criteria for developing clinical performance evaluation

Carrie B. Lenburg
CRITERIA FOR DEVELOPING
CLINICAL PERFORMANCE EVALUATION

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CRITERIA FOR DEVELOPING CLINICAL PERFORMANCE EVALUATION

There is a growing interest in performance examination in all sections of the country and in all types of nursing education programs. In fact, the interest is far from limited to nursing. Programs in dentistry and dental assisting, respiratory therapy, radiological technology, medical technology, and some other health care disciplines are known to be searching for objective ways to measure the clinical competence of their students and graduates.

I believe this interest is a logical and natural outgrowth of some rather remarkable changes that have been taking place over the past decade or so. Some more notable changes include the following:

1. The trend of experienced and mature adults seeking a college education either for their first degree or for a mid-career change of direction;
2. The trend of offering more flexible and individual methods of learning or satisfying degree requirements;
3. The trend of awarding college credit for learning that was acquired elsewhere, especially based on proficiency examinations;
4. The rapid expansion of knowledge and technology and the concomitant obsolescence of basic preparation;
5. The increasing concern for developing ways to measure the quality of performance of workers, whether they're physicians, nurses, teachers, or auto mechanics.

All of these, along with others not mentioned, are closely interrelated parts of a complex matrix of changes within society and the nursing profession.

There is a growing awareness that the competencies of the graduate, or
the outcomes of the educational experience, should be a tangible evidence of learning, and that they should be measured in a systematic and objective fashion. Therefore, educators in nursing, as well as in many other fields of study, are focusing attention on determining the specific competencies to be measured and the methods to be used in evaluating them. Clarification of these two basic points allows the learning experience to become more individualized and less restricted by the time and space dimensions of academic traditions. The responsibility for learning is placed squarely on the learner.

These notions clearly call for a reassessment of the teacher's role, the teaching-learning process, and the meaning of an education. The central emerging theme is evaluation of competencies, achieved through the learning process; central to this overall evaluation is the objective examination of clinical performance abilities.

All of these factors have contributed to the growing interest in the development of performance evaluation instruments and methods. The New York Regents External Degree Program in Nursing is one example of work being done in this area. Primarily based on my experience with this program, I would like to offer a summary of considerations related to the development and implementation of performance evaluation, and from that experience to draw some general conclusions and evolve criteria that might be helpful to those interested in the same complex endeavor. But first I think a concise review of key aspects of this program should be made.

(Complete details about the External Degree in Nursing are described in Open Learning and Career Mobility in Nursing. Details also may be found in an article in Nursing Outlook.)

DEVELOPMENT OF REGENTS EXTERNAL DEGREE PROGRAM

The New York Regents External Degree Programs were initiated in New York in 1970, and since then seven different degree options have been completely developed, including the AA, AS, BA, BS, BSBA, and the associate degree in nursing. This last offers either an AS or AAS degree in nursing, depending on the general education component. The BS in nursing external degree is currently being developed; we expect to open BSN enrollments in April [1976].

These external degree programs differ from traditional degree programs in that they are noninstructional and based entirely on assessment of learning rather than on a structured sequence of courses. In fact, the very

meaning of external degree as used by the New York programs is that a degree is awarded by one agency or institution, based on learning acquired elsewhere. The learning is external to the agency awarding the degree. The University of London, which served as a model for the New York program, has had such a program for more than 135 years. Encouraged by the New York program, institutions in other states are beginning to offer similar opportunities (for example, Edison College in New Jersey and the Board for State Academic Awards in Connecticut).

The nursing program, now fully accredited by NLN and the New York State Education Department, operates through an Overall Faculty Committee which established the philosophy and objectives, degree requirements, and the content to be learned, and determined the acceptable methods candidates may use to demonstrate achievement of both nursing and general education requirements. Emphasis is placed entirely on assessment of learning both in transcript evaluation and examination results. How, where, and when learning takes place is the responsibility of the learner and is dictated by such factors as prior learning and experience, motivation, current life circumstances, learning style, and preference.

