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Becoming familiar with competency based student assessment: An evaluation of workshop outcomes

ALISON FERGUSON¹, SUE McALLISTER², MICHELLE LINCOLN², LINDY McALLISTER³, and SUSANNE OWEN⁴

¹*University of Newcastle, Newcastle, Australia*

²*University of Sydney, Sydney, Australia*

³*Charles Sturt University, Albury, Australia*

⁴*University of South Australia, Adelaide, Australia*

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Correspondence: Associate Professor Alison Ferguson

Speech Pathology, School of Humanities and Social Science

Faculty of Education & Arts, University of Newcastle

Callaghan NSW 2308 Australia

Phone: +61-2-49215716

Fax: +61-2-49216933

E-mail: Alison.Ferguson@newcastle.edu.au

Author note: Sue McAllister is now at Flinders University, Adelaide and Lindy McAllister is now at The University of Queensland, Brisbane.

Abstract

The identification and specification of competency based standards in speech language pathology has provided practitioners, educators, employers and government regulators with information and guidance. This paper reports the outcomes of workshops that provided familiarisation with the new competency based assessment tool, COMPASS[®], which was introduced for the assessment of speech-language pathology (SLP) students across all 13 SLP professional preparation programs in Australia during 2007. An anonymous evaluation was administered before and after the first 8 familiarisation workshops held nationally, involving 240 clinical educators. Quantitative data were analysed descriptively, and qualitative data were entered into NVivo qualitative analysis software for content analysis. Post workshop, results indicated partial or full uptake of the main concepts involved in the new approach to assessment. Least uptake was observed for the need for direct observation of competence in workplace performance. Qualitatively, post workshop, formative assessment was more apparent within student goals formulated in response to a hypothetical scenario. A possible contributor to this outcome is suggested to be the alignment between the tool and the professional community of practice, due to the collaborative process of its development. Research into the longer term impact of the new assessment in the context of everyday practice is suggested.

The identification and specification of competency based standards in speech language pathology provides practitioners, educators, employers and government regulators with information and guidance. Internationally, competency based frameworks influence educational programs for professional entry to differing extents (Ferguson, 2006b; S. McAllister, Lincoln, Ferguson, & McAllister, 2010). In the Australian context, professional entry programs need to demonstrate the assessment of graduates meets the requirements as specified in the Competency Based Occupational Standards for Speech Pathologists – Entry level (SPAA, 2001). This paper reports the outcomes of workshops that provided familiarisation with the new competency based assessment tool, COMPASS® (S. McAllister, Lincoln, Ferguson, & McAllister, 2006), which was introduced for the assessment of students across all 13 speech-language pathology professional preparation programs in Australia during 2007. The new assessment tool, COMPASS®, will first be described briefly and placed in its socio-historical context, before outlining the rationale for the evaluation reported in this paper.

The new assessment tool, COMPASS® was developed to assess the development of clinical competence in speech-language pathology students undertaking clinical practicum as part of their professional preparation programs (at either undergraduate Bachelor or postgraduate Masters level). The development of the tool was supported through a national collaborative research project, involving Australian universities and the Speech Pathology Association of Australia (Speech Pathology Australia) and funded through the Australian Research Council's linkage grant scheme. The COMPASS® assessment approach represents the first such assessment tool in the discipline of speech-language pathology that has been empirically validated (S. McAllister, 2005) and for which validity data is available. COMPASS® embodies best practice in ensuring that the assessment effectively facilitates

