35TH INTERNATIONAL ASSOCIATION FOR EDUCATIONAL ASSESSMENT ANNUAL CONFERENCE
ASSESSMENT FOR A CREATIVE WORLD
September, 13th – 18th, 2009 – Brisbane, Australia

EVALUATION FOR THE APPRENTICESHIP IN CLINICAL TEACHING OF NURSING

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Introduction

The teaching of Nursing in Portugal has undergone profound changes in the last 25 years. These changes have as consequence a quality improvement and the acquisition of a larger number of skills by students.

Over the years and with the definition of new goals aiming to meet the needs of our days, it is a general objective commonly accepted that nursing schools aim the formation of "reflective nurses with technical, scientific and relational skills, able to meet the needs of individuals and communities, in the scope of human development" (Carvalho, 2002: 146.147). Thus, it is due to nursing schools to adopt attitudes that allow their students and teachers to achieve the ability to face situations of uncertainty, instability, complexity, which require more effective and appropriated answers.

The stake on a model which promotes a professional with the above competences presupposes adopting the principle that learning true knowledge – action knowledge - is the result of personal elaboration. This kind of knowledge is the result of an internal thinking process throughout the individual coordinates different concepts, giving a meaning, organizing and linking them with previous knowledge (Sastre, 1997). Therefore it is expected that the process of learning how to become nurse constantly asks for reflection and for the use of metacognitive mechanisms, searching for more adequate answers to each single situation. The critical attitude

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used to teach these assumptions is the same that constantly questions the concepts that we nowadays assume as the most correct. This paradox results from the search of more adequate concepts that will be the stakeholders of the future's knowledge and action.

The concepts of this type of learning "are fundamental to an education that must be addressed to help the students learning to learn" (Pozo, 1999:16), raising professionals that seek for answers criticising themselves Professionals that become more flexible, effective and autonomous, rebuilding learning of all that is conceived as experience "and not only knowledge or specific knowledge that are not long-lasting" (*idem*).

The teaching of nursing in Portugal is characterized by two quite different moments of learning, that are complementary and inter-structured not only at the semantic level, but also at the empirical and cognitive levels to. Thus, the Nursing degree is divided into two different cycles of training. The first cycle is dedicated to theoretical, theoretical/practical and practical teaching, and take place within the institution of superior education. This training is taught in classes aiming to develop expertise in theoretical, theoretical/practical or practical knowledge within a controlled environment such as the classroom. In the second cycle, "clinical teaching", training is provided in clinical contexts and through *practicum* periods, aiming to train students in clinical and community environment (Freitas, 2007). The clinical training is often defined as training in nursing care for which the student, part of a team, and in direct contact with healthy or sick individuals and/or the community learn how to plan, to evaluate and to provide global nursing care, on the basis of previous knowledge and skills.

The acceptation of such a learning conception, as described above, presents different stages if developed at the theoretical or clinical training level. At the theoretical level the self-regulation and continuous reflection about the produced knowledge is constructed almost strictly at the cognitive and/or abstract scale. This construction is as good as its own regulation trough the relation established with other reference knowledge. At the clinical training level the reflection on the practice and the interaction with the environment oblige the individual to apply theoretical, practical and experimental knowledge. This knowledge materialises, consolidates and transforms gaining new meanings in the reality in which are developed and to the individual that integrates and uses them.

So, the nursing learning (theoretical and clinical) is based, fertilized and restructured in straight relation with the opportunities that clinical experiences provide to be understood through different theoretical frameworks. Therefore, cognitive conceptions assume personal meanings when applied and reflected in and on the practice.

The relevance of a new evaluation model to clinical learning

The in so far considerations, impelled us to think about a new evaluation model for clinical learning. It is aimed a new evaluation model able to produce a critical judgement about a certain training situation and, at the same time, that it's application constitutes a learning process and helps to discover new paths in evaluation which may lead us to learning self-regulation.

