Clinical Assessments

Thoughts, Examples and Discussion

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Objectives

• Classify types of clinical assessments.
• Discuss variables that affect type and frequency of assessments.
• Review Standards and Guidelines that relate to clinical assessment
• Evaluate examples of clinical assessments.
• Determine improvements that will be helpful to current assessment methods.
Types of Clinical Assessment

• Preceptor evaluation of the student.
• Instructor evaluation of the student.
  – Formal
  – Informal
• Student Self-Evaluation.
• Student Clinical Site Evaluation.
• Student Case Prep
  – First Case of the Day
  – Notebook, Journal, Reports
• Case Records/Documentation.
“No single tool of assessment of clinical competence is ideal”.... “a combination of long and short cases with OSCE (objective structured clinical examination) is suggested as a more rational examination of clinical competence” – Assessment of Clinical Competence of Undergraduate Medical Students, VK Paul (1995)
Some Variables

• Who does the assessments?
  – Preceptors
  – Coordinators
  – Instructor/Clinical Coordinator

• Length of Clinical/locations.

• How often do you do assessments?
  – Daily/Weekly
  – Per Rotation, Mid-term

• Rubrics

• Other?
Standards and Guidelines

• Maintenance of Records
  – Standard V.D. Page 37 of 2013 SIG.
    • Programmatic student records maintained no less than 5 years.

• Standard IV. A. – Student Evaluation
  – Frequency and purpose
  – Documentation
  – Page 27 and 54 of 2013 SIG

• Standard III.C. – Curriculum
  – Ensure the achievement of program goals and learning domains.
  – Must meet or exceed the content and competencies specified in the current edition of CCST.
  – Page 24 of 2013 SIG
Preceptor Evaluation of Student

• Include Cognitive, Psychomotor and Affective Learning Domains.
• Connect to clinical course and program objectives.
• Show progression.
• Frequency and feedback.
• Preceptors will evaluate differently, interrupt accordingly.
• Student/Preceptor/Instructor Signatures
Instructor Routine Evaluation

• Informal
  – Routine daily/visit.
  – Immediate versus delayed.
  – Formats for informal communication.

• Formal
  – Documentation of clinical visits.
  – Specific Clinical Case Evaluation.
Instructor Interval/Summative Evaluation

• Timing/Frequency
  – Weekly
  – Mid-term/Final
  – Program Completion

• This to Consider
  – Grade attached
  – Show progression
  – Connect to objectives and Learning Domains
  – Student/Instructor signatures

• Documentation of Concerns
  – Progression/History of Concern
  – Probation/Notice of Deficiency
Documentation of Student Concerns

- Progression/History of Concern
  - Clinical Notes
  - Instructor Evaluations
  - Clinical/Preceptor Evaluations
- Probation
- Notice of Deficiency
Case Records

• Maintenance of Records
• Format of Records
  – Paper
  – Electronic
• Meet current Core Curriculum Requirements
  – Case Logs
  – Case Summary
Case Log Requirements

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- Name of student, clinical facility and Preceptor/Clinical instructor
- Date surgical procedure performed
- Surgical procedure
- The specialty designation
- Role/Skill level performed (pg 175 CCST6e)
- Signature of student, Preceptor (if applicable) and instructor
- All cases recorded even if don’t count.
Case Log Summary Requirements

• Summary of daily/weekly logs
  – Term/Final

• Must demonstrate for each student
  – Total number of cases performed
  – # of first scrub cases in general surgery
  – # of second scrub cases in general surgery
  – # of first scrub cases in at least 5 surgical specialties
  – # of second scrub cases in at least 5 surgical specialties
  – # of diagnostic endoscopy cases in second scrub role
  – # of vaginal deliveries in second scrub role
Questions and Discussion
Contact Information

• Feel free to contact me for an electronic form of any of the examples shared in the presentation.

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