learning through (a) appropriate processes (e.g., authentic assessment based in the real workplace), formative and summative components and validated rating scales; and (b) content that is based on concepts and descriptions of professional competence that have been identified as meaningful to the profession and effectively describe the development of competence in the *Competency Based Occupational Standards for Speech Pathologists - Entry Level* (revised) (S. McAllister et al., 2010; SPAA, 2001). The philosophy of learning that underpinned the tool's development was influenced by the work of Paul Hager who argued for an holistic view of competency development, involving learning which, "...is integrated in judgments, which reflect a capacity for successful acting in and on the world" (p.662, Hager, 2005; S. McAllister et al., 2010). The development of the tool included an extensive consultative process with both clinicians and students (S. McAllister, Lincoln, Ferguson, & McAllister, 2002, 2004, 2008), across all programs in universities in Australia during that development timeframe (2000-2003). The main concepts that emerged through the development phase that were embedded within the design of the new tool were *formative assessment, developmental learning, and scaffolded learning*. Formative assessment was pivotal, as the tool required in-depth formative feedback and evaluation at the mid-point of learning experiences (Bloom, Madaus, & Hastings, 1981; Boud, 1998). Developmental learning was integral, as the tool was designed to be used to describe the longitudinal development of individual students across multiple experiences from the start to end of their student clinical experience across the totality of their university program (Benner, Tanner, & Chesla, 1996; Ericsson & Charness, 1997). The tool included a scoring system that generated an interval level score placing student performances along a continuum of competency (S. McAllister, 2005; S. McAllister et al., 2004) from novice to entry-level. Scaffolded learning was implicitly embedded, as the tool's Resource Manual provided detailed behavioural description of indicators of competence designed to assist the

identification of hierarchies of learning and the nature of support along the continuum of competency development (Hagstrom & Wertsch, 2004; Vygotsky, 1978; Wertsch, 1985).

The development of a competency based approach to the assessment of speech-language pathology students' clinical skills emerged within a wider professional context in which the speech-language pathology profession in Australia had developed competency-based occupational standards for entry-level speech-language pathologists, known as CBOS (Dawson, Worrall, & Davidson, 1993; SPAA, 2001). This acceptance of a professional competency framework was itself situated in a wider political context (Hager & Gillis, 1995), as the Australian government had both required and supported the development of professional competencies for the recognition of professionals who qualified overseas for migration purposes (Ferguson, 2006a). CBOS was developed through an extensive consultation process with the profession, and the speech-language pathology professional program accreditation process adopted by Speech Pathology Australia shifted to require evidence of the adequate assessment of students' competence in relation to the entry-level standards articulated in CBOS, and so the competency framework quickly became embedded within the curricula for speech-language pathology students nationally (Dawson, 1995; Dawson, Cichero, & Pattie, 1996; Dawson, Robertson, & Mortensen, 1996; L. McAllister, Rose, & Dawson, 1996). While CBOS made the standards required of entry-level clinicians clear, it is not in itself an assessment tool. Instead, prior to the introduction of COMPASS®, each professional education program used a range of tools to assess the clinical performance of their students in relation to these standards, and while data internal to each program guided interpretation of student performance, there were no published accounts of the validity or reliability of these tools. The consultative and research process involved in the development of COMPASS® (S. McAllister, 2005) supported the role of both content-specific and generic problem-solving skills in the development of clinical competence (Wimmers, Splinter,

Hancock, & Schmidt, 2006), and so the final tool included both the seven occupational competencies represented in CBOS (assessment; analysis and interpretation; planning of management; implementation of management; service delivery, professional, group, community education; and professional development) and four generic competencies developed through the research (reasoning, communication, lifelong learning, and professionalism) (S. McAllister et al., 2006).

In the education research literature, considerable attention has been given to the impact of testing on individuals, teachers, curriculum, and society in general, and the term *washback* (and the interchangeable term, *backwash*) is often used to describe the specific impacts of testing on what is taught and how (Wall, 1997). Washback can be seen as positive when a well-grounded assessment makes learning and teaching goals clearly associated with explicit and valid assessment targets. However, critical perspectives in education research have highlighted that washback can also be negative, in that tests can serve to promote covert political and institutional agendas with resultant lack of transparent relationship between teaching practices, tested outcomes, and the goals of learners and teachers (Shohamy, 1998). Such critical perspectives have highlighted the importance of the investigation of the consequences of test use as an integral part of test development (Shohamy, 2001). In the area of education for health professionals, it has long been recognized that assessment drives learning, such that students may become strategic or surface learners in their attempts to prepare for assessment (Tiwari et al., 2005). However, we have not been able to identify any previous recognition within health professional education of the effects of assessments on clinical educators and their practices. For these reasons, it was considered important to examine the impact of the introduction of this new assessment procedure on clinical educators' ability to apply the main concepts involved in the tool.

