A STANDARDIZED CLINICAL GRADING RUBRIC

MARY LOU KOPP PHD, RN, CHPN, CNE

CONCORDIA UNIVERSITY WISCONSIN
School of NURSING

CHALLENGES: CLINICAL PERFORMANCE EVALUATION

- Great Rewards!
- Subjective Nature (Helminen et al, 2016)
  - *Multiple Evaluators, Clinical Sites, & Experiences*
  - *Trying to be fair*
- NLN Nurse Educator Competency III
  - *Use Assessment and Evaluating Strategies*
- SAFETY is vital (QSEN)
- Letter Grade vs. Pass/Fail

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CLINICAL EXPECTATIONS

- Novice to Less Novice:
  - Improvement Over Time (DeBrew & Lewallwen, 2014)
- Performance vs. Written Work (Bonnel, 2016; O'Connor, 2015, Helminen et al, 2016; Terry, 2017)
  - Preferred Multiple-method Evaluation Approach
    - Unobserved Moments
    - Affective Learning
    - Problem Analysis
    - Clinical Judgment

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CHALLENGES: SYLLABUS VS. CRITERION-BASED BEHAVIORAL OBJECTIVES

Noticing deviations	- Noticing high temperature and fever-related symptoms, i.e., high temperature more than 38.3°C, dried oral membrane, depressed anterior fontanel. - When noticing high temperature, further assessment of fever-related symptoms. - Noticing the stage of fever as well as high temperature, i.e., saying that "The patient is in the chilling stage."	- Noticing high temperature and fever-related symptoms, i.e., high temperature more than 38.3°C, dried oral membrane, depressed anterior fontanel. - When noticing high temperature, further assessment of fever-related symptoms.	- Noticing high temperature but showing frustration or hesitation of the further assessment.	- No noticing high temperature when assessment of temperature (with febrile patient).

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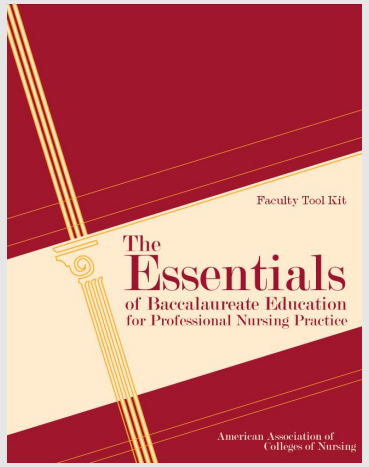
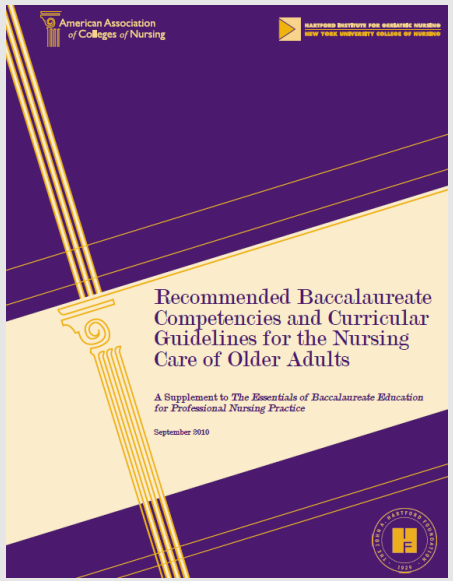
RUBRIC DEVELOPMENT HISTORY

- Request of Students & Instructors
- Extensive Literature Review
  - Almost 3 decades
- Input of 23 Clinical Instructors
  - From 2010 to 2015
- Gerontological Nursing Experience
  - Criterion-Specific Subscales
  - **Critical Indicators =** SAFE





ConsultGeri
a clinical website of The Hartford Institute for Geriatric Nursing

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RUBRIC DEVELOPMENT HISTORY

- Specific Criterion Behavioral Objectives

(Bofinger & Rizk, 2006; Bourbonnais et al, 2008; Clark, 2006; Heaslip & Scammel, 2012; Isaacson & Stacey, 2009; Killam et al, 2010; Lasater, 2007; Seldomridge & Walsh, 2006).