While there are no entrance requirements, rigid exit requirements must be met before candidates are awarded the degree. However, maximum flexibility is allowed in satisfying the degree requirements. Most candidates have had some form of prior postsecondary education and considerable work experience. In the nursing program, about 61 percent are LPNs; 7 percent, diploma-prepared RNs; 12 percent, aides, orderlies, or attendants; and nearly 20 percent have a variety of other backgrounds including military corpsmen, allied health workers, and those who enrolled in but never completed one of the RN preparatory programs. Nearly eight out of ten are employed full time in some health care facility. The average age is 38 years; 17 percent are men (which is about three times the national average for men enrolled in ADN programs). Most candidates are married and have children; many are grandparents. The first three graduates are typical: all were LPNs and one was a man. The male maintained two full-time jobs while taking college courses and studying independently for the nursing exams. One woman had started her college education 25 years ago, had worked and gone to school while rearing her family and had obtained an LPN certificate a few years ago. The third graduate was the mother of nine children and a recent grandmother; she worked full time in a local hospital as an LPN, but nonetheless was able to earn almost straight A's in her general education courses at the Community College; at the same time she was studying independently for the nursing exams. Based on this level of background information, candidates seem to have a high level of motivation, commitment, and nursing ability. The follow-up studies of the first graduates are reported in detail in the Outlook article, but the data clearly

\[\text{bid., pp. 427-428.}\]
indicate that these graduates are performing more than satisfactorily as RNs, and that directors would employ others and encourage their staff to seek an external degree.

Like most other ADN programs, the external degree requires that 50 percent of the total curriculum content be in general education and 50 percent in nursing. Knowledge of nursing content is evaluated through seven cognitive exams, developed by nurse educators from schools throughout the state of New York in cooperation with our psychometrics staff. These are integrated exams that evaluate all content areas contained in the blueprint and specifications established by the faculty committee. These cognitive requirements also may be satisfied by appropriate college courses or previously acquired degrees. Some candidates fulfill all requirements by examination and some have satisfied them entirely by college courses—except the Clinical Performance in Nursing Examination (CPNE), which is required of all candidates.

As an aside, I am particularly glad to announce that, beginning in November 1976, all of the written examinations prepared by the Regents External Degrees and the College Proficiency Examination Program will be available through the auspices of The American College Testing Program. This means that our candidates who live in all other 49 states will have the convenience of taking the written examinations in their own state. It also means that regular on-campus programs may readily use the CPEs or RED examinations for advanced placement, entrance or exit screening, or in special career mobility programs.

I should point out that there is one sequence requirement in the nursing program. All candidates must take the CPNE, but they are eligible for that exam only after all other nursing requirements have been satisfied. This is for the protection of both candidates and patients. Those who cannot demonstrate ability to meet the cognitive portion of the program cannot earn the degree; since taking the written exams is both less expensive and less complicated, these must be satisfied first. Furthermore, candidates who cannot demonstrate a basic and sufficient knowledge of nursing content are considered unsafe to administer care to patients.

It is this clinical performance examination that will be the focus of the remainder of this paper: its development, refinement, and implementation; its problems and limitations; and its usefulness as a model for others who wish to conduct performance evaluation.

CRITERIA FOR CLINICAL PERFORMANCE EVALUATION

There are seven norm-referenced, cognitive exams. These written exams were refined and standardized based on the achievement of a norming population; external degree candidates are evaluated against this peer group. The norming group for the seven AD nursing exams consisted of
about 3,000 AD nursing students. The majority of the nine AD programs in New York participated to some degree in this norming process.

In contrast, the Clinical Performance Exam is a criterion-referenced, competency-based examination, measuring the ability of each candidate against an expected standard of competence, regardless of the achievement of a given peer group. It is not a matter of how well one candidate performs in relation to the rest of the class, but how well each candidate is able to achieve a predetermined level of competence under consistent and prescribed conditions. Thus, the individual is in competition with a designated standard of performance rather than with a peer group.