This new evaluation model necessary breaks with the principles of a traditional evaluation, implementing "evaluation dynamics that stress the duration over an ex-post moment" (Estrela and Nóvoa, 1993: 11). The evaluation must abandon the idea of "judging or proving whatever. Rather, evaluation should concerns with action and, in this sense, should be closely linked with the decision-making process" (*ibidem*). Thus, according to the authors, the decision-making process must be conceived not as the result of a macro-evaluation that judges an it is external to the real, but, instead, should be based in articulation of micro-evaluations that nourish and refocus the processes of change.

Likewise, the evaluation in clinical learning is intended to be wider than just to evaluate in a restrict sense. In this line of thought, it is intended not only an holistic evaluation but also an evaluation for understanding. This kind of evaluation emerges from the concepts of "evaluate to teach" and "teach to understand" of Perkins and Unger (2000). According to these authors, when we desire learning to be founded in constructive assumptions, involving reflection, it is absolutely necessary to know deeply the functionality of phenomenon more than just recognise them.

The way we look at evaluation designs it as a way of orienting and supporting the knowledge construction, a logical and expected result of an evaluation continuous. As well, the way we look at evaluation as an element of demystified judgement and analysis, avoiding power abuses, but using different perspectives in order to reduce arbitrary, increases its justice and confidence of the student in himself and in the training system.

Bringing these concepts for evaluation of clinical learning, Carvalho (2002:148-149) presents some basic ground rules for the processes of evaluation, that we would like to outline and comment now:

1. ***The permanent and conscious involvement of the student, throughout the evaluation process***

It is for us the most important principle in the course of the entire clinical learning, because it has the potential to guide the student in understanding the phenomena (allowing them to define strategies to optimize work and performance). However this principle is the main cause of dissatisfaction and uncertainty and can lead the student to take on strategies of errors and weaknesses concealment, as they are not implicated in their own process of evaluation and learning regulation. We defend that the student implication needs necessary to overcome the limits of self-evaluation as a pedagogical formality that takes place at the end of a training cycle. When self-evaluation is a mere formality it is not valuable to the teacher, does not provides the student development, given that this moment of self-evaluation is not followed by the possibility of reformulation and improvement. So, we think that a continuous process of evaluation of the difficulties encountered and progress made should be instituted.

2. ***The implementation of measures to promote reflection***

In accordance with the implication of students in the evaluation process moments of reflection should be created to provide behaviour changes and attitudes adjustment in order to optimize a critical and conscious performance to promote changes and the continuous construction, preparing students for professional life. In order to encourage this reflection it is recommended to develop learning diaries. It's a record made by the student, about their activities according with a reflexive and critical perspective aiming for their future improvement and aiming the understanding of skills required by those activities. The learning diary is essential for a metacognitive learning but only if it meets the requirements for which it was created: the simple description of activities without a critical reflection by the student, or its use as a justification for the attribution of a mark or even as a way to select students, makes the diary worthless and frustrating for students and useless as a way of establishing a mediation between teaching and learning.

3. *Teachers and students assumption of evaluation subjectivity in clinical learning*

In this kind of training the observation is the main instrument of data collection and a fundamental tool in which evaluation draws upon. Thus, it is useless and short-minded to insist in objectifying results, to the point of trying to quantify and express the difference among students. One of the major ideas of our work is centred in this principle. Following Carvalho (2002: 460) "if we intend a nurse with relevant scientific, technical, relational and cultural skills, able to assume a reflective and appropriate position, adequate to a changing society requirements, a nurse as a progress agent bio-psycho-socio-cultural, then it is necessary a training philosophy that allows to achieve this goal". Therefore the no assumption of subjectivities, either by the student as critical, singular and creative element, whether by the teacher as evaluator not omnipresent and with self-judgements referred to its own principles and values, results in a profound inconsistency considering a constructivist teaching approach.

The acceptation of evaluation subjectivity in clinical learning means taking a new step in the pedagogical training of nurses, as its values the learning and the its personal construction, while integrating the teacher as evaluator (for purposes of construction) and not as a classifier (or selector).

