



The Open Journal of Occupational Therapy

Volume 4
Issue 3 *Summer 2016*

Article 7

July 2016

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Recommended Citation

Henderson, W. (2016). Development of a Clinical Performance Assessment Tool for an Occupational Therapy Teaching Clinic. *The Open Journal of Occupational Therapy*, 4(3). <https://doi.org/10.15453/2168-6408.1217>

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Development of a Clinical Performance Assessment Tool for an Occupational Therapy Teaching Clinic

Abstract

Health professional education is experiencing increased accountability from higher education and professional accrediting bodies to produce professionals who are prepared to meet the demands of the complex, fast-paced, ever changing health-care environment. Using competency-based assessment methods to evaluate a student's performance can assist to decrease the gap between education and practice and ease the critical transition from the classroom to the clinic. A variety of assessment methods that use a Competency-Based Medical Education (CBME) framework to assess student performance and competency can be found throughout the health professions literature. Because of the lack of literature about the assessment of student performance in occupational therapy education, and because of the inability to find an appropriate assessment tool for the on-site teaching clinics in the author's program, the author developed a new assessment tool to measure student competency and performance in the clinical education setting. This paper discusses each phase of development; the professional literature used; and the reasoning for domain, item, and scoring selection. The final assessment includes a 5-point rating scale to score 42 items in six domains in order to assess student performance and competency during an occupational therapy teaching clinical education experience.

Keywords

clinical education, competency-based assessment, student performance, occupational therapy education

Cover Page Footnote

I acknowledge Dr. Brenda Coppard, PhD, OTR/L, FAOTA, professor at Creighton University, for feedback and guidance on this paper; Mr. James Hart for editing and feedback; and the faculty, staff, and students at the University of Missouri-Columbia occupational therapy program for the continuous feedback and willingness to incorporate the assessment into clinical education.

Credentials Display and Country

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DOI: 10.15453/2168-6408.1217

The health care system in the United States is a complex, fast-paced, ever-changing environment. The public's concern with current health care practice requires that professionals provide high quality care that is safe, effective, and patient-centered (Kogan, Conforti, Lobst, & Holmboe, 2014). Health professional education is experiencing increased accountability from higher education and professional accrediting bodies to produce professionals who are prepared to meet these demands. These demands also encourage shifting from a focus on content to a focus on competency in curricular and assessment methods (Dawson, Miller, Goddard, & Miller, 2013). Using competency-based assessment methods to evaluate a student's performance can help decrease the gap between education and practice and ease the critical transition from the classroom to the clinic (Costello, Plack, & Maring, 2011; Hsu & Hsieh, 2013). Although the multifaceted nature of clinical skills makes it difficult to develop a perfect assessment tool, the ability to assess a student's performance is an essential component of health professional education (Anderson et al., 2014; Costello et al., 2011).

Clinical education provides students with clinical experiences that are integrated throughout a curriculum (Wilson, 2014). These experiences incorporate the basic sciences through didactic coursework with early exposure to clinical skills and encounters (LaRochelle, Dong, & Durning, 2015). These opportunities are critical for the development of student competency in preparation for full-time internships and entry-level practice (Costello et al., 2011; LaRochelle et al., 2015;

Wilson, 2014). The assessment of a student's performance in clinical education is important for the development and attainment of new competencies (Holmboe, Sherbino, Long, Swing, & Frank, 2010). Wu, Enskär, Lee, and Wang (2015) define clinical competency as "theoretical and clinical knowledge used in the practice of nursing, incorporating psychomotor skills and problem-solving ability with the goal of safely providing care for patients" (p. 348). It is necessary for educators to use a holistic, outcome-based assessment to determine a student's competency in a set of complex, multidimensional skills (Dawson et al., 2013; Hsu & Hsieh, 2013). In the Department of Occupational Therapy at the University of Missouri-Columbia, occupational therapy students participate in faculty-supervised on-site teaching clinics to develop the skills and competencies needed for future success. However, the program lacks an effective assessment to measure student achievement.