Therefore, in the case of the external degree nursing program, the Clinical Performance Exam is based on that standard of nursing performance against which all candidates will be equally and consistently evaluated in the patient care areas. And because this is only one of a whole series of exams, it is designed to measure only that which cannot be evaluated through a written format. It is not a re-test, but a different test designed to evaluate the candidate's ability to integrate knowledge, make judgments, apply the nursing process, and perform skills unique to the administration of nursing care at the associate degree level, on behalf of selected hospitalized patients.

With these parameters clearly established, the faculty and staff turned to the task of specifying exactly what should be measured, as well as where, when, how, and by whom it should be evaluated. My purpose here is not to recount all the developmental details or the scores of problems, arguments, and impasses we encountered, but to generate from this experience a number of criteria that might apply to other programs as well.

In order to determine the answers to these developmental questions, it should be clarified at the outset that the task is considerably easier if the expertise of both nurse educators and psychometricians is combined. The nursing faculty developing the performance exam must be knowledgeable, competent, and experienced clinical teachers in those clinical areas to be included in the exam, and they must be able to function within the frame of reference of the expectations for nursing students at the designated degree level. Only with such a background can faculty develop a performance exam that incorporates both the reality of clinical nursing and the appropriate level of competence.

The psychometric expert provides a more objective point of view, as well as expertise in test construction and methods of evaluation. Working together, these two specialist groups can blend knowledge and experience to create an exam that includes necessary content and applies appropriate methods of evaluation. Without one or the other, the exam may be deficient, therefore influencing the process and perhaps even invalidating the outcome.

The panel of experts who developed the external degree CPNE consisted of ten nurse faculty members, an academically prepared psychometrician,
and the coordinator of the nursing program. Five of them had earned doctorates; the remainder had master's degrees. Nurse members were experienced in both adult and child clinical care areas, and in medical-surgical, maternal-child, and psychiatric-mental health content areas. All of the nursing panel were experienced in associate degree nursing education. One, Dr. Mildred Montag, was instrumental in its creation, and another, Dr. Helen Burnside, was one of Dr. Montag's first master's students in 1952 at Teachers College in a program designed to prepare the first AD educators. Another, Alice Rines, was a long-time associate of Dr. Montag and professor at Teachers College, preparing teachers of AD education. Seven other members were clinical teachers in seven different ADN programs throughout the state. The psychometrics expert had worked in the State Education Department for several years, a large portion of his time having been spent developing both the college proficiency exams in nursing and the Regents External Degree written exams in nursing.

WHAT IS THE STANDARD?

The first and major problem that confronted the Regents External Degree (REX) Faculty Committee (and one that will confront any other group developing a similar exam) was the identification of the exact components of the standard against which candidates would be measured. The particular frame of reference, the basic unit of measurement, the organizing theme had to be determined. This is an extremely difficult task when the entire range of potential nursing actions is considered. Exactly which kinds of nursing actions, in which clinical areas, and with reference to which other groups should the candidate be evaluated? Should all major medical specialty areas be included (i.e., medical-surgical, labor and delivery, nursery, neurology, ICU-CCU, psychiatric units, etc.)? Should the scope of concern include the nurse's responsibility to team leaders, head nurses, coworkers, MDs, those in other departments, families and others, as well as her prime responsibility to the patient receiving care? Should the basic unit of measurement be a weighted list of procedures, administered to a number of patients who require them? Or should the base be complete care given to one specific patient who requires the administration of several areas of care but not necessarily all areas that are theoretically possible for evaluation? The problem is not so much deciding what to include, but what not to include!

Nurses perform hundreds of tasks and functions and relate to scores of others in a very complex role-set. Should every one of these be evaluated in order to insure competent practice in nursing? Is successful performance on some of these areas indicative of competence generally? How should we cope with the range, variety, and complexity of tasks and roles in nursing?