Furthermore, to assume subjectivity brings the possibility to give alternative responses instead of just judging what it is right or wrong. Thus, the student is encouraged to find more and more certain and adequate answers, without the necessity to hide behind its fragilities camouflage to guarantee its grade. The overall objective would be to improve the capacities and skills of each one and not only to seek for a correct model to whom that everybody has to compare.

4. *The objectives of each clinical learning should be discussed in groups before learning activities*

The previous definition of general and specific objectives should be discussed by all elements in a participatory and active way. This previous discussion shall result in the awareness, in each one involved, about the path they have to cover and about the general parameters that will be focused in the evaluation. This definition does not limit learning, but intends to lead it, being one of the key elements of formative evaluations that will occur during all clinical learning.

5. The achievement of the evaluation criteria

We believe that this is one important point throughout the evaluation process, mainly when there is little time to carry out formative evaluations throughout the pathway. It is extremely important that students and evaluators share "the same language", have the same references to observe a specific phenomenon, thus extending the debate, the exploitation of ideas, the reflection about the activity and arguing about decisions to be made. The definition of these criteria can ensure the progress of students as well as a larger reliability on evaluation by the evaluator. The definition of criteria allows to control in a more efficient way the personal subjectivity that is responsible for evaluation criteria variation and its importance degree according to each evaluator. Thus, we believe that the anxiety inherent to clinical learning evaluation would decrease, leading to the strengthening of the teacher/student relation and to a consequent reduction of the use of concealment strategies by the students, which hinder the student development of its learning. It is important to remember that the keynote is not the criteria for evaluation, but the acquired learning.

6. The explanation of the process

As Carvalho (2002: 149) stresses, "after the definition of objectives and evaluation criteria, the next procedure should be the result of a compromise between all concerned in evaluation". Perrenoud (1995:138) argues that, commonly, evaluation is not a collection of information on an inert object, but a tactical game between players whose interests are opposite: the teacher wants to judge the student judging its true value and the student attempts to pervert the situation in his benefit, trying to hide his shortcomings" (Perrenoud, 1995). But this game - that will ever last - must be as transparent and honest as possible in clinical learning. In this learning setting the study object is human life, that deserves the best care. On the other hand, we search to achieve the largest level of competence and autonomy possible for nursing students, which can only be ensured if the teacher and the student meet together, playing in the same team and not on opposing teams.

7. Make frequent evaluations

Perrenoud argues that evaluation only is formative if it "results in a form of regulation of the action of teaching or learning" (Perrenoud, 1993: 177), making

"available to the teacher more precise information, more quality information on the learning processes, attitudes and all that students have acquired" (*Idem*, 178). Continued use of this type of evaluation allows the correction of errors, the reorientation of paths to cover, the reflection, the constant repositioning of the student in the three worlds – clinical, school and professional - and early detection of problems of personal and group understanding.

8. Multiplicity of information

The evaluation process of clinical learning is multifocal, multi-procedural, multidisciplinary and multi-contextual. Thus, the amount of information that can and should arise from this set of factors should be as broad and inclusive as possible so that the permanent and final evaluation can be the most correct and fair.

We believe, therefore, that the adoption of an evaluation in clinical training that takes account of these eight ground rules will lead to a reflexive learning, constructivist, critical, and adequate to school and society necessities, as well as the nurses' training according the profile defined by the teaching institution. Fundamentally, it is intended that these ground rules contribute to make pupils feel more prepared and fulfilled, hence they dominate their own training and evaluation process.

Putting in action the principles of evaluation for learning

Based on the above mentioned ground rules, we try to develop a set of methods and strategies to apply in clinical training, designed to achieve a double objective:

- Foster an evaluative attitude that integrates, adapts and is able to understand the development of students in different fields of learning;
- Develop an evaluative set of tools for learning in clinical environment.

Thus, we developed a set of assumptions that are not intended to be rigid and unchangeable, but, otherwise, as pillars on which the actors in clinical training support their action, learning and consequent evaluation. These assumptions, more than a disjointed set of strategies or procedures, will be helpful as an evaluative tool for learning if articulated with each other and collectively reflected by each one of the

actors in clinical learning. We agree that knowledge construction is a singular task, produced in accordance to lived and internalized life experiences by each individual, but we want to stress that sharing and discussion, with and to one another, that new knowledge is grounded and reconstructed.