  - Difficult to Level each
- First Clinical Experience
  - 60% of final grade
  - 40% written work

A B C D

EXEMPLARY : ACCOMPLISHED : BEGINNING : UNSAFE

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EXEMPLARY- A	ACCOMPLISHED - B	BEGINNING - C	UNSAFE - D
A1. Performs safely and accurately each time behavior is observed	**B1.** Performs safely and accurately each time behavior is observed	**C1.** Performs safely and accurately with close supervision	**D1.** Performs in an unsafe manner, or unable to demonstrate appropriate behavior
A2. Never requires supportive cues	**B2.** Occasionally requires supportive cues	**C2.** Frequently requires supportive cues	**D2.** Requires continuous supportive and directive cues
A3. Always demonstrates coordination	**B3.** Demonstrates coordination most of the time	**C3.** Occasionally demonstrates coordination	**D3.** Consistently lacks coordination; Attempts behavior, yet unable to complete
A4. Always utilizes time on activities efficiently	**B4.** Spends reasonable time on activities. Able to complete behavior	**C4.** Takes longer than reasonable time to complete activities	**D4.** Performs activities with considerable delay; activities are disrupted or omitted
A5. Always appears relaxed and confident. Demeanor consistently puts patients or families at ease	**B5.** Usually appears relaxed and confident. Occasionally anxious but does not interfere with skills. Patient/family do not question or feel uneasy	**C5.** Anxiety occasionally interferes with ability to perform skills; results in questioning or uneasiness in patient/ family	**D5.** Anxiety interferes with ability to perform skills; results in questioning or uneasiness in patient/family
A6. Applies theoretical knowledge accurately each time while demonstrating critical thinking (making decisions based on client's assessment data)	**B6.** Applies theoretical knowledge accurately with occasional cues	**C6.** Identifies principles of theoretical knowledge, but needs direction to identify application	**D6.** Applies theoretical knowledge principles inappropriately
A7. Consistently focuses on client during skills without cues	**B7.** Focuses on client initially without cues, as complexity increases, focuses on skills	**C7.** Focuses on client initially with cues, as complexity increases, focuses on skills	**D7.** Focuses on activities or own behaviors, not on client

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CRITERION-REFERENCED BEHAVIOR OBJECTIVE SUBSCALE

PO: Demonstrate knowledge of healthcare policy, finance, and regulatory environments.	**RUBRIC ROWS**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. Recognizes and respects the geriatric patients' increased health care complexity as evidenced by clinical preparation (assessing payment source & correlating medical diagnosis in concept map), and comparing nursing & resident-directed care models in pre/post-conference discussions, and/or personal reflections.		X	X				X	X
2. Seeks appropriate level of supervision prior to performing skills & interventions.		X	X		X	X	X	X
3. Recognizes and complies with skilled nursing facility resident rights		X	X			X	X	X

RELIABILITY ASSESSMENT

- Internal Consistency: Congruence of Instrument Concepts
- Rare in the literature
  - Usually assessed for simulation evaluation tools
    - Inter-rater
    - Test-Retest
- One-test Administration
  - Subscale coefficient equivalence reliability (Devon et al, 2007)

HYPOTHESES

1. A reliable assessment method will detect increased scores from midterm to final evaluation
2. A reliable assessment method will detect no correlation between written assignment scores and clinical performance scores.

METHOD

- Several Criterion-Referenced Behavioral Objectives
- ASSESSMENT of the Clinical Performance Grading Rubric
- First semester undergraduate BSN students: 58
- Seven clinical instructors : Nine clinical sites
- Expedited institutional review board approval
  - Students informed of purpose, voluntary nature
  - De-Identified data

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ANALYSIS

- SPSS version 24 with significance level set at $p<.05$

Compared Midterm & Final Performance scores

- Means scores of Nine Subscales

→ ANOVA

Compared Performance scores (rubric) & Written work

→ Independent sample *t*-tests
Pearson Correlation

Cronbach's alpha

RESULTS

- Difference between Midterm & Final Performance Evaluations:
  - (*M* =.89) and overall final performance evaluations (*M* = .94) (t(57) = -15.896

    ***p* <.001 (two tailed)**
- No correlation between Written work & Performance Evals:
  - (*r*56) = .164, ***p* =>.05**
- Difference between Written work (*M* =.973) & Performance Evals: *(M =.915)*
  - *t(114) = 14.536,* ***p = <.001***
- Over-all Cronbach's alpha = **.917**