Having thoroughly considered these questions, the Committee made several basic decisions. The focus would be on nursing that cuts across
specialty boundaries. But perhaps the most fundamental decision was that sampling of nursing behaviors in the clinical area is just as valid as sampling of content to be evaluated on written examinations. Because it clearly is irrational and unnecessary to attempt to observe every nursing procedure, interaction, and situation, the Committee began the task of identifying which areas of nursing performance should be included in the potential array for evaluation. The ideal content must be balanced with what is reasonable and economically feasible, since performance evaluation is very costly in both time and money.

The Committee finally agreed on a two and one-half day time frame to cover the orientation, simulated lab, and actual patient care situations (PCS) evaluation. Sampling would be used, but each PCS would include the entire spectrum of the nursing process. Some designated areas of nursing care were considered important enough to be evaluated in more than one situation and were labeled "Required Areas of Care." A whole range of other areas, called "Selected Areas of Care," were identified for potential use, although no concerted effort would be made to evaluate every one of them. A specific range of areas of care was determined for each PCS to assure reasonable comparability and consistency for each candidate experience, but the specific areas to be evaluated could vary from one PCS to another.

The Committee decided that the exam would be more cohesive if it focused on the administration of total care to one patient at a time, selected because of the nursing care required, in keeping with prescribed criteria for patient selection. They also decided that, by using several PCSs, chances were very good that a sufficient variety of nursing behaviors would be presented for evaluation over the three to five PCSs required for the total exam. And indeed this has been demonstrated.

Therefore, the what question gradually was answered by the Faculty Committee as they identified the array of areas of nursing care considered most important and most frequently required for hospitalized patients, within the usual expectations of the associate degree nurse, and consistent with the program's philosophy and objectives. The process of identification and final selection took many months—and several pilot testing episodes, some of which fell absolutely flat.

The Overall Faculty Committee and the performance subcommittee agreed that, since the AD graduate is expected to be able to administer technical nursing care to patients, usually in institutions, the Clinical Performance Exam should be conducted in an actual hospital setting and should involve planning and caring for both adults and children in general patient care areas. This, in spite of their awareness of the multitude of problematic and uncontrollable variables that would have to be governed. Simulation was considered, but was rejected, given the unique nature of the entire program, the complexity of the performance setting, and the need for objective data upon which to base certification of the graduates. Finally, following the pilot tests, the subcommittee decided to simulate a limited
Figure 1. Steps in the Evaluation of Clinical Competence.

Evaluation of Clinical Competence

- 3-5 Patient Care Situations
- Nursing Process
  - Planning
    - NCP Guidelines
  - Implementation
    - Required Areas
      - Selected Areas
        - Overriding Areas
    - Critical Elements
      - (150-250 Critical Behaviors)
        - 100% accuracy
  - Evaluation
    - Modified NCP Report
    - Nurses Notes
    - Guidelines
    - Critical Elements
      - (25-50 critical behaviors)
        - 100% accuracy
- 1-2 Simulated Labs
  - Areas of Care
  - Critical Elements
portion of the exam, using a nursing lab setting.

Once the unifying theme and the principle areas of nursing care to be evaluated were identified and arranged within the context of the nursing process, more detailed aspects of the what question had to be resolved. Ultimately, the concept of Critical Elements was adopted. Over a two-year period the panel of nursing experts sorted out traditions, procedural steps, subjective biases, and individual preferences from the actual and basic critical nursing behaviors essential to the administration of a particular area of nursing care. This was no easy task; every word was considered with the utmost care. The resulting critical elements are those aspects of care essential to protect and promote the patient’s well-being. They are labeled critical elements because the omission or unsatisfactory performance of any one of them indicates the candidate’s failure to administer safe and effective care to that patient. By using only the prespecified critical elements of care, success on the exam is based on 100 percent accuracy in the candidate’s performance.