During 2007, the new assessment tool was taken up by all 13 speech-language pathology programs in Australia (administered by eight universities, with some universities offering professional entry qualification programs at both undergraduate and postgraduate levels), with additional up-take in all three programs in New Zealand. Six of the eight Australian universities had participated actively in the consultation process and field trials involved in the development of COMPASS®. By 2008, the new development had been integrated by all programs as the key assessment of professional entry-level competence within curricula (Ferguson, Lincoln, McAllister, & McAllister, 2008). The tool formed the foundation for the current developments underway to use the tool for benchmarking purposes to inform curriculum renewal within programs as well as to facilitate collaborative educational evaluation (Lincoln, Ferguson, McAllister, & McAllister, 2008). As part of a project that supported the national roll-out of COMPASS® (Ferguson et al., 2008), over 1,000 clinical educators participated in workshops designed to familiarise them with the new assessment tool (Ferguson et al., 2008). It is important to note that previous research had already established that COMPASS® was able to be administered validly and reliably by educators without formal training (S. McAllister, 2005). In view of this, the workshops aimed for increased confidence and understanding about the tool rather than formal training. An interim evaluation of the first eight of these familiarisation workshops run as part of the project involving 240 clinical educators was conducted to provide feedback and direction to the ongoing roll-out of the new tool. This paper presents the evaluation of the immediate impact of the initial workshops providing familiarisation with the new assessment approach.

Method

This project evaluation was designed and conducted as a quality assurance activity meeting the criteria in relation to design, consent, data analysis and dissemination of findings (NHMRC, 2003), as confirmed in correspondence from University of Newcastle

Human Research Ethics Committee, reference #QA01. The evaluation compared aggregated anonymous data collected pre and post workshops in order to gauge the immediate outcomes on participants' approach to student assessment. The methodology was informed by both qualitative and quantitative methodologies (Creswell, 2003). These data were collected so that findings could be used to inform the ongoing implementation of the project to roll-out the new assessment tool nationally.

Participants

Data was drawn from eight workshops involving 240 clinical educators hosted by university programs across five states (codes were used to maintain confidentiality, see table 1). In line with the scope of the quality assurance project design, no data were collected regarding demographic information or other factors such as years of experience. However, participants were familiar with CBOS (as it had formed the basis of previously used assessment tools used by different universities, and had been a major platform of the professional association's activities for over fourteen years). It was expected that some participants in the workshop may have had preliminary experience using COMPASS[®] in the field trials during its development (approximately four years prior), but that the majority would be unfamiliar with the tool. Participants were informed about the evaluation process, and invited to complete all data anonymously, and indicating through a tick box whether or not the data they completed as part of the workshop could enter the evaluation process. In six of the workshops (U1 to U6), an extended scenario was used both before and after the workshop that sought clinical educators' generation of learning goals for a hypothetical student (see Appendix A). For this extended scenario evaluation, 110 of the 202 educators who participated in the pre-workshop written task consented to their responses being used for this evaluation (54.5% response rate), and 144 of the 202 educators who participated in the post workshop written task consented to their responses being used for this evaluation (i.e. 71.3% response rate). Note that for one

workshop (U4) the pre-workshop written task was not administered (due to time restrictions on the workshop duration). Data collection using the extended scenario was ceased after the first six workshops, in order to ensure that analysis of all data collected could be analysed within the duration of the project.

In all eight workshops (U1 to U8), two short scenarios were used after the workshop (see Appendix) to gauge application of the concepts of the new assessment tool that had been highlighted during the workshop. The eight workshops involved a total of 240 clinical educators, of whom 214 consented to their responses being used for this evaluation (89.2% response rate).

INSERT TABLE 1 ABOUT HERE

Content of workshops

Each workshop lasted approximately one and a half to two and a half hours and was run by one of the project team. The workshops made use of the materials previously developed through the support of Speech Pathology Australia and which form part of the materials within the published tool (S. McAllister et al., 2006). These materials consist of three Modules: the first Module involving an introduction to the concepts and processes involved in COMPASS, the second Module involving a more detailed focus on the assessment for learning, and the third Module on ways to use the tool to assess and support the learning of marginal students. All workshops involved in this evaluation used both Modules 1 and 2, except for the U2 workshop which also involved Module 3.

The workshop materials include content provided on PowerPoint^(R) slides, comprising a suggested script and voice over should it be required (e.g., for self study). Materials and instructions for interactive small and large group activities are provided to deepen participants' understanding of the topics presented, including developing an understanding

and ability to apply best practice principles of assessment and learning. Thus, the workshops were highly replicable and consistent across sites, while providing for responsive and adjustment of content (e.g., through added explanation) for participants in the range of interactive learning activities provided.