Literature Review

A variety of assessment methods that use a Competency-Based Medical Education (CBME) framework to assess student performance and competency can be found throughout the health professions literature. One popular method of assessment includes the use of an Objective Structured Clinical Examination (OSCE). An OSCE uses multiple stations at which students perform identified clinical tasks with standardized patients. Standardized patients are trained individuals who receive compensation for simulating a clinical scenario (Mookherjee, Chang, Boscardin, & Hauer, 2013). Traditionally, basic

skills, such as obtaining a history, performing a physical examination, maintaining professional behaviors, and demonstrating appropriate communication skills, have been assessed through the use of an OSCE (LaRochelle et al., 2015). An OSCE offers a valuable assessment, as it challenges students to demonstrate clinical skills rather than just simply knowing clinical skills, and provides students with the opportunity for practice and feedback (Holmboe et al., 2010; Mookherjee et al., 2013). The use of standardized patients also allows for increased reliability and validity in the assessment of a student's performance (Mookherjee et al., 2013). However, using an OSCE to assess student performance and competency has limitations. These limitations include the lack of authentic patient encounters, increased cost and time associated with standardized patients, and the restricted amount of clinical skills that can be assessed through these interactions (Costello et al., 2011). Although widely used and established in medical education, the OSCE in occupational therapy is less understood and researched (Costello et al., 2011; O'Brien & McNeil, 2013). In occupational therapy literature, O'Brien and McNeil (2013) studied the correlation of scores from the short OSCE with scores from Level II fieldwork in occupational therapy education. While faculty and students found the OSCE useful, scores from the OSCE did not correlate with performance scores on the *Fieldwork Performance Evaluation (FWPE) for the Occupational Therapy Student*. Additionally, an OSCE established in medical education lacks fluency to the occupational therapy profession. An

education lacks assessment of specific clinical skills and competencies demonstrated in a teaching clinic, such as grading an intervention according to the client's response or performing appropriate skilled and evidence-based interventions.

An additional competency-based assessment is a workplace-based assessment. Kogan et al. (2014) state that workplace-based assessments are "conducted in authentic situations (i.e., day-to-day practice) and evaluate multiple, essential competencies in an integrated, simultaneous fashion" (pp. 721-722). Through direct observation of a student's interaction with a "real-life" patient, educators are able to assess a set of interconnected, complex clinical skills (Holmboe et al., 2010; Kogan et al., 2014). This type of assessment can help identify students who would benefit from remediation or determine which students to consider for advanced placement (Holmboe et al., 2010). Although workplace-based assessments are tremendously valuable, they place demands on educators because of increased time commitments and a need for keen and accurate observation (Holmboe et al., 2010). In addition, concerns for reliability exist when there are multiple raters who have different expectations and frames of reference affected by the variability among and within patients (Kogan et al., 2014). The use of workplace-based assessments is frequently seen in medical education literature. Similar to medical education, occupational therapy education provides students with clinical experience following their early years of education. However, there is little evidence supporting the use of workplace-based assessments in occupational therapy education.

Many articles addressing student assessment are found in medical education literature, and several articles exist about the development of an assessment for student performance in other disciplines of professional education. However, discussion of the development of a reliable and valid assessment for measuring student performance in occupational therapy clinical education remains limited. Muhamad, Ramli, and Amat (2015) discussed a pilot study to determine the reliability and validity of the Clinical Competency Evaluation Instrument (CCEVI). This assessment measures the clinical competency of physical therapy students using a 5-point Likert scale to assess 40 items across eight domains. Hsu and Hsieh (2013) discussed the development of a competency inventory for baccalaureate nursing students. This assessment tool uses a 7-point Likert scale to measure clinical competency of 52 items across eight domains. Finally, O'Brien and McNeil (2013) studied the relationship between case-based and performance-based examinations for student performance on Level II fieldwork in occupational therapy education. The OSCE was used to assess clinical skills, while the Integrated Performance Procedural Instrument (IPPI) was used to assess clinical reasoning throughout a case. The IPPI demonstrated greater correlation with student performance on fieldwork performance (O'Brien & McNeil, 2013). While each of these assessment methods has strengths and weaknesses, these methods did not fit the context for the assessment of student competency and performance in this institution's on-site teaching clinic because of the

lack of similar and demonstrable skills related to the profession and setting.