The level of competence, therefore, expected of a candidate during the CPNE is satisfactory performance of all designated critical elements, for an array of areas of nursing care, required by several selected child and adult patients in the hospital setting. These prespecified behaviors must be met at the designated level of performance in order to achieve a satisfactory evaluation and therefore to pass the exam. A typical PCS includes approximately 45-55 different critical elements; therefore, over the three required PCSs, some 175 critical elements must be performed with 100 percent accuracy (or for those who undergo four PCSs, 225 critical elements are observed). This means that a candidate may have to perform 224 out of 225 nursing behaviors correctly to pass the CPNE. Figure 1 summarizes the evaluation of clinical competence.

In the near future we expect to publish a monograph on the development of the entire ADN program. It will include all aspects of the performance examination, the candidates’ study guide, and the evaluator’s manual. It also will include recently revised study guides for the seven written examinations.

Based on the experience of the Regents External Degree nursing program, the criteria for developing a performance examination are summarized below. This list is not meant to be exhaustive, but rather is suggestive of aspects that require consideration. Individual situations, of course, will require modifications. The following are criteria regarding what to evaluate:

1. The scope and complexity of nursing behaviors to be evaluated must be sorted out from the total that are possible. Some organizing theme must be identified as a way of integrating these behaviors and making the exam one cohesive whole. The REX faculty determined that the performance would revolve around the steps of the nursing process: planning, implementation, and evaluation of patient care.
2. A sampling of possible areas of care to be evaluated must be determined and priorities assigned to meet the specified objectives and/or level being tested; some areas would apply to every situation and others would be selected in different combinations. These decisions are made by a panel of nursing experts and are refined on the basis of pilot testing.

3. Certain behaviors are continuously monitored throughout the exam, regardless of the particular nursing activity. We named these overriding areas of concern physical jeopardy, emotional jeopardy, and violation of asepsis. Any one of these is grounds for failure, whenever it occurs and can be documented.

4. The essential critical elements that serve as the most finite units of measurement must be written explicitly and objectively, as free of bias and ambiguity as is humanly possible. This requires several stages: they must be written, pilot-tested, and refined—perhaps two or more times before the acceptable critical elements are finally derived. In this process the faculty must recognize and examine their own traditions, biases, and preferences and separate these from patient-oriented critical elements.

5. The level and extent of expected competence must be clearly specified, whether 100 percent or some lesser proportion of performance.

6. The conditions under which the exam will be administered and the candidate evaluated must be systematized and outlined in detail; statements must be free of ambiguity and also must be all-inclusive. As with any criterion-referenced exam, candidates as well as evaluators must be informed of these conditions well in advance of the exam.

7. Each point of measurement or critical element to be evaluated must describe a directly observable behavior rather than a belief or an assumption about that behavior. Only that which is seen, heard, measurable, or otherwise observable is legitimate and admissible evidence.

8. Each critical element must contain only one behavior for evaluation. Each element must be a single, discrete behavior, to be enacted because it is essential to the patient’s well-being, related to that particular area of care.

9. Each area of care and each critical element must be written in such a way as to apply to a variety of patient care situations rather than to only one particular situation. In our case they were written to refer to both children and adult patients in a number of situations. Each critical element identifies specific behavior, but it may apply to any number of different patient situations; it is the explicit, expected behavior that applies to a general classification of performance. For example, the area of care called “medications” relates to any patient care situation and any type of medication. The critical elements (such as “selects the
correct drug” and “administers to correct patient”) pertain to all situations.

10. Ultimately, exact areas of care and critical elements to be evaluated must be approved by the panel of experts and then scrutinized through objective pilot-testing and validation studies. The timing, mechanics, and other conditions also must be tested and refined before the exam is administered to students. For those readers familiar with computer programming, this process is rather like getting caught in what I call a “developmental do-loop”—develop the test, administer it, refine it, then retest, refine, administer, refine, and administer until the examination clearly functions satisfactorily and smoothly.

IMPLEMENTATION

In relation to the implementation of performance evaluation, still other factors must be considered and other criteria applied. These relate to the setting, the personnel, and the conditions controlling the process of candidate evaluation.

