESSMENT FOR STUDENTS' CLINICAL COMPETENCE

OSCEs are popular, are convenient for large groups of students and offer effective methods of assessing clinical competence, but they are costly and labour intensive (Nulty *et al.*, 2011:146; Mitchell *et al.*, 2009:402; Byrne & Smyth, 2008:3284), and require careful planning and organization (McWilliam & Botwinski, 2010:40) to be successful.

The participants in this study acknowledge the fact that good administration can lead to good use of OSCE as summative assessment for students' clinical competence. However, the efficiency of the OSCE as summative assessment for students' clinical competence is hampered by a lack of financial, human and material resources faced by the provincial nursing college. A lack of financial, human and material resources is perceived by the participants in this study as a huge obstacle of OSCE as this adds stress and strain on the nurse educators and nursing students.

The participants of this study raised a number of aspects that they perceive as obstacles to use of the OSCE as summative assessment for clinical competence.

3.2.2.1 Sub-theme 2.1: Human resources

Participants in this study perceived the lack of human resources as a challenge for the effective use of OSCE. The inappropriate numbers of the nursing students in relation to the total number of nurse educators (assessors) negatively influences the planning and the actual implementation of OSCE as summative assessment of students' clinical competence.

- **Assessor-student ratio**

The participants in this study reported a ratio of four (4) nurse educators (responsible for teaching theory and practice) versus ninety-four (94) nursing students to be assessed for clinical competence. The shortage of nurse educators implies that all nurse educators, irrespective of whether they are familiar with the subject content, are compelled to act as assessors during OSCE. The shortage of clinical practitioners in the nursing practice implies

that should clinical practitioners be used as assessors during OSCE, patient care will be compromised.

“...use of assessors not directly involved in that year level because with OSCE more manpower is needed. The very same students when they are confronted with the real situation then become overwhelmed because of being incompetent.” (F1; F3)

“...I think it can also be the numbers...” (F1; F3)

“...it is a dilemma because it is really a lot of students that we have to assess and we don't have time and ...” (F3)

Brosman and Evans (in Kayihura & Mtshali, 2010:108) and Byrne and Smyth (2008:284) warn that the OSCE is a stressful experience and requires considerable preparation and effort by nursing students and academic staff. According to the findings of this study similar stressful experiences emerged.

Byrne and Smyth (2008:284) and Rentschler *et al.* (2007:136) oppose the finding of this study as they state that the popularity of utilizing OSCE increased among nurse educators because OSCE is appropriate for use with large numbers of learners, despite the extensive preparation involved in executing them.

Hatala *et al.* (2011:4) argue in support of the finding of this study by stating that for examinations with large numbers of nursing students, logistical issues may constrain the implementation of OSCE. The ratio of nursing students to assessors allows for “snap shot” assessment (Kayihura & Mtshali, 2010:108; Walsh, 2007:7).

- **Minimal number of stations**

The participants of this study indicated that the shortage of nurse educators to act as assessors during the OSCE and the large number of nursing students to be assessed in a limited time, led to an OSCE with a limited number of stations where only a limited number of nursing skills can be assessed. This compromises the OSCE's efficiency as assessment method for students' clinical competence.

“...too many students and less lecturers...makes it difficult for proper assessment...number of stations will be reduced” (F1; F3)

“...students are exposed to three, four stations...OSCE should have several stations.” (F3)

Rushforth (2007:485) indicates that in an OSCE testing a narrow range of skills, fewer stations are required, but it is questionable whether the aim of the OSCE will be achieved. This confirms the findings of the participants who indicated that fewer stations during OSCE do not allow proper assessment.

McWilliam and Botwinski (2010:39) emphasize that the more stations (and assessment tasks) included in an OSCE, the more likely assessors can assess “true competence”. Fewer than 10 stations are inadequate for satisfactory range of skills or topics to be examined, but more than 20 stations can become unwieldy and will require a large number of assessors.

More stations need more assessors to man the stations. According to the participants this is a big challenge at the provincial nursing college.

3.2.2.2 Sub-theme 2.2: Financial constraints

Participants in this study reported that the number of nursing students that have to be assessed, the number of stations that have to be constructed, the use of standardized patients who have to be remunerated, assessors and other staff required, are all factors that contribute to the cost of an OSCE.

According to Khattab & Rawlings (2008:756) all the above-mentioned factors explain why the cost of running an OSCE is generally agreed to be higher than administering traditional written examinations, involving only one or two invigilators and no equipment. However, they further argue that the costs are outweighed by the educational benefits of OSCE. Mitchell *et al.* (2009:402) as well as Cowan *et al.* (2008:904) confirm the fact that OSCEs are expensive and labour intensive, but also say that there is evidence that they enhance the quality of health professional education. Rentschler *et al.* (2007:135) confirm the findings of this study as they

state that because of the cost involved to develop and administer OSCEs, further research is necessary to determine whether implementation of this method as an assessment method in the undergraduate program is feasible.

Several significant issues arose when considering the resources involved in OSCEs as stated by the participants:

- **Standardized patients**

OSCE requires each student to demonstrate specific skills and behavior in a simulated environment with standardized patients. Standardized patients refer to an individual hired to portray a patient in a health case scenario with an assigned or actual health condition (McWilliam & Botwinski, 2010:37).

The participants in this study confirm that in order to meet the standard required for OSCE, standardized patients need to be recruited and trained extensively, and/or intermediate to high fidelity simulators have to be purchased to achieve the aim of comprehensive assessment for competence.

“...because of the costs implication we cannot use standardized patient.” (F2; F3)

...live uhm or real patient or high technology life models are really difficult to get...” (F1; F2;F3)

“...very same retired nurses are going to volunteer ... pay them R50 or whatever so it is costly...and it is the same because you can’t catheterize them... Invasive procedures still a problem...” (F3)

Both international (Mitchell *et al.*, 2009:402) and national studies (Mash, 2007:5) confirm that OSCEs are logistically complex and labour extensive because they require large space for storing models, and involves much preparation for both patients (standardized) and examiners. McWilliam and Botwinski (2010:40) state that standardized patients should preferably not be health care professionals, but be trained for their specific roles and evaluated to assure consistency and accuracy.

Byrne and Smyth (2008:284) state that OSCEs are effective methods of assessing clinical competence, but they also acknowledge that OSCEs are costly to execute in terms of manpower, resources and time elements (Kurz *et al.*, 2009: 186). According to McWilliam and Botwinski (2010:37) nursing students who were exposed to standardized patients reported less anxiety, more positive experiences and increased self-confidence when compared to students exposed to peers as patients.

McWilliam and Botwinski (2010:37) confirm what participants in this study echoed, namely that the recruiting and training of standardized patients are cornerstones of successful OSCE programs.

- **Preceptors**

The participants in this study perceived the lack of preceptors as an obstacle in the use of OSCE as summative assessment for students' clinical competence. They argue that wider availability of preceptors can be beneficial to the clinical accompaniment of students and ease the workload of the nurse educators in the accompaniment and assessment of students. The preceptors can assist with the formative assessment in the clinical practice, as well as the summative assessment (OSCE).

The creation of posts for preceptors is a challenge due to the provincial nursing college's dependence on approval from both the provincial and national department of health regarding funding.

“... But the situation with us is that we don't have preceptors... “ (F3)

“... It would lessen our workload if we had preceptors...” (F3)

“I don't think we are being honest if we say we cope with hundred learners... with two or three lecturers having to accompany them or do formative assessment...Definitely not!” (F3)

“It is true to say we are not coping, that is why we need preceptors.” (F3)

The nursing education stakeholders group (CPAS, DENOSA, FUNDISA, NEA, Nurse Managers, PHEPSA) (SANC, 2010) and the National Department of Health's Strategic Plan (2012/2013-2016/2017) developed a Model for Clinical Nursing Education in which a system of clinical preceptors is proposed. The clinically experienced preceptors will function primarily in the clinical setting as accompanists for nursing students and assistant to the nurse educators. The aim is to optimize learning in the clinical area to produce competent nurses and midwives. This initiative is in line with the need expressed by the participants of this study.

Rutkowski (2007:39) supports the participants' suggestions by stating that if collaborative partnerships and preceptors are utilized, it could give rise to a more robust system of clinical assessment and ultimately improve nursing student clinical competence.

Conclusive statement: Theme 2

The lack of human and financial resources are major obstacles in the use of the OSCE as summative assessment of students' clinical competence at the site of this study. These obstacles contribute to the manner in which the OSCE is implemented and in the process compromise the quality of summative assessment, and thus the clinical competence of the newly qualified professional nurse.

3.2.3 THEME 3: ALTERNATIVES SUGGESTED

Participants in this study suggested a number of alternative actions as improvements on the current practices of using the OSCE as summative assessment for students' clinical competence at the provincial nursing college.

3.2.3.1 Sub-theme 3.1: Planning and organization

The participants in this study acknowledged that the OSCE is convenient for assessing large numbers of students over a short period of time as summative assessment for clinical competence if continuous, formative assessment was done in order to prepare students for the summative assessment.

The participants expressed concern for the manner in which the OSCE is managed and identified a need for proper administration (planning, organization and implementation). Insufficient planning leads to:

Unprepared assessors who follow the assessment tool blindly;

A lack of standardized patients, leading to either peers or other workers acting as patients, and they are ill prepared for the role they have to portray;

The repetitive use of the same assessment tools and scenarios; making it easy for students to memorize the assessment tool;

Last minute changes to the assessment tool; causing confusion and uncertainty;

“[OSCE] is not time consuming where planning was done well in advance.” **(F2)**

“OSCE ...can be more effective...planning from the start of the year including appointing preceptors, looking at the tool, looking at more real model or standardized patient.” **(F3)**

“...everything you do in formative assessment in preparing for summative assessment should have clinical competence in mind.” **(F3)**

Jones *et al.* (2010:137); Street & Hamilton (2010:39); Byrne and Smyth (2008:284); Mash (2007:5); Hanley and Higgins (2005:272) and Chabeli (2001a:88) confirm that OSCEs require careful planning to be successful for assessing clinical competence during summative assessments. Walsh *et al.* (2009:1592) emphasized that the design and intent of an OSCE should receive appropriate attention long before implementation. An OSCE should be properly planned and organized to achieve its goal.

- **Assessors and standardized patients**

The participants in this study expressed a need for the adequate preparation of assessors and simulated patients as an important factor that facilitates the use of OSCE as summative assessment for students' clinical competence.

“...difficult to use own discretion because you are not involved in that subject” (F1)

“...so you are not assessing this person as a future professional nurse, you are checking what the tool is saying.” (F1)

“...can be given the scenarios or whatever beforehand ...” (F1)

“We can have the standardized models ...they train people, real live models to participate in OSCE” (F2)

“...if those simulated clients have been accurately trained, then they will be able to act that condition. (F2)

Khatab & Rawlings (2008:756) report that both assessors and moderators need preparation for their roles during an OSCE. Adequate time must be allowed for staff development.