Method

Lacking literature about the assessment of student performance in occupational therapy education and accepting the inability to use previously developed assessments because of a poor match, the author sought to develop the Clinical Performance Assessment Tool (see Appendix) to measure student competency and performance in the on-site clinical setting at the University of Missouri-Columbia. Similar to the program discussed by Wilson (2014), the University of Missouri-Columbia occupational therapy program's curriculum includes two semesters of clinical education experiences in the on-site pediatric and adult clinics. These on-site clinics serve individuals with a variety of diagnoses and impairments in the local community who might not otherwise receive occupational therapy services because of financial reasons. In addition to and aside from Level I fieldwork, these clinical experiences occur in the graduate portion of the curriculum during the second and third years of the occupational therapy program. Under the supervision of a faculty member, the students provide one-on-one occupational therapy services to individuals once a week for the duration of the semester. Each student is responsible for developing the evaluation and intervention plans, implementing the intervention plans, and documenting the outcome of the interventions. The supervising faculty member provides written feedback on the evaluation plan, weekly treatment plans, weekly documentation, and client education materials, and provides verbal

feedback on the intervention implementation following each session. The students meet with the supervising faculty member at midterm and at the end of the semester to discuss their progress and score in clinical performance. Prior to the development of the Clinical Performance Assessment Tool, the faculty in the University of Missouri-Columbia occupational therapy program lacked a comprehensive, objective tool to measure clinical performance, competency, and educational outcomes.

Several resources were useful for developing the Clinical Performance Assessment Tool. First, Keating, Dalton, and Davidson (2009) outlined six phases in the development of an assessment tool for clinical education. The first three phases of this outline were used in the development of the Clinical Performance Assessment Tool, whereas the last three phases could be used at a later date. Mookherjee et al. (2013) also provided an outline for the development of an assessment of the clinical skills and competency of students in medical education; however, this outline discussed the longitudinal development and assessment of skills as a medical student progresses throughout the program. Although somewhat different, Moorkherjee et al. (2013) provided several areas of overlap to the phases discussed by Keating et al. (2009), such as identification and development of relevant objectives and the use of professional documents and competency-based frameworks to guide development of the assessment.

Map the Construct

The first phase of this process is mapping the construct, which includes determining what the assessment tool will measure, the continuum of performance, and the identification of domains (Keating et al., 2009). As previously stated and discussed, it was determined to measure the clinical performance and competency of students during on-site clinical experiences at the University of Missouri-Columbia. In order to determine the continuum of performance and domains, attention was turned to the review of the literature. The common theme identified in the literature was the use of professional documents to guide the development of the assessment (Anderson et al., 2014; Costello et al., 2011; Dawson et al., 2013, Hsu & Hsieh, 2013; Mookherjee et al., 2013; Wilson, 2014; Wu et al., 2015). Based on this information, the author consulted the *Accreditation Council for Occupational Therapy Education (ACOTE) Standards and Interpretive Guide*, the *Standards of Practice for Occupational Therapy*, and the *FWPE for the Occupational Therapy Student* for selection of domains and items (American Occupational Therapy Association [AOTA], 2002; AOTA, 2010; AOTA, 2011). Section B (which is the Content Requirements from the *ACOTE Standards and Interpretive Guide*) identifies the expected outcomes of students who graduate from an accredited occupational therapy education program (AOTA, 2011). The *Standards of Practice for Occupational Therapy* discusses the minimum practice standards for professionals practicing in the field of occupational therapy (AOTA, 2010). Finally, the *FWPE for the*

Occupational Therapy Student is the assessment used by fieldwork educators to determine entry-level competency of occupational therapy students during Level II fieldwork (AOTA, 2002). These three documents were compared and contrasted, and then the author extrapolated common areas appropriate for the context. During this process, the *FWPE for the Occupational Therapy Student* proved to be most applicable and useful because this tool measures a student's performance throughout the delivery of the occupational therapy process (AOTA, 2002). The *Standards of Practice for Occupational Therapy* proved to be the least applicable and useful because this document discusses the minimum practice standards of an occupational therapy practitioner and not a student (AOTA, 2010).

