EXAMINATION ASSESSMENT

This is a summary: the full paper can be accessed at nursingtimes.net

AUTHOR Dawn Brookes, MA Ed, BA, RGN, is community matron, Derbyshire County PCT.


This article considers the use of Objective Structured Clinical Examination (OSCE) nurse-prescribing courses and sets out an evaluation of the system in place at the time of the author’s involvement in OSCE assessment. OSCEs are re-marked using videos and the differences that occur are discussed. As a result of this appraisal recommendations were made, some of which were taken up by the course team.

While doing a master’s degree in education, I was involved in assessing the extended and supplementary prescribing course for nurses, midwives and health visitors. The nurse groups involved included practice nurses, district nurses, nurse practitioners, specialist nurses and family planning nurses. There were 14 students in total who were studying at academic level 3 (degree level). I was involved in assessing the extended and supplementary prescribing course for nurses, midwives and health visitors. The nurse groups involved included practice nurses, district nurses, nurse practitioners, specialist nurses and family planning nurses.

There were 14 students in total who were studying at academic level 3 (degree level). I was involved in assessing the extended and supplementary prescribing course for nurses, midwives and health visitors. The nurse groups involved included practice nurses, district nurses, nurse practitioners, specialist nurses and family planning nurses. There were 14 students in total who were studying at academic level 3 (degree level). I was involved in assessing the extended and supplementary prescribing course for nurses, midwives and health visitors. The nurse groups involved included practice nurses, district nurses, nurse practitioners, specialist nurses and family planning nurses.

Traditionally, the assessment requires that students rotate through simulated professional tasks set up as ‘stations’. The students stay at each station for a set period of time and then move on. They are usually marked via a detailed checklist marking schedule, which is given to the assessor.

AIM AND METHOD

The aim was to establish how students responded to OSCE and to examine the internal and external validity of the process. Evaluation involved my completing the following stages:

1. Assessing and marking a mock OSCE;
2. Reflecting on the process;
3. Re-examining the OSCE using videos and comparing the results;
4. Making recommendations to the course team.

For the assessment at the university where I worked, two stations were used. The course team decided on two in-depth, simulated consultations as opposed to lots of different stations, due to the nature of nursing and the way nurses carry out consultations. The simulated OSCEs used were for 15 minutes. In practice, consultations are shorter for practice nurses and longer for specialist nurses, district nurses and community matrons.

A mock OSCE is commonly used by many universities to prepare students for their final examination. It also introduces the process to those who have not experienced this form of assessment before. Many universities video the assessment as well as having examiners present. Where this evaluation took place one examiner was present and videoing. The videos were used as a teaching tool to help students highlight areas they might need to work on and, because of the nature of the assessment, they helped resolve any discrepancies. The students are allowed two attempts at the final OSCE, in keeping with most university policies.

As the OSCEs used by most – if not all – universities involve simulated consultations, patients are not put at risk. If the practice supervisor considered a student ‘unsafe’, she or he would not be able to qualify.

There was no second marking of OSCEs at the time of this evaluation. External moderation of some of the finals was done by an external examiner who has access to the marking schedule and videos.

RESULTS

I was given an OSCE scenario and marking schedule. There were two stations – one relating to hay fever and the other to chest symptoms. I was assessing the latter station, the aim being to test history-taking and consultation technique giving special regard to negotiation skills. The student was given a brief and drama students (also given a brief) acted as patients.

On being given the morning timetable, the first thing I noticed was there was no break scheduled and that the assessment process would take three hours for 13 students. Each OSCE was timetabled for 15 minutes with no time allotted to make comments on the marking schedule, which was to be marked during the process. Research has demonstrated that concentration wavers after 30–60 minutes. This can be longer in older people but three hours’ intense concentration is very difficult.

Each student had to pass 10 areas. No marks or percentages are allocated to the individual areas, only pass, borderline or fail. The results showed many of the students achieved borderline passes in a number of the areas. Some only failed in one area. The
This form of assessment was pioneered by the medical profession. It has since been adopted by other professions, including occupational therapy, physiotherapy, radiotherapy and, more recently, nursing. The process has been positively evaluated by students (Anderson and Stickley, 2002).

The validity, however, is dependent on the quality of the problems presented at each station as well as on the design of the assessment schedule (Nicol and Freeth, 1998). Continuous assessment has been criticised due to shorter practice and hospital placements; other forms of assessment are being considered following the nursing Fitness for Practice document issued by the UKCC (now the NMC) (UKCC, 1999).

My concern was that it did not appear to matter how many borderlines are obtained – these constitute a pass. It was not obvious what the point of giving the borderline score was or whether giving a particular number of borderlines would constitute a fail.

REFLECTIONS ON THE PROCESS

- The majority of students were extremely nervous;
- The assessment process was taxing and it was difficult to mark it properly in the time allotted;
- Drama students were new to the process and made some mistakes, thereby making it easier for some nursing students and harder for others;
- The majority of candidates responded to what they saw in front of them (an 18-year-old), instead of what they read on the card (date of birth: 12 March 1936). This may have influenced their decision-making;
- Roughly half of students did not follow a consultation structure and so did not extract the information they needed. Those who did follow a structure gained more information;
- Only two or three students were proficient at performing a chest examination;
- None of the students were familiar with the formulary used for nurse prescribing;
- The majority (11/13) of students were used to having information at their fingertips by way of a computer. The two who usually worked in patients’ homes were more at ease with asking the patient for information.

Many of the findings from the assessment of the OSCE relate to adult learning theory – for a discussion on this and taxonomies of learning see nursingtimes.net.

Marking schedule

The marking schedule was not standardised and doing this may be difficult. Three columns are included (pass, borderline, fail) with 10 areas to be assessed in this way. I followed the criteria strictly and ticked what I considered to be the appropriate boxes – as such, the majority of students would fail.

It was not clear whether ticking one fail box meant failing the OSCE or whether ticking a majority of borderline boxes would also mean a fail. Following the assessment this was discussed with the course leader but there did not seem to be any real clarity over what constituted a fail. It seemed that other examiners tick the pass boxes in the main, perhaps to avoid this uncertainty.

Ticking a fail box does indicate a fail but there is no agreed pass percentage. So what does ‘borderline’ constitute?

Another area of some concern was that I felt rushed. As a result I could not be certain that the marking was absolutely correct. This was discussed with the other examiner who agreed that the process is rather hurried due to the rapid turnover of students from one station to the next. Unhappy with this, I decided to carry out an exercise for my personal development, which was to re-mark the OSCEs using the videos. For tables showing the results of video marking in full and comparisons with the original marking see nursingtimes.net.

Five students fared better following the video marking and two fared worse. Had this assessment been video marked the discrepancies would not have occurred and, with two video markers, the increased scrutiny would have added further validity. The video marking was more objective than marking see nursingtimes.net.

CONCLUSION

Since carrying out this exercise and as a result of the recommendations, video marking has been introduced for both mock and final OSCE assessments. The camera is set up before the start of the OSCE and no assessor is present. The videos are later marked by two members of the course team, which has improved validity and reliability of the results.

Both students and assessors find the process less stressful and it has reduced the labour intensity of OSCE marking. Other recommendations are being considered and the OSCE examination is being reviewed on an ongoing basis.