The exam setting must be selected so as to maximize opportunities to administer the exam as designed. Clearly stated criteria for selecting hospitals and patient units help to insure having the appropriate clinical facilities for the exam. Some points for consideration include: a sufficient number of adults and children in non-specialty areas to facilitate selection; adequate nursing staff, supplies and equipment, and physical space; and an attitude of support and cooperation toward the performance examination by agency and unit personnel.

After the hospital and particular patient units to be used are selected, all levels of personnel must be given a thorough and detailed orientation, especially emphasizing the importance of their part in supporting the objectivity and availability of all aspects of the examination. The distinctions between clinical instruction and clinical examination must be made explicit. Controls placed on exactly what nursing care will be administered; the time restrictions for each PCS, and the need for complete staff cooperation must be clearly understood. Without such an understanding the patient may be neglected; because staff do not understand the process; on the other hand, the exam can be nullified if staff perform certain aspects of care that are crucial to the examination. For example, in one situation involving a first-day post-op patient clearly assigned for the 10 to 12 a.m. PCS, the staff assumed that the candidate was taking care of the patient from 7:30 until noon since we were all on the unit during those hours and since those hours were typical of other student programs. Consequently, the patient received minimal care until we arrived at 10:30. The patient later developed symptoms of pneumonia, which may have related partially to nursing neglect before we began that PCS. On the other hand, staff have repeatedly performed aspects of patient care that were areas of nursing care assigned
in the exam. For example, the medication nurse has automatically administered drugs, even though assignment slips have been attached to the medication Kardex and team leaders have been fully informed. Nurse aides and LPNs—regulars and floats—frequently have given personal hygiene, made the patient's bed, ambulated patients, etc., just before the PCS was to begin.

These have not been malicious attempts to frustrate us, but routine and automatic behaviors that under ordinary circumstances would be acceptable or at least not catastrophic. However, a patient is selected for a PCS specifically because he requires the administration of a particular configuration of nursing care, and the candidate has only the maximum of five patient care situations in which to demonstrate the required knowledge and abilities and has paid $250 for that privilege; when a staff member, whether knowingly or unknowingly, provides the care that should have been a part of the candidate's activities, this does constitute a minor catastrophe.

Consequently, detailed staff orientation and continuing communication are imperative if the performance exam is to be conducted successfully. I personally worked with the hospital personnel in our testing center over a period of six to seven months before we were free of undesirable incidents. This included many meetings with the director, inservice instructors, supervisors, head nurses, and unit staffs. Part of the problem relates to the mobility of some workers from unit to unit, limited close supervision by team leaders, some staff away on vacation or days off, and new members joining the staff without sufficient orientation about the exam process. Therefore, several months of orientation and reinforcement are necessary before everyone realizes the difference between clinical examination and clinical instruction and is therefore able to cooperate fully in support of these efforts.

THE EVALUATORS

All of the effort spent in identifying and defining precisely what is to be evaluated and all of the effort spent in orienting a large segment of the hospital staff, however, are useless unless those who conduct the examination are thoroughly prepared and capable of performing the exclusive role of objective evaluator. In our case all evaluators must be teachers of nursing, prepared at the master's level, with at least three of the past five years in clinical instruction at the ADN level. The subcommittee developed specific criteria for selecting and monitoring evaluators but these alone do not insure a satisfactory evaluator. In fact, part of the essential orientation for evaluators is a reprogramming of their usual and instinctive approaches to students.

Two of the biggest problems teachers have in becoming evaluators is that they constantly want to use their hands to help, and they find it almost impossible to remain silent. Furthermore, some have great difficulty refraining from giving non-verbal clues. Facial expressions and body
movements can be quite effective in influencing the candidate, whether on a conscious or subconscious level. However, in a clinical performance exam, the evaluator must be as objective an observer as possible, an honest reporter of the candidate's actions and inactions. She has two major functions, both terribly important: (1) to observe and evaluate objectively the candidate's performance in relation to the specified behaviors, and (2) to protect patients from harm or threat of harm. Therefore, each evaluator must undergo a rather intensive orientation which involves becoming aware of the influence of her own verbal and non-verbal behavior on the candidate, and the presence of biases, personal preferences, and habits that actually are not critical to the patient's welfare but are nonetheless entrenched in her clinical frame of reference. The orientation also includes, of course, a thorough review of the explicit areas of care and critical elements to be used in evaluating candidates and the specific conditions under which the exam will be conducted.