Khatab and Rawlings (2008:758), as well as Ward and Barratt (2005:38) support the findings in this study and suggest the OSCE organizer to send each assessor details of their role in the OSCE around four to six weeks before the examination to ensure proper planning and to give examiners time to familiarize themselves with the area they will be examining.

Mash (2007:5) reiterates the findings of this study by citing that assessors and standardized patients may need prior training as reliability of the OSCEs is increased by performing and assessing the station in the same way with each nursing student.

Jones *et al.* (2010:137) confirm the findings of Mash (2007:5) in their recommendations that all examiners should be specifically briefed on the day of the OSCE.

- **Assessment tools**

The participants in this study verbalized concerns regarding the assessment tools used in the OSCE and made the following suggestions. These suggestions endorse the need for proper planning of OSCE long before the exam date.

“...tools to be discussed and fine tuned at the beginning of the year... and also be tested... by all [nurse educators]...” (F3)

“...we need to test that tool before so that we can identify problems”. (F2; F3)

“...we use the same tool for continuous assessment ...as the tool we are going to use for finalist assessment. Sometimes it gets difficult...a lot of critical points which were not there during continuous assessment that creates a problem.” (F2)

“The inter-rater reliability discussion...if it is done just before the assessment, it affects how the assessor goes into that station. (F3)

In support to the findings of this study, Major (2005:446) views the appropriate preparation of the environment, well-designed marking sheets, preparation of assessors and simulated clients and dummy runs as essential to reduce assessors' "role-strain" and to promote inter-rater reliability.

Byrne and Smyth (2008), as well as Mash (2007:6) indicate that the testing of the tools and planning of everything pertaining to OSCE should be done at the beginning of the year.

Nulty *et al.* (2011:146-147) developed seven (7) Best Practice Guidelines for OSCEs.

OSCEs should:

Focus on aspects of practice related directly to delivery of safe client/patient care;

Focus on aspects of practice that are most relevant and likely to be commonly encountered;

Be judged via a holistic marking guide to enhance both the rigor of assessment and reliability;

Require students to perform tasks in an integrated rather than piecemeal fashion by combining assessments of discrete skills in an authentic manner;

Be structured and delivered in a manner that aligns directly with mastery of desired knowledge and skills. This alignment should be both internal to the course and aligned prospectively with clinical tasks likely to be encountered;

Be appropriately timed in the sequence of students' learning to maximize assimilation and synthesis of disparate course content and to minimize the potential for students to adopt a piecemeal, superficial learning approach;

Allow for ongoing practice of integrated clinical assessment and intervention skills, thereby also ensuring the appropriate and timely use of feedback to guide students' development.

3.2.3.1 Sub-theme 3.2: Innovative approaches

In light of the obstacles relating to human and financial resources faced by the provincial nursing college, the participants in this study identified the need for innovative strategies to maximize using OSCE as summative assessment for students' clinical competence.

- **OSCE over several days**

The participants acknowledged that the obstacles that are associated with resources and the large number of nursing students compromise the value of OSCE as summative assessment for clinical competence negatively. Participants reported incidences where an OSCE will run for 11hrs, with no rest in between except for tea and lunch breaks. This resulted in both assessor and the nursing student fatigue, with further consequences explained under Theme 1. The participants suggested that the OSCE should run over a week, which implies assessing twenty(20) nursing students per day.

“...or maybe if it can be done in a week, may be if it is fourth years we allocate a week for those only... and divide student ±20 per day.” **(F3)**

Khattab & Rawlings (2008:756) support this suggestion. They indicate that between eighteen (18) and twenty-four (24) nursing students should be assessed over a two (2) day period, with six (6) assessors and three (3) volunteers. They further explain that nursing student numbers influence the number of stations to be constructed and the duration of the clinical examination.

- **Variety of scenarios/procedures**

The participants in this study were concerned about how the scenarios are constructed. They indicated that students sometimes do not understand the scenarios or find them confusing, which mean that nurse educators should critically assess the scenarios. A number of scenarios need to be compiled in order to prevent using the same scenarios and assessment tasks repeatedly, especially if the OSCE is run over several days, when it will be possible to exchange scenarios and assessment tasks.

“We can spread the days for OSCE...” **(F1)**

“... fourth years ... we allocate a week for those only because the objective is the same but the scenario’s can differ.” **(F1)**

“...our learners become so confused because of this thing of “you have already scrubbed””.
(F2;F 3)

Mcwilliam and Botwinski (2010:37) indicates that when an OSCE case scenario is developed for the use of assessing nursing clinical competencies, it is important that each case scenario incorporates a specific range of nursing knowledge and skill. According to Mcwilliam and Botwinski (2010:37) this will allow nursing students to demonstrate the use of assessing, planning, implementing, or evaluating care given in response to a single patient encounter.

Conclusive statement: Theme 3

The administration (including the planning, organization and implementation) of an OSCE as summative assessment for students’ clinical competence requires commitment, critical evaluation and innovative strategies from the nurse educators and the management of the nursing education institution to cope with the given challenges and to achieve the set aim.

3.3 SUMMARY

Chapter 3 discussed the results of this study, illustrated with direct quotes from the participants and related to findings from studies found in literature. The three themes were concluded with conclusive statements that serve as starting points for the suggested recommendations to the provincial nursing department, nursing education management and the nursing educators. The recommendations suggested are discussed in chapter 4, together with the limitations of the study.

CHAPTER 4

EVALUATION OF THE STUDY, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The previous chapter discussed the research findings and offered support for the findings with direct quotes from the participants during the focus group interviews. The collected data was integrated with the findings from national and international research literature.

This chapter includes the researcher's evaluation of the study, the limitations of the study and recommendations for nursing education, nursing education management and suggestions for further research.

4.2 CONCLUSIONS

Data analysis resulted in three themes and associated sub-themes pertaining to the nurse educators' perceptions of OSCE as summative assessment for students' clinical competence. Three conclusive statements are formulated below that will serve as the basis for the recommendations for nursing education and nursing education management.

Conclusive statement for theme 1:

The value of the OSCE as summative assessment for students' clinical competence is compromised by:

Inconsistent performance of both the assessors and the simulated patients, resulting in behavior and practices that may impact negatively on the outcome of the OSCE;

Poor planning and organization of the OSCE, resulting in the repetitive use of the same assessment tasks and instruments, last minute changes and poor preparation of stakeholders, which gives rise to confusion and poor efficiency.

Conclusive statement for theme 2:

The lack of human and financial resources is a major obstacle in the use of OSCE as summative assessment for students' clinical competence at the site of this study. These obstacles contribute to the manner in which OSCE is implemented and in the process compromise the quality of summative assessment, and thus the clinical competence of the newly qualified professional nurse.

Conclusive statement for theme 3:

The administration (including the planning, organization and implementation) of an OSCE as summative assessment for students' clinical competence, requires commitment, critical evaluation and innovative strategies from the nurse educators and the management of the nursing education institution to cope with the given challenges to achieve the set aim.

4.3 RECOMMENDATIONS FOR NURSING EDUCATION, NURSING EDUCATION MANAGEMENT AND NURSING RESEARCH

The result of the study has highlighted critical issues that can be of value to nursing education institutions. Aspects that may require further research are indicated in the following paragraphs.

4.3.1 NURSING EDUCATION

The programme objectives set by the South African Nursing Council (R425) state clearly that on completion of the course of study, the nursing student should have the cognitive, psychomotor and affective skills to serve as a basis for effective practice. The role of the nurse educators in

the achievement of the above-mentioned goal is to ensure that diplomandi from nursing colleges are professionally developed and are competent to render high quality comprehensive/holistic care to the patient (Muller, 2009:7; Meyer & Van Niekerk, 2008:88).

The researcher recommends:

OSCE's should be properly planned and organized to be successful as summative assessment for students' clinical competence;

Planning pertaining to OSCE should be done at the beginning of the year, well in advance to the actual event. It should include decisions on what procedures should be covered during continuous assessments and what should be covered during summative assessments.

The time allocated for the OSCE as summative assessment should be extended to three (3) or four (4) days in order to increase the number of stations from the current four (4) to at least ten (10) stations to assess "true competence";

Attention should be given to the construction and variety of scenarios in order to prevent the repetitive use of the same scenarios;

Urgent attention should be given to the development of assessment instruments/tools to fit the scenarios in order to prevent the repetitive use of the same instruments, something that makes it easy for students to memorize the instruments;

The assessment instruments/tools should be tested before implementation to increase the inter-rater reliability;

All assessors should be familiar with the expectations and assessment tools; a pilot run may be feasible;

Nurse educators should take note of the Best Practice Guidelines for OSCE (Nulty *et al.*, 2011:146-147).

The researcher commits to give feedback to the provincial nursing college (both campuses) followed by a workshop to explore the innovative approaches on how to improve OSCE as summative assessment for students' clinical competence.

4.3.2 NURSING EDUCATION MANAGEMENT

The administration (including the planning, organization and implementation) of an OSCE as summative assessment for students' clinical competence requires commitment, critical evaluation and innovative approaches from the management of the nursing education institutions to cope with the given challenges and to achieve the set aim. The management of the nursing institution should:

Motivate for funding from the Provincial Government to expand the human resources necessary to increase the efficiency of OSCE as summative assessment for students' clinical competence;

- Negotiate for the implementation of a system of clinical preceptors employed by the provincial nursing college to assist nurse educators in the clinical accompaniment and assessment of nursing students;
- Recruit, train and remunerate candidates to act as standardized patients during OSCE;
- Acquire high fidelity simulators to increase the value of OSCE as summative assessment for students' clinical competence.

Support nurse educators in exploring alternative and/or innovative measures to improve the efficiency of OSCE as summative assessment for students' clinical competence.

The researcher commits to give feedback to the management team of the provincial nursing college (both campuses) followed by a workshop to explore innovative approaches to improve OSCE as summative assessment for students' clinical competence.

4.3.3 NURSING RESEARCH

Based on the research findings, literature and conclusions of this research, it is evident that some issues have been triggered that need further scientific research:

The impact of poor planning and implementation on the value of OSCE as summative assessment for students' clinical competence.

The use of standardized patients versus real patients during clinical assessment.

The role of clinical preceptors in enhancing the value of OSCE as summative assessment for students' clinical competence.

The impact of intermediate or high fidelity simulation models on students' clinical competence.

4.4 EVALUATION OF THE STUDY

As nurse educator at a provincial nursing college, the researcher became aware of concerns raised by nurse educators regarding the appropriateness of OSCE as summative assessment for students' clinical competence and some difference of opinion on the matter. This awareness prompted this study. The study was of significance to the researcher as it was unique and it was the first to be conducted at the provincial nursing college. The findings of this study should contribute to a change in the current practices and improve the efficiency of OSCE as summative assessment for students' clinical competence.