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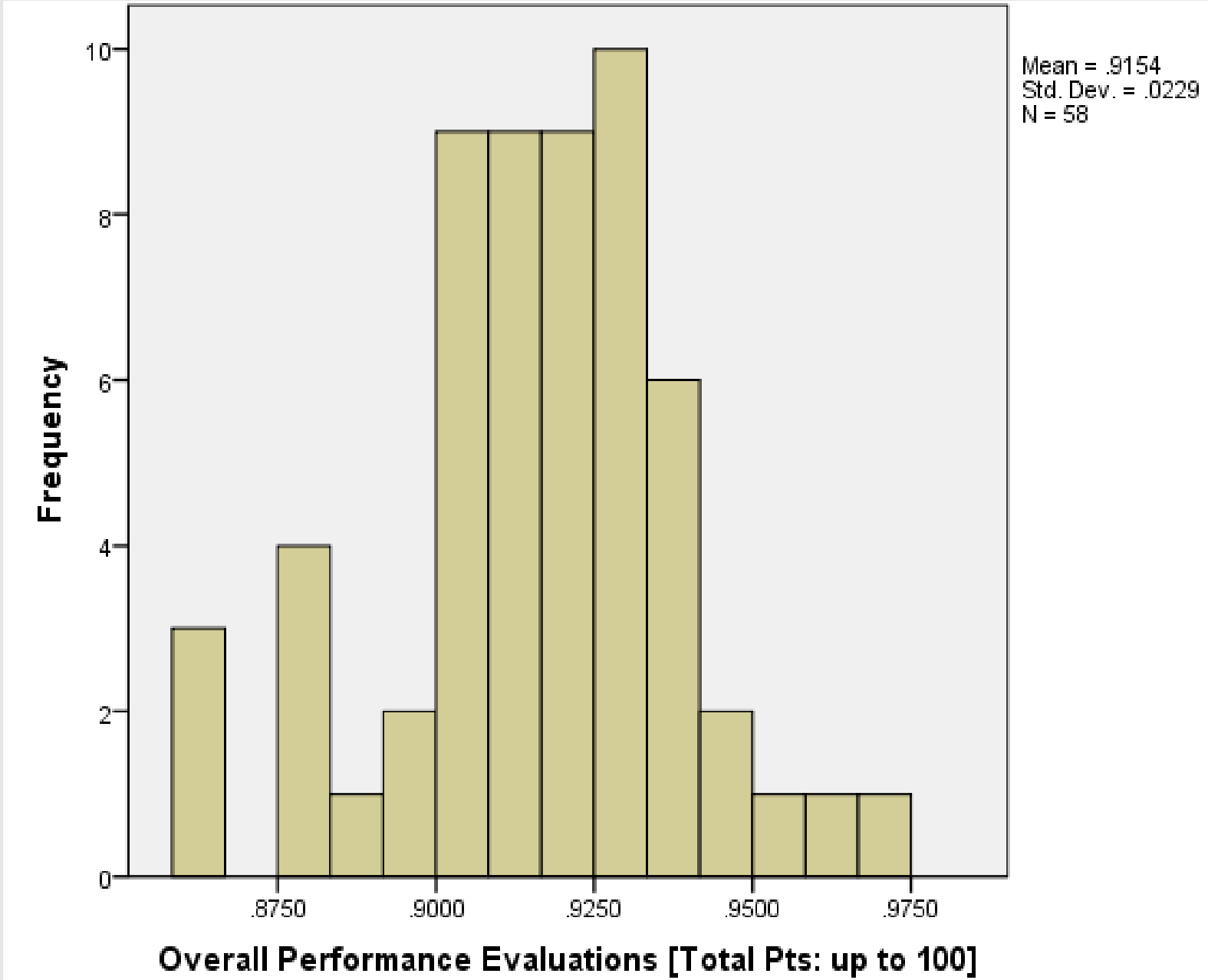
RUBRIC FINAL SCORES



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LIMITATIONS

- Convenience sample of 58
  - Slightly small Effect Size *(d=.262)*
  - Need 92 students to obtain a power of .80
- One cohort: One school: One clinical setting
- No Inter-rater reliability
- Potential grade inflation
  - Critical Indicator expectation of Accomplished (B)

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CONCLUSIONS

- Integrate Educational Pedagogy with Clinical evaluation
  - Separate grading rubric from clinically-specific expectations
- Clinical Instructors Require Guidance
- Fair Grading can Equate to Consistency and Reliability
- Critical Indicators help Identify Safe Practitioners
  - Supporting pass/fail and letter-grade policies
- Needs Replication
  - Future cohorts; Multiple schools; Multiple clinical environments

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THANK YOU!

Mary Lou Kopp PhD, RN, CHPN, CNE

Associate professor School of Nursing

Concordia University Wisconsin

12800 North Lake Shore Drive

Mequon, WI 53097

262-243-4314

Marylou.kopp@cuw.edu