Data collection

Before and after the workshops, each participant was invited to anonymously provide three learning goals for a hypothetical student that they would discuss with her if they were her clinical educator. The same scenario ('Scenario A') was used before and after all workshops, as follows.

Jane is mid-way through her first adult clinical placement (she has previously successfully completed her child clinical placement). Jane reports that she was confident in child clinical work, but is anxious about their ability to work with adults with communication difficulty. Below are some examples of written feedback that Jane received from her clinical educator in the two weeks prior to them completing the mid placement evaluation using COMPASS®. The full scenario and instructions is provided in Appendix 1. We refer to this scenario as the extended scenario in the rest of this paper.

After the workshop, each participant was invited to anonymously write responses to the following two scenarios (Scenario B and Scenario C, described as the short scenarios in the rest of this paper).

Scenario B: Your placement has not been able to provide the student with the experience of administering an assessment to a client. However, the student has had a significant amount of experience providing therapy and you have also observed the student practising the administration of a case history and a standardised test. Would you be prepared to rate Unit 1, Element 3 (Administers assessment) at mid placement? Why?

Scenario C: Your student is finishing the placement with you. While you are aware of areas that will continue to develop with experience, the student has achieved everything that you would expect of someone whom you might employ. The student has another placement to follow at another location. Would you be prepared to mark your rating of the student at the far end of the rating line as ‘entry-level’ on the overall statement of competence at the end of COMPASS®? Why?

Data analysis

The pre- and post-workshop learning goals generated in response to the extended scenario (Scenario A) were examined for changes relating to the new approach to assessment. In keeping with the undertaking to participants regarding the quality assurance nature of this evaluation, individual institutions and individual participant’s pre/post responses were not matched nor compared. Instead, consistent with the purpose of this data in informing project evaluation, all respondents’ data from all institutions were combined for a global comparison of pre versus post workshop goal setting.

Data collation and analysis of the responses to the extended scenario (Scenario A) involved typing and importing respondents’ written learning goals into NVivo qualitative analysis software (QSR). Content analysis was based on coding for the focus of the goal (each goal was coded as either student or client focused), and the unit of competency as described within COMPASS® generic (G) and occupational (O) units of competency. Multi coding was possible for up to four units of competency, drawing on the descriptors for the following units: G1 Reasoning, G2 Communication, G3 Lifelong Learning, G4 Professionalism, O1 Assessment, O2 Analysis and Interpretation, O3 Planning of management, O4 Implementation of Management, O5 Service Delivery, O6 Professional, Group and Community Education, and O7 Professional Development. Content analysis also

included the coding for the following main concepts of COMPASS®: FA Formative Assessment (formative activity in nature and with some assessment involved), DL Development Learning (learning as developmental in nature and involving growth, improvement, or change as part of the goal), and SL Scaffolded learning (goal explicitly stating clinical educator involvement in supporting development). Thus, each goal was coded three times: in relation to student/client focus, in relation to units of competency, and in relation to the concepts (see above).

Scenario B was designed to elicit responses that indicated the extent of understanding of the requirements of performance based assessment, particularly in relation to the need for direct observation as the basis for evaluation. Scenario C was designed to elicit responses that indicated the extent of understanding of the use of the visual analogue scale to describe performance across the continuum of development of competence. To analyse the short scenarios B and C, a 3-point rating scale was designed for use by the researchers to describe the clinical educators' responses, where 3 fully reflected the application of the main concept provided in the COMPASS® Modules, 2 partially reflected the application of the main concept provided in the COMPASS® Modules, and 1 did not reflect the main concept provided through COMPASS Modules. Each of the points on the scale for each scenario was operationally defined prior to rating (see Appendix 2).

Reliability

In order to verify the reliability of coding for the learning goals based on the extended scenario (Scenario A), all responses from the first workshop (U1) were independently coded – a total of forty-eight learning goals (twenty-four before and twenty-four after the workshop). Overall total percent agreement was 95.2% (119 agreements across 125 coding decisions). The percent agreement for coding of focus of learning goals was 97.92% (47/48),

for generic and occupational competencies 93.33% (42/45), and for coding of COMPASS® concepts 93.75% (30/32). Coding differences were discussed and resolved by consensus. Subsequently, the entire data set was analysed by one of the researchers, and it is the results of this analysis that is presented in this paper.