The study has achieved the two set objectives:

To explore and describe the perception of the nurse educators' at the provincial nursing college with regard to OSCE as summative assessment for students' clinical competence.

To explore and suggest alternatives for the current summative assessment practice for clinical competence.

An explorative, descriptive, contextual qualitative research design was followed. Data was collected by means three focus group interview sessions, of which the third also served as opportunity to confirm the truthfulness and interpretation of the collected data. Data was collected until saturation was reached, and analysis was done by using the principles for content analysis as described by Creswell (2008:251).

The central theoretical statement for this study has been successfully confirmed.

Knowledge of the nurse educators' perception regarding the use of OSCE as summative assessment for students' clinical competence together with the integration of relevant literature

should lead to a better understanding of the issue at hand and facilitate change in the current practice.

4.5 LIMITATIONS OF THE STUDY

Although the study provided rich discussions on the nurse educators' perception of OSCE as summative assessment for clinical competence, there are some limitations that need mentioning:

Only the perception of the nurse educators who met the inclusion criteria (involvement with OSCE's for 5 years or more) were explored; not all the nurse educators in this provincial nursing college were included.

During the second focus group interview, data saturation was not reached. After discussion with the independent co-coder, the researcher arranged for a third round to probe more deeply into the themes mentioned in the initial focus group.

Only seven (7) of the original fourteen (14) participants were available to partake in the third focus group interview that served as confirmation of the truthfulness and interpretation of the collected data and gave an opportunity to clarify and enrich the data.

4.6 SUMMARY

This chapter evaluated the study, discussed the limitations of the study and made recommendations to nursing education, nursing education management and regarding further research.

This study aimed to explore nurse educators' perceptions of OSCE as summative assessment for students' clinical competence and suggestions for alternatives. The central theoretical statement for this study has been successfully achieved.

BIBLIOGRAPHY

- Allinier, G., Hunt, B., Gordon, R. & Harwood, C. 2005. Effectiveness of intermediate-fidelity simulation training technology in undergraduate nursing education. *Journal of advanced nursing*, 54(3):359-369.
- Babbie, E. 2007. *The practice of social research*. 11th ed. Belmont, CA: Thomson/Wadsworth.
- Babbie, E. & Mouton, J. 2001. *The practice of social research*. Cape Town: Oxford University Press.
- Brookes, D. 2007. Objective structured clinical examination assessment. *Nursing times*, 103(43):30-31.
- Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. *Research in health sciences*. Cape Town: Heinemann Pearson.
- Brink, H. 2006. *Fundamentals of research methodology for health professionals*. 2nd ed. Pretoria: Juta.
- Bruce, J.C., Klopper, H.C. & Mellish, J.M. 2011. *Teaching and learning the practice of nursing*. 5th ed. Cape Town: Heinemann Pearson.
- Burns, N. & Grove, S.K. 2009. *The practice of nursing research: appraisal, synthesis, and generation of evidence*. 6th ed. St. Louis, MO: Elsevier Saunders.
- Byrne, E. & Smyth, S. 2008. Lecturers' experience and perspectives of using an objective structured clinical examination. *Nurse education in practice*, 8(4):283-289.
- Chabeli, M.M. 2001a. Nurse educator's perceptions of OSCE as a clinical evaluation method. *Curationis*, 24(1):84-92.
- Chabeli, M.M. 2001b. Alternative methods for clinical nursing assessment and evaluation. *Health SA Gesondheid*, 6(3):18-30
- Cowan, D.T., Wilson-Barnett, D.J., Norman, I.J. & Murrells T. 2008. Measuring nursing competence: Development of a self-assessment tool for general nurses across Europe. *International Journal of Nursing*, 45, 902–913.

- CPAS, DENOSA, FUNDISA, NEA, Nurse Managers, PHEPSA & SANC 2010. A model for clinical nursing education for South Africa. Proposed by the Nursing Educator stakeholder Group.
- Creswell, J.W. 1998. *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks, CA: Sage.
- Creswell, J.W. 2003. *Research design: qualitative, quantitative and mixed method approaches*. 2nd ed. Thousand Oaks, CA: Sage.
- Creswell, J.W. 2008. *Educational research, planning, conducting, and evaluating quantitative and qualitative research*. 3rd ed. Upper Saddle River, NJ: Pearson Education.
- Creswell, J.W. 2009. *Research design: qualitative, quantitative, and mixed method approaches*. 3rd ed. Belmont, CA: Sage.
- De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L. 2005. *Research at grass roots: for the social sciences and human service professions*. 3rd ed. Pretoria: Van Schaik.
- Furlong, E., Fox, P., Lavin, M. & Collins, R. 2005. Oncology nursing students' views of a modified OSCE. *European journal of oncology nursing*, 9(4):351-359.
- Greeff, M. 2005. Information collection: interviewing. (*In De Vos, A.S., ed. Research at grass roots for the social sciences and human service professions*. 3rd ed. Pretoria: Van Schaik. p. 291-320).
- Gubrium, J.F. & Holstein, J.A. 2002. *Handbook of interview research: context & method*. Thousand Oaks, CA: Sage.
- Hanley, E. & Higgins, A. 2005. Assessment of clinical practice in intensive care: a review of the literature. *Intensive & critical care nursing: the official journal of the British Association of Critical Care Nurses*, 21(5):268-275.
- Hatala, R., Marr, S., Luncic, C. & Bacchus, C.M. 2011. Modification of an OSCE format to enhance patient continuity in a high-stakes assessment of clinical performance. *BMC medical education*, 11(23). <http://www.biomedcentral.com/1472-6920/11/23> Date of access: 9 Feb. 2013.
- Harden, R.M., Stevenson, M., Downie, W.W. & Wilson, G.M. 1975. Assessment of clinical competence using objective structured examination. *British medical journal*, 1(5955):447-451.
- Holland, K., Roxburgh, M., Johnson, M., Topping, K., Watson, R., Lauder, W. & Porter, M. 2010. Fitness for practice in nursing and midwifery education in Scotland, United Kingdom. *Journal of Clinical Nursing*, 19, 461–469

- Jones, A., Pegram, A. & Fordham-Clarke, C. 2010. Developing and examining an objective structured clinical examination. *Nurse education today*, 30(2):137-141.
- Joy, R. & Nickless, L.J. 2008. Revolutionising assessment in a clinical skills environment: a global approach: the recorded assessment. *Nurse education in practice*, 8(5):352-358.
- Kayihura, C.N. & Mtshali, N.G. 2010. Assessment of student nurses' clinical learning in Rwanda. *African journal of nursing and midwifery*, 12(1):100-108.
- Khattab, N.D & Rawlings, B. 2005. Use of modified OSCE to assess nurse practitioner students. *British journal of nursing*, 17(12):754-759..
- Kingry, M.J., Tiedje, L.B. & Friedman, L.L. 1990. Focus groups: a research technique for nursing. *Nursing research*, 39(2):124-125.
- Krefting, L. 1991. Rigor in qualitative research: the assessment of trustworthiness. *American journal of occupational therapy*, 45(3):214-222.
- Kurz, J.M., Mahoney, K., Martin-Plank, L. & Lidicker, J. 2009. Objective structured clinical examination and advanced practice nursing students. *Journal of professional nursing*, 25(3):186-191.
- Lincoln, Y.S. & Guba, E.G. 1985. *Naturalistic enquiry*. London: Sage.
- Love, B., McAdams, C., Palton, D.M., Rankin, E.J. & Roberts, J. 1989. Teaching psychomotor skills in nursing: a randomized control trial. *Journal of advanced nursing*, 14(11):970-975.
- Major, D.A. 2005. OSCEs: seven years on the bandwagon: the progress of an objective structured clinical evaluation programme. *Nurse education today*, 25(6):442-454.
- Mash, B. 2007. Assessing clinical skills standard setting in the objective structured clinical exam (OSCE). *South African family practice*, 49(3):5-7.
- McWilliam, P. & Botwinski, C. 2010. Developing a successful nursing objective: structured clinical examination. *Journal of nursing education*, 49(1):36-41.
- Meyer, S.M., Naude, M., Shangase, N.C. & van Niekerk, S. E. 2009. *The nursing unit manager: a comprehensive guide*. 3rd ed. Cape Town: Heinemann Pearson.
- Meyer, S. & Van Niekerk, S. 2008: *Nurse educator in practice*. Cape Town: Juta.
- Mitchell, M.L., Henderson, A., Grooves, M., Dalton, M. & Nulty, D. 2009. The objective structured clinical examination (OSCE): optimizing its value in the undergraduate nursing curriculum. *Nursing education today*, 29(4):398-404.
- Morley, M. 2007. *Simulation and Baccalaureate students' clinical competence*. Ottawa, Ontario: University of Ottawa. (Dissertation – MSc).

- Mouton, J. & Marais, H.C. 1996. Basic concepts in the methodology of the social sciences. Pretoria: HSRC Publishers.
- Muller, M. 2009. Nursing dynamics. 4th ed. Cape Town: Heinemann Pearson.
- North West. Department of Health. 2002. Annual report.
- Nulty, D.D., Mitchell, M.L., Jeffery, C.A., Henderson, A. & Groves, M. 2011. Best practice guidelines for use of OSCEs: maximizing value for student learning. *Nurse education today*, 31(2):145-151.
- Oxford Advanced Learner's Dictionary (OALD) 2010. Oxford: Oxford University Press.
- Oxford Dictionary of Current English. 2006. Cape Town: Oxford University Press.
- Polit, D.F. & Beck, C.T. 2006. Essentials of nursing research methods, appraisal and utilisation. 6th ed. Philadelphia: Lippincott.
- Polit, D.F. & Hungler, B.P. 2001. Essentials of nursing research: methods, appraisal and utilisation. 4th ed. Philadelphia: Lippincott.
- Polit, D.F., Beck, C.T. & Hungler, B.P. 2004. Essentials of nursing research: methods, appraisal and utilisation. 3rd ed. Philadelphia: Lippincott.
- Redfern, S., Norman, I, Calman, L., Watson, R. & Murrels, T. 2002. Assessing competence to practice in nursing: a review of the literature. *Research papers in education*, 7(1):51-77.
- Rentschler, D.D., Eaton, J., Cappiello, J., McNally, S. F. & McWilliam, P. 2007. Evaluation of undergraduate students using Objective Structured Clinical Evaluation. *Journal of nursing education* : 46(3):135-138.
- Ross, M., Carroll, G., Knight, J., Chamberlain, M., Fothergill-Boubannais, F. & Linton, J. 1988. Using the OSCE to measure clinical skills performance in nursing. *Journal of advanced nursing*, 13(1):45-56.
- Rouse, J. 2010. An evaluation of observed structural clinical examination. *Paediatric nursing*, 22(7):26-30.
- Rushforth, H.E. 2007. Objective structured clinical examination (OSCE): review literature and implications for nursing education. *Nursing education today*, 27(5):481-490.
- Rutkowski, K. 2007. Failure to fail: assessing nursing students' competence during practical placements. *Nursing standard*, 22(13):35-40.
- Selby, C., Osmon, L., Davis, M. & Lee, M. 1995. Set up and run an objective structured clinical examination. *British medical journal*, 310:1187-1190.
- South Africa. 2005. Nursing Act 33 of 2005. Pretoria: Government Printers.

- South Africa. Department of Health 2012/2013-2016/2017. The national strategic plan for nurse education, training and practice. Pretoria.
- South African Nursing Council. 1992. SANC regulations: education and training of a Nurse and Midwife. (Government notice, no. R425). <http://www.sanc.co.za/regulat/Reg-4yr.htm> Date of access: 17 Jul. 2012.
- Stommel, M. & Wills, C.E. 2004. Clinical research: concepts and principles for advanced practice nurses. New York: Lippincott Williams &Wilkins.
- Street, P. & Hamilton, L. (2010). Preparing to take objective structured clinical examinations. *Nursing standard*, 24(34):35-39.
- Strydom, H. 2005. Ethical aspects of research in the social sciences and human service professions. (In De Vos, A.S., ed. Research at grass roots for the social sciences and human service professions. 3rd ed. Pretoria: Van Schaik. p. 56-69).
- Strydom, H. & Delpont, C.S.L. 2005. Sampling and pilot study in qualitative research. (In De Vos, A.S., ed. Research at grass roots for the social sciences and human service professions. 3rd ed. Pretoria: Van Schaik. p. 327-332).
- Walsh, M. 2007. Objective structured clinical evaluation for first year nursing students: a research study. Sudbury, Ontario: Laurentia University. (Thesis - MSc).
- Walsh, M., Bailey, P.H. & Karen, I. 2009. Objective structured evaluation of clinical competence: integrative review. *Journal of advanced nursing*, 65(8):1584-1595.
- Walsh, M., Bailey, P.H., Mossey, S. & Koren, I. 2010. The novice objective structured clinical evaluation tool: psychometric testing. *Journal of advanced nursing*, 66(12):2807-2818.
- Ward, H. & Barratt, J. 2005. Assessment of nurse practitioner advanced clinical practice skills: using the objective structured clinical examination (OSCE). *Primary health care*, 15(10):37-41.
- Wilkinson. M.F & Frampton, C.M 2004. Comprehensive undergraduate medical assessments improve prediction of clinical performance. *Medical education*, 38: 1111-1116.
- Zaidi, I.F. 2006. Developing and running an OSCE. *British journal of midwifery*, 14(12):725-729.

ADDENDUM A: APPROVAL CERTIFICATE FROM UNIVERSITY



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Ethics Committee

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ETHICS APPROVAL OF PROJECT

This is to certify that the next project was approved by the NWU Ethics Committee:

Project title : *Exploring Nurse educators' perceptions of objective structured clinical evaluation as summative assessment for clinical competence*
Student : S Maruping
Project leader: Dr. M Williams
Ethics number: **NWU-00051-11-A1**
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation
Expiry date: 24 Junie 2016

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal Ethics approval certificate will be sent to you as soon as possible.

Yours sincerely

Me. Marietjie Halgryn
NWU Ethics Secretariate

ADDENDUM B1: REQUEST FOR PERMISSION

136 Jasmyn street

Fliemida

Klerksdorp

2571

29 October 2011

TO: Directorate of Policy, Planning, Research, Monitoring and Evaluation
Department of Health: North West Province
Private Bag X2068
Mmabatho
2735

SUBJECT: PERMISSION TO CONDUCT RESEARCH

Sir/Madam

Attached please find the following documents with regard to the request for permission to conduct research at the two nursing colleges in the Province.

Request for permission to conduct research at North West Provincial College of Nursing.

Information leaflet to research participants.

Informed consent form for research participants.

Ethical Approval Certificate from the North West University: Potchefstroom Campus.

The research proposal.

Thank you,

.....

Sophie Segomotso Maruping

Cell phone number: 0723628130

E-mail: marupings@nwpg.gov.za

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Sir / Madam

My name is Sophie Segomotso Maruping, appointed as lecturer at Excelsius Nursing College. I am a currently registered for a M.Cur (Nursing Education) degree at the North- West University, Potchefstroom campus. One of the requirements for this degree is a research project and therefore, I request permission to include the two campuses of the Provincial Nursing College in the proposed project with the title:

Exploring nurse educators' perception of Objective Structured Clinical evaluation as summative assessment for students' clinical competence.

The use of the Objective Structured Clinical Evaluation (OSCE) as summative assessment seems to gain popularity due to its ability to accommodate large groups of students in a relative short period of time. Although the use of the OSCE is gaining popularity in nursing, its appropriateness as summative clinical assessment is questioned. The question arises whether the OSCE is adequate as comprehensive assessment for the application of relevant knowledge, skills, attitudes in complex health related situations required of a reflective, competent nursing practitioner functioning within the South African health system.

The objectives for this study are:

To explore and describe the perception of the nurse educators at the provincial nursing college with regard to OSCE as summative assessment for students' clinical competence.

To explore and suggest alternatives for the current summative assessment practice for clinical competence.

The target population is nurse educators who are actively involved in assessing the final year nursing students, registered for the D4 program, for clinical competence by using the OSCE. A sample based on certain criteria, will be selected from the target population.

The researcher plan to conduct a qualitative research study with at least one semi structured focus group interview at each of the campuses of the Provincial Nursing College as data collection method. The focus group interviews will be recorded for transcription purposes to ease the data analysis process.

The researcher undertake to comply with the ethical principles regarding measures to protect the participants human rights of informed consent, justice, respect, confidentiality and voluntary participation as described in the Information leaflet attached to this letter and the Informed Consent to be signed by the participants in this study.

Thanking you in anticipation

.....

Maruping Segomotso Sophie (M. Cur Student)


Cell phone number: 072 362 8130

E-mail: marupings@nwpg.gov.za

Dr MJS Williams

Study supervisor

ADDENDUM B2: PERMISSION FOR RESEARCH

 **health**
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

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POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : Ms S.S Maruping

From : Policy, Planning, Research, Monitoring & Evaluation

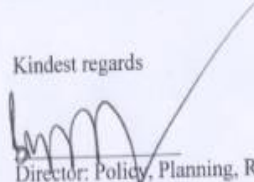
**Subject: Research Approval – Exploring Nurse Educators Perceptions Objectives
Structured Clinical Evaluation Assessment for Students Clinical Components.**

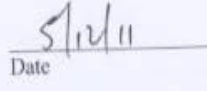
Purpose

To inform your good selves that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as prove that the Department has granted approval to the districts or health facilities that form part of the study.


Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards


Director: Policy, Planning, Research, Monitoring & Evaluation
Mr B Redlinghys


Date

1


Healthy Living for All

ADDENDUM C1: REQUEST FOR RESEARCH

136 Jasmyn street

Fliemida

Klerksdorp

2571

29 August 2011

Mrs M Montshiwa

Campus Head

Mmabatho College of Nursing

Private Bag X2068

2735

Dear Mrs Montshiwa

REQUEST: RESEARCH AT MMABATHO COLLEGE OF NURSING

I am a currently registered for M.Cur (nursing education) degree at the North- West university, Potchefstroom campus. One of the requirements of this course is that I have to conduct a research project. I hereby wish to request permission to conduct research at your institution on the topic: *Exploring nurse educators perception of objective structured clinical evaluation as summative assessment for students' clinical competence.*

My supervisor is Dr Marthyna Williams from the school of Nursing Science, North- West University, Potchefstroom campus.

This study is approved by:

Ethical Committee of the North-West University (Certificate number NWU-00051-11-A1 attached to this letter).

Directorate of Policy, Planning, Research, Monitoring and Evaluation, Department of Health: North West Province.

The objectives for this study are:

To explore and describe the perceptions of the nurse educators at the provincial nursing college with regard to OSCE as summative assessment for students' clinical competence.

To explore and suggest alternatives for the current summative assessment practice for clinical competence.

The target population is nurse educators who are actively involved in assessing the final year nursing students, registered for the D4 program, for clinical competence by using the OSCE. A sample, based on certain criteria, will be selected from the target population.

The researcher plan to conduct a qualitative research study with at least one semi structured focus group interview at each of the campuses of the Provincial Nursing College as data collection method. The focus group interviews will be recorded for transcription purposes to ease the data analysis process.

The researcher undertake to comply with the ethical principles regarding measures to protect the participants human rights of informed consent, justice, respect, confidentiality and voluntary participation as described in the information leaflet attached to this letter and the informed consent to be signed by the participants in this study.

Your support and cooperation in this regard is appreciated.

.....

S S Maruping

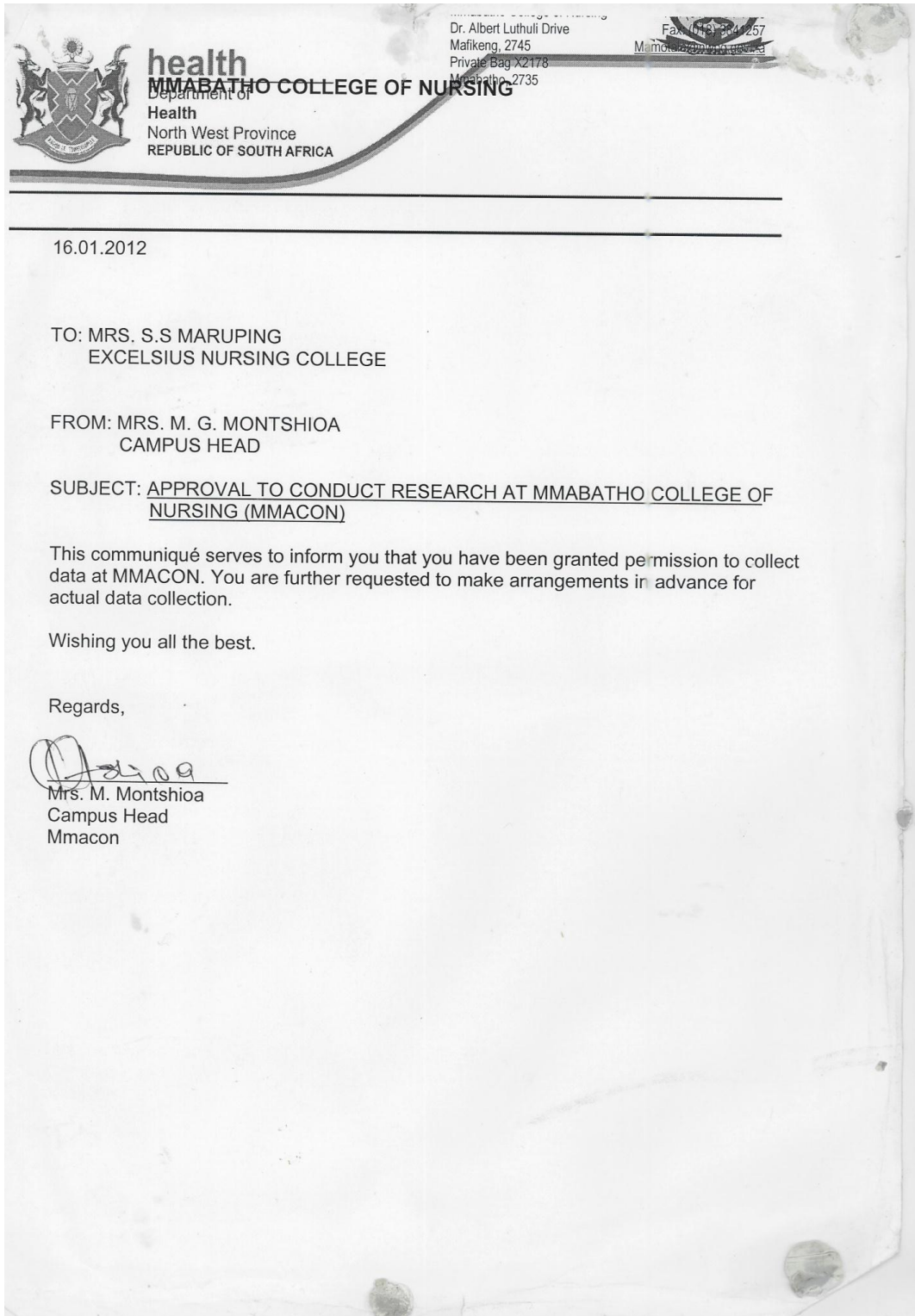
Cell phone number: 072 362 8130

E- mail address: marupings@nwpg.gov.za


Dr MJS Williams

Study Supervisor

ADDENDUM C2: PERMISSION FOR RESEARCH




ADDENDUM C3: PERMISSION FOR RESEARCH



health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

Tel: (018) 406 8600
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EXCELSIUS NURSING COLLEGE

VISION To facilitate physical, psychological, social and spiritual wholeness for all people of the North West Province Through the provision of innovative nursing education and training.

MISSION The college will strive towards preparing a nursing student through innovative dynamic nursing education and training in order to become a reflective, critical analytical thinker and a professional leader in striving towards wholeness.

To : Mrs. S. S. Maruping
HOD: NBS

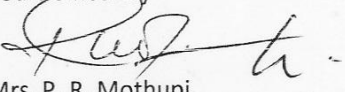
From : Mrs. P. R. Mothupi
Campus Head

Date : 09 December 2011

Subject: **COLLECTION OF DATA FOR THE MASTERS PROGRAMME RESEARCH PROJECT**

Permission is granted for data collection within the College, subject to conditions set out by both University and Departmental Research Ethics Committees.

I wish you well for your studies and hope that the outcomes of the research study will benefit the college.

Yours Sincerely

Mrs. P. R. Mothupi
Campus Head

EP S I H R U S O R P I N I

ADDENDUM D1: INFORMATION LEAFLET

Dear Sir / Madam

I am currently registered for the M.Cur (Nursing Education) degree at the North- West university :Potchefstroom campus. I hereby request you as nurse educator, involved in the summative assessment of final year nursing students to participate in the research study as explained below. Your opinion and experience regarding the issue at hand will be highly appreciated and it will contribute to new knowledge and possible recommendations for future practice. Please read this information leaflet carefully before committing yourself to participating.

Research Title: Exploring nurse educators' perception of objective structured clinical evaluation as summative assessment for students' clinical competence.

The aim of the study is to explore and describe the perceptions of the nurse educators at the Provincial Nursing College with regard to OSCE as summative assessment for students' clinical competence. When your perceptions are known, to explore and suggest alternatives for the current summative assessment practice for clinical competence.

Your participation will include:

At least one focus group interview with other colleagues involved in OSCE as summative assessment for final year nursing students.

The focus group interview will be arranged in time with the participants, conducted at the college and will last for forty-five minutes to an hour.

The proceedings will be recorded on a voice recorder, transcribed to ease the data analysis process.

The interview will take place in a private, comfortable room.

No names will be used during the interview as you will not be allowed to address each other by names.

Data will be kept in a safe place by the researcher for confidentiality; only the researcher and co- coder have access to the raw data.

Your names will neither be on the voice recorder, in the research report or publication.

Your participation in this study is totally voluntary; you can stop or withdraw your participation at any stage without any consequences to you. It will however be appreciated if you participate for the duration of the study.

Should you have any questions concerning the study or on your participation in this study, please feel free to contact me at cell phone number 0723628130 or per E-mail at maruping@nwpq.gov.za

You are kindly requested, if you agree to participate, to sign the attached form to confirm that you are willing to participate in this study.

Thanking you in anticipation to your participation.

**ADDENDUM D2:
INFORMED CONSENT FORM: FOCUS GROUP INTERVIEWS**

RESEACH TOPIC: Exploring nurse educators' perception of Objective Structured Clinical Evaluation as summative assessment for students' clinical competence.

The Researcher:

I have discussed the purpose, procedure risks, benefits and confidentiality involved in this research study with the participants and in my opinion, the participants understand this information.

Researcher

Date

CONSENT TO PARTICIPATE IN RESEARCH

RESEARCH TOPIC :Exploring nurse educators' perception of Objective Structured Clinical Evaluation as summative assessment for students' clinical competence.

The Participant

I _____ here by consent to participate voluntary in the above research project. The objectives, benefits. Risks and obligations of the research are clear and I understand the implications of participation. I am willing to be contacted for focus group interview that will be recorded by a voice recorder.

Participant _____ Date _____

ADDENDUM E: TRANSCRIPT OF FOCUS GROUP INTERVIEW (FOCUS GROUP 3)

S S MARUPING

STUDENT NUMBER: 21777802

I :: INTERVIEWER

R : RESPONDENT

TITLE : Exploring nurse educators' perception of objective structured clinical evaluation as summative assessment for students' clinical competence

I So as we said it it is a conversation with a purpose and as Mrs Maruping has explained it, the purpose of this conversation it is just to dig a bit deeper into your views on OSCE, not only OSCE but OSCE as used for final assessment. For clinical competence.

I Assessment.

I Assessment for clinical competence not only OSCE on its own but what do you see OSCE or how do you see OSCE as the summative assessment for clinical competence? So let's hear from you, as Mrs Maruping said there is some information that came up from the previous focus group. Some of the positive information about OSCE was that it can be used for a large number of students, uhm minimal need for patients, limited time allocated, assessment where models or simulated r patients instead of live patients can be used, so it seems to be accessible, do you agree that is what you have said more or less?

R Yes

I And then the negative information is that it does not allow for affective interpersonal, reflective and critical thinking skills as it would have on real patients, uhm you can only use such a number of stations and not more due to cost and time and most learners and assessors may allow mistakes because it is not on real patients. And then it is subjective sometimes and then learners may be coached sometimes beforehand, so the real results will not be in actual fact reliable.

R Yes.

- I So just these are the themes that were analysed from the previous focus groups i.e with you and the other campus but now when you listen again to the question what comes to mind? if you want to add information you can just spontaneously share your views. Use of OSCE as summative assessment for clinical competence.
- R I can just make an example of an incident that I know, because what happened one of the clients told one learner that you have failed the critical point and that disturbed the very learner, throughout from the stations because they were doing four or more, I think it was four stations and then this one came out of the first station and then very client told the learner that you have failed a critical point, that disturbed the whole thing, so that is why we say standardised patient will work much better than students that we are using.
- I Okay and if you say standardised patients what do you mean with that?
- R Like in PBL course, the workshop that we attended in Canada, those people are coached they are told what is it and they can enact a certain condition or whatever it is, now with us because of the costs implication we cannot use standardised patient and may be let's we can use say the retired nurses or people that are available in the community that we can use that knows about the conditions.
- I Okay you said PBL what does that stand for?
- R It is problem based learning.
- I Okay problem based learning.
- R Yeah.
- I So based on the problem based learning approach they prescribe that you use the standardised patient for example a retired nurse.
- R No, we can use any person as long as they can be trained as actors i.e we can use retired nurses or can use what we have around here.
- I Okay, okay.
- R I think even people from the community.
- R Yes.
- R Uhm **volunteers** from the community, volunteers because I think even with volunteers or a **retired nurses** you may also have a problem that **they know more than the students and you know just their body language will show the student**, but you know you are going wrong so I think if it is people from the community you train them and tell them that is how you should act but not having a background of nursing, that could also work.

R also you can use drama students, you know they would be happy if they could participate in that, because in some places they use them. So they are taught about what is expected from them.

R And I actually wanted to say sometimes the problem is not from the students it is from us as lecturers discussing the outcome or marks in front of the learners especially what we are practising here. So we need to look at ourselves also because we are actually discussing the learners performance in front of the simulated clients.

I Outcome.

R But I think that one was addressed because we no more do it because the simulated clients i.e other students are excused after each round for finalising marks by the two assessors.

R Hmm. Maybe another thing that can help is maybe we exchange the simulated clients (the learners), we don't have to use the same client on the same procedure throughout you know if maybe after one cycle or maybe after the second one we change because they also learn very quickly to know that this student is correct or not so even if we don't discuss them as lecturers they can just learn from there to know that maybe this one is wrong or right, so maybe by exchanging them time and again it will also help.

I Okay. So it seems to me from what you are saying is that OSCE as a way of assessment for clinical competence might be hampered by who the client is,

R Yes.

I As well as by who the lecturer is.

R Yes.

I Okay so if I can understand correctly the client might give some indication of whether the student is wrong or right, so how does that influence clinical competence or how does that influence assessment of clinical competence?

R Negatively. I think it would influence it negatively because I don't think that ultimately what we are producing, the end result of that student it is what is expected or it is what you as a lecturer is expecting that student to be competent in, as you said something about subjective sometimes I know how good or how bad this student is, I start the whole process with that in mind and even little mistakes that you could have overlooked in a real live patient they become magnified or because you know that this student is good maybe in theory and maybe the student is not good in practical you know the student, this student goes through but that student when they are faced with real live people they don't perform well because it is overwhelming or they don't know, so I have

a problem with not using real situations but there is nothing we can do. I was even thinking about what if because we do go to clinical settings for formative assessment , if maybe we can plan that during summative OSCE we obtain the informed consent from the patients so that we can perform the procedure on them, but I also thought because we are assessing the very same students on real patients during formative assessment that we do the same. Because some of the procedures if are done on the doll, like inserting the catheter it is on the doll neh and I don't think they are as 100 % as they would be on a real live patient. Sometimes they inject the water and it does not run in, but we just take it that is okay, it is done, but it is not in because this thing is rigid, but no okay fine it is in and the ward okay it is fine everything is fine you just take that the person can do it and in the real situations they can't.

R Hmm, they cannot do it.

R Hmm it is like maintaining sterility and interacting .

R Hmm their maintenance of sterility is also a problem with that because, with a doll you overlook a lot of things but with a real live person that person would know how to interact with the person, how to scrub and even how to handle the instrument and the patient without contaminating. Interaction also becomes a problem because some of the learners even though they are told to regard the doll as real patient, in most cases that skill is not demonstrated and because they pass the OSCE and that skill was not effectively assessed they go out to clinical practice not being 100% competent in that skill. Even the position that they adopt during the procedure is a problem , because of the mere fact that they don't regard this model as a real patient.

R Hmm you cannot.

R You change position, you stand this side and you are not comfortable and you stand this side and you are not comfortable and I stand and okay you can stand there and sometimes it loses the whole thing but,

I Okay so I see heads nodding,

R Yes I think we have realised with experience, I have realised that you will find a person is very good in theory but when coming to practical she cannot do it, because that is why we are seeing our products now days they are not good enough in practical most of them they get out, usually they get on and they do education and management just to get away from the patient bed side because they cannot cope, because I think that maybe the way we have done our summative assessment was not good enough just to make sure that this people they are capable but I think we, there is something we are

lacking and the OSCEs are not helping us at all, because we are not doing that on real patients.

I Okay.

R Using real patient allows flexibility because with the real patient anything can disturb you then you will be checking the competence of the skill or whether does this nurse really have those skills you know to juggle around to do the procedure as expected and at same time attending to that disturbances

R Hmm.

R And also **looking at assessors because as it is other assessors are lenient and others are strict.**

R That is true

R We are in extremes.

R Yeah.

R Hmm.

I And if we look at the real situation how will that be different, why would that be different?

R I think that the difference is that uhm when I have to assess a student in the ward I would be alone and here we are two and we look at these things when we do an OSCE on uhm when we doing our OSCEs there will be two and the person that is too strict, if I am the strict one and I have got Sophie with me, she might be able to convince me otherwise and say okay I think here she did it but, and whereas in a real life I am alone there and I can make decisions on my own right and which can also be negative because if I am too lenient then I would overlook the other things and if I am too strict because there would be no one to correct me to say that this thing was not taught this way, then I can also be too strict and then disadvantage the learner.

I Okay.

R During OSCE the affective skills, how this learner is relating to this person, the eye contact the space and audibility and everything when I talk , you look at me and I get you to buy in what I am saying but with a doll there is nothing like that and we give them marks and that is the other thing that I have a problem with because with a patient yes you might take this patient to the loo before you start the procedure and start and you ask can you get the permission and the person is physiologically burdened and something happens and disturbs this so if that happens then as a nurse next to this patient you will know or must know how to now handle this situation that is coming up from what you are trying to do.

I Hmm.

R But what we are doing here is that a model is regarded as a thing that is lying there and she puts a catheter in and there is no pain there is nothing maybe even if she does not put it correctly that doll is not saying anything and she changes and she goes to the right orders but in the right person those things you would pick up and yes I think you would prepare our learners ultimately to be competent when they go out to practise.

R I think, hey I don't know I also think like my colleague mentioned your standardised patient I also think we would have the same problem because if we take a retired nurse and we need to catheterize we are not going to catheterize physically, you understand we not going to suture or remove sutures so we are still sitting with the dilemma which one is the right one because it works out the same, it boils down to the same thing because these very same retired nurses are going to volunteer but as when they gave us feedback about the PBL we gave them a certain amount, you pay them R50 or whatever so it is going to be costly and it is going to have the same effect as a doll because I mean if I don't have reason to be catheterized but why then but things like your blood pressure and your urine analysis things like that but procedures that are invasive are still not going to be performed.

I Okay.

R And the other thing that I actually wanted to add on what uhm you said is about the reaction, I am worried about the reaction of the patients because these learners they don't know what to do, if there is no reaction like you said from the patient like in wound dressing they need to ask about pain, they don't. They tend to forget important things because it is not done on a real patient because before you dress you need to ask "do you have a pain:" or maybe the doctor has prescribed something before you can dress a patient, they don't because it is not painful because it is a doll they tend to forget that. On a real patient because this is a wound , you can see that they need something the patient is in pain then you will give something before you start to dress. So the reaction of the patient and what to do as a nurse like she is taught in class, they don't do because it is a doll it is just something that is lying there.

R Another challenge that we are having with the OSCE neh, there are some procedures that are fading out you know that are not so common like those days maybe it is a problem with our learners now days. For example I will talk about the dressing like she was just talking about the dressing ne, now days they have got a special dressing that they are using that they will open after five days or whatever so our learners don't get the chance of really practising the real things on the patients because they don't see that, sometimes they go to the ward for a week and maybe even the patient will be

-
- discharged without even opening the wound maybe the wound will be opened but the patient has maybe to go to the consulting room of the doctor to open that so our nurses don't get the chance and see the progress of the wound after that dressing.
- R You know those are some of the smaller challenges we are having when we are doing some other things.
- R To add on that, even the vital signs they no longer use the thermometers in the wards but we expect them to do the blood pressure with the manual meanwhile they are using pulse meters
- I Okay so you are saying a lot of things now like the OSCE if you should keep up with practice, current practise because it is different than what you taught in class and the students might not have all the opportunities in practise that they need to be assessed on when using the OSCE. Also what I have been hearing by what you have been saying in the group is that the lecturer might play a role in being subjective because lecturers are assessing the students based on their past performance and also maybe have different viewpoints and also be too lenient and too strict and then the client may play a role, that the client might give an indication of right and wrong and not be if you use the standardised patient not being willing to be done on all the procedures you know there is not a need for them for all the procedures to be done on them which limits the assessment of competence and then you have also mentioned briefly the instrument, the tool that is used. What do you say about that, the tool that is being used in OSCE for summative assessment for clinical competence what is your views on that?
- R I think uhm we are not consistent, what we do is we got these practical manuals that we assess our learners on and then uhm with your certain, your critical points that they know and when it comes to OSCE then we add all these others which is to me it is not fair towards the learner because we are used to having these and then when comes to the exams then we add on to them so I don't think we are being fair and that is something that we need to look at.
- R And sometimes we find that the very learners because sometimes you won't add new critical points they will know where the critical point is because they will be carrying this practical manual for how many months then they will be doing this and remember you are following what is written on the tool, sometimes you are not even the subject lecturer for that particular group now you are only concentrating on those aspects because if she is done, she is done and there she goes.
- I Okay you also mentioning now an important thing about not being the lecturer for that particular group how does that influence the summative assessment for clinical competence?
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- R I think it influence it in such a way that sometimes because you are not involved in that group neh, you will be allocating marks or ticking based on the marking guide. Sometimes it is even difficult with other assessor to use their informed discretion, to credit or discredit the student so in most cases some student can be declared competence where as they are not. (Use of assessors not directly involved in that year level because with OSCE more manpower is needed) The very same students when they are confronted with the real situation then become overwhelmed because of being incompetent
- R Yeah. Hmm
- R But if you are on that level at least you know even if maybe it is not there in the guide maybe you can just credit it then this one can go through or discredit and he then does not go through.
- R But it also works both ways because I have seen some of the people in the same group following the very same guide to the T and with your experience even if you are not there you know that this thing it is a point it is correct you can credit a learner there but the guide it does not have that and the person that drew out the guide wants you to go according to the guide. So it works both ways because sometimes you would know that even if this is not in here but really this is correct, really you have seen that. Sometimes the learner follows the tool exactly but when you are looking at the how part this learner is incompetent but because she has memorise the tool she just passes.
- I Okay.
- R The other thing is before we uhm start with OSCE interator reliability is done and some questions are raised from the lecturers and then okay the tool will be corrected or for no apparent reason be corrected there and the other thing is that the same moderator that approved the tool will agree work together with the lecturer so,
- R I was coming to that, what my colleague said that at the end of it all the tool would differ from what we have been assessing the student for the whole year, why is it that when we make up the tool for the summative why don't we show our moderator the same thing and then you discuss and draw out based on what you have been teaching your student for the whole time so that we don't spring this other important points that they don't know of at the end of the year they know this then two or three have been added and those that they knew throughout the year as critical and important they are no more critical and important any more, after discussing with the lecturer or with this moderator when we stand there and somebody says but a patient won't die here remove this and it has been removed and the learner knows as, as a critical thing so I think the other thing that should be done before at the beginning of the year the tools should be discussed and
-

what happens is that they are fine tuned at the end of the year everybody the should start when the year level starts till it ends it shouldn't only be something that happens when we do the summative because that is where we change and do that and after the moderator has signed and sometimes the points that are brought up there they make sense they do make sense really but they were missed and it is now late.

R And it also then saves the examiner the embarrassment because sometimes we are not being sensitive in how we pose the questions, we are not asking constructive questions but we are asking to insult credibility of that person. so what my colleague says it is right that it should be done, all the lecturers should know this is what the tool is going to be like, ask your questions and stretch it out there instead of waiting for that day and wasting about one and a half hours because we want the tool to be according to what we want it.

I Which means that the tool needs to be tested.

R Yes, the tool need to be tested and we the professional nurses, the lecturers I mean we need to test that tool before so that we can identify problems before hand not on the day of the exam so that all aspects of competencies are assessed before the student can be declared as clinically competent.

R The interator reliability discussion if it is done just before the assessment, it affects how the assessor goes into that station and how I am going to assess those students after that because sometimes I feel I have a point here and it was not taken so my mood or that now has changed and the people those that come to my station are going to be affected.

R Hmm. That is why I say it is subjective.

R And I think maybe the unfortunate part of everything is that we have got this large numbers of students and there is no other way we cannot use the OSCE, uhm perhaps it would lessen our workload if we had the preceptors that are there on a continuous basis because we cannot be with the learners every day the whole day so if I have been to jubilee this week and I have done my part then there is a preceptor who will follow up on them to make sure that they know how to catheterise, they know how to do this and that, so that when we do our OSCEs then we are certain that our learners have been exposed and accompanied in all their clinical outcomes and they were found to be competent.

R With regard to the invasive procedures e.g catheterising really I don't think even the actors will allow ten students to catheterise but again if as a college we get, I have seen the models at the university they are like real people with yeah they communicate and

they will tell you that sjoe eina and all that so if we want to draw blood there is blood that is coming out and if this thing is in the vein you would see so they cause constraints and yes and for now maybe the dilemma that we have to go on with what we are using but I think maybe if we start with the interator reliability and the moderators check the tools at the beginning of the year and not at the end of it.

R I have just heard my colleague talking about the preceptors neh, saying that if the preceptors are appointed for each discipline or year level then we will be 100% sure that students when we come to our summative assessment, students will be competent because of **the continuous accompaniment and formative assessment done by those preceptors.** But the situation with us is that we don't have preceptors, and with the large numbers of students continuous assessments or proper accompaniment is not done, hence to test a certain portion using OSCE for summative assessment becomes a problem. With the real patient you take time and all aspects are tested but with the OSCEs we have got limited time to test all aspects because of the number of stations and students. so I think our student are challenged because of the time factor because some time they become confused of the scenario that we put there, for example I was telling the other lecturer that you will find that a scenario will tell you that you have scrubbed already then you have to attend to your procedure. Imagine you have scrubbed, then you ask for a glove automatically this said to you that you have identified the patient, I have done so many other things, I have screened I have done whatever, our learners become so confused because of this thing of we have already scrubbed and then at the same time according to our tool we have made and ensured privacy, identified training we have made it critical, can you really make it critical in that tool whereas you said in your scenario you have already scrubbed, is it fair because you have identified your client before you do all those things and verify with the files and everything, but now why must we make it critical, we also as lecturers we really need to use our common sense how and when to make a thing critical in the tool. I know that identification they like it in first year that it can be critical but when we come now to fourth year or whatever when you said maybe a person or maybe I am doing midwifery now neh, I have to glove and get started with the procedure, you cannot make it now a critical point but rather make it important.

R For example we have 17 procedures in first year against 117 learners. Lecturers will only assess four compulsory procedures during continuous assessment but during the OSCEs all procedures can be assessed even though the rest of the procedures were assessed by the professional nurses. learners will come and do the summative assessment but it will be expected that even on the 13 that you did not physically assess the student on, they have to be included also in the examination can you see

now you are not sure if the learners during their practice in the clinical facilities were 100% competent in this particular procedure because they were assessed by the professional nurse and now this procedure because of time factor it cannot be assessed from A to Z. the question is what about the other part that is not tested during the OSCEs?

R The other thing that she mentioned of identification, scrubbing, identification, scrubbing and screening or what, I think most of the time it is not only one station that they have, maybe if we make it that the first station they should deal with identification and stuff so that we can assess them on the identification of the patient because it is important, identify but where you now are dealing with a septic technique then you have already or somebody else in that station have checked that this person has identified competently and what so it doesn't have to go around in all four stations this identification when the person has scrubbed the person has scrubbed full stop.

R So how are we going to sensitise them because we said when we do the formative we assess them on a real patient and summative is on a model because the other time when we were doing a procedure, it was POP, the client had POP but none of them ever bothered to look at that foot, I only say one that was about to attend to that lady and show the client how to elevate and do all that because as much as they going to be continuously with a preceptor they will still be doing it on live patients so how we going to sensitise them to the fact that when they do the summative it will be a model it won't be a real patient because the other issue here is uhm it is uhm we talked about the cognitive aspect to say when they are doing it on the real patient it is different the way a patient responds and all that and when it is a model they don't do all that and then along the way they have to bring into the fact to say that as much as you are doing an assessment on the real patient when you go for the OSCE it will be a model and it will be one two three because I don't know do they forget that fact or what?

R I think most of the time they know that at the end of it all they know it is going to be a model and only when they are doing health education it would be another fellow student but because there is no pain they are not going to check e.g the leg, they are not going to elevate they are not going to educate suppose to be. The reasons being they are using a model and the time frame that will be given, because sometimes we will find that even if the time frame is enough, after five minutes she is finished she didn't touch a lot of things that she was supposed to have touched and she is now like, she is finished.

R And now we have no way actually of uhm comparing whether if it was a real patient during a formative assessment, how would they respond you see, has that been done

for us to come to that conclusion that they do this because it is the model, they don't do this because it is the real patient have we ascertain that?

R But what I have seen neh, is even if it is a model if you check the guide and the tool neh, it doesn't, they don't give a lot of stuff, the person can enact as they are supposed to be on a real patient it is just that now they know that this is not a real patient and some of the the things they omit.

R They failed to simulate real situation.

R Eh they treat it just like you would treat a stone.

R So it has nothing to do with the fact that it is a summative so it is more to do with the patient.

R Yeah because when we are doing the structured demonstration we bring the doll.

R Hmm.

R With them we teach them most with the doll before they are going to the patient, the same doll they are going to use in the OSCEs you see.

R You see also on that one is quiet debatable because when you are doing formative I think it is different tool will be the same, everything might be the same but the fact that it is uhm because whatever we are saying here we are assuming it is because it is a model but there is no scientific evidence to prove that to say we tested this like she said about testing the tool, has it been tested like we take the same procedure on a certain number of patients, students they do it on a model and they do it on a real patient then we compare to see how did these ones perform and how did these ones perform.

R OSCE in itself unlike the traditional method of assessment will definitely make them more anxious.

R If it was a real patient that is what I am saying.

R Because the person was going to do whatever in a relaxed situation knowing what to do, but today because it is OSCE and these two assessor are looking at me and then I have to do this, they are just anxious, they forget things so would we say definitely we are assessing what we supposed to assess?

R That is what I have been trying to establish, is it the fact that it is summative or that is why they are behaving in that manner. or is two fold i.e is like I say have we tested it to say here we had twenty learners who did uhm this on a real patient and this number did it on a model and the ones on a patient performed better or this one's did not perform well, is it because it is an example that is because we are behaving like that.

R I think the other thing that I also picked up during formative is the language issue you know in the formative one uhm it is a Tswana patient so the student feel much relaxed interacting with the patient, she knows what to ask and she can explain but coming to, to summative they are forced to speak English and yes we want them to, to relate in English but they are not as comfortable talking to this client who is now the patient in English that they are not used to because let's face it most of our patients are black in the wards and it is just easier for them to speak to the patient or to interact with the patient in the language that they are comfortable with but coming to OSCE I know I mean we have experienced that some terminology or something they just don't know how to ask to ask the patient and it can just be so wrong.

R And in the same uhm client or guide they guide because the client will ask or the learner will ask do you have any questions then the client will ask something that guides any question that eh she sees that she didn't touch some aspects, she will ask so they tend to guide them.

R They ask leading questions.

R Yeah.

I So from what you have been saying, if I take it from the start you have been saying that OSCE is not always so effective in assessing clinical competence but because of time and costs you are forced to use it and you started making suggestions of how the OSCE can be implemented so it can be more effective in assessing clinical competence by saying planning from the start of the year including appointing preceptors, looking at the tool, looking at more real model or a standardised patient. Are there any other suggestions that you would like to add to say how can an OSCE be affective in summative assessment for clinical competence?

R I think it can also be the numbers, the numbers because in the morning if you have ninety four learners and they are supposed to do four procedures, in the morning you might be like awake as an assessor but imagine at eight o'clock at night will you be the very same person that you were in the morning, NO. It is disadvantaging or advantaging some of the learners.

R And even the very learners, you have been waiting since eight o'clock in the morning and you are only going to be assessed at eight o'clock in the evening, and I think this is not right.

R Hmm they are tired.

R It does have a negative effect on them also.

R Or maybe if it can be done in a week, not having a week to do it maybe if it is fourth years we allocate a week for those only because the objective is the same but the scenario's can differ.

R And you know exactly,

R For today yes,

R Procedures you can mix and whatever and you know they can do all seventeen.

R Maybe first years can do that in a week's time then the following week it is second years just like that, not one day for second years because what my colleague said it is true, what they said it is true because from eight up to twenty hours really it is not normal, yes. So if you can maybe allocate a certain period, I am just making an example of the week but if you can allocate e certain period.

R So you do twenty student each day!

R But it comes back to time, where do we get all the time?

R Unless maybe if we try when we are doing this formative ne throughout the year like you said we can just check on what procedure are we going to do summative, then we assess these learners throughout the year and then come with some short things that we can do during OSCE just to add to what they have because really sometimes you will find that we discredit a learner who is very good maar because of some factors that made this learner to fail at the end of the year for summative then we say our learner has failed. Only to find that the student was competent and sometimes maybe with us lecturers we cannot pick up the skill form this learner then we just fail the learner who was supposed to pass that procedure and pass those who have memorised the tool or those who have been favoured by the tool.

R Another thing is that some assessors because they are not subject lecture, they are only looking at what the student is doing and just concentrating on the tool.

R The tool.

Yes the tool, which most of the time had categorise aspects under critical or important. I know only of the critical point because it is life threatening if the student doesn't know that he can fail but you can find that the student can pass those aspects neh critical points because they memorise the critical aspects of the procedures but in actual fact the student cannot perform, you know other things the learner will fail but he will pass the critical point then you will say that the learner is competent.

I So,

R Like one student said to a patient okay I have to ask if you have emptied the bladder because it is a critical point. You know I never even got to the rational items like the blood, even said I am going to ask because it is a critical point.

R That is the first thing they ask because they are too afraid they are going to forget.

R Yes.

R They come in and they don't even greet the patient. So will you say that that learner is competent, no there are so many things that you can check to see if our learner is competent or not.

I So from what you are saying is that the assessment for clinical competence should not only rely on the OSCE but should be throughout.

R Yes throughout, yes.

R You know we, we once had uhm what do you call the outcome based learning we had an uhm ten learners; I want the exact word that we used. Yes I remembered it i.e the pilot group, we had this for outcome based learning, were the learners were not assessed by OSCE for summative but for them to be declared competence was based **continuous assessment** and i think it worked, why it stopped then I don't know because that was also a good way of testing clinical competence.

R Yes because we cannot test, test someone's competencies in ten minutes or whatever.

I So how did that outcome based differ from what you are using now, in what way.

R 10 matriculant students were selected from the group and their were accompanied on continuous bases on all their clinical learning until such time that they book for assessment when they feel they were ready and no marks is allocated only Competent or not Competent and if they are found to b competent in all clinical learning outcomes they will not be exposed to summative OSCE.

R Yeah. So there were no marks allocated for them.

I Okay what I also hear from you is that the lecturer should from the onset of the assessment should have clinical competence in mind when assessing the students or when there is any interaction with the students.

R With the learner yes.

I So everything that you do in **formative assessment in preparing for summative assessment should have clinical competence in mind.**

R Yes because at the end of this summative they can sit down those people who have done the formative and see really is this learner not competent or not, you know

because sometimes I think we are really breaking those who are really very good, because of that small thing that made this learner to fail at the end of the year.

R Hmm.

R You will find really we have failed a learner who is really competent.

I Anything that you would like to add anything that you think we haven't discussed yet?

R I think the number of learners are the biggest challenge But on the other hand with the same breath we are doing the formative with the same number of learners on the real patients, the question is are all learners exposed to all the clinical learning opportunities before doing their summative assessment and this is a dilemma.

I You have mentioned the word dilemma throughout the conversation, can you explain that dilemma.