In addition to these three documents, two additional documents provided valuable contributions to this phase. First, addressing similarities in clinical experiences provided during the educational program at the University of Puget Sound, the article written by Wilson (2014) served as a useful resource for further identification of domains. Second, in addition to Keating et al. (2009), the *Undergraduate Clinical Evaluation Tool* used at the University of North Carolina Chapel Hill School of Nursing (2012) provided an excellent continuum of the measurement of student performance and competency. Following synthesis and analysis of this information, the six domains and continuum were identified and selected based on (a) the relevance to the institution's on-site educational setting, (b) a review of literature and professional documents, and (c) identified

importance by supervising faculty. The six domains include communication, documentation, safety and judgment, evaluation, intervention, and professional behaviors, and the continuum includes dependent, novice, assisted, supervised, and self-directed stages of performance (University of North Carolina Chapel Hill School of Nursing, 2012).

Assemble an Item Pool

Keating et al. (2009) report that the second phase of assessment development is the assembling of an item pool. This includes collecting and categorizing individual items for each domain from multiple resources. An item must meet the following four criteria for selection and inclusion:

- Target one attribute (explicit learning outcome).
- Describe an observable and measurable behavior.
- Be unambiguous, clear, and defensible.
- Be important to students, educators, and/or key stakeholders. (Keating et al., 2009, p. 164)

The three previously mentioned occupational therapy documents, as well as the addition of the *Occupational Therapy Essentials for Clinical Competence* (Jacobs, MacRae, & Sladyk, 2014), were compared and contrasted an additional time to determine important items to include in each domain. Articles that included a discussion of the items were reviewed and relevant items were added to the pool. The articles included Costello et al. (2011), which assessed 23 items with physical therapy students; Hsu and Hsieh (2013), which assessed 52 items with undergraduate nursing

students; and Muhamad et al. (2015), which assessed 40 items with physical therapy students. The five characteristics of a successful clinical student, as described by Goldie, Dowie, Goldie, Cotton, and Morrison (2015), were also considered. After completion of this thorough review of literature, 42 items were identified for the Clinical Performance Assessment Tool (see Table 1).

Table 1

Number of Items Assessed in Each Domain

Domain	Number of Items Assessed
Communication	7
Documentation	6
Safety and Judgment	3
Evaluation	7
Intervention	13
Professional Behaviors	6

Mookherjee et al. (2013) recommended these items be translated into observable and measureable objectives, and Hsu and Hsieh (2013) recommended assessing a combination of cognitive, affective, and psychomotor skills. Based on these recommendations, Gronlund and Bookhart's (2009) textbook, *Gronlund's Writing Instructional Objectives*, provided the best model for each of the 42 items. Examples of selected items include (a)

demonstrates therapeutic use of self throughout the occupational therapy process (communication domain), (b) writes client-centered goals according to the COAST format in which the occupation is measureable (documentation domain), (c) modifies the evaluation plan based on the client's clinical presentation (evaluation domain), (d) uses creativity and a variety of treatment methods to facilitate the client's progress toward established goals (intervention domain), and (e) demonstrates effective time management of session (professional behaviors domain).

Determine Indicators and Scales

The third and final phase used for the development of the Clinical Performance Assessment Tool was the determination of performance indicators and rating scales (Keating et al., 2009). According to Anderson et al. (2014), the use of a 5- to 7-point scale provides the highest level of reliability. With this information in mind, the rating scales described in the Keating et al. (2009) and the University of North Carolina Chapel Hill School of Nursing (2012) documents were combined and modified to develop a 5-point rating scale for each item (see Figure 1).

Rating Scale	
Rating	Description
Self-Directed (4)	Almost always demonstrates excellent standard of the clinical skill
	Almost never (0-10% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill
Supervised (3)	Very often demonstrates the clinical skill at a high standard
	Occasionally (10-25% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill
Assisted (2)	Often demonstrates the clinical skill at an adequate standard
	Sometimes (25-50% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill
Novice (1)	Infrequently demonstrates adequate level of the clinical skill
	Very often (50-75% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill
Dependent (0)	Almost never or does not demonstrate criteria for the clinical skill
	Almost always (75-90% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill

Figure 1. Rating scale used to rate each item.