Each clinical performance exam covers a period of two and one-half days, and it takes at least this period, in addition to the orientation time, for evaluators to feel comfortable with this new and demanding role, which is indeed very different from that usually performed by the clinical teacher. In the CPNE, all show-and-tell, coaching, excusing, and helping are explicitly forbidden. After going through her first CPN exam, one teacher identified three different stages through which an evaluator goes in becoming a "good evaluator." At first she feels like a perfectionist, applying to the nth degree every possible critical element (the degree of purity and perfection depends on the basic personality involved, but all go through this stage). By the second day of the exam, the evaluator realizes it's impossible for anyone to be absolutely perfect, it's not human and certainly not part of her own experience with herself or others. Having allowed a little common sense and reality to override perfectionism, as a result she experiences a guilty feeling akin to that of being a prostitute; this is stage two. The cycle continues for most, fortunately; in time the evaluator becomes surer of both her own ability and the effectiveness of the examination process. On reaching stage three, this clinical "pilgrim" begins to feel like a proselytizer, confident and desirous that others should know and use the same process. Having gone through this cycle of becoming, she is much better prepared to perform her critical role with reason, objectivity, consistency, and self-control, all of which are critical characteristics for effective evaluators.

ADMINISTRATION OF EXAMS

Criteria governing how the exam shall be administered are also most important. Without going into a detailed discussion, I would list the following areas that must be considered:

1. Patients must be selected according to predetermined specifications
Figure 2. Interrelationships in the Patient Care Situation (PCS) Examination.
and should present comparability of nursing needs for each PCS, so that all candidates have an equal opportunity of passing or failing. Criteria for patient selection should insure that patients are of comparable difficulty, have a comparable language, are present at the times designated for the exam, and require the essential areas of nursing care, to name just a few considerations.

2. To insure patient safety and thorough and objective evaluation of candidates, each PCS must be evaluated singly, i.e., one candidate administering care to one patient with one evaluator carefully observing. The evaluator must observe every critical element or its omission in order objectively to complete the examination record. Hunch, inference, assumption, or any other such category is unacceptable. Figure 2 illustrates the direct and indirect relationships among candidate, evaluator, staff, and patient.

3. The examination record is the conclusive evidence of the candidate's clinical competence. Each critical element is listed for each area of care, and each must be completed as specified in order to pass. These are exactly the same as in the candidate's study guide. Any omission or error results in failure and is described in detail for the permanent record.

4. Candidates are informed of the prespecified behaviors expected during the performance exam well in advance. These are explicitly identified in the candidate's study guide and are the same points of evaluation used by evaluators. The critical elements listed in the study guide are exactly the same critical elements listed on the examination report.

5. Candidates should receive the examination study guide as soon as possible to allow maximum time for learning the designated competencies and conditions. Where possible, they should have the choice of taking the exam when they feel ready. In structured, on-campus programs this may be difficult, but in the external degree program candidates apply for the CPNE whenever they feel ready.

6. Some aspects of nursing care do not require actual patients for the examination setting. Where possible, test these aspects in a simulated laboratory setting.

7. Interference should be kept to a minimum. Select patients who are expected to remain in their rooms during the exam period. Select times when units are reasonably quiet. Weekends have proved most useful for us.

8. Students require a specific period of orientation to this kind of objective and thorough clinical performance examination. Their end-of-course anxiety could become critical if they do not understand from the beginning the nature of the exam and its consequence. Telling them once is not enough, and it may take the experience of the first group to help others to understand the new system.
9. Faculty also need to understand and accept all aspects of the performance examination, if it is to be used successfully. Each member must apply the exam consistently, as agreed upon. Patient situations must be selected as specified to insure comparability of testing episodes.