R It is a dilemma because it is really a lot of students that we have and we don't have time we don't have facilities but in the same breath you do cope with formative assessment and maybe we have to re look and plan correctly for the clinical assessment.s

R Yes.

R I, also wonder whether do we cope with formative assessment, or do we really do the right thing doing summative clinical assessment? Do we go and accompany the learners from the onset and say now they are ready formative assessed in order for them to qualify for summative assessment.. Do we really do it, that's another question, do we cope or do we wait for three months before final exams and then push the students. No. no we rush because I know these are the things that happen and then the other thing is if we say we want to do a continuous assessment if we wanted to be authentic we can also say we wanted to have two lecturers to make sure that it is authentic you know, because it is not going to be authentic if it is only one person so as we go on then we can do it with two lecturers and say this is now the last day that we are going to do this person continuous in the ward on a real patient. But I don't think we are being honest if we say we cope with hundred learners over the year with two lecturers or three lecturers having to accompany them or assess them on Midwifery, General Nursing Science& Ethos & Professional practice all of those, I don't think we are honest if we say we are copying with them. Definitely not.!

R It is true to say we are not coping that is why we need preceptors, we are rally not coping.

R Hmm.

R It is not real what we are doing it is still not real.

I So that is still the reality.

R Yes, hmm.

I Too many learners.

R That is why we need preceptors because they will assist with accompaniment and formative assessment. And at least we will be certain that our students are competent and ready for summative clinical assessment. In this case if OSCE is used it wont be a problem because they could have had extensive accompaniment by the preceptors.

R The lecturer have to go to the practical situation to accompany learners and to come back and prepare for theory. Isn't it with the preceptors the preceptor is always there and with this number of students she will make turns to reach all the learners. For instance if their are meetings that lecturers attend , at least for that day student will be with the preceptor.

R Hmm.

R Then it won't be bad.

R And even the sisters in the ward they don't have time for us to depend on them.

R They don't.

R They don't have time because of shortage of staff.

R So our learners are disadvantaged because I saw how it should have happened and learners from the other institution I won't mention the name but you find they are with the preceptor and she has time with them, she sits down with them she goes through with them she does procedures with them.

R Hmm.

R She assesses them you know she is guiding them throughout.

R And you are lucky with these preceptors,

R Yes it is continuous,

R Hmm.

I Anything from your side Mrs Maruping.

R No I think we are covered, can I make my addition because maybe from what is coming out very clearly, is that there are some factors that are affecting the student clinical competency negatively in general. For example there are those students that will be failed by a tool and in actual fact they are competent and they are denied that opportunity. Others are missed and are said to be competent and where as in actual fact they are not

competent it was just a portion a fraction that was tested in that five minutes and a learner was declared to be competent and facing the reality in the clinical situation the learner will be overwhelmed as it was said and that is where now it is a real case of putting practice. So it is the dilemma but the OSCE for what I can say is effective only when formative assessment is being attended to correctly. Because when you are doing OSCE you are doing it to say the formative is being achieved the competency but the situation we are in you will find the formative is not done so effectively because of the number of students., then we are faced with the summative that is where you cannot rely on the summative as your final to say clinical competency for this learner.

R Yes.

I Thank you so much for your participation, I learnt a lot from his conversation so thanks a lot for that.

R Conversation with a purpose.

I Thank you very much.

THEMES AND SUB - THEMES as agreed with the co- coder.

MAIN THEMES	POSITIVE THEMES	_ NEGATIVE THEMES
<p>Value of OSCE as an assessment method: the OSCE has limited value as summative assessment method for clinical competence, due to:</p> <p><u>Assessor influence:</u></p> <p>Lecturers might be biased towards learner</p> <p>Lecturers might not have depth in the subject being assessed</p> <p>Limited numbers of assessors in relation to large numbers of students</p> <p><u>Theory practice gap:</u></p> <p>Learners are not exposed to all procedures that are assessed</p> <p><u>Instrument:</u></p>	<p>Large number of students can be handled in a short space of time</p> <p>Limited time allocated</p>	<p>Lack of human resources was perceived as a limitation for OSCE as nurse educators have to assist in assessment even if teaching in another year level.</p> <p>Can only test a portion of the skill because of the time factor and number of students</p> <p>Not effective because of the challenges of accompaniment and formative assessment which is sometimes also simulated because of lack of clinical opportunities.</p> <p>Not effective because there are no preceptors and lecturers are involved in both theory and practical accompaniment of student.</p> <p>Assessors allows mistake to occur because ...</p> <p>Minimal stations due to large number of students - explain</p> <p>Moderation of tools problematic if done without taking the teaching and assessment that took place during the year into account</p>

<p>Not possible to assess competence comprehensively</p> <p>Changed during moderation</p> <p><u>Learners:</u></p> <p>Tense about critical points and limited time</p> <p>Memorise tool, focus on passing the OSCE procedure, not on comprehensive nursing care</p> <p><u>“Patient” influence</u></p> <p>Not a real patient, can not assess comprehensively</p> <p>Actors / simulated clients can benefit learner (non-verbally)</p> <p>Intrusive procedures not assessed</p> <p><u>Suggested solutions:</u></p> <p>Thorough planning for comprehensive assessment, including formative and</p>		
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<p>summative assessment</p> <p>Appointment of preceptors to continuously accompany and assess learners in practice</p> <p>Less reliance on summative assessment by means of OSCE to assess clinical competence</p> <p>(And others as indicated in text)</p>		
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<p>ASSESSORS</p>	<p>Objective i.e two examiners and sometimes a moderator</p>	<p>Just guided by the tools and not clear about the guiding principles of OSCE</p> <p>Subjective assessment</p> <p>Less in number in relation to the large number of learners thus influencing objective assessment</p> <p>Prolonged examination because of the large numbers of students leading to assessor fatigue influencing fair assessment</p> <p>Not actual involved in that year level This is mentioned before</p>
<p>NURSING STUDENTS</p>	<p>Master critical skills</p>	<p>Students not sure of themselves and in most cases anxious because its OSCE</p> <p>Memorizing the clinical summative assessment tools</p> <p>Language barriers.</p> <p>The OSCE does not allow for real situations ... Not able to simulate real situation thus resulting in students failing to interact with the patient in a comprehensive manner.</p> <p>Not thoroughly accompanied because of manpower and their large numbers</p>
<p>SIMULATED PATIENT OR CLIENTS</p>	<p>If accurately and extensively trained can be able to act as real patient</p>	<p>Lack training hence affecting learner performance and very difficult to display comprehensive domains i.e</p>

		<p>affective functioning (do you mean if it is a model? Please separate ideas – simulated patient or model?)</p> <p>Responses differ therefore has a negative impact on the results .learners should be able to cope with differing responses.</p> <p>Ask leading questions in order to assist the learner being assessed.</p> <p>Revealing the result to learners because they tend to know what was done wrong because of the duration they stay in that station</p>
<p>ASSESSMENT PROCESS (TOOLS AND PROCEDURES)</p>	<p>Test many outcomes as possible within time frames set</p>	<p>Criteria for evaluation and critical points are not clearly defined</p> <p>Interator reliability not done correctly, leading to ...</p> <p>Tools not tested before assessment</p> <p>Limit the number of procedures to be tested</p> <p>Practicality limited due to (Modern equipment)</p> <p>Scenarios sometimes confusing to learners</p> <p>Procedures fading out in real practice</p>

ADDENDUM F:

FIELD NOTES

Focus group 1

Descriptive Notes:

The nurse educators signed the consent form to participate voluntarily in the focus group interview. The aim of the study and the reason for the focus group was explained to the participants. They were nine (7) in number, and all of them have been involved with the clinical assessment of OSCEs for more than (5) five years. Their age group ranges from 32 to 54 years, teaching different disciplines i.e. General nursing science, Psychiatric nursing science, Midwifery nursing science and Community nursing science. They all appeared professional in their dress code, which displayed the corporate image of their nursing college. They all looked calm and showed signs of willingness to partake in the group focus interview. They maintained eye quite throughout the focus group interview.

Reflective Notes:

The participants were looking forward to this interview, they appeared so energetic even though their “core” function of teaching (theory and practice) was disrupted for about an hour (1 hour). They were involved in the discussions of their perceptions about OSCEs, and they gave each an every participant a chance to voice out her/his perceptions without any form of intimidation. The questions aroused the interest of the participant, as some of them wanted to include other things which were not part of the questions though relevant to OSCEs. At other instances their tones were raised because most of their perceptions cited more of the obstacles than the positives, hence their voices were loud and even stressing issues.

Demographic Notes:

The interview was conducted on the 26 March 2012 at 11H00 in the tea room (nurse educators' tea room), and the notice written ‘silence please’ FOCUS GROUP INTERVIEW in progress was placed on the door. The room was relatively quiet and private as the room's door could be closed, keeping most of the noise from the nurse educators' corridor. The room temperature was moderate and very conducive to allow the deliberations. Chairs in the room could be moved so that they form a circle, which allowed the researcher and the participants to see each other with no obstacles between them. An electricity point was available to plug in the audio tape recorder. The demographic conditions were thus conducive for an interview to take place effectively. One field worker was present to take field notes.

Focus group 2

Descriptive Notes:

The nurse educators signed the consent form to participate voluntarily in the focus group interview. The aim of the study and the reason for the focus group was explained to the participants. They were nine (7) in number, and all of them have been involved with the clinical assessment of OSCEs for more than (7) seven years. Four of the participant were subject matter experts. Their age group ranges from 37 to 53years, teaching different disciplines i.e General nursing science, Psychiatric nursing science, Midwifery nursing science and Community nursing science. They all appeared professional in their dress code, which displayed the corporate image of their nursing college. They all looked calm and showed signs of willingness to partake in the group focus interview. They maintained eye quite throughout the focus group interview.

Reflective Notes:

The participants were looking forward to this interview, even though at the beginning it was though they were in a hurry for another meeting. during the interview they appeared so calm and comfortable, even though their “core” function of teaching (theory and practice)was disrupted for about an hour (1hour) . They were involved in the discussions of their perceptions about OSCEs, and they gave each an every participant a chance to voice out her /his perceptions without any form of intimidation. The participants perceptions was mostly positive about OSCEs as clinical assessment for competence. They answered in warm tone of voices and they were willing to share their perceptions in depth.

Demographic Notes

The e interview was conducted on the 28 May 2012 at 13H30 in the boardroom. The boardroom was relatively quiet and private as the room's door could be closed and it is situated far from all other offices. It was not even necessary to write a "silence board", but we did that in order avoid any form of disturbances. The room temperature was moderate with the heater on, and very conducive to allow the deliberations. Chairs in the boardroom and table were arranged in such a manner that it facilitated the discussions and for the assistance who was taking the field notes was more convenient for taking notes. An electricity point was available to plug in the audio tape recorder. The demographic conditions were thus conducive for an interview to take place effectively.