Kogan et al. (2014) strongly suggested using the midpoint of a rating scale as the determination for satisfactory or competent performance, as this is the minimal standard of care required for a particular setting. This appeared appropriate for the educational level of the students in the on-site clinic. It is not the expectation that the students are independent or near independent at this point in their education, as that would defeat the purpose of Level II fieldwork experiences.

Scoring guidelines were developed based on evidential support; however, reassessment with potential revision is anticipated following

implementation of the tool (Anderson et al., 2014; Keating et al., 2009; University of North Carolina Chapel Hill School of Nursing, 2012). Scoring guidelines are as follows: A score of a 0 (*dependent*) and 1 (*novice*) are an acceptable score for an item at midterm, as long as a plan is identified for student development for the item evaluated. However, a score of 0 or 1 for any item at final is unacceptable. Kogan et al. (2014) support this decision with the statement that “being competent is not the aspiration, it is the floor” (p. 724). It is also not the expectation that students will obtain a score at midterm that would be considered

passing at final, as this would negate the need for ongoing growth and development of skills and competency throughout clinical experiences. Therefore, a competent distribution of scores was considered to determine a passing score of 115 at the time of final. A student must achieve this score to pass the clinical education component of the curriculum prior to beginning Level II fieldwork.

In addition to the quantitative information provided by a rating scale, an opportunity to provide qualitative feedback was incorporated into the assessment tool. According to Holmboe et al. (2010), educators should incorporate qualitative approaches to assessment in order to provide narrative feedback about student performance. In addition, Dawson et al. (2013) reported that students desired more qualitative feedback and that students perceived increased validity with the addition of qualitative feedback to a quantitative assessment. Therefore, an area for subjective feedback was added to each assessed item. The assessment also included a development plan at the end in order to articulate and identify clearly a student's strengths and suggested areas for improvement, and to provide an opportunity to discuss with the student a meaningful plan for progress and development. Finally, the purpose and directions of the assessment tool were written with guidance from the *FWPE for the Occupational Therapy Student* and the *Undergraduate Clinical Evaluation Tool* (AOTA, 2002; University of North Carolina Chapel Hill School of Nursing, 2012).

Discussion

Clinical educators need accurate and

objective assessments in order to communicate and

evaluate the development and achievement of clinical performance and competency (Anderson et al., 2014; Kogan et al., 2014; Muhamed et al., 2015). Not only is this crucial for the development of clinical skills and competency, but the assessment of clinical performance provides information on current curriculum and educational outcomes, promotes professional self-regulation by assuring students can meet high standards of practice, and prepares students to meet the demands of the rapidly changing health care environment in future clinical experiences and entry-level practice (Holmboe et al., 2010; Hsu & Hsieh, 2013). While the Clinical Performance Assessment Tool currently lacks reliability and validity, the author hopes that the assessment can be used and further developed in the on-site clinical education portion of the curriculum at the University of Missouri-Columbia. It is hoped that the assessment will provide both students and educators with measureable successes of their aims to prepare client-centered health care professionals.

As described by Keating et al. (2009), the final three phases of development, which include a pilot test, a field test for validity, and a field test for reliability, will be implemented to establish an effective assessment for measuring student competency and performance in a clinical education experience. The Clinical Performance Assessment Tool will undergo pilot testing with graduate students enrolled in the clinical education component of the curriculum during the spring and fall semesters of the 2016 calendar year. Efforts to recruit experienced educators engaged in clinical education are underway to establish the content

validity of the assessment. Following completion of these steps, feedback and data will guide the revision of the assessment. Once revisions have been completed, further reliability and validity studies will be completed during the 2017 calendar year.