10. To insure objectivity, the examination must be administered consistently as agreed upon by the faculty, and pass-fail outcomes must be based entirely on the critical elements. Personal feelings and subjective biases should be eliminated as much as possible.

To summarize, I will mention just a few of the key variables that must be carefully considered in developing a clinical performance examination: objectivity in evaluating performance; consistency in application of the instrument by all concerned; comparability of testing episodes, whether in the lab or in an actual patient situation; sampling of nursing care to be evaluated; flexibility in patient selection and other conditions to make the exam functional in the real setting; predetermined level of acceptability of performance; and distinctions between clinical examination and clinical instruction.

In closing, let me emphasize once again that a performance examination is not the "be-all and end-all." It should be understood and used for what it is: an objective examination of clinical competence. Cognitive competence is best tested on written examinations. Deportment, dress, values, and compliance with institutional rules and regulations also should be measured elsewhere. The Clinical Performance Exam does not test everything, nor should this be expected. At first there will be a tendency to make the exam so rigorous that not even the ablest student could pass. There also will be the tendency for faculty to slip back into a helping-coaching posture instead of maintaining the necessary distinction between teaching and examining responsibilities. But once the faculty are convinced and fully oriented to objective performance evaluation, a great change takes place: teaching and evaluation take on new meanings. I believe students benefit from knowing what is expected of them and having an objective examination of their competence. And surely patients benefit, too, because only those students whose competence has been demonstrated are graduated to serve the public.

The New York Regents External Degree Nursing Program has led the way in developing objective clinical performance evaluation instruments at the ADN level. More work has to be done, and we intend to continue these efforts as we develop the external baccalaureate degree in nursing. I trust that many other institutions will be encouraged to apply these principles to their settings and to move toward the development of more objective performance evaluation—for the sake of students, patients, and the nursing profession.
9. Faculty also need to understand and accept all aspects of the performance examination, if it is to be used successfully. Each member must apply the exam consistently as agreed upon. Faculty situations must be selected as specified to ensure comparability of testing episodes.

10. To insure objectivity, the examination must be administered consistently as agreed upon by the faculty, and pass-fail outcomes must be based entirely on the clinical elements. Personal feelings and subjective biases should be eliminated as much as possible.

To summarize, I will mention just a few of the key variables that must be carefully considered in developing a clinical performance examination: objectivity in evaluating performance, consistency in application of the instructions by all concerned, comparability of testing episodes, whether in the lab or in an actual patient situation, sampling of nursing care to be evaluated, flexibility in patient selection and other conditions to make the exam functional in the real setting, predetermined level of acceptability of performance, and distinctions between clinical examination and clinical evaluation.

In closing, let me emphasize once again that a performance examination is not the “be-all and end-all.” It should be understood and used for what it is: an objective examination of clinical competence. Cognitive competence is best tested on written examinations. Discomfort, dress, behavior, and compliance with institutional rules and regulations also should be measured, of course. The Clinical Performance Exam does not test everything, nor should this be expected. At first there will be a tendency to make the testing rigorous that not even the ablest students can pass. There also will be the tendency for faculty to slip back into a testing-outlining posture instead of maintaining the necessary distinction between teaching and examining responsibilities. But once the faculty are persuaded and fully oriented to objective performance evaluation, it will change little about teaching and evaluation take on new meanings. I believe students benefit from knowing what is expected of them and having an objective examination of their competence. And surely patients benefit, too, because only those students whose competence has been demonstrated are graduates to serve the public.

The New York Regents External Degree Nursing Program has led the way in developing objective clinical performance evaluation instruments at the ADN level. More work has to be done, and we intend to continue these efforts as we develop the external baccalaureate degree in nursing. I trust that many other institutions will be encouraged to apply these principles in their settings and to move toward the development of more objective performance evaluation—for the sake of students, patients, and the nursing profession.