Criteria for scoring of the responses to the short Scenarios B and C (post workshop) were generated by the researchers prior to scoring, and the responses for the first 16 participants were independently coded by two of the researchers (Ferguson, McAllister, S.) to verify adequacy of each of the three operational definitions for each scenarios. Subsequently the entire data set was analysed by one of the researchers (McAllister, S.).

Results

Extended scenario (Scenario A): Impact on formulation of student learning goals

For the extended Scenario A, a total of 731 learning goals were generated, with the 254 respondents writing an average of 2.9 goals each (i.e. not all respondents provided 3 learning goals). There were 329 goals in total for the 110 participants involved in the five workshops in which pre-workshop data was collected. At the conclusion of six of the workshops, data was gathered for 144 participants, which resulted in 402 post-workshop goals being documented. The results are presented in four sections. The first section looks at the results of the analysis of the focus of goals, and the second section looks at the content of goals with reference to the units of competency covered within COMPASS®. The third section looks at the extent to which the main concepts driving COMPASS® were reflected in the goals.

Focus of goals.

The focus of the learning goals was examined in order to describe the nature of the responses elicited by use of the hypothetical scenario. Of the 329 pre-workshop goals, 290 (73.9%)

were student-focused and 102 (26.1%) were client-focused. A similar proportion of the focus of post-workshop goals was observed, with 319 of the 402 goals (79.4%) being student-focused and 83 (20.6%) being client-focused. Examples of focus of learning goals follow.

Student focused (pre-workshop): “To have clear rationales for goals and therapy intervention and to be proactive in sharing/explaining these with your clinical educator” (pre U3.3, LG2)¹

Student-focused (post-workshop): “To increase confidence in communication” (post U4.4, LG1)

Client focused (pre-workshop): “Identifying and providing specific and appropriate feedback to the client” (pre U3.2, LG1)

Client-focused (post-workshop): “Develop client centred goals for therapy” (post U5.8, LG2)

Content of goals.

The workshops focused on familiarising clinical educators with the tool’s development of a set of generic competencies (as well as reviewing their knowledge of the occupational competencies, and providing experience in the use of the tool’s scoring system). A comparison of the degree to which the learning goals reflected generic codes and occupational units of competency pre and post workshop is provided in table 2. There was little change for either generic or occupational categories of competency, either before or after the workshop with 389 of 793 (49.1%) involving generic units before the workshop, and 455 of 928 (49%) involving generic units after the workshop (with each learning goal able to be coded for up to four units of competency).

INSERT TABLE 2 ABOUT HERE

Qualitatively, while not consistently evident, there was a shift in the language used for the learning goals written post familiarisation with the new assessment tool. For example pre

¹ Participant responses were coded as pre or post workshop, and then for University (e.g., pre U4), and then for response number (e.g., pre U4.4). Since matching of participants pre/post workshop was not within the scope of the consent provided by participants, response numbers do NOT identify participants. For example, pre U4.4 and post U4.4 were different participants. Learning goals were numbered in the order written for each response (e.g., LG1, LG2, LG3).

workshop goals tended to be described as single entities; for example “Being more proactive in group discussions” (pre U1.50, LG1), whereas post-workshop, interrelating elements with units of competency were outlined in the goals, for example “More specific communication: feedback, participating in discussions, interacting with other professionals” (post U5.50, LG1); “Integrate information from all data sources to develop a holistic interpretation and plan for therapy” (post U5.85, LG2).

Additionally, sometimes post-workshop learning goals were described using direct quotation from the 11 Units of competency in the assessment, e.g., “Develop a number of relevant intervention goals that are related to appropriate theory, interpretation of assessment data, client needs and chosen intervention” (post U5.91, LG1). This post-workshop goal is a direct quote from Competency Unit 3: Planning of Speech Pathology Intervention, and is used as a descriptor for an Intermediate Student. Similarly in relation to generic competencies, post-workshop learning goals were sometimes described using direct quotation from the assessment resource materials, e.g., “Generic Competency – Communication. To monitor impact of communication skills on client and maintain a focus on communication partner” (post U5.92, LG1). This post-workshop goal used the wording from the detailed behavioural description of entry-level (competent) performance indicators in the assessment resource manual and directly relates to the COMPASS® second generic competency of communication. Post-workshop (but not pre workshop) respondents also made use of the unit labels for competencies, with and without additional descriptors; for example:

LG1: Generic professional competency Unit 3: lifelong
 LG2: Generic professional competency unit 1: reasoning
 LG3: CBOS competency unit 3: planning of speech pathology intervention
 (post U5.55)

LG1: Communication
 LG2: Planning, maintaining and delivery speech pathology services
 LG3: Analysis and interpretation
 (post U4.11)

Incorporation of main concepts within goals.

The concepts related to COMPASS[®] that were covered in the workshop were about importance of the formative assessment process, the developmental nature of competency, and the capacity of the tool as part of a teaching strategy to scaffold learning. The learning goals were coded for these concepts, with not all goals relating to these categories and with multi coding possible (see table 3 for results). Overall there was a similar proportion of main concepts pre- (51.37%) and post-workshop (56.22%) (expressed as a percentage of total goals formulated for purposes of comparison). There was no apparent change in the proportional use of concepts involving scaffolded learning. A decrease (5.23%) was observed in the proportional use of concepts involving developmental learning (from 31.91% to 26.62%). Due to the multi coding of these concepts, statistical analysis to gauge the significance of this difference is not appropriate. However, qualitatively, it can be noted that development learning was expressed in general rather than specific ways both pre and post workshop, for example, “Developing confidence in case conferencing...” (pre U3.4, LG3). “To improve assessment, analysis and goal development for patients” (post U4.16, LG2). There was an increase in the inclusion of aspects relating to student formative assessment within the generation of learning goals post-workshop, shifting from 6.38% pre-workshop to 14.68% post workshop (again expressed as a percentage of total goals for comparison purposes). The proportion in this instance more than doubled, and is suggested to warrant further discussion. Familiarisation with COMPASS[®] may have fostered awareness of the role of formative assessment. For example, one workshop participant formed the learning goal (post workshop) “To reflect on own practice through reflection diary and for Jane to feedback re performance to therapist after sessions” (post U5.60, LG2).

INSERT TABLE 3 ABOUT HERE

Short scenarios (Scenarios B and C): Post-workshop responses

Generally, the responses to the scenarios were either fully or partially reflective of the main concepts of the tool that were emphasised in the workshop (see table 4). However, nearly 10% of participant responses did not reflect the need for direct observation of competence in workplace performance. This minority of responses suggests that some clinical educators believe that the basis for determination of capacity to perform competently in one aspect could be inferred from other observed performances.

INSERT TABLE 4 ABOUT HERE

Discussion

The workshops provided the opportunity for familiarisation of speech-language pathology clinical educator participants with the newly developed competency based approach to assessment of students' performance in clinical placement. Workshop impact was evaluated through using a hypothetical scenario, with participants writing pre and post workshop learning goals, and applying main concepts post workshop to two short scenarios. There was little change in the focus (student/client) of the post workshop learning goals. The lack of change in the number of student focussed learning goals rather than client focussed goals may have been influenced by the nature of the extended scenario which provided information about the student rather than clients. There was little change in the content of the learning goals (units and/or elements of competency), for either generic or occupational competencies. Clinical educators were already familiar with the content of the occupational units of competency due to the previous widespread use of the professional association's description of these in the Competency Based Occupational Standards for entry-level speech-language pathologists (Speech Pathology Australia, 1994, 2001). The lack of change in the

incorporation of generic competencies within learning goals could reflect lack of impact of familiarisation, but it needs to be noted that these units were well represented in the pre-workshop learning goals. Furthermore, the generic competencies had been developed via a consultative action research process which aimed to capture the profession's understanding of the holistic and integrative aspects of speech language pathology practice.

Based on the formulation of learning goals, the analysis of post-workshop responses indicated that of the main concepts integrated within COMPASS® emphasised in the workshop, there had been an uptake of the aspect of formative assessment. Formative assessment was not routinely included within the approaches of previously used student assessment tools, and so the increased emphasis on this aspect may have involved change for many educators. On the other hand, post-workshop responses indicated a possible reduction in goals that involved recognition of the developmental nature of learning, but no apparent change in the way the developmental nature of learning was integrated within the learning goal.

The finding that a number of clinical educators continued to indicate that the judgments for specific competencies could be made without direct observation warrants attention. This type of inferential judgment process had been a feature of a number of previously used student assessment processes, and so it appears that this difference in the new approach requires further familiarisation for some educators.

This evaluation was limited by the hypothetical nature of the scenarios used to investigate impact, by the use of the same scenario both pre- and post-workshop (for the extended scenario), and by the lack of a control group. It was possible that shifts in the learning goals formulated by participants reflected effects of the experience of engaging in a workshop about clinical education generally, rather than specifically in relation to COMPASS®. Whether any of the observed changes would generalize to influence education

within the clinical setting or be maintained longer term was outside the scope of this study. The evaluation was also limited by the quality assurance project design which precluded matched-pair analysis. This design limits the evaluation to general comparisons, and precludes observation of any intra-individual changes and patterns of impact associated with other factors, such as years of experience.

We suggest that the results can be interpreted, cautiously, to support the proposition that the familiarisation with COMPASS[®] was sufficient to affect specific aspects of educators' approach to assessment. The immediate impact may be attributable, at least in part, to the workshop packages that accompany the tool as well as their delivery for this evaluation by the developers of the tool. However, it is also important to recognize that this assessment tool was developed through high engagement strategies with educators and students (S. McAllister et al., 2008), and so there is close alignment between the tool's approach and the values and orientation to learning of the professional community of practice (Wenger, McDermott, & Snyder, 2002).

The immediate effects of familiarisation with the new assessment tool, suggests that the introduction of COMPASS[®] may be expected to impact on the actual teaching practices of clinical educators. The extent to which this washback is positive or negative is uncertain, since for example, the apparent movement toward incorporation of generic goals may be seen positively as more powerful for the facilitation of learning, or alternatively seen negatively as watering-down the specificity and clarity of goals aimed at fostering the development of occupational competencies (Wimmers et al., 2006). We suggest that the present findings support the usefulness of conducting further evaluation (in actual rather than hypothetical situations) when clinical educators have more hands-on experience in using the tool, in order to consider the impact of the introduction of a new assessment tool in speech-language pathology education.

In conclusion, in the context of a history of collaborative engagement in the development of a new student assessment tool, this evaluation found that familiarisation workshops were sufficient to change educators' incorporation of formative approaches within their formulation of student learning goals.

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Appendix 1. Pre- and post-workshop extended scenario A

Jane is mid-way through her first adult clinical placement (she has previously successfully completed her child clinical placement). Jane reports that she was confident in child clinical work, but is anxious about her ability to work with adults with communication difficulty. Below are some examples of written feedback that Jane received from her clinical educator in the two weeks prior to them completing the mid-placement evaluation using COMPASS®.

- *Good attempt at engaging Mr Jones in conversation at the start of the session. What do you think his main priorities are for his work with you in therapy?*
- *Your feedback through the session with Mr Jones stayed fairly general, e.g. ‘good try’. Do you think you are clear about what it is that you want him to achieve? How could you communicate that more clearly to him (given his auditory comprehension problems)?*
- *Thinking back over today as a whole I didn’t get much of a chance to hear what you have been reading and thinking about the cases we have been seeing – I think you tend to ‘sit back’ a bit and let the other students ‘go first’ – this makes it hard for me to know what’s going on in your thinking.*
- *You have mentioned a few times that you dread going to the wards on your own – and certainly Ward 4 is very busy and staff tend to be a bit rushed – we need to set aside a time to talk about ways you could manage this situation.*
- *Your report on Mrs Green was very succinct and you did a good job at providing detailed results of assessment under each heading on the template.*

Task

Write down three learning goals that you would discuss with this student if you were her clinical educator.

Appendix 2. Post workshop short scenarios B and C – guide to interpretation of responses

In the following guide to interpretation of responses, the reasoning based on COMPASS® is provided, along with a scoring system designed to allow for the collation of responses. In all cases the scoring system is a 3 point rating, where 3 fully reflects the main concepts provided in COMPASS® Modules, 2 partially reflects main concepts provided in COMPASS® Modules, and 1 does not reflect the main concepts provided through COMPASS Modules.

- B. Your placement has not been able to provide the student with the experience of administering an assessment to a client. However, the student has had a significant amount of experience providing therapy and you have also observed the student practising the administration of a case history and a standardised test. Would you be prepared to rate Unit 1, Element 3 (Administers assessment) at mid placement? Why?

Looking for responses that indicate recognition that while simulation of clinical practice allows INFERENCE of clinical competence, it does not allow DIRECT OBSERVATION of clinical competence.

Scoring guide:

1. *Says that would be able to rate confidently*
2. *Says that may be able to rate, but with caveats*
3. *Says not able to rate, other than as NOT OBSERVED*

Your student is finishing the placement with you. While you are aware of areas that will continue to develop with experience, the student has achieved everything that you would expect of someone whom you might employ. The student has another placement to follow at another location. Would you be prepared to mark your rating of the student at the far end of the rating line as 'entry-level' on the overall statement of competence at the end of COMPASS®. Why?

- C. *Looking for responses that indicate awareness that the tool is only descriptive up until entry level, and once beyond that point no further descriptive ratings are made. Some students will be working at above entry level in any or even all Units/Elements of competence at any stage of their program. We are aiming for familiarisation workshops to counteract any bias against using the end points of the scale.*

Scoring guide:

1. *Not prepared to rate as entry level, since student has not completed training.*
2. *Not prepared to rate as entry level, since next placement will provide more experience and expertise.*
3. *Prepared to rate at entry level, given competence at this level. Next placement will serve to further extend and consolidate beyond entry level.*

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Table 1. Participants and workshops

Host university (code)	# workshop participants	Extended scenario Scenario A respondents		Short scenarios B and C respondents (post workshop only)
		Pre workshop	Post workshop	
U1	9	8	8	9
U2	16	16	16	16
U3	45	26	31	37
U4	29	na	29	29
U5	71	45	49	55
U6	32	15	11	32
U7	10	na	na	10
U8	28	na	na	26
TOTAL	240	110	144	214

(na = not administered)

Table 2. Generic and occupational units of competency pre and post workshop

<i>Units of competency (G=Generic; O=Occupational)</i>	<i>Pre workshop</i>				<i>Post workshop</i>			
	<i>#</i>	<i>%</i>	<i>#</i>	<i>%</i>	<i>#</i>	<i>%</i>	<i>#</i>	<i>%</i>
G1 - Reasoning	94	11.85			123	13.26		
G2 - Communication	169	21.31	389	49.05	181	19.51	455	49.04
G3 – Lifelong learning	95	11.98			116	12.50		
G4 - Professionalism	31	3.95			35	3.77		
O1 - Assessment	7	0.88			9	0.96		
O2 – Analysis & interpretation	9	1.13			32	3.45		
O3 – Planning of management	96	12.11			101	10.89		
O4 – Implementation of management	102	12.86	404	50.95	107	11.53	473	50.96
O5 – Service delivery	29	3.66			38	4.09		
O6 – Professional, group & community education	65	8.20			66	7.11		
O7 – Professional development	96	12.11			120	12.93		
Total	793	100	793	100	928	100	928	100

Table 3. Main concepts related to COMPASS® pre- and post-workshop identified within responses to Scenario A.

Key concept	Pre workshop concepts		Post workshop concepts	
	#	%* (n=329)	#	%** (n=402)
Formative assessment	21	6.38	59	14.68
Developmental learning	105	31.91	107	26.62
Scaffolding of learning	43	13.07	60	14.92
Total	169	51.37	226	56.22

* Percent of total goals pre-workshop, for comparison purposes

**Percent of total goals post-workshop, for comparison purposes

Table 4. . Main concepts related to COMPASS® pre and post workshop identified within responses to Scenarios B and C.

<i>Response to scenario indicates application of main concepts regarding:</i>	<i>n</i>	<i>No Application (1)</i>	<i>Partial Application (2)</i>	<i>Full Application (3)</i>
		<i>#(%)</i>	<i>#(%)</i>	<i>#(%)</i>
Scenario B: The need for direct observation of competency	208	20 (9.6%)	50 (24.1%)	138 (66.3%)
Scenario C: The use of the rating scale for entry-level description	213	1 (0.4%)	18 (8.5%)	194 (91.1%)