Since the purpose of the Clinical Performance Assessment Tool is to assess student performance during an on-site clinical education component of a curriculum, this tool should not, without further research development, be used to assess student performance on Level I fieldwork or in clinics in which faculty complete a majority of the occupational therapy process. Occupational therapy programs with a clinical education component of the curriculum are invited to use the assessment and collaborate with the author to contribute data toward its psychometric development. However, educators should complete an in-depth review of the assessment to ensure an appropriate fit with the clinical education experience. As with any new assessment, educators using this assessment outside of a research context should do so with caution because of a lack of psychometric data at this time.

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Appendix
Clinical Performance Assessment Tool

Student:		Semester:	Client Initials:
Client Diagnosis:		Midterm	OR
Number of Sessions at Midterm		Number of Sessions at Final	Final

Purpose: The Clinical Performance Assessment Tool is intended to assess a student's performance during the clinical education portion of the curriculum. Additionally, this assessment tool is intended to monitor and document a student's progress, growth, and competency prior to initiation of Level II fieldwork. The Clinical Performance Assessment Tool also evaluates a student's ability to connect concepts learned in the classroom to clinical practice.

Directions: The Clinical Performance Assessment Tool includes 42 objectives across six domains. Every objective must be scored using the 5-point rating scale described below. The student and clinical educator should review the rating scale descriptions prior to midterm and final evaluation. The clinical educator should highlight or circle the number that best corresponds to the student's performance for each clinical skill. Provide additional feedback in the feedback column as needed. Total and record each domain separately and total all domains for an overall score of the student's performance. The clinical educator and student discuss the results of the Clinical Performance Assessment Tool at a midterm and final meeting. The assessment is used to identify strengths and weaknesses in order to collaboratively determine a plan for growth and development of clinical skills and competency. Finally, the student and clinical educator need to sign and date the midterm and final document to confirm discussion and understanding of clinical performance and the development plan.

Scoring:

Midterm: The score of 0 (*dependent*) and 1 (*novice*) are acceptable scores for an objective at midterm and should be accompanied by an identified plan for student development. A score of 4 (*self-directed*) should rarely be used at midterm. It is not the expectation that the student receive a passing grade at midterm.

Final: A score of 0 (*dependent*) and 1 (*novice*) are unacceptable at final. If a student accumulates enough points to pass the clinical experience but scores a 0 or a 1 on any objective at final, remediation is at the discretion of the clinical educator. A score of 115 or higher is required to pass the clinical experience. A score of 114 or lower will result in failure of the clinical experience. In this case, remediation of the clinical experience will be offered at the discretion of the clinical educator and should be accompanied by an identified plan for student development.

Rating Scale	
Rating	Description
Self-Directed (4)	Almost always demonstrates excellent standard of the clinical skill
	Almost never (0-10% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill
Supervised (3)	Very often demonstrates the clinical skill at a high standard
	Occasionally (10-25% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill
Assisted	Often demonstrates the clinical skill at an adequate standard

(2)	Sometimes (25-50% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill
Novice (1)	Infrequently demonstrates adequate level of the clinical skill
	Very often (50-75% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill
Dependent (0)	Almost never or does not demonstrate criteria for the clinical skill
	Almost always (75-90% of time) requires direction, guidance, prompting, support, and/or supervision for completion of skill

