EVALUATING EVALUATIONS

A study of the issues and problems surrounding the assessment of clinical competence in general and the clinical assessment of Occupational Therapy students in particular.

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ABSTRACT

An initial study was made of literature from a variety of medical, paramedical and nursing sources relating to the assessment of clinical competence. These issues are examined and discussed in some detail. Thereafter nine experienced Occupational Therapy clinical supervisors were interviewed, using repertory grid technique, in order to establish what factors they considered important in assessing students' competence to practice. These grids were analysed both manually and by computer using the Focus programme. The supervisors then met to discuss issues and topics arising out of the analysis.

Following the analysis and discussion of the findings some conclusions are drawn and recommendations made for their potential uses.
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INTRODUCTION

ASSESSMENT OF CLINICAL COMPETENCE: A thorny problem

All professional groups must have some means of assessing work performance and skill prior to certifying individuals as competent to practice. This can prove to be a very difficult task for those involved in the assessment of competence and there are many potential pitfalls and hazards in the process.

This study aims to consider the major difficulties surrounding the assessment of clinical competence, to look at how supervising staff reach decisions about student performance and finally to consider ways of alleviating the problems encountered.

Occupational therapy students, like those in other paramedical, medical, nursing and dental courses, are required to undertake a stated amount of clinical work during their professional education. In the case of the Bachelor of Science course in Occupational Therapy at Queen Margaret College students require to complete a minimum total of 1000 hours over six different placements. Failure to gain a pass in any individual placement requires that the student completes an additional block of practice in a similar area, but at a different location. Failure in two placements in any one year means the termination of training for the student involved.
Students are supervised and assessed during their placements by qualified therapists who also have a clinical commitment. Much of the assessment is carried out by observation, this necessarily means that there is, in many instances, a very large degree of subjectivity. Errors can occur in judgements made and this in turn can affect the reliability of the judgements and the validity of the assessment tool. This situation may lead to problems which become self-generating e.g. a student may be certified competent by a series of, often unrecognised but occasionally acknowledged, rater errors, that student will in turn be a less competent therapist. If she subsequently becomes a clinical supervisor her lack of professional skills will directly affect her capacity to supervise and assess students on placement and may lead to reliance on subjective impressions which may be coloured more by a student’s personality than by clinical skills. This potential vicious circle would have serious implications for the profession.

Squire (1981) in studies with student psychiatric nurses goes so far as to suggest that most ratings of students in a clinical setting are based on “hearsay, guesswork, stereotypes and caution” (1, p159).

Concern about assessment of clinical competence in occupational therapy comes from four main sources, the professional group through the College of Occupational Therapists and the Council for Professions Supplementary
to Medicine (C.P.S.M.); college staff; students and from clinical supervisors.

C.P.S.M. in the reports "The Next Decade" 1979, and "Registration and Self Regulation" 1980, tackle the competence issue in a rather global manner but emphasise the need for practical and workable definitions of competence at various levels and for the enforcement of minimum standards.

College staff are aware that some supervisors tend to mark strictly while others act more leniently and tend towards giving students the benefit of the doubt, the latter group are probably the most common.

Topetzes (1951) summarises the consequences of such leniency as follows:-

"There is room, and need in our society for .... able practitioners. There is hardship however on the one hand for the student who finally gets through and is ill-fitted for the profession and on the other hand for the disabled public when serviced by poor practitioners" (2, p264).

It must be added that there is hardship too for the profession which has to carry its weak members. College staff hear the concerns of both the students and the clinical supervisors and aim to help council both about the difficulties encountered. It is not unknown for
clinical staff to state that they should have failed a student but felt unable to do so.

Discussion with students raises several very important issues, they sometimes feel that judgements are made on very little evidence and that they are judged too often on the process of learning rather than on the end product or final consistent performance.

Lenberg (1979) also found this situation with nursing students, she likens the process of learning in a clinical setting to that of an actor rehearsing a play. The actor has the script prior to rehearsals, students have theoretical knowledge; the actor is given the opportunity to rehearse lines with feedback from the director prior to the 'test' of the opening night and subsequent performances. Students should also be given the opportunity to practice skills with supervision and feedback, Lenberg argues that this is not always the case and that students are often judged before they have the opportunity to practice skills. Some assessments must be made at intermediate stages in learning in order to provide constructive feedback from which students may learn. What should be assessed ultimately is the adequacy and consistency of performance after learning and practice have occurred, it appears from students' comments that this may not always be the case.

Some students feel that assessments can be made at a superficial level and that the way to gain good grades
is to get on well with the supervisor on a personal level, do as she does and not ask too many questions. This is rather disconcerting since it implies that in some instances the professional group is discouraging innovative thinking and questioning about what is being done and why.

Many students also feel that those students who are most articulate and outgoing gain better grades than those who are more reticent and that good interpersonal skills can mask lack of knowledge. It is true that therapists need to be able to quickly form good working relationships with patients and be able to work cooperatively with other staff, but they also require a thorough knowledge of what they are doing otherwise their interventions may at best be superficial and at worst be downright dangerous. If such knowledge is not tested thoroughly in an applied setting students may appear to be working well, but in fact be functioning in a limited way and carrying out treatment in an automatic, unthinking manner.

De Mers (1978) sums up the problem as follows:

"in observing students performance instructors are usually in the position of inferring that students possess the knowledge base if the procedures are carried out correctly. Making these assumptions is inherently dangerous. Students may know the rule by rote and apply it consistently, yet misunderstand the rationale for it and therefore have difficulty in those instances when exceptions to the rule need to be made" (3, p90).
If students are not assessed in a searching way they will soon become aware of this and learn what they must know in order to pass. What they should and might know is likely to become displaced to the bottom of the list or indeed fall off it completely, to their personal and professional detriment and to the detriment of the professional group and its clients alike.

Clinical supervisors also express concerns regarding assessment of clinical competence. Courses for supervisors are run at Queen Margaret College and take the form of a basic two-day course and an intermediate five-day course. Assessment is usually the issue which generates most debate and concern amongst course participants. It is unfortunate that the time that can be allocated to dealing with the topic is necessarily short and coverage of the topic is therefore rather superficial.

Major concerns expressed by supervisors are that they find it difficult to fail students who are performing badly. Some feel this would be an admission of their inadequacy as supervisors. In nursing Rezler (1978) identified the same problem and suggests that supervisors often give pass grades rather than have students and college staff question their rationale behind a fail grade.

Many supervisors are aware of and express concern about the subjectivity of their judgements and seek guidance in order that they can be fair to students.
One of the exercises which has been carried out during clinical supervisors courses is to ask participants to grade student performance from a video of a student in a clinical setting. Many supervisors have been willing to make fairly concrete judgements on what was effectively very little evidence and the interpretations, as in real life, have varied enormously. This may be an indication of how supervisors assess on clinical placements.

Another exercise used has been to ask participants to rate summaries taken from student assessment forms. Results suggest that supervisors are much happier to allocate a fail grade to an anonymous summary than to a student on placement.

It could be argued that the present system of student assessments asks too much of clinical staff in the time they have available and with the level of expertise they have.

With so many people expressing concern about the issue of assessment of competence, it is vital to study the issue in some depth and seek ways of helping those involved in it. The clinical area is the proving ground of the profession and if it cannot prove itself to be useful and effective it could sink without trace in an economically austere environment.

The major objectives of this study are to explore some problems and issues in assessment of competence. To consider how clinical supervisors make decisions about
student performance and to ask those involved to make a critical analysis of their assessment strategies. A third objective is to consider ways of eliminating or at least minimising errors which may occur and to suggest ways of helping supervisors make more objective and rationale decisions than seem to be made at present.

In order to carry out the study use is made initially of personal construct theory, as proposed by George Kelly (1955), as a means of studying how people interpret and make sense of their environment. This would seem to be the ideal approach in this study as it allows for the use of repertory grid technique which uses ideas generated from the study subjects rather than from the researcher. Kelly argued that this technique is similar to a structured interview but allows for more objectivity in administration and interpretation.

The study group consisted of nine experienced clinical supervisors all of whom have an ongoing commitment to supervising and assessing students. Because of the small number of participants this research can be considered a pilot study the results of which may indicate the direction of and/or form the basis for future studies. Efforts have been made to make the group representative of experienced supervisors in the hope that results may be generalised to the wider population of clinical supervisors. However, the group are employed by the same Health Board and this may have some influence on their perceptions and interpretations of student performance.
The study consists of five chapters.

Chapter 1

*Evaluation of Clinical Competence:*— some issues and problems.

Considers the nature of the problems surrounding assessment of clinical competence and also some recent suggestions for alleviating some of these difficulties.

Chapter 2

*Personal Construct Theory:*— and its possible applications to clinical supervisors.

Deals with the research methodology and the theory upon which it is based.

Chapter 3

*Clinical Competence Decisions:*— how, what and why.

Deals with the study itself and reports the use of repertory grid technique to elicit how supervisors make decisions about students' clinical competence. It details how the study was carried out, includes information on grids of the supervisors involved and covers the analysis of these grids using the FOCUS computer programme developed by Thomas (1976).
Chapter 4

Analysis of Study Results.
Covers the analysis of the study, the conclusions that can be drawn from this and the implications of the results. It also deals with the group discussion following the individual interviews.

Chapter 5

Summary and Conclusions.
Covers a summary of the study and offers suggestions and recommendations for the use of the study findings and for additional research.
CHAPTER 1

EVALUATION OF CLINICAL COMPETENCE:— some issues and problems.

In order to consider how clinical competence is evaluated it is necessary initially to look at issues in and definitions of competence itself. If competence cannot adequately be defined it follows that it cannot adequately be assessed.

La Duca et al (1978) argue that this is the crucial first step and suggest that

"it should be obvious that the quality (technically the validity) of whatever follows is limited by the underlying competence definition" (1, p150).

Argyris and Schon (1974) also consider this to be the major issue; they take the argument further to suggest that professional education suffers from insufficient theory on two counts. Firstly, that many professions are loosely defined:—

"practice is based on models such as habit, the artist as hero or craftsmanship. They suffer in short because there is not 'theory of action' for the profession" (2, p36).
Secondly, professional education itself suffers because there is a lack of educational 'theory of action' for instruction and they suggest that practical instruction comes off worst.

"In some fields apprentices are educated by methods ranging from hero worship to trial and error" (3, p38).

This problem has also been raised in the field of social work. Millard (1972) points out that there is, as he describes it, no satisfactory

"anatomy of professional competence such as might allow for the measurement individually of its component parts" (4, p14).

It is not feasible here to discuss in detail the issues surrounding theory of action in occupational therapy. There have however been major advances in recent years towards the development of frames of reference and the establishment of theoretical models for treatment within the profession. This being the case it should be easier to assess student performance more objectively than in the past by evaluating their understanding and execution of treatment using the various models now employed. There may however be some problems if established clinicians do not keep abreast of new trends because they will be working from a different base from the students.
Despite advances in professional identity, competence remains a somewhat blurred concept. Burg et al (1982) point out that the term competence has been commonly used interchangeably with terms like performance and competent performance. They suggest that competence should be defined as

"the ability to carry out a set of tasks or a role adequately or effectively" 
(5, p60)

while performance relates to actually carrying out the task or role.

It follows therefore that competent performance is the carrying out of a task or role adequately. This still leaves the problem of what in fact constitutes an adequate performance. Work may also be carried out competently or incompetently, this is the issue which must be judged for students on placement. It is important to note that incompetent performance may or may not indicate the absence of competence in the student.

Burg et al add "competence is generally neither wholly possessed by someone nor wholly lacked; it exists by degrees, and a person is either more or less competent in relationship to some standard or frame of reference" (6 p60).
This suggestion goes back to Argyris and Schon's argument that professions must be able to identify the standards by which to judge their members. Occupational therapy and similar professional groups are working hard to refine and maintain such standards.

Having established that there are difficulties the next step is to review attempts which have been made towards defining standards or frames of reference against which student performance may be judged. Burg et al (1982) suggest that any definition of competence must have several strands, initially the specific abilities of a competent individual must be described followed by the conditions in which these abilities will be manifested. Finally it is necessary to state the standards of performance at or above which an individual may be deemed competent. They add, however, that in reality very few definitions ever achieve the successful balance of these strands.

La Duca et al (1978) develop this argument and add an additional problem in attempting to define competence by suggesting that

"performance appropriate to any situation is determined by the situation itself" (7 p151).

This means that stating the conditions under which a task should be carried out as suggested by Burg et al can be very difficult or indeed impossible. La Duca
suggests using the language and concepts of role theory, which states that the 'situated activity system' imposes on an individual the obligations of the role, it also distinguishes between role obligations and actual role performance. La Duca argues that professional competence implies concern for what should be done not merely what is done and therefore that the focus of attention should be shifted from any individual task, the appropriateness of which will vary in any encounter, to the situation which gives identity to the professional by demanding appropriate performance. This makes the assessment of the situation even more complex because it puts the focus onto what is, should and could be done in a variety of complex situations.

O'Reilly et al (1985) caution that fear about the complexity of the issue of competence can lead towards an over-simplistic view of the problem and further that rigid definitions tend towards the use of behaviourally anchored rating scales which he adds too often give the assessor a laundry list of items to observe and rate. He argues that this is too narrow and does not reflect the "active, ongoing operation of interdependent systems or dimensions of behaviour" (8 p398) seen in clinical work. The clinical situation may throw up a host of uncontrolled variables which the assessor must take into account when making judgements otherwise students may be penalised for events which are outwith their control but which by their existence affect performance.
King 1980, suggests that overall measurement of competence is defined by

"the manner in which the occupational therapist uses abilities to carry out the tasks which help resolve or ameliorate the presenting problems" (9, p194).

This definition reinforces the importance of the way in which a task is carried out rather than merely the capacity to complete it.

From the discussion to date it can be concluded that competence is a very difficult attribute to quantify and define. Rigid definitions tend to narrow it to a very simplistic level and tend to favour behaviours which are easy to observe and relatively easy to quantify. They tend to relate to the activity and its completion rather than the quality of performance. Assessments based on them may be more objective but are likely to be less searching. More thorough definitions of competence which include more depth and scope by incorporating such issues as quality, effectiveness, efficiency and consistency of performance in a variety of contexts are more difficult to formulate assessment procedures from. The procedures used therefore tend to be less well defined and may lead to more varied interpretations on the part of assessors.

It would be much more comfortable for all concerned if definitions of competence were easy and straightforward
generating in turn assessment procedures with the same qualities. In real life however this is not the case, competence is a complex issue and as such should be addressed in a thorough and searching way in order to find the most effective and fairest methods of assessing it. The C.P.S.M. report, The Next Decade 1979, suggests that it may well be that lack of informed debate about competence is really a discreet avoidance of difficulties but adds that the issues must be confronted "because competence is central to the guaranteeing of high standards and service effectiveness" (10 p41).

Because adequate definitions of competence are complex and may not always generate clear assessment procedures and because of suggestions, from students and others, that assessments of competence are sometimes influenced by a variety of factors not primarily concerned with competence as such it is worthwhile to consider how people actually view others, what factors influence their perceptions and on what grounds they make judgements about them.

PERCEPTION OF COMPETENCE AND ITS ASSESSMENTS

John Dewey pointed out that evaluation has two qualitatively different meanings, the first being to esteem or hold dear, which could be described as an emotional type of evaluation. The second being to appraise, which implies a more objective, less personal
type of measure. Lenburg 1979, suggests that the evaluation of nursing students has probably leaned more in the direction of the emotional rather than the intellectual interpretation of the task. Many similar professional groups would probably also recognise this in their student appraisals.

It may be that differences in interpretation of the task come from differences in perception of its purpose. Most supervisors and students seem to see the major function of evaluation of clinical work as a system of examining student performance to contribute to their overall assessments of proficiency. The major function of assessment should be an enabling process where students are given feedback about performance in order that they can progress, this however is regarded by many as of secondary importance. It is obviously very difficult to separate the two functions and it must be added that assessing in order to give constructive feedback throughout the learning process may easily colour supervisors views.

Lenburg 1979, suggests that there is a tendency for students to be

"stereotyped very early in the course of events and therefore observed accordingly" (11 p40).

A number of students have expressed feelings that if they perform badly in the early stages of a placement
they are sometimes not given the opportunity to disprove the possibly inaccurate view their supervisor has of them. Indeed this problem could start in college before students are even involved in clinical placements. Academic staff react towards students in particular ways and may be either supportive or critical in their dealings with them. If for example academic staff are influenced by a student’s friendly personality they may give the student positive feedback suggesting that this is very appropriate and either overtly or covertly intimate to the student that she should cope well in a clinical setting. The student in turn is probably more likely to present herself in a more self assured and confident manner while on placement. The student, on the other hand, who has been given less supportive messages may have less cause for confidence in her approach and may present in a more reticent manner. It is probable that if this situation does exist it is more likely to occur in students who are school leavers, who are still in the process of establishing their own identities, than with more mature students.

Berger and Luckman 1966, summarise this issue by stating that

"the self is a reflected entity reflecting the attitudes just taken by significant others towards it, the individual becomes what he is addressed as" (12 p152).

Argyle 1978, also notes problems in this type of interaction and suggests that "our impressions of others
are partly based on inferences from their appearance" (13 p108) and that through our first impressions we apply stereotypes which are difficult to reconstruct even in the light of new and entirely contradictory evidence. Argyle goes on to suggest that people try too hard to construct a consistent picture of others by assuming they will behave in the same way across contexts.

Jones and Nisbet 1972, suggest that variations in subjective impressions of what is happening also occur and that performers, in this instance students, are more likely to attribute behaviour to situational factors while observers, in this case supervisors, are more likely to attribute performance to students personality. Clinical supervisors may therefore underestimate situational factors affecting student performance and may be unaware of their own influence on students behaviour.

Presseler 1983, goes so far as to state that

"the most significant aspect of fieldwork experience is the relationship between the student and the supervisor" (14 p164).

In the areas of social work Brandon and Davies 1980, also recognise this problem and suggest that assessment in fieldwork should be re-thought. Using evidence from assessments of students considered to be working at a marginally competent level they conclude that all
students should be required to disprove incompetence and add

"it is generally assumed that a pass grade should be given if there is no evidence of incompetence, rather than that there should be positive evidence of good practice" (15 p335).

The suggestion here being that the onus should be on the student to build up the components of competent practice rather than for competence to be assumed in the light of no evidence to the contrary. Brandon and Davies also found a tendency for fieldwork teachers to delay making decisions or raising the issue of poor performance too soon for fear of deflating students and undermining their confidence. The ideal balance has to be found here and decisions made about how and when to intervene in the case of poor performance. It must not be left so late that the student has no opportunity to improve or that the supervisor feels pressurised into passing the student because of lack of constructive intervention early enough.

As noted earlier some students have the feeling that personality can unduly influence decisions made about their competence. A number of studies have considered this issue and looked at both personality traits and academic grades in relation to clinical performance in occupational therapy. Booth 1957; Anderson and Jantzen 1965; Bailey, Jantzen and Dunteman 1969 and Bannister 1985, have all tended to conclude that there are no
significant personality factors which would indicate success in clinical work. It could be that the problem with these studies lies in the validity of the personality inventories used or in their administration. It may also be that students alter significantly from pre-college to post-college with the consequence that this type of study has little or no value.

In a study with medical students Wigton 1980, asked fifteen experienced examiners to rate five first-year students who had been coached to present clinical cases in a variety of ways. Considerable variation was found in the rankings given. Wigton suggested that the ranking depended as much on what the students did during the presentation as on its content and organisation and concluded that evaluations "can be significantly influenced by the personal characteristics of the students" and that examiners "do not appear to share common standards" (16 p206) for evaluation student performance. Wigton also looked at the students later clinical ratings and found that there was a similarity between the clinical ratings which he suggests may be more than an intriguing coincidence.

Crites 1969, discovered that this was a problem found in many areas. In a comprehensive review of inter-rater reliability over a wide range of occupations he found
that only a small proportion of them attained satisfactory levels of reliability. He suggests that raters may well be influenced by a variety of factors, including the personality of the person being assessed.

Mann and Banasiak 1985, and Ross and Leichner 1984, found a statistically significant correlation between interview and fieldwork grades suggesting that the same influences are at work in both situations. Vargo et al 1986, caution that statistical significance in this instance may not equate to practical importance.

These types of study do not necessarily prove that evaluation of clinical competence is always influenced by students personality but should indicate that caution is needed in any rating situation since assessors may be influenced by factors they are unaware of.

What is emerging is a picture of assessment of clinical competence littered with problems such as inter-rater reliability caused by differences in standards between raters and variations in their perceptions of performance, along with the suggestion that clinical evaluations are heavily influenced by factors related to both student and supervisor personalities. Squire 1981, concludes that the primary source of difficulty lies in what can be termed globally as rater error.

It is worthwhile to consider in more detail some of the factors influencing raters since awareness of these may indicate the route to take in controlling them.
FACTORS INFLUENCING ASSESSMENT AND ASSESSMENT INFLUENCE ON OTHER FACTORS

Thorndyke and Hagen 1977, suggest that there are two main types of problem in obtaining sound ratings. Firstly there are a number of factors which limit the raters willingness to rate honestly and conscientiously in accordance with instructions given, the rater may be unwilling to take the time and effort needed to complete the appraisal procedure. Secondly there are factors that limit his ability to rate consistently and correctly even with the best of intentions, many of these factors fall into the category of rater error.

Ebel 1979, concluded that the problem is not completely remediable by stating that "error is unavoidably involved in any measurement" (17 p274). More specifically in relation to the type of assessment discussed here Guilbert 1987 suggests that

"an evaluation made by a human observer is more or less subjective and thus subject to error" (18 Sect. 4, 23).

Various types of error have been described by a number of authors eg Rowntree 1977; Thorndyke and Hagen 1977; Levine 1978 and others. Those errors most commonly cited in the case of assessment of 'on the job' skills are:--

**GENEROSITY OR LENIENCY ERROR** is a tendency on the part of the raters to mark higher than they should. In nursing Rezler and Stevens 1978, suggest that this is
more problematic in a friendly rather than a formal relationship. This type of error could easily occur in occupational therapy because supervisors and students work closely together over a period of time and often develop friendly as well as professional relationships. Thorndyke and Hagen 1977, suggest that there is a tendency in this case for most ratings to be made at the top end of the scale and for average grades to become an indication of lower performance.

The opposite to generosity error is stringency error in which raters undervalue and under-rate performance. This is probably less common but may well occur in situations where students either get off to a poor start or are weak in certain areas.

**ERROR OF CENTRAL TENDENCY** occurs if raters hesitate to use either end of a scale, this means that there is a tendency to group most students about the mean and does not distinguish those who deserve the extremes. Some students have encountered this error and feel that they performed better in some aspects than is acknowledged on their assessment forms. In nursing Rezler and Stevens 1981, suggest that the error of central tendency occurs mostly in situations where the supervisor has not seen the task performed sufficiently often or in the recent past.

**HALO ERROR** is a tendency to rate in terms of an overall, general impression without differentiating specific aspects. As early as 1925 Symonds suggested that halo
is more prevalent in rating items that are not easily observable and in those that are not clearly defined or are ambiguous. This adds weight to Argyle’s suggestion that people try too hard to construct a consistent picture of others.

Squire 1981, cites halo error as the basic difficulty in ratings and suggests that as a result of it clear profiles of students’ strengths and weaknesses fail to emerge. If this is the case then one of the major functions of assessment is lost.

**LOGICAL ERROR** is similar to halo error and occurs when the assessor assumes there is a relationship between two items or variables and subsequently rates them in a similar way. This may arise out of idiosyncratic ideas about various tasks and cause variations in perceptions of them.

**CONTRAST ERROR** has been described by Thorndyke 1977, as bias that occurs when the rater tends to rate others in the opposite direction from himself for a given trait.

**PROXIMITY ERROR** As described by Guilbert 1987, occurs when the evaluation of one factor tends to influence another, he suggests that the shorter the interval between the two the more pronounced the tendency will be.
There are probably more errors of this type, but all of those mentioned are recognisable as occurring in assessment of occupational therapy students. The existence of them should be drawn to the attention of all involved in rating students in an effort to minimise them.

Kelly 1969, has speculated that rater errors may be distributed evenly amongst the population and that if students are assessed by a variety of people in a variety of contexts then the errors may cancel each other out. This is a difficult argument to sustain since the general trend appears to be for raters to be over rather than under generous. There is also always the problem of the student who, by chance, is rated by similar raters.

ADDITIONAL FACTORS INFLUENCING ASSESSMENT

THE EXISTENCE OF ASSESSMENT The fact that students know that they are being assessed may influence their performance either positively or negatively, most students suggest it is the latter. Assessment may produce a Hawthorne Effect, as described by Roethlisberger and Dickson 1969, ie the mere fact that assessment is happening may affect and alter perceptions of the situation. This phenomenon may also establish the foundations of a self fulfilling prophecy.
FALACY OF FALSE QUANTIFICATION Rowntree 1977, suggests that there is a risk of committing the fallacy of false quantification or McNamaras Fallacy, i.e. focusing on those skills or objectives that are most easily measured thus creating the possibility of

"making the measurable importance when we would be better employed in making the important measurable (or at least discernable)" (19 p68).

If in fact the easily measurable becomes important students will learn in accordance with that to the detriment of other vital, but less tangible, aspects of performance.

OPPORTUNITY AND TIME Lack of either of these may influence ratings. Opportunity to see a student perform a task is difficult to guarantee because of the sometimes unpredictable nature of clinical work. Time too may be limited in some cases because of pressure of other work. In both cases there is evidence from discussions with supervisors that they tend to commit the error of central tendency and feel obliged to rate all items even when they have had little opportunity to observe them. The latter could be described therefore as an 'obligation error'.

AMBIGUITY in the meanings of traits being rated also causes problems. Because of the abstract nature of some of the traits supervisors are asked to rate
eg initiative, confidence etc. Thorndyke and Hagen 1977, suggest that the first step towards consistency in ratings is to "achieve consistency from rater to rater in the meanings of the qualities being rated" (20 p456).

This may well be the key issue in resolving some of the problems.

DIFFERENCES BETWEEN RATERS may also influence and bias how they perceive a student. The raters background, experience, personal preferences etc, may all affect ratings. Thorndyke and Hagen 1977, suggest that differences in raters perceptions are not due solely to chance, but are very heavily influenced by both personal characteristics and value structures. They add too that often bias arises out of a general liking for or aversion to a student.

LACK OF COMMITMENT may produce problems, if supervisors feel that the processes of supervision and assessment ask too much of them they may be less inclined to deal with them in a thorough manner. It must be added that supervisors cope with students in addition to their clinical caseload, and that at times of pressure patients must be their first priority.

INSTABILITY OF BEHAVIOURS BEING RATED Inter-rater and rater reliability may also be influenced by the relative instability of behaviours being rated because of the effects of context and environment on the student's
performance. It may be that reliability can not be
sought too rigorously because of these influences.

The list of problems surrounding and influences on
assessment of clinical and practical skills seems to be
endless. At best assessment can be described as
difficult and demanding, at worst it seems to be no more
effective than a game of snakes and ladders as a means
of deciding on a student's future - where most reach the
ultimate goal eventually, some take longer than others
and some have the good fortune to have all elements in
their favour. The problems which have consistently
emerged in studies on this topic are rater and inter
rater reliability, validity, lack of objectivity
and fairness. These have been tackled in a number of
ways, but none of the proposed solutions appear to solve
all of the problems. Attempts to reduce subjectivity and
increase reliability and validity have taken several
directions i.e. assessments of a more objective nature;
improvement in rating formats, especially rating scales;
better training for raters. Each of these will be
considered in turn.

ASSESSMENTS OF A MORE OBJECTIVE NATURE:- Various tests
to assess clinical competence have emerged in recent
years, most notably of the Objective Structured
Practical Examination (O.S.P.E.) and the Objective
Structured Clinical Examination (O.S.C.E.) (Harden
1973). These are test or exam situations consisting
of a series of sub-tests that aim to assess specific
areas of knowledge which if completed successfully
should collectively equate to competence. The sub-tests may take the form of different types of work eg laboratory work, written test or tasks, problem solving tasks, encounters with real or simulated patients etc. They are all time limited and marked by pre set criteria. The paper and pencil and laboratory type sub tests are scored in the same ways as any other test of that type. The sub-tests using patients are rated by an examiner who is primed to look for specific aspects of competence desirable in the task and rates these on a standard form for all students. The examiner may have to consider such issues as how well the task itself was performed but is also likely to be required to rate such items as how the student reacted to the patient, the student’s attitudes etc. This goes back to the same situation which exists in examining competence in a clinical setting with all the same problems. This type of test may be even less efficient than clinical assessment because it involved only a limited exposure to a situation or problem and does not have prolonged involvement and the need for sustained good practice. It is also probably more likely to cause students more stress at the time of the test. Weiss 1987, has suggested that

"simulated exercises ..... may not necessarily match the reality of working with live patients and the real world situation" (21 p6).

O.S.P.E. and O.S.C.E. type tests may well be useful however as part of an overall battery for the assessment of clinical competence.

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The World Federation of Medical Education Congress on "Newer Developments in Assessing Clinical Competence" 1985, notably dealt very largely with O.S.P.E. and O.S.C.E. types of assessment, approximately sixty of the sixty-five papers presented related to this area and lead Newble 1987, to conclude that

"the most pressing issue has hardly been mentioned i.e. the need for reliable measures of assessing performance in the ward or practice setting. We need to know whether the student can put into operation (in the real clinical situation) the knowledge and skills that we can test objectively in a piece-meal fashion" (22, p44).

IMPROVEMENTS IN RATING FORMAT

In recent years there has been a move by many professional groups towards refining rating scales as a means to improving assessment procedures. Such scales provide all raters with a common frame of reference from which to work. The use of behavioural objectives in parallel with rating scales is also now common practice. These objectives state the desired behaviour and in some cases the conditions under which they should be demonstrated and/or the level of proficiency required to indicate competence. This approach encompasses the ideals suggested by Burg et al in relation to definitions of competence, but has the same problem that very few assessment procedures reach these ideals.
The current occupational therapy clinical assessment form used for Queen Margaret College students is expressed in terms of semantic differentials which provide raters with a brief verbal account of what constitutes excellent and, at the other extreme, unacceptable performance for a series of tasks or behaviours which they are required to rate students on. Clinical staff write objectives which describe how the student will have the opportunity to fulfil each of the elements which will be assessed. The objectives vary from placement to placement because the contexts, opportunities etc are variable from unit to unit.

Long 1976, in the Kings Fund Assessment Project on assessing nursing competence developed a five-point Likert scale where a behaviour or trait was listed or described and raters were asked to rate the students ability to accomplish each element. The scale required raters to note whether a student carried out a task: always; usually; sometimes; occasionally; never.

These types of scale and the refinements made to them in the light of experience no doubt help focus raters' attention on the task in hand. By attempting to identify important factors this will hopefully assist raters in going beyond what Newble 1983, described as the students fascade. They should also help students by informing them of what should be seen as good, bad or indifferent in their performance. Three major problems however still exist. In any scale raters may differentially
interpret the meaning of the words used eg what is the difference between sometimes and occasionally? In fact the word competent itself can conjour up different interpretations from merely coping to coping well.

The second problem is that some aspects of performance are difficult or impossible to describe in behavioural terms, this leads to the problem that they are described in less concrete or quantifiable forms which in turn leads to the potential for wide interpretations of what students should be able to do or demonstrate. The less tangible qualities are often the most important and at the same time are least easy to describe in a common language.

Finally, despite the fact that all raters may be focusing on the same area they may not all be seeing the same thing or interpreting it in the same way.

TRAINING OF RATERS

Literature on rater training has produced conflicting evidence. In dentistry Haupt and Kross 1973, suggest that training raters can improve inter-rater reliability considerably and further that people with no particular skill in an area could, if trained what to look for, agree with experts about student performance. Also in dentistry Abourass (1975), found an improvement from 54% - 77% in agreement beween raters following a series of six seminars designed to emphasise definitions, meanings and measurements. On the other
hand Rezler and Stevens 1978, and Squire 1981, found no improvement in inter-rater reliability despite modifications to rating scales and careful preparation of raters. Squires results led him to conclude that halo effect was so powerful that it acted to overwhelm and unbalance any efforts to improve assessment procedures.

It may be that it is relatively easy to improve inter-rater reliability in some areas eg those which have already been noted as easier to observe and describe, these are perhaps the areas used by Houpt and Kross and others who claim an improvement in reliability after training of raters. Those tasks which are more involved with cognitive and affective aspects of performance may by their very nature be less easy to claim success with.

Finally, it must be added that despite the gloomy picture presented over many years of inaccuracy, bias and unreliability of rating in clinical work, rating scales completed by human raters remain very largely in use. Kelly 1969, suggests that the only reason for this must be that there is no better alternative and that decisions regarding their use must be

"based on considerations other than demonstrated evidence of their validity"

(23 p87).
He also suggested that they may possess some kind of 'spurious criteria' of validity and offers three possibilities here, 'face validity', because it looks as though it should measure what it sets out to; 'validity by fiat' because the person who developed the rating scale is in a superior position to those upon whom it is administered and because that person says it measured what it sets out to; and 'faith validity' ie a belief by the assessor in the technique used.

It may be that attempting to delve deeper than the apparent manner of how supervisors set about the task of assessing students on clinical practice will help in some way towards improving the validity of measures used. Hubbard 1987, pinpointed the essence of the issue when he stated that

"there is something much more scarce, something finer far, something rarer than ability. It is the ability to recognise ability" (24 p6).

In considering the various ways suggested to improve assessment of competence the following points should be made. Assessment of a more objective nature, of the type described by Harden et al undoubtedly have their uses but are probably most appropriate at college level. As Newble suggests, what needs to be addressed is the issue of ongoing, integrated assessment in the clinical field.
Another avenue is to improve the rating scale and format used. This has recently been revised for the Occupational Therapy course and seems to go some way towards being a usable, useful and acceptable format for all involved in its use.

The final approach suggested is that of training raters, this too has probably a role to play in improving reliability of assessments.

One apparent gap in the studies and suggestions however is the consideration of what assessors actually look at students doing and what inferences they then draw about levels of competence. Operationlisation of George Kelly’s Personal Construct Theory using Repertory Grid interviews offers an opportunity to explore this area. The remainder of this dissertation focuses on such a study carried out with the help of occupational therapy clinical supervisors.

As a precurser to the actual study the following chapter deals with Kelly’s Personal Construct Theory and considers its application to clinical supervisors.
George Kelly (1955) proposed a theory of personal constructs in an effort to explain man's behaviour. Constructs can be viewed as the dimensions that man uses to conceptualise aspects of his day to day world, they are necessarily idiosyncratic since they are built up by an individual's exposure to a variety of unique personal experiences.

Kelly suggests that there is no absolute truth and that events are only meaningful in relation to the ways they are construed by an individual. The primary focus of Personal Construct Theory is on the way an individual perceives his environment and on how he interprets his perceptions in terms of his existing constructs. This in turn will influence how he acts or reacts in any situation.

Kelly suggests that man is actively engaged in making sense and extending his experience of the world and offers the analogy of man the scientist in which man, like a scientist, generates hypotheses about his world against which he tests out his interpretations or constructions for their adequacy in predicting what is likely to occur next.

Kelly's theory is stated as one fundamental postulate
supported by eleven elaborate corollaries. Each of these will be briefly described and their relevance to the world of the clinical supervisor will be explored.

FUNDAMENTAL POSTULATE

"A person's processes are psychologically channelised by the ways in which he anticipates events."

The implication of this statement is that man in general, and in this study clinical supervisors in particular, are not so much reacting to the present as reaching for the future. They weigh up current situations by seeing how well their 'sense', built up by exposure to a variety of previous similar situations, enables them to anticipate what is likely to happen next.

It may be that in doing this supervisors can give cues to students about what they expect to happen and therefore get the response or action which they expect thus reinforcing and confirming their constructs. This bears some similarities to the concept of self-fulfilling prophecy discussed in Chapter 1, and is likely to carry with it many of the same problems.

CONSTRUCTION COROLLARY

"A person anticipates events by construing their replications."
In this corollary Kelly suggests that similar events or experiences can only be appreciated as discrete units by abstracting similarities and differences between them. This leads to the formation of bipolar constructs by means of which people can discriminate between variations on a similar theme.

For clinical supervisors this implies that they will see current students in the light of previous ones, this could lead, as noted regarding the fundamental postulate, to supervisors generating the behaviour from students that they expect to see. This, in turn, could lead to students 'towing the line' and to supervisors construing a situation in which they have either overtly or covertly defined the rules.

The construction corollary also implies that clinical staff who are new to supervision have only their own student experiences to reflect on in order to anticipate how others may behave. This, along with the insecurity which tends to accompany any new role, could lead to the new supervisor expecting that students will act or react in a similar way to themselves, and as discussed above lead to tight definition of what is expected. On the other hand it could lead to lack of definition about what is expected. Students in that situation would have few ground rules and could have difficulties knowing what they should do.

If a student acts in a manner which is totally unexpected
this may serve to broaden the range of convenience of the supervisors constructs i.e. to subsume more within the definition of what is acceptable for any given construct. It may also cause difficulties within the supervision and assessment situations if the supervisor is unable to accept different behaviour or attitudes into her own construct system.

INDIVIDUALITY COROLLARY

"Persons differ from each other in their construction of events."

Fransella and Bannister (1971) suggests that the best way to describe this corollary is to consider each individual as viewing the world through the 'goggles' of his or her personal construct system.

The significance of this corollary for clinical supervisors is that they may be observing the same event or behaviour, but because of the individual nature of their constructs they may place differing interpretations on the significance or meaning of the event or behaviour.

Kelly suggests however that people may resemble each other in construing situations. This offers some hope to occupational therapy students who are exposed to at least six clinical supervisors during their course, if these supervisors did not work in at least a vaguely similar way students would be unable to gain any reasonable idea of their performance from placement to placement.
ORGANISATION COROLLARY

"Each person characteristically evolves for his convenience in anticipating events, a construction system embracing ordinal relationships between constructs."

In order to deal efficiently with the volume of potential constructs each individual has to group some of them together, with subordinate constructions being subsumed into superordinate ones. This seems to lead to some assumptions being made i.e. if Z occurs X and Y have been forerunners of it.

In the case of clinical supervisors this may be rather dangerous territory, it may be that a supervisor will assume that students understand the theory base behind a task because they carry it out properly. Therefore understanding the theoretical concepts involved in treatment may be subsumed within its execution. The problems surrounding this issue were discussed in Chapter 1.

DICHTOMY COROLLARY

"A person’s construction system is composed of a finite number of dicotomous constructs."

Kelly argues here for the usefulness of bipolar rather than unipolar constructs, he does not view these as rigid lines along which to view situations, but as
'portable axes of reference'. He stresses the importance that if we give someone or something a label it has to be within a context.

The significance of this corollary in student assessment is that if a clinical supervisor labels a student as competent in an area of work she must have a clear idea of the limits of competence and therefore what constitute incompetence.

The bipolar nature of constructs also gives clinical supervisors the opportunity to view student performance at various points on a continuum which spans from what they view as being excellent to what they view as being totally unacceptable within any given construct.

CHOICE COROLLARY

"A person chooses for himself that alternative in a dichotomised construct through which he anticipates the greater possibility for the elaboration of his system."

Kelly suggests that man is constantly striving for clearer definition and extension of his construct system in order to gain a clearer sight of his world. It is possible however that man may be tempted along the path of least resistance and may make an element 'fit' an existing construct rather than taking the trouble to extend or redefine it to fully accommodate the new element. This is rather like the point made earlier about
people seeing what they expect to see rather than what is actually in front of them.

It could also be that in an ideal situation man will actively seek to extend his construct system, but in a pressurised or stressful environment he may 'make do' with long-standing, well established constructions.

It must be added that many clinical supervisors work in a pressurised situation, and they may well consider students in the light of established constructs and either through complacency or due to pressure of time fail to extend or redefine their construct systems.

RANGE COROLLARY

"A construct is convenient for the anticipation of a finite range of events only."

Kelly suggests that there are limits to what he refers to as the focus and range of convenience constructs. By that he means that there is a set of events which an individual can conveniently categorise into any given construct, at the same time, however, there are often broader sets of events with which the construct can deal, albeit somewhat less effectively, and by implication a further series of events which do not have any place within the construct.

Events falling into the focus of convenience are likely to be those which people see most clearly. For clinical
supervisors as for others, these are likely to be the events which have defined, reinforced and extended their construct systems. These may become rigid and not amenable to change e.g. supervisors may have a focus of convenience for how a student performs a task — if a student adopts a different approach the supervisor may have difficulties subsuming it into her existing focus or range of convenience thus creating conflict between herself and the student.

The concepts of flexibility and lateral thinking seem to have a major role to play in this corollary.

EXPERIENCE COROLLARY

"A person’s construction system varies as he successively construes the replication of events."

This corollary allows for constructs to be fluid and dynamic in nature. Kelly suggests that man tests out his predictions, and in the light of evidence which either supports or invalidates his constructs, will then consolidate or redefine them accordingly. Kelly stresses that events as such are not repeated but aspects of similarity and difference between events can be seen. He also adds that it is not the number of events that is the most significant factor here but the investment made in the anticipations and the revisions of constructions which follow facing up to the consequences.
This corollary has particular significance for inexperienced supervisors in that they initially have only their own impressions of being on the receiving end of clinical supervision and assessment. This could lead to problems since their constructs have developed from a different perspective and their new constructs must at least initially be very fluid in order to accommodate their new role in the student-supervisor relationship. A number of new clinical supervisors state that the role is very different when viewed from an alternative perspective.

It is difficult to decide how best to equip new clinical supervisors with the 'tools of the trade'. It may be useful for them initially to discuss issues and expectations with more experienced staff and before, during and after supervision of students, verbalise their feelings or anxieties about it.

MODULATION COROLLARY

"The variation in a person's construction system is limited by the permeability of the constructs within whose range of convenience the variants lie."

Kelly uses the notion of permeability to indicate relative willingness to change construction systems. Some constructs may be impermeable and not amenable to additions or alterations, others may be relatively permeable and allow for development and reconstruction.
Kelly suggests that man actively seeks to extend and develop his constructs, however the evidence presented in Chapter 1, that people are often unwilling to alter perceptions of people or events, even in the light of contrary evidence, could counter that argument. It is possible that, as noted in relation to the choice corollary, in an ideal world man is able and willing to adopt or develop new constructs or to consider existing ones on a more superordinate level.

On the other hand people who have several different aspects of work to attend to e.g. clinical supervisors who are employed primarily as therapists and as such must give the greater part of their attention to this role, may use habitual constructs especially in secondary roles e.g. assessing students. Therapists may have constructs which are viewed on different levels of importance, if student assessment is placed at the lower end of the priority list there is a danger of it being based on superficial evidence which 'appears' to imply or indicate competence and which, at least loosely, fits the supervisors existing construct system. It may be that the capacity to extend and develop constructs is an active, ongoing process requiring the raising of accepted or assumed constructs to a conscious level in order to examine their current state prior to development or redefinition. It could be that this ability does exist, but that it is thwarted by a number of intervening variables e.g. pressure of work and lack of time.
Kelly suggests that construct systems may not be completely logically related and that an individual may act in a variety of ways within the context of one superordinate construction. In the case of the clinical supervisor this could occur when she both protects a student and at the same time encourages independence towards the same end of developing competence in professional skills. This variation in means towards the same end may cause some confusion to the observer because of the apparent lack of consistency. Kelly also suggests that people may not be aware of the contradictions within their own systems. This too could cause difficulty for new supervisors, in trying to develop the most useful approach.

COMMONALITY COROLLARY

"To the extent that one person employs a construction of experience which is similar to that employed by another, his processes are psychologically similar to those of the other person."
In this corollary Kelly suggests that people may develop the same constructions without having experienced the same or even similar events.

This may represent a key corollary in this study since it implies that clinical supervisors may, through the experience of assessing students over time, develop constructs which are similar to each others, despite the fact that the actual events, students, situations and contexts differ. There are however likely to be some variations from supervisor to supervisor. These could account for the problem raised by some students, that they work and present in a similar way from placement to placement, but can be graded very differently. The similarities and differences experienced by students must represent the balance between the commonality and the individuality corollaries.

SOCIALITY COROLLARY

"To the extent that one person construes the construction processes of another, he may play a role in a social process involving the other person."

Kelly offers two concepts of role here, one at a descriptive, behaviourist level, the other at a more interpretative level. The latter being especially open to misinterpretation and inaccuracy.
In the case of clinical supervisors they very often make interpretations about student behaviour which they assume infer knowledge and/or understanding. If the supervisor acts in accordance with this belief the student will work from the basis that all is well and may not be inclined to develop and extend her own constructions about the areas being dealt with. This could lead to both the student and the supervisor working from a misconstrued base.

The various corollaries all have implications for both clinical supervisor and student. However, two major themes seem to re-emerge, firstly it may be that clinical supervisors, by the nature of their construing and their subsequent actions, convey to students covert messages which directly influence the sequence of ensuing events, and secondly that the process of reconstruction and development of constructs seems to be an active process requiring time and effort for reflection and reconsideration, it is possible that many clinical supervisors do not have the time, inclination, energy or commitment for such processes.

The next stage is to consider the construct systems of a number of clinical supervisors in relation to assessing competence in students in order to raise to a conscious level processes that supervisors may deal with in an almost purely subconscious manner. The process may also
see if there are any common areas and ground rules, formulated over time, which could be of use to new clinical supervisors.

The means of operationalising personal construct theory is found in repertory grid technique. This involves considering elements of experience, how an individual construes them and in what ways the various elements and constructs differ from or are similar to each other. The process involves an interview situation between a researcher and an interviewee, in this case a clinical supervisor.

Details about the study subjects and the various stages of repertory grid technique as applied to this study will be considered in Chapter 3.
CHAPTER 3

CLINICAL COMPETENCE DECISIONS: how, what and why

THE STUDY GROUP

Nine clinical supervisors from the Edinburgh area were involved in the study. Occupational Therapy students from Queen Margaret College have placements throughout Scotland, but in order to avoid excesses of travelling time on the part of the researcher it was decided to restrict the study participants to those working in and around Edinburgh.

Fourteen hospitals in the area offer student placements, of these nine take students on a very regular basis, these nine were selected for the study. Students occasionally have placements in the community or in specialist areas such as special schools and hospices. These placements tend to be reserved for third year students and any supervisor in such areas may only have one student in a year. Because of the limited and sporadic nature of student contact in these areas they were eliminated from the study.

The head of each department was contacted initially to request their cooperation and to give them the opportunity to discuss the matter with staff. In many cases there were only one or two staff in the department who were senior and experienced enough to be involved. One of the nine hospitals felt that staff could not give
up enough time to be involved. Two study participants were from the same hospital which has a large establishment and an ongoing commitment to student supervision.

Six of the supervisors worked in physical hospitals dealing with a variety of patient groups from general medical to surgical neurology and stroke rehabilitation. Four of the supervisors worked in psychiatric units again covering a wide area from acute rehabilitation to psychogeriatrics. This division almost represents the balance of physical and psychiatric placements available for students.

The group consisted of eight females and one male, this again is fairly representative of the profession, which has very few male members.

The supervisors were all experienced clinicians holding either senior, or in one case, head of department, posts. All were experienced supervisors who had been involved with students from all three years of the course. The number of years they had been supervising students ranged from three to fifteen, most averaging about four-five years. It must be added that the number of years is not necessarily indicative of numbers of students supervised. Some supervisors have students with them almost constantly, others have students on placement for only part of the year. As noted in Chapter 2 Kelly would argue that actual numbers of students is not the most significant factor but that it is the investment the
supervisor makes which is all important.

The participants trained initially at a variety of colleges of occupational therapy. All had attended both the basic level and intermediate clinical supervisors courses. Most of the participants were fairly well known to the researcher mainly because of the nature of the researchers job in coordinating clinical placements. Three had been students at Queen Margaret College and as such had been taught by the researcher. Each member of the group was allocated a study number ranging from CS1 to CS9.

The reason for choosing more experienced staff was that they should have had the opportunity through experience, to formulate and revise their construct systems regarding the assessment of competence in students.

Given that the group were all involved in supervising and assessing students it could be surmised that there would be some similarities in the way they viewed events, as discussed in relation to the commonality corollary. The actual events the supervisors assessed were also likely to have a lot of similarities due to the structure of the clinical assessment form which focusses on specific areas of performance. There were however likely to be various ways of looking at events and attaching meaning to them, as discussed in relation to the individuality corollary. It could also be that the area in which a supervisor works might influence how they look at students and what conclusions they draw from their perceptions.
Two 'trial run' repertory grids were carried out with the assistance of colleagues who had recently moved from the clinical area to teaching. These proved invaluable in helping the researcher become familiar with the technique and its various stages.

Repertory Grid Technique: The stages as applied to the study.

Thomas & Harri-Augstein (1985) and Pope & Keen (1981) itemise the various stages they suggest should be followed in constructing a raw repertory grid. Each of these stages and how they were dealt with in this study will be discussed in turn.

1. Negotiation of the purpose of the Grid

The actual purpose of the grid elicited in this study was decided on by the researcher. The purpose was clearly explained to all participants prior to their agreeing to be involved in the study and again at the start of each grid elicitation.

The major purpose of using the grid was to consider how individual supervisors assess students on clinical practice and to attempt to raise to a conscious level those responses and assumptions which usually exist at a subconscious level and therefore to explore attitudes to and in assessing clinical competence. It was hoped that considering what experienced supervisors view as significant in student performance might be used to help inexperienced supervisors avoid
pitfalls and focus on major and significant aspects of student performance from the start of their supervision careers rather than having to learn it all the hard way by trial and error.

This concept follows the recommendations made by Nesbit and Shucksmith (1985), who suggest that experienced practitioners with a good grasp of a subject can assist those inexperienced in a subject by verbalising how they deal with problem solving within it.

2. Identify the type of 'Elements' which best allow the purpose of the Grid to be achieved

Elements represent items of personal experience, in this case the elements must be situations or events in which supervisors can observe students in order that they can make decisions about the students level of competence in a variety of situations.

It was initially considered that it might be useful to use 'given' elements i.e. elements supplied by the researcher. Mair & Bannister (1968) suggest that this can be very useful in attempting to give greater compatibility between subjects. If the elements had been supplied they would have consisted of the major areas of the clinical assessment form used for the occupational therapy students on placement i.e. professional development, interpersonal relationships, assessment, the practice of occupational therapy, communication, organisation and management, plus an
overall summary. However, in an attempt to use Kelly's ideas regarding the importance of personal meaning at all stages of the process, given elements were rejected in favour of elements generated by the supervisors. This allows for subjects to state their own elements and emphasises the idiosyncratic nature of the process.

3. Elicitation of Elements

The elicitation question used for all subjects was:

"In what situations or from which events do you identify and assess competence in students on clinical practice?"

This was followed by the supplementary question:-

"What do you look at or ask students to do in order that you can assess their level of competence?"

Pope & Keen (1981) suggest that eight to fifteen represents a useful number of elements. It was decided to restrict the number of elements in this study to eight. Nearly all participants initially generated more than eight but felt happy to condense or combine them for the purposes of the grid. All were happy that they had covered all relevant aspects of student performance within the eight elements they finally decided on.
In considering the situations or events the subjects adopted two main strategies, some thought through a placement from day one, others offered major areas, usually starting with the ones they considered most significant in gauging competence.

It is interesting to note that the elements generated from all of the supervisors closely resembled the areas dealt with on the clinical assessment form e.g. assessment, treatment planning, reporting, written work, relationships, management and personal qualities such as sense of responsibility and initiative crop up on several occasions. There were, however, variations in the ways these were expressed and individual constructions could be seen to emerge, even at this stage.

4. Elicitation of Constructs

Personal constructs represent a dimension of meaning and form the structure within which items of experience, i.e. elements, acquire their significance. Kelly suggests that these constructs are bipolar in nature and are represented as such in a repertory grid.

Constructs in this study were elicited by using a sequential form, tradic sort. Kelly suggests that this represents the most thorough and systematic way of dealing with generating them.
Subjects were initially given elements A, B and C and asked to select two which they viewed as similar in some way in relation to assessing competence in students. They were asked to describe the similarities, this then became the emergent pole of construct one. They were then asked to describe what they felt was the opposite of that role within the clinical assessment context, this became the contrast pole for construct one. The subjects were then asked to consider the combinations B, C and D; C, D and E; D, E and F; E, F and G; F, G and H; G, H and A, and finally H, A and B. Subjects were then given the opportunity to consider all elements in light of the constructs generated to ensure that they had covered all aspects of competence within the elements and constructs they had generated.

Pope & Keen (1981) suggest that it is preferable to allow subjects to select their own combination of elements to form triads and argue that those selected by the researcher may miss important dimensions. It could be argued, however, that free selection of elements by the subjects could also miss important dimensions because of the potential for focussing on the obvious and perhaps not considering other less immediate areas. The opportunity to consider all elements together at the end should help to rule out the possibility of omissions.

The contrast pole was elicited by asking subjects to consider what they viewed as the opposite of the
emergent pole. Epting (1971) suggests that this is the most effective way of generating it and further that it reinforces the notion of bipolarity. Asking why the third element is different may well confuse the issue because it may be encapsulated within a completely different and unrelated construct from the two elements in the emergent pole. Beail (1985) also suggests that emphasis or differences may lead to 'odd', unbalanced constructs which are difficult to analyse.

On several occasions the technique of laddering was employed as a means of seeking out deeper meanings and relationships, this proved useful to subjects in helping them move beyond the assumed and unquestioned. Mostly why? questions were used in this context and the supervisors were encouraged to think of examples to focus their perceptions.

It proved very difficult for the researcher not to offer suggestions when the study participants were searching for the 'right' word, which conveyed for them the meaning they wanted. The temptation to make suggestions was resisted and instead the researcher took careful notes which were reflected back to the participants as a reminder or prompt about what they had said. It is interesting to note that often the word in the researchers head which would have summarised what participants had said was in fact different to the word or words which the supervisors eventually decided on. This reinforces the notion that
both situations and words can have different meanings and significance for different people.

A conversational approach, as advocated by Thomas & Harri-Augstein (1985), was used at all the stages involving both researcher and interviewer, this allowed for verbal review and reflection back on what had been said. This approach also allows for checking that subjects are happy with the words used in expressing their personal meaning.

5. Rating of Grid

Rating was used as the means of allotting elements to constructs. Mair & Bannister (1968) suggest that a scale of 5-7 points is the most satisfactory, a 5-point scale was used. Subjects were asked to rate each element in relation to each construct, a rating of 1 indicated that the element was near the emergent pole, a rating of 5 placed it closest to the contrast pole.

Rating was selected because it has advantages over similar techniques. It allows subjects the freedom to place any number of elements in the various positions along the construct from the emergent to the contrast pole in contrast to ranking which requires that elements are placed in rank order, thus perhaps forming divisions which may in fact not exist.

Rating also gives a finer discrimination between elements than scaling which requires subjects to allot elements to either the emergent or contrast pole of a construct.
With one exception the subjects completed the rating task in their own time and returned the grid to the researcher.

The other subject, who was first to be interviewed, completed the rating while the researcher was still present. Because of the passive role of the researcher at this stage it was decided to offer all the remaining subjects the opportunity of completing this task either at the time of the interview, or at a time convenient to themselves, all selected the latter option.

6. Grid Analysis

The main purposes of grid analysis are to reveal how elements relate to each other, how constructs relate to each other and how patterns of elements and constructs combine to form a unique personal meaning for individuals, relating to a particular topic. The analysis in this study was carried out using a computer package developed by Thomas & Harri-Augstein at the Centre for the Study of Human Learning (C.S.H.L.) at Brunel University.

The grids were initially FOCUSED in order to identify clusters of elements and constructs in each grid, these were then SPACED to produce a visual representation of the relative differences between items on the grid. The grids were also analysed and scored for matching scores and pairs. The raw grids
with verbal labels, the focused grids with verbal labels and the spaced focused grids for each interviewee are included in the Appendix.

7. Talkback through the Grid
A meeting was arranged for the study participants to be involved in discussion about the grids. Eight out of the nine supervisors involved in the study attended this meeting. Each was given a printout of his or her own grid in raw form and in SPACED - FOCUSED format. The group was given the opportunity to consider their own personal grids, to make brief comparisons between the grids from other group members and to comment on or discuss any matters or issues arising out of either the grip interviews or their analysis. The results of these discussions are included in Chapter 4.

Chapter 4 deals with major findings from the grids and considers similarities and differences between the various grids. It also deals with the conclusions and recommendations arising from the discussions of the group.
ANALYSIS OF STUDY RESULTS

The analysis of the grids took several forms. Initially each grid was analysed using the FOCUS computer programme which processes the raw data by calculating the difference between the various elements and constructs and involves a two-way cluster analysis of the data. The elements and constructs are reordered from their positions on the raw grid according to mathematical relationships to each other, as calculated from the ratings. Spacing is then carried out, this gives a visual representation of the relative differences between the various elements and constructs and highlights clusters of each.

The second part of the analysis involved comparing the various grids, studying the clusters of elements and constructs and aiming to identify common or recurrent themes arising from the grids. It must be noted that the common features identified may not be exactly parallel in the eyes of individual interviewees, they were however construed by the researcher as appearing to have a common link from the basis of the grid labels and the discussions held at the time of grid elicitation.

The third stage of the analysis involved the study group in discussion of the raw grids, the individual computer analyses and the manual cross grid analysis along with
any additional interpretations of the data offered from the group.

Each stage of the analysis will be considered in turn.

RAW DATA AND COMPUTER ANALYSIS
The elements elicited from the study group were varied and wide ranging. The following elements were identified by the individual supervisors.

CS1: personality/relationships, communication, patient contact/rapport, reporting, groupwork, responsibility/management of self, initiative, assessment/treatment skills.

CS2: professional appearance, initiative, questioning/feedback, patient-student relationships, assessment/treatment planning, management of patients/self, written work/discussion, upgrading of programmes.

CS3: patient handling, patient interviews, written work, confidence/initiative, honesty in treatment, interaction with others, relationships with patients, responsibility.

CS4: contribution to discussion, interviewing patients, data collection/assessment, treatment programmes, practice of occupational therapy, evaluation of treatment plans, promotion of occupational therapy, confidence as a therapist.
CS5: initial assessments, communication, group techniques, management within the department, rapport/therapeutic relationships, developing treatment plans, analysis and critical appraisal, relinquishing the student role.

CS6: interaction with patients, interaction with staff, management, identification of resources, treatment skills/use of media, communication, developing treatment and professionalism/role.

CS7: contact with patients, personal qualities, organisational skills, contact with staff, reporting/recording, use of activity, application of theory, professionalism.

CS8: assessing patients, treating patients, written work, home visits, management, interaction with staff, patients etc, reporting, use of knowledge.

CS9: interaction with staff and patients, assessment of patients, treatment skills/techniques, management of patients, management of self, written reporting/treatment plans, verbal reporting, sense of responsibility.

The elements are represented on the raw grids (see Appendix) as numbers 1-8 along the top of the grids and are individually named along the bottom of the grids, they therefore form the columns of the nine grids.
The focusing and spacing of the elements places them in clusters which are rated in similar ways e.g. in CS1 the elements, assessment/treatment skills, patient contact/rapport, personality/relationships, communication and initiative all form one cluster. In fact patient contact/rapport and personality/relationships are rated in exactly the same way by CS1 as are communication and initiative thus indicating that they may be recognised by the same features in the construct system of that particular supervisor. The elements grouped together in this grid could be said to show a strong relationship between interpersonal and treatment skills. Reporting, responsibility and group work are represented as more isolated elements and as such are probably seen as relating to a different set of qualities.

The grid for CS4 on the other hand illustrated no particular element clusters, all the elements are represented a similar distance apart. This could suggest that CS4 sees each element in a clearly differentiated way, although by their placing on the grid some elements are more related than others e.g. data collection/assessment and interviewing patients are next to each other on this grid and as such can be said to have some similarities by contrast data collection/assessment and evaluation of treatment plans are at opposite ends of the grid and are therefore less closely allied to each other.

**COMPARISON BETWEEN ELEMENTS CROSS THE GRIDS**

In considering the elements across the grids it becomes apparent that different supervisors see apparently
similar elements in varying ways. There are however similarities between some of the grids. CS1, CS2, CS6, CS7 and CS8 all have clusters of elements which seem to indicate a strong relationship between interpersonal skills e.g. patient contact/rapport (CS1), patient-student relationships (CS2) and assessment/treatment skills e.g. assessing patients (CS8) and treatment skills/use of media (CS6). It could be concluded then that these supervisors see relationships and interpersonal skills as having a high correlation with assessment and treatment skills.

In the remaining four grids it is interesting to note that three (CS3, CS4 and CS5) placed elements relating to early patient contact e.g. interviewing and assessment, close to relationships on their grids. This may reflect the need for good interpersonal skills at least in the early stages of patient contact. CS3, CS4 and CS5 all tended to separate out assessment from treatment. This may indicate that they see interpersonal skills as having less significance once contact is established and as treatment progresses.

It could also be that they have more elaborate construct systems which allow them to represent the elements in a more differentiated manner from those supervisors who put interpersonal assessment and treatment skills in one group.

CS9 placed assessment and treatment skills next to each other but did not include an element related to interpersonal skills.
Since eight out of nine of the group indicate a strong relationship between initial patient contact and interpersonal skills and five out of the group also relate interpersonal skills strongly to treatment, it could be concluded that the concerns of the students noted in the introduction, that personality plays a major role in assessment of clinical competence, are in fact realistic ones. These results also tentatively support the findings of Wigton's 1980 study (see Chapter 1) which suggests that the manner of self presentation is an important influence on assessors.

These concerns may be further reinforced by the fact that only two supervisors (CS7 and CS8) actually mentioned theory in the elements elicited, both related them to its application. In previous discussion De Mers suggested that merely watching students apparently use theory is not an infallible means of assessing their capacity to relate it to practice. What in fact might be assessed is the capacity of students to rote learn practical applications of techniques rather than understanding of theoretical underpinnings of treatment approaches.

Five of the group identified elements relating to professionalism; CS2 referred to professional appearance, CS4 to promotion of occupational therapy, CS5 to relinquishing the student role, CS6 to professionalism/role and CS7 to professionalism itself. It is interesting to note that the last four mentioned all work in the area of psychiatry. At this stage it could only be hypothesised that those occupational
therapists who work in psychiatry are more conscious of their role and the need to promote it because of the amount of role blurring that can occur between the various professional groups involved in the treatment of people with psychiatric problems. Because of this the supervisor concerned may feel it is important for students to be aware of their role in that context. Occupational therapists who work in physical units may on the other hand feel more secure in their role definition, partly because they usually wear uniforms which help to distinguish them from other professions.

No other significant common patterns or trends emerged from the elements. Some seemed to be easier for the supervisors to isolate e.g. written work, management, reporting etc. It may be that the components which make for efficiency in those areas are more definable and tangible than those which relate to assessment and treatment and as such are represented in a clear way in the supervisors construct systems.

CONSTRUCTS IN AND ACROSS GRIDS
The constructs produced by the group, on the whole, resulted in less clustering than the elements. However, some major common themes emerged. Each individual construct system will be considered initially followed by examination of some of the common constructs. For the purposes of this paper the constructs will be described by their emergent pole label only.
INDIVIDUAL CONSTRUCT PATTERNS

CS1 produced one major fairly tight cluster grouping interpersonal skills, relationships, professional conduct, appropriate attitude and effective communication together. Two constructs were relatively isolated, namely problem solving and administrative skills.

CS2 produced one major loose cluster, involving confidence/competence, establishing rapport, professional role, combine theory and practice, management skills and using knowledge base. Two more isolated constructs dealt with practical (application) and first impressions.

CS3 had no clusters, the constructs emerged evenly spaced on the grid. Some of the constructs placed next to each other were establishing relationships with collation of information; awareness of job role with practical/theoretical knowledge and awareness of personal strengths and weaknesses and working to a standard. This suggests a relationship between awareness of self and professional standards.

CS4 also produced an evenly spaced grid and placed sound theory and practice on theory together, confidence/realism about self and selectivity/objectivity were fairly closely allied as were communication and evaluative skills.
CS5 again had no particular clusters but the grid seems to fall into two categories, at the top were holistic view, ability to question theory, understand/forward planning and understand and apply theory, all of these need a sound theoretical base to work from. The remaining four constructs: confident/independent, aware of self in the treatment situation, high level communication skills and projecting self could be described as more related to self concept.

CS6 produced one minor cluster involving thinking as a therapist and balanced use of skills. Close to thinking as a therapist emerged confidence to use skills and next balanced use of skills was sound basic knowledge. Confidence to use skills, appropriate use of self and appropriate interpersonal approach were all represented in fairly close proximity to each other with understanding importance of occupational therapy and can take responsibility being relatively isolated on this grid.

CS7 again there were no clusters of elements on this grid, but the themes of effective use of theory, accepting attitude, awareness of and confidence in self and the profession all emerged along with personal approach to problem solving and sensitivity/objectivity.

CS8 produced one minor two construct cluster involving effective use of interpersonal skills and dealing with the patient as a whole. Three other constructs together in the grid were, sure of facts, realistic application
(of theory) and forward planning. The other three appear relatively unrelated.

CS9 produced one minor two construct cluster of effective use of time and forward planning. Also noted together, although not in a cluster, were sound theory, practical application of skills, understanding of occupational therapy and professional attitude. Good interactional skills on this grid emerged as being relatively isolated.

COMPARISON BETWEEN CONSTRUCTS ACROSS THE GRIDS
All the supervisors interviewed identified in their constructs the importance of interpersonal skills and relationships in some form. Some produced several constructs relating to interactional or interpersonal skills e.g. CS1 and CS2.

This would seem to add weight to the issues of influence of personality in assessment of competence. However the second major theme to emerge should help to allay that concern because eight out of the group identified the use and application of theory in some form while six actually noted that they look for evidence of a sound theory base in assessing competence.

The argument could still be made that students may appear to have a reasonable theory base because they can work effectively in normal situations. Theory may not be properly tested unless the supervisor seeks to go beyond the obvious or unless an unusual or extraordinary event occurs.
This study did not consider in depth how supervisors assess theory but these results indicate that the majority of the group do assess it in some form.

The balance of these two major construct themes probably indicates that effective interpersonal skills are a vital part of an occupational therapists repertoire and as such must be assessed but at the same time so too must theory and its effective application.

The theme of professionalism which emerged in the elements re-emerged in the constructs. Seven out of the nine grids included it in some way. In contrast to the elements professionalism in the constructs was not so exclusively related to those supervisors working in psychiatry. This construct could be generated from the fact that occupational therapists tend to have to make an effort to portray an accurate image of the profession and as such feel it is also important for students to do.

Another theme involving planning and problem solving was identified by seven out of the nine. This was seen by some to relate fairly closely to theory e.g. CS5 placed understanding and forward planning next to understanding and application and sure of facts together. In other grids these were separated e.g. CS9 placed sound theory and forward planning some distance from each other.

One final theme which emerged was that of awareness of self. This was seen by some at an interpersonal level and by others as related to professionalism e.g. CS7 placed
sound self awareness next to awareness of the limitations of occupational therapy, CS6 placed appropriate use of self next to confidence to use skills, while CS9 on the other hand distanced self awareness from professional attitude.

There were a number of other constructs which were common to more than one of the grids, but any which occurred in three or less grids were considered as having less significance for this study.

It may be that considering what constructs are related to each other on the grids is of little significance and that what really matters is the whole construct picture. Though the individual constructs are distanced on the grids they may well be inter-related with and interdependent on each other within the constructs system of each supervisor. The system could be likened to a circular pie with several wedges, if one were removed this would expose one side of the two adjacent wedges and thus affect them in a major way. At the same time it would affect all the other pieces, because they all touch at the centre, in a less important but nevertheless significant way.

It can be concluded that there seems to be quite a lot of common ground between the expectations of supervisors in relation to assessing competence of students on practice. There are however many individual interpretations of what is being assessed and how. These findings tend to reinforce the section in Chapter 1 dealing with
definitions of competence which tended to suggest that context is very significant in any measure of competence. They probably indicate that the best that can be hoped for in a diverse profession are similarities in themes of what is being assessed with the specific requirements dictated by the demands and opportunities of each individual situation. This also relates to Kelly's suggestions that there may be similarities in the way that individuals construe situations but that individual interpretations will be influenced by personal past and current experience.

DISCUSSION GROUP

Eight of the supervisors involved in the study attended a meeting arranged to discuss the results of the grid analysis. Topics for discussion were raised by the researcher and focused on issues and themes identified in the analysis. The meeting was informal and lasted for about two and a half hours.

Each supervisor received a print out of her/his own raw, focused and spaced-focused grids. They also received the matching score analysis for their own elements and constructs (this is part of the focusing analysis and helps clarify how relationships between items are worked out). The group members were also given a copy of all the element names and the emergent role labels for the constructs of every other member of the group, these were listed in random order and remained anonymous.
The topics and themes generated out of the computer and manual cross grid analyses were raised for discussion. The group was encouraged to debate, question and comment on the study in general and the analysis in particular.

The initial reaction was amazement at the sheer volume of elements produced. Each supervisor had thought that they would probably all be looking for or at more or less the same aspects of performance. On discussion they realised that there were many similarities between the elements, but acknowledged that there were individual interpretations of these and a lot of grey areas.

The issue of the apparently high number of elements relating to interpersonal skills was discussed. It was agreed that this is a very important area for occupational therapists and that students with good theory and poor interpersonal skills are likely to become less effective clinicians than those with good interpersonal skills and an average grasp of theory. It was also acknowledged that it can be more difficult or take longer to assess levels of competence in students who 'appear' to be performing well because of effective interpersonal skills. The group all felt they did not allow personality to influence their judgements too much.

The significance of theory, forward planning and problem solving in the constructs of most of the grid would suggest that, while interpersonal skills are important, supervisors are concerned with more than that and seek to go beyond students' personal presentations to assess both
theory and its application. All the supervisors in the group felt that they did assess theory. The group were asked if they felt that students could rote learn practical work. They suggested that this is precisely what many students attempt to do, at least in the early stages of a placement. It was noted that many supervisors appreciated originality and adaptability on the part of students but it was also recognised that there are instances when these qualities could be a threat to some supervisors. It was agreed that supervisors should create a 'safe' environment in which students could feel comfortable to challenge accepted practice and experiment with new ideas and techniques. Such an attitude requires security on the part of the supervisor and it was felt that many would find this difficult because of the lack of clarity of professional roles for some occupational therapists.

This took the discussion on to the common topic of professionalism. The hypothesis suggested earlier, that occupational therapists have to make an effort to inform people of their role, was reinforced by the group discussion. The supervisors working in psychiatry felt that it was true that because of role blurring they had to be aware of personal and professional contributions within the treatment team. This awareness is reflected in student assessment. The supervisors working in physical units felt that wearing uniform helped a little in establishing professional identity but they too were aware of the need to explain and justify professional roles. Wearing uniform may represent the reason for the
occupational therapists from physical units largely leaving the issue of professionalism until the construct stage of the grid elicitation.

In considering personal and shared constructs a number of the group felt that the variety of them reinforced the rather subjective nature of the task of assessing students. It was agreed that careful pre-placement preparation, good guidelines and aims for each placement and a searching, but easy to complete assessment form, all helped to focus attention on the important aspects of student performance. More help and advice might be useful on how to assess rather than just what. It was felt that this would go towards reducing the variations or themes evident from the various grids.

During discussion the importance of analysis and evaluation of treatment was raised but it was noted that this had not emerged as a key feature at the time of grid elicitations.

The group concluded that the grids probably reflected their day to day feelings and thoughts and that now, having had time to consider what they felt should be significant, they would probably produce grids which contained what they thought were the 'correct' responses or the responses they would like to have made at the time of the initial interviews. The discussion centering around this topic succeeded in fulfilling one of the initial aims of the study, that of raising to a conscious level those assumptions and ideas about assessment which exist at a subconscious level in the minds of the supervisors.
There was a lot of discussion about what should and what does happen in assessment and for the apparent gaps between the two. Time and opportunity available emerged as the major problems here. Clinical supervision is only part of the workload of clinicians, it appeared that even the best intentions could weaken and crumble under a hectic and erratic workload. This lead to some discussion of the rater errors noted in Chapter 1. The group recognised many of them and felt that awareness of their existence along with careful organisation of the placements should help to guard against them having an undue influence.

The final part of the discussion centred around what points from the study could be used in an attempt to help inexperienced supervisors on clinical supervisors courses.

One suggestion involved brainstorming participants about what they look at, or think they should look at, when assessing students. This is rather like the start of a repertory grid interview. It was felt that this would be useful in helping participants see the variations that would undoubtedly emerge from the group and would form a useful base from which to work in considering how people make judgements about different aspects of performance.

As noted previously it was felt that awareness of sources of rater error would help too in minimising them.
It was suggested that it is invaluable to include experienced supervisors on the staff of clinical supervisors courses. People familiar with the job of supervision can offer a great deal to others by talking through how they reach decisions.

As a final point the group noted the need for ongoing support for supervisors to allow for exchange of ideas, discussions and sharing of problems and solutions. It was felt that although there is regular contact with and easy access to college staff that some supervisors feel they work in a vacuum with students.

By the time the meeting was finished most major themes and issues had been discussed albeit not exhaustively. It may have been beneficial, if time had allowed to meet again for further discussions, this however was not feasible in the time available.
SUMMARY AND CONCLUSIONS

The research involved in and the findings from this study should be regarded as a basis for further in-depth study in the area of assessment of clinical competence. The conclusions drawn from the study are necessarily tentative because of the small sample number and the restricted geographical and work areas they represent. It must be added too that the statistical correlations found in the study may not equate to actual or significant correlations in real life.

There are limitations too in the technique of Repertory Grid, as utilised here. All the study participants provided idiosyncratic elements and constructs thus making cross-grid analysis more difficult than if elements had been supplied. Assumptions had to be made about similarities of and differences between the verbal labels used by the study participants. Thomas & Harri Augstein (1985) and Pope & Keen (1981) all caution against drawing any firm conclusions from comparisons of grids because of the fact that Personal Construct Theory emphasises the personal nature of viewing the world and reinforces the use of labels which convey meaning for the individual.

The results may have proved more useful and easier to analyse if all participants had been given the same elements e.g. in the form of items on the students'
clinical assessment forms. The data could then have been processed using a Socio-grid analysis (Thomas & Harri Augstein 1986) which compares constructs elicited from a common element base. Such an approach may have produced more valid conclusions. This too would however have limitations in that much depends on individual meanings even within common areas and again assumptions would have to be made regarding similarities and differences between constricts elicited. Grids also tend to reflect what people think they do and it may have been useful to elicit and compare grids of students and peers of clinical supervisors to see if what people think they do is the same as what other people view them as doing. Such a study could be extended by collecting data using other means.

The overall validity of the results may have been affected by the grid administration largely due to the researcher's lack of expertise in the technique. The interviewees could have been challenged further in order to question their assumptions more rigorously to this end the technique of laddering could have been employed more effectively.

The fact that only one of the group knew anything of Personal Construct Theory prior to the study was probably an advantage, in that the participants responded spontaneously rather than offering answers which they thought they should. Yorke (1985) suggests that this is a key factor in validity, he feels that the greatest potential of a repertory grid interview is its potential
to accurately reflect the individuals present constructions of a situation.

Despite the seemingly large number of problems and deficiencies in this study, some tentative conclusions and useful suggestions have emerged.

It would appear that the clinical supervisors in the study consider a wide ranging set of issues, as represented by the elements in the grids, when assessing students' competence. It also seems that different supervisors see students' actions in varying ways, as represented by the constructs produced in relation to the elements. There are however several recurring and shared theories.

The major conclusion is that effective interpersonal skills are seen as very important attributes for successful occupational therapists. At the same time however, so is grasp of theory and its application in a clinical setting. From students' comments it would appear that they are unaware of theory being assessed. If students feel that interpersonal skills take precedence in supervisors' assessments of them there is a danger that they will neglect theory in favour of trying to create a good impression. Students in that situation may also rote learn theory and practice and work without question or thought about the foundations of the treatment approaches they use. This is a dangerous route for any professional group to travel down since it only leads to dead ends.
The way towards alleviating this apparent difficulty requires effort on two fronts. Initially understanding of subjects should be constantly promoted in college based studies. This requires a problem orientated, student centred approach, involving students in the active use and integration of information rather than passive acceptance of it. This approach should be continued in clinical practice with both students and supervisors explaining the theoretical framework upon which their treatment regimes are based. Such a combined effort would in turn make students more aware of the need for sound theory. There would also be reciprocal benefits in sharing problem solving strategies, which was noted by the group to be very important. Problem solving by sharing resources is very much more effective than problem solving in isolation.

Through this, assessment of theory would become more overt and would be seen as an integral part of clinical assessment.

The other major recurrent study theme of professionalism and the need for promotion of Occupational Therapy would also benefit from this approach to learning and assessment. If occupational therapists at all levels constantly review, research and question the foundations upon which treatment is based they will be able to defend what they do, project a competent professional image and thus improve professional self respectability by arguing from a well founded empirical base.
In order for this type of approach to be adopted there is a need for all clinicians, teaching staff and students to keep abreast of current developments. Some problems arise in relation to this, mostly relating to lack of time, opportunity and finance to attend courses and conferences. An additional problem however is the general complacency of many people in thinking that education and learning is something which ends after school, college or university. This attitude must be discouraged especially in the light of professional changes in particular and technological and other advances in general. In the words of John Dewey, the founding father of recurrent education - education should be about participation in life rather than preparation for life.

THE WAY FORWARD FOR CLINICAL SUPERVISORS COURSES.

There are a number of issues and ideas from this study which could be developed for use in clinical supervisors courses. In such courses the participants are students and as such should be exposed to theoretical concepts relating to aspects of clinical supervision. They too should be encouraged to understand, question, use and apply theories of learning, assessment, and such like. The need for such a strategy has been recognised by the College of Occupational Therapists who are currently advocating a sequential approach to clinical supervisors' education, involving a series of six hierarchical stages to replace the current two short courses. This will allow participants the opportunity to examine topics, consider
their applications and review and evaluate them both individually and collectively. Such a scheme might also form the foundations for an ongoing clinical supervisors' support group which was an avenue considered to be worth pursuing by the study group.

This approach can also be viewed in the light of Personal Construct Theory which suggests that if new information is not reflected upon and actively integrated into a construct system it is likely to be lost to habit of previously well established constructs. Active integration needs time and effort. It is rather like receiving a document with new information which does not seem to fit into any of the established files in a system. There are two possibilities of dealing with this, one is to consider the new information carefully and either make a new file for it or append it to an existing file as a part of it. The other is to put it into the bottom drawer of the filing cabinet thinking that it can be dealt with later. The latter is often what happens unless people have time to consider new information and occurs especially when people are under pressure and are coping with the strategies they currently use. It is possible that information dealt with on clinical supervisors' courses has in the past largely fallen into this category.

What would be of value is sharing information. Experienced supervisors should be involved in discussing supervision and assessment with those who are less experienced. This would be of benefit to both in
examining how people make decisions about students' levels of competence and in raising to a conscious level the assumptions that people make and inferences they draw. This approach follows recommendations made by researchers in learning such as Selmes (1987); Corno (1987), and others. They suggest that there are major benefits to be gained by experienced individuals verbalising the approaches they use in relation to problem solving and learning. In this case this would also help raise awareness of rater errors and may lead to improved inter-rater reliability in students' assessments.

One way of achieving this process using Repertory Grid processes would be the use of exchange grids (Thomas & Harri Augstein, 1984). This allows for individuals to produce grids and compare their perceptions with those of others.

This study, it must be said, is not an ending, but rather an introduction to study of assessment of clinical competence with occupational therapy students. Several suggestions have been made in this chapter regarding the development and direction of continuing studies. What emerges, as a major recommendation, is the need to share resources and tap the expertise of people familiar with a topic in order to assist those who are new to it. There is also a need for ongoing study into definitions of development of frames of reference for competence. This must be done in an open yet analytical manner if the profession of Occupational Therapy is to develop and advance in the years to come.
### Raw Grid with Verbal Labels

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<th>Construct Pole Rated - 1</th>
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<td>E1 E2 E3 E4 E5 E6 E7 E8</td>
<td>E1 E2 E3 E4 E5 E6 E7 E8</td>
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**Elements**

**Interpersonal Skills**
- C1: Lacks self confidence
- C2: Lacking interest
- C3: Familiarity
- C4: Patient related
- C5: Apathetic
- C6: Lack interest
- C7: Unable to reason
- C8: Lack significance

**Appropriate Relationships**

**Prof Conduction**

**Admin Skills**

**Enthusiasm**

**Appropriate Attitude**

**Problem Solving**

**Effective Communication**

**Assess/Treatment Skills**

**Initiative**

**Responsibility**

**Groupwork**

**Reporting**

**Patient Contact/Rapport**

**Communication**

**Personality/Relationships**

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CONSTRUCT POLE RATED - 1 -

**ELEMENTS**

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RAW GRID WITH VERBAL LABELS

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*RESponsibility
*RELationships with PTs.
*INteraction with OTHers
*HONesty in TREATment
*CONFidence/INITiative
*WRitten WOrk
*PT. INTERVIEWS
*PT. HANDLING

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### RAW GRID WITH VERBAL LABELS

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* LACK/RIGID IN PLANNING
* UNAWARE OF COMMUNICATION
* LACK OF THEORY
* UNREALISTIC EVALUATIONS
* LIMITED UNDERSTANDING
* POOR SELF CONCEPT
* SUBJECTIVE APPROACH
* DIFFERENT COMMUNICATION/STANDARDS

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CONSTRUCT POLE RATED - 1 -

ELEMENTS

E1  E2  E3  E4  E5  E6  E7  E8

CONSTRUCT POLE RATED - 5 -

UNDERSTAND/APPLY THEORY  C1  3  3  1  3  4  1  3  3  C1  LACK/UNABLE TO APPLY THEORY

PROJECTION OF SELF  C2  2  2  5  1  5  5  1  C2  LACK CONFIDENCE

AREE OF SELF IN TR.SITN.  C3  2  2  1  4  2  4  2  2  C3  UNABLE TO EST. RAPPORT

HOLISTIC VIEW  C4  3  4  1  1  3  1  1  1  C4  LACK KNOWLEDGE OF PROCESS

ABLE TO QUESTION THEORY  C5  4  3  2  2  4  2  1  2  C5  UNABLE TO DEVELOP/DISCUSS

CONFID/INDEPENDENCE  C6  3  1  1  3  2  2  2  1  C6  LESS MATURE/CONFIDENT

UNDERSTANDING/FORWARD PLAN  C7  1  3  1  2  4  2  2  2  C7  LIMITED VISION/UNDERSTANDING

HIGH LEVEL COMM.SKILLS  C8  1  1  4  1  3  1  2  C8  BASIC COMMUNICATION

RELINQUISHING STUDENT ROLE

ANALYSIS/Critical APPRAISAL

DEVELOPING TR.PLANs

RAPPORT/Therapeutic RELs.

MANAGEMENT/PT.RECORDs

GROUP TECHNIQUES

COMMUNICATION

INITIAL ASSESSMENTS

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CONSTRUCT POLE RATED - 1 -

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<td>UNDERSTAND IMPORTANCE OF OT</td>
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CONSTRUCT POLE RATED - 5 -

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<tr>
<th>Construct Pole Rated - 1</th>
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<tbody>
<tr>
<td>E1 E2 E3 E4 E5 E6 E7 E8</td>
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**ELEMENTS**

**Construct Pole Rated - 1**

- Accepting Attitude: C1 + 1 1 2 2 2 1 3 2
- Awareness of Limitations: C2 + 1 1 2 1 3 2 1 2
- Sound Self Awareness: C3 + 1 1 1 1 2 2 3
- Confidence in TR. Used: C4 + 2 1 1 1 1 1 3 3
- Personal Approach to Probs: C5 + 1 1 2 3 4 1 2 3
- Sensitivity/Objectivity: C6 + 1 1 2 3 1 2 2 1
- Balance of Self/Profession: C7 + 1 1 1 3 1 3 1
- Accurate/Effective Use Theo: C8 + 1 1 2 2 2 1 1 1

**Construct Pole Rated - 5**

- Insecure in PT/TH Relations: C1
- Uncertain of O.T. Role: C2
- Lack of Confidence: C3
- Vague in Treatment: C4
- Lack Originality: C5
- Lacks Sensitivity/Objective: C6
- Inappropriate Approach: C7
- Confused Application: C8

---

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<th>Construct Pole Rated</th>
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<tbody>
<tr>
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<tr>
<td>5</td>
<td>Uninformed Approach, Unadaptable in Tr Progs, Disorganised, Works in Isolation, Hesitant about Facts, Inflexible Use of Theory, Uninterested/Uninvolved, Lacking Insight</td>
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**USE OF KNOWLEDGE**

**REPORTING**

**INTERACTION WITH PTS/STAFF**

**MANAGEMENT**

**HOME VISITS**

**WRITTEN WORK**

**TREATING PTS**

**ASSESSING PTS**
RAW GRID WITH VERBAL LABELS

ELEMENTS

CONSTRUCT POLE RATED - 1 -

E1 E2 E3 E4 E5 E6 E7 E8

SOUND THEORY C1 * 5 1 * 5 5 2 1 5 * C1 LACK OF THEORY BASE

MANAGEMENT/RE-EVALUATION C2 * 3 1 1 2 1 2 3 1 * C2 LACK ORGANISATIONAL SKILLS

FORWARD PLANNING C3 * 5 2 1 1 1 2 2 1 * C3 ILLOGICAL APPROACH

EFFECTIVE USE OF TIME C4 * 5 2 2 1 1 1 2 1 * C4 INFLEXIBILITY

UNDERSTANDING OF OT C5 * 3 1 1 1 1 1 1 1 * C5 CANT INTEGRATE ALL ASPECTS

PROFESSIONAL ATTITUDE C6 * 1 1 1 2 2 1 1 * C6 DEPENDENT ON SUPERVISOR

GOOD INTERACTIONAL SKILLS C7 * 1 2 1 2 5 2 5 1 3 * C7 LACKS AWARENESS OF SELF

PRAC APPLICATION OF SKILLS C8 * 4 1 4 3 2 1 3 * C8 ILLOGICAL APPLICATION

*****************************************************

* SENSE OF RESPONSIBILITY
* VERBAL REPORTING
* WRITTEN REPORTING/TR PLANS
* MANAGEMENT OF PTS
* MANAGEMENT OF SELF
* TR SKILLS/TECHS
* ASSESSMENT OF PTS
* INTEGRATION WITH PTS/STAFF

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C.S.H.L.  GRID --CSI--

FOCUSED GRID WITH VERBAL LABELS

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* ASSESS/TREATMENT SKILLS
* PATIENT CONTACT/RAPPORT
* PERSONALITY/RELATIONSHIPS
* COMMUNICATION
* INITIATIVE
* GROUPWORK
* RESPONSIBILITY
* REPORTING

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Focused Grid with Verbal Labels

Elements

Construct Pole Rated - 1 -

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Aware of Relationships RC3*
Collation of Info C1*
Isolated Approach RC5*
Practical/Theory Knowledge C6*
Aware of Strengths/Weakness C2*
Working to Standard C4*
PT Orientated C7*

Related Elements

*PT. Interviews
*Relationships with Pts.
*Interaction with Others
*Confidence/Initiative
*Written Work
*Responsibility
*Honesty in Treatment

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FOCUSED GRID WITH VERBAL LABELS

ELEMENTS

CONSTRUCT POLE RATED - 1 -

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<th>E7</th>
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HOLISTIC VIEW

ABLE TO QUESTION THEORY

UNDERSTANDING/FORWARD PLAN

UNDERSTAND/APPLY THEORY

CONFID/INDEPENDENCE

AWARE OF SELF IN TR.SITN.

HIGH LEVEL COMM.SKILLS

PROJECTION OF SELF

CONSTRUCT POLE RATED - 5 -

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<th>E6</th>
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LACK KNOWLEDGE OF PROCESS

UNABLE TO DEVELOP/DISCUSS

LIMITED VISION/UNDERSTANDING

LACK/UNABLE TO APPLY THEORY

LESS MATURE/CONFIDENT

UNABLE TO EST. RAPPORT

BASIC COMMUNICATION

LACK CONFIDENCE

DEVELOPING TR.PLANS

MANAGEMENT/PT.RECORDS

ANALYSIS/CRITICAL APPRAISAL

GROUP TECHNIQUES

RELINQUISHING STUDENT ROLE

COMMUNICATION

RAPPORT/ThERAPEUTIC RELS.

INITIAL ASSESSMENTS

COPYRIGHT CENTRE FOR THE STUDY OF HUMAN LEARNING
<table>
<thead>
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<tr>
<td>Appropriate I.P. Approach</td>
<td>C8 ♦ 3 3 2 2 1 1 4 5 ♦ C8 INEFFECTIVE USE OF I.P.SKL</td>
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<td>Appropriate Use of Self</td>
<td>C1 ♦ 2 3 3 1 1 2 4 5 ♦ C1 SELF ORIENTATED</td>
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<td>Thinking as a Therapist</td>
<td>C5 ♦ 1 1 3 2 2 2 4 5 ♦ C5 LOCKED INTO STUDENT ROLE</td>
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<tr>
<td>Balanced Use of Skills</td>
<td>C7 ♦ 1 1 2 2 2 3 4 5 ♦ C7 RIGID THINKING/APPROACH</td>
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<tr>
<td>Sound Basic Knowledge</td>
<td>C3 ♦ 1 2 2 3 3 4 5 5 ♦ C3 LACK/CANT USE THEORY</td>
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<td>C2 ♦ 2 2 3 1 1 4 5 4 ♦ C2 LACKING SELF CONFIDENCE</td>
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**Elements**

* ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ MANAGEMENT
* ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ IDENTIFY RESOURCES
* ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ PROFESSIALISM/ROLE
* ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ INTERACTION WITH PTS.
* ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ INTERACTION WITH STAFF
* ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ COMMUNICATION
* ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ DEVELOPING TREATMENT
* ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ TR.SKILLS/USE OF MEDIA

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<table>
<thead>
<tr>
<th>Construct Pole Rated</th>
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<tr>
<td>Balance of Self/Profession</td>
<td>C7</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Accepting Attitude</td>
<td>C1</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Accurate/Effective Use Theo</td>
<td>C8</td>
<td>2</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Awareness of Limitations</td>
<td>C2</td>
<td>3</td>
<td>1</td>
<td>2</td>
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<td>Sound Self Awareness</td>
<td>C3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Confidence in Tr.Used</td>
<td>C4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Personal Approach to Probs</td>
<td>C5</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sensitivity/Objectivity</td>
<td>C6</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
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Construct Pole Rated - 5 -

- C7 Inappropriate Approach
- C1 Insecure Interpersonal Relations
- C8 Confused Application
- C2 Uncertain of O.T. Role
- C3 Lack of Confidence
- C4 Vague in Treatment
- C5 Lack Originality
- C6 Lacks Sensitivity/Objective

*APPLICATION OF THEORY
*PROFESSIONALISM
*CONTACT WITH STAFF
*ORGANISATIONAL SKILLS
*USE OF ACTIVITY
*PERSONAL QUALITIES
*CONTACT WITH PTS.
*REPORTING/RECORDING

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### Focused Grid with Verbal Labels

#### Elements

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<th>Construct Pole Rated - 1</th>
<th>Construct Pole Rated - 5</th>
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<tbody>
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<td>E1, E2</td>
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<table>
<thead>
<tr>
<th>Sure of Facts</th>
<th>C5: 2, 2, 2, 1, 1, 2, 2</th>
<th>C5: Hesitant about Facts</th>
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<tbody>
<tr>
<td>Realistic Application</td>
<td>C6: 1, 4, 3, 1, 1, 1, 1</td>
<td>C6: Inflexible use of theory</td>
</tr>
<tr>
<td>Forward Planning</td>
<td>C2: 4, 1, 1, 1, 1</td>
<td>C2: Unadaptable in TR PROBS</td>
</tr>
<tr>
<td>Effec.Use of Int/Per Skills</td>
<td>C7: 5, 5, 4, 1, 1, 1, 1</td>
<td>C7: Uninterested/uninvolved</td>
</tr>
<tr>
<td>Deal with Pt.as a Whole</td>
<td>C8: 4, 5, 4, 2, 1, 1, 1, 1</td>
<td>C8: Lacking insight</td>
</tr>
<tr>
<td>Effective Communication</td>
<td>C4: 4, 3, 2, 2, 2</td>
<td>C4: Works in isolation</td>
</tr>
<tr>
<td>Use of Practical Skills</td>
<td>C1: 4, 3, 4, 3, 2, 1, 1</td>
<td>C1: Uninformed approach</td>
</tr>
<tr>
<td>Organisation Skills</td>
<td>C3: 3, 3, 3, 3, 3</td>
<td>C3: Disorganised</td>
</tr>
</tbody>
</table>

---

* ♦ Use of knowledge
* ♦ Treating pts.
* ♦ Assessing pts.
* ♦ Home visits
* ♦ Interaction with pts/staff
* ♦ Reporting
* ♦ Management
* ♦ Written work
* ♦ Use of knowledge

---

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## Focused Grid with Verbal Labels

<table>
<thead>
<tr>
<th>Elements</th>
<th>Constructs Pole Rated</th>
<th>Constructs Pole Rated - 5</th>
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<tbody>
<tr>
<td>Sound Theory</td>
<td>C1: 1 1 1 2 5 5 5</td>
<td>C1: LACK OF THEORY BASE</td>
</tr>
<tr>
<td>Practical Application of Skills</td>
<td>C8: 1 1 1 2 4 3 4</td>
<td>C8: ILOGICAL APPLICATION</td>
</tr>
<tr>
<td>Understanding of OT</td>
<td>C5: 1 1 1 3 3 3</td>
<td>C5: CANT INTEGRATE ALL ASPECTS</td>
</tr>
<tr>
<td>Professional Attitude</td>
<td>C6: 1 1 2 1 1 2</td>
<td>C6: DEPENDENT ON SUPERVISOR</td>
</tr>
<tr>
<td>Management/Re-Evaluation</td>
<td>C2: 3 1 2 2 1 1 3</td>
<td>C2: LACK ORGANISATIONAL SKILLS</td>
</tr>
<tr>
<td>Forward Planning</td>
<td>C1: 2 1 2 1 1 5</td>
<td>C3: ILOGICAL APPROACH</td>
</tr>
<tr>
<td>Inflexibility</td>
<td>RC4: 4 4 5 5 5</td>
<td>RC4: EFFECTIVE USE OF TIME</td>
</tr>
<tr>
<td>Good Interactional Skills</td>
<td>C7: 1 2 2 5 3</td>
<td>C7: LACKS AWARENESS OF SELF</td>
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</table>

* Integration with PTS/STAFF
* Management of PTS
* Sense of Responsibility
* Management of Self
* Written Reporting/TR Plans
* TR Skills/Techs
* Assessment of PTS
* Verbal Reporting

---

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C.S.H.L. GRID --CS1--

SPACED FOCUSED GRID

ELEMENTS

CONSTRUCT POLE RATED - 1 -

CONSTRUCT POLE RATED - 5 -

INTERPERSONAL SKILLS C1 # 4 3 1 11 11 1 # C1 LACKS SELF CONFIDENCE

APPROPRIATE RELATIONSHIPS C2 # 4 2 1 11 11 1 # C2 LACKING INTEREST

ENTHUSIASM C5 # 4 1 1 11 11 1 # C5 APATHETIC

PROF CONDUCT C3 # 3 1 1 11 11 1 # C3 FAMILIARITY

APPROPRIATE ATTITUDE C6 # 2 1 1 11 11 1 # C6 LACK INTEREST

EFFECTIVE COMMUNICATION C8 # 1 1 1 11 11 1 # C8 LACK SIGNIFICANCE

PROBLEM SOLVING C7 # 1 1 3 11 11 1 # C7 UNABLE TO REASON

ADMIN SKILLS C4 # 1 1 2 11 33 5 # C4 PATIENT RELATED

ASSESS/TREATMENT SKILLS

PATIENT CONTACT/RAPPORT

PERSONALITY/RELATIONSHIPS

COMMUNICATION

INITIATIVE

GROUPWORK

RESPONSIBILITY

REPORTING

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### Spaced Focused Grid

<table>
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**Elements**

- **Practical**
  - C4: 2
  - C4: Academic

- **First Impressions**
  - C1: 1
  - C1: Lasting Impressions

- **Confidence/Competence**
  - C7: 2
  - C7: Tentative Approach

- **Establishing Rapport**
  - C2: 1
  - C2: Failure in Communication

- **Professional Role**
  - C6: 1
  - C6: Difficulty with OT Role

- **Combine Theory/Practice**
  - C5: 4
  - C5: Lacking Integration

- **Management Skills**
  - C8: 4
  - C8: Haphazard Approach

- **Using Knowledge Base**
  - C3: 5
  - C3: Unable to Use Knowledge

**Additional Elements**

- Upgrading Progs
- Written Work Discussion
- Assessment/Treatment Plans
- PT/Student Relationships
- Management PTs/ Selbst
- Initiative
- Questioning/Feedback
- Prof Appearance

---

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| Construct Pole Rated - 1 | Construct Pole Rated - 5 |

**Elements**

| 1 | 5 | 8 | 3 | 4 | 6 | 7 | 2 |

---

**Unaware of Relationships**
- RC3
  - 2 3 2 2 5 5 5
- RC1
  - 3 3 2 2 2 2 5
- RC1
  - 3 3 2 2 2 2 5

**Hands On Treatment**
- RC3
  - 2 3 2 2 5 5 5
- RC1
  - 3 3 2 2 2 2 5

**Awareness of Job Role**
- C5
  - 4 2 2 2 2 2 2 2
- C6
  - 2 1 2 2 2 2 2 2

**Practical/Theory Knowledge**
- C6
  - 2 1 2 2 2 2 2 2
- C6
  - 2 1 2 2 2 2 2 2

**Aware of Strengths/Weakness**
- C2
  - 1 1 2 2 3 3 2 1
- C2
  - 1 1 2 2 3 3 2 1

**Working to Standard**
- C4
  - 1 1 2 2 4 4 3 1
- C4
  - 1 1 2 2 4 4 3 1

**PT Orientated**
- C7
  - 1 1 3 2 2 1 1
- C7
  - 1 1 3 2 2 1 1

---

- PT. Interviews
- Relationships with Pts.
- Interaction with Others
- Confidence/Initiative
- *Written Work
- *Responsibility
- *Honesty in Treatment
- PT. Handling
SPACE FOCUSED GRID

CONSTRUCT POLE RATED - 1 -

CONSTRUCT POLE RATED - 5 -

SOUND THEORY C5 3 2 1 1 1 4 3 2 + C5 LIMITED UNDERSTANDING
PRACTICE ON THEORY C3 2 2 1 1 2 2 4 5 + C3 LACK OF THEORY
CONFIDENCE/REALISM RE SELF C6 3 2 2 3 2 2 3 3 + C6 POOR SELF CONCEPT
SELECTIVITY/OBJECTIVITY C1 5 3 2 1 5 3 2 4 + C1 LACK/RIGID IN PLANNING
FLEXIBLE/EVALUATIVE C7 3 2 1 5 5 3 2 + C7 SUBJECTIVE APPROACH
EVALUATIVE SKILLS C4 1 4 2 4 4 5 4 2 + C4 UNREALISTIC EVALUATIONS
UNAWARE OF COMMUNICATION RC2 1 3 2 4 4 5 5 5 + RC2 INTERACTION WITH PTS
DIFF COMMUNICATION/STANDARDS RCB 2 2 3 4 5 5 4 4 + RCB EFFECTIVE COMMUNICATION

***************

**DATA COLL ASSESSMENT**
**INTERVIEWING PTS**
**CONT TO DISCUSSION**
**PROMOTION OF OT**
**TREATMENT PROGS**
**PRACTICE OF OT**
**CONFIDENCE AS THERAPIST**
**EVALUATION OF TR PLANS**

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C.S.H.L. GRID --CS5--

SPACED FOCUSED GRID

CONSTRUCT POLE RATED - 1 -

E E E E E E E
1 5 2 8 3 7 4 6

ELEMENTS

CONSTRUCT POLE RATED - 5 -

HOLISTIC VIEW C4 # 3 3 4 1 1 1 1 # C4 LACK KNOWLEDGE OF PROCESS

ABLE TO QUESTION THEORY C5 # 4 4 3 2 2 1 2 2 # C5 UNABLE TO DEVELOP/DISCUSS

UNDERSTANDING/FORWARD PLAN C7 # 1 4 3 2 1 2 2 2 # C7 LIMITED VISION/UNDERSTANDING

UNDERSTAND/APPLY THEORY C1 # 3 4 3 3 1 3 3 1 # C1 LACK/UNABLE TO APPLY THEORY

CONFID/INDEPENDENCE C6 # 3 2 1 1 1 2 3 2 # C6 LESS MATURE/CONFIDENT

AWARE OF SELF IN TR.SITN. C3 # 2 2 2 2 1 2 4 4 # C3 UNABLE TO EST. RAPPORT

HIGH LEVEL COMM.SKILLS C8 # 1 1 1 1 1 4 3 # C8 BASIC COMMUNICATION

PROJECTION OF SELF C2 # 2 1 1 1 2 5 5 5 # C2 LACK CONFIDENCE

DEVELOPING TR.PLANS
MANAGEMENT/PT.RECORDS
ANALYSIS/Critical APPRAISAL
GROUP TECHNIQUES
RELINQUISHING STUDENT ROLE
COMMUNICATION
RAPPORT/THERAPEUTIC RELS.
INITIAL ASSESSMENTS
**Elements**

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**Elements**

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<th>Understand Importance of DT</th>
<th>C2: 2 2 2 2 3 1 3 4 C6. Unclear of Prof. Boundaries</th>
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<tr>
<td>Appropriate I.P. Approach</td>
<td>C3: 3 3 2 2 1 1 4 5 C8. Ineffective Use of I.P.Skill</td>
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<tr>
<td>Appropriate Use of Self</td>
<td>C1: 2 3 3 1 1 2 4 5 C1. Self Orientated</td>
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<tr>
<td>Confidence to Use Skills</td>
<td>C4: 1 2 3 2 1 3 4 5 C4. Unquestioning Approach</td>
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<tr>
<td>Thinking as a Therapist</td>
<td>C5: 1 1 3 3 2 2 4 5 C5. Locked into Student Role</td>
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<tr>
<td>Balanced Use of Skills</td>
<td>C7: 1 1 2 3 2 3 4 5 C7. Rigid Thinking/Approach</td>
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<tr>
<td>Sound Basic Knowledge</td>
<td>C5: 1 2 2 3 3 4 5 5 C3. Lack/Cant Use Theory</td>
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<tr>
<td>Can Take Responsibility</td>
<td>C2: 2 2 3 1 1 4 5 4 C2. Lacking Self Confidence</td>
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</table>

**Elements**

- *Management*
- *Identify Resources*
- *Professionism/Role*
- *Interaction with Pts.*
- *Interaction with Staff*
- *Communication*
- *Developing Treatment*
- *Tr.Skills/Use of Media*
C.S.H.L. GRID --CS7--

SPACED FOCUSED GRID

ELEMENTS

CONSTRUCT POLE RATED - 1 -

BALANCE OF SELF/PROFESSION C7  •  3  1  1  1  1  1  3  C7 INAPPROPRIATE APPROACH

ACCEPTING ATTITUDE C1  #  2  1  1  1  2  2  2  C1 INSECURE IN PT/TH RELATIONS

ACCURATE/EFFECTIVE USE THEO C8  #  2  1  1  2  2  1  1  C8 CONFUSED APPLICATION

AWARENESS OF LIMITATIONS C2  #  3  1  1  2  2  1  2  C2 UNCERTAIN OF D.T.ROLE

SOUND SELF AWARENESS C3  •  1  1  1  2  1  1  3  2  C3 LACK OF CONFIDENCE

CONFIDENCE IN TR.Used C4  •  1  2  1  1  3  3  3  3  C4 VAGUE IN TREATMENT

PERSONAL APPROACH TO PROBS C5  •  4  1  1  2  3  3  3  2  C5 LACK ORIGINALITY

SENSITIVITY/OBJECTIVITY C6  •  1  1  1  2  2  3  1  2  C6 LACKS SENSITIVITY/OBJECTIVE

*APPLICATION OF THEORY
*PROFESSIONALISM
*CONTACT WITH STAFF
*ORGANISATIONAL SKILLS
*USE OF ACTIVITY
*PERSONAL QUALITIES
*CONTACT WITH PTS.
*REPORTING/RECORDING

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SPACED FOCUSED GRID

ELEMENTS

CONSTRUCT POLE RATED - 1 -

SURE OF FACTS C5 2 2 2 1 1 1 22 C5 HESITANT ABOUT FACTS
REALISTIC APPLICATION C6 1 4 3 1 1 1 1 C6 INFLEXIBLE USE OF THEORY
FORWARD PLANNING C2 4 4 3 1 1 1 1 C2 UNADAPTABLE IN TR PROGS
EFFECTIVE USE OF INT/PER SKILLS C7 5