Therefore, the evaluation model we propose is based on:

- **Principle**: An evaluation concerned with learning should enhance the process and product and constitute a structuring and unifying strategy.

Strategy: From the beginning the clinical training evaluation should move away from the final act of grading students. In this sense, evaluation should be entirely reflective, adopting a concern with learning, the exaltation of the process and knowledge acquisition. The acquittal of the punitive aspect, aggregate to the act of making mistakes, or simply to express reasoning/opinions wrong or incorrect, will necessarily be demystified and contradicted. The more solid and lasting learning is constructed by reflection about the error. It is necessary that executing tasks by imitation, the monotony and stagnation of procedural thinking will be replaced by the freedom to think, create and rebuild creatively.

- **Principle**: The evaluation process should enhance all participants. The participation of all social actors (teachers, students and tutors) is essential.

Strategy: Shared-group reflection and discussion sessions, where all participants take part in clinical learning and must give their opinions or to submit their ideas on specific topics, such as the presentation and exploration of clinical case studies, exploration of methods and strategies of intervention, sharing problems, teamwork and scaffolding methods, etc…

- **Principle**: The progress must be balanced and planned.

Strategy: The preparation of clinical learning should be anticipated by the participation of all actors implicated in order to: to define general principles of action, to structure general and specific objectives taking into account the characteristics of the group and the context of clinical learning, to discuss the different stages of learning in clinical training, etc;

- **Principle**: The evaluation criteria must be relevant, clear and open;

Strategy: All those involved in clinical training (specially students) should know and intervene in the design, development and reflection of the different moments of evaluation. Only accepting the evaluation as a process of themselves, built by themselves and for themselves, the students can work it out and use it as a resource for learning.

- **Principle**: The evaluation process should provide frequent moments of evaluation, but in a more informal way;

Strategy: There should happen several evaluation moments; all actors in clinical learning must be aware of the continuous characteristic of evaluation. Evaluation has multiple faces: diagnostic, formative (centred in the teacher or centred in students' autonomy) and summative, but the most important actor in all this kinds of evaluation is the student and, therefore, he should have a central role in all process.

- **Principle**: Multiple sources should be used to enable all participants to identify the aspects to learn and already learned.

Strategy: It should be encouraged the search for information through a set of tools for data collection and analysis. The direct observation by the evaluator and benchmarking the quality of written work produced during the clinical learning must be added to other techniques such as interviews (much look a like mirroring technique), learning diaries and discussion groups. This set of tools encourage both the learning (by the exchange of views and justification for clinical decisions) and contribute to better understanding the abilities of each student by himself, by the group and by the evaluator. In one of the most complex training contexts imaginable, these procedures reduce the scarcity of data to support evaluation.

- **Principle**: Evaluation for learning should be based on qualitative grounds, which takes the subjectivity as cause and consequence of choices made.

Strategy: The evaluation in clinical learning can not be separate from training processes upon which relies and reflects. At the same time, the legal imposition of

classifying quantitatively all students in clinical learning should not reduce the complexity inherent in the therapeutic gesture, attitude or posture. Thus, the teacher, as all group members, should assume their own subjectivity to the group. All group members have the same information, based upon the data collected by the various tools mentioned above, and all group members can appeal the inter-subjectivity to reach a more consensual and fair judgement (Terrasêca, 2002).

Finally, and without the intention of translating into a single number the pathway of nursing students in clinical learning, the final classification, legally imposed to be quantitative, should be the transposition result of the referred qualitative principles to a numeric scale. It is the teacher responsibility to make this transposition in the basis of the assumptions above mentioned, and which we can summarize: a) development of an evaluation model stressing learning processes; b) implementation of monitoring and tutoring processes to enable reflection on learning and its intimate articulation with evaluation; c) development of a set of evaluation tools allowing to understand the complexity of the clinical learning process.

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