Domain	Item Number	Objective	Score					Feedback
			Dependent	Novice	Assisted	Supervised	Self Directed	
Communication	1	Defines role of occupational therapy to the client, caregiver, family, etc.	0	1	2	3	4	
	2	Articulates the value of occupation as a means and as an end to the client, caregiver, family, etc.	0	1	2	3	4	
	3	Uses verbal communication appropriate to situation and to the client, caregiver, family, etc., and level of understanding.	0	1	2	3	4	
	4	Uses non-verbal communication that is appropriate for the client, caregiver, family, etc.	0	1	2	3	4	
	5	Demonstrates therapeutic use of self throughout occupational therapy process.	0	1	2	3	4	
	6	Collaborates with the client, caregiver, family, etc., throughout the occupational therapy process.	0	1	2	3	4	
	7	Demonstrates an understanding of health literacy when providing education and training to the client, caregiver, family, etc.	0	1	2	3	4	
Communication Total:								
Documentation	1	Uses correct spelling, punctuation, and grammar in documentation.	0	1	2	3	4	
	2	Provides accurate and professional documentation according to clinic guidelines (abbreviations, L/R, ROM rules, treatment media, etc.).	0	1	2	3	4	
	3	Documents evaluation results that provide an objective measurement of the client's function.	0	1	2	3	4	
	4	Writes client-centered goals according to the COAST format in which the occupation is measurable.	0	1	2	3	4	
	5	Communicates need and rationale for OT services in documentation.	0	1	2	3	4	
	6	Accurately documents the client's performance and response to intervention.	0	1	2	3	4	
Documentation Total:								
Safety and Judgment	1	Adheres to clinic safety and cleaning procedures.	0	1	2	3	4	
	2	Demonstrates sound judgment and awareness of client safety throughout occupational therapy process.	0	1	2	3	4	
	3	Provides client with appropriate assistance and supervision techniques to ensure safety.	0	1	2	3	4	
Safety and Judgment Total:								

Henderson: Clinical Performance Assessment Tool

Evaluation	1	Provides a clear rationale and appropriate selection of screening and/or assessment methods.	0	1	2	3	4	
	2	Is prepared to administer planned standardized and non-standardized assessments.	0	1	2	3	4	
	3	Develops an occupational profile that is detailed and comprehensive.	0	1	2	3	4	
	4	Accurately administers assessments to measure client factors and performance skills.	0	1	2	3	4	
	5	Uses skilled observation to accurately identify the client's strengths and weaknesses.	0	1	2	3	4	
	6	Modifies the evaluation plan based on the client's clinical presentation.	0	1	2	3	4	
	7	Analyzes and interprets assessment data accurately. This includes interpretation of criterion and norm-referenced assessments.	0	1	2	3	4	
Evaluation Total:								
Intervention	1	Selects interventions that are appropriate to the client's clinical presentation.	0	1	2	3	4	
	2	Articulates a rationale for therapeutic interventions, which includes a connection to the client's goals and discussion of theory, models of practice, and frames of reference.	0	1	2	3	4	
	3	Uses in-class resources in the development of treatment plans.	0	1	2	3	4	
	4	Uses outside resources in the development of treatment plans.	0	1	2	3	4	
	5	Selects and performs interventions that are skilled and evidenced-based.	0	1	2	3	4	
	6	Selects and performs interventions that motivate and challenge the client.	0	1	2	3	4	
	7	Performs interventions that are client-centered and occupation-based.	0	1	2	3	4	
	8	Uses creativity and a variety of treatment methods to facilitate the client's progress toward established goals.	0	1	2	3	4	
	9	Appropriately incorporates remediation and compensation strategies into intervention.	0	1	2	3	4	
	10	Performs appropriate "hands-on" techniques to facilitate the client's progress toward goals.	0	1	2	3	4	
	11	Demonstrates flexibility through appropriate modification and grading of interventions.	0	1	2	3	4	
	12	Develops and monitors a home exercise program that is appropriate for the client's clinical presentation.	0	1	2	3	4	
	13	Appropriately refers the client to additional resources and disciplines.	0	1	2	3	4	
Intervention Total:								
Professional Behaviors	1	Demonstrates effective time management. This includes arriving to the clinic 15 min prior to session, managing time in session appropriately, and adhering to deadlines for clinic documentation.	0	1	2	3	4	
	2	Maintains professional appearance through adherence to clinic dress code policy.	0	1	2	3	4	
	3	Maintains professional attitude and behavior.	0	1	2	3	4	
	4	Appropriately collaborates with the instructor and peers during and outside of clinic sessions. This includes appropriately seeking assistance when needed.	0	1	2	3	4	
	5	Responds to and incorporates the instructor's constructive feedback.	0	1	2	3	4	
	6	Remains actively engaged and eager to learn.	0	1	2	3	4	
Professional Behaviors Total:								
Total Score:								

Student Development Plan	
Student's Strengths:	
Student's Areas for Improvement:	
Plan:	
Student Signature:	Date:
Clinical Educator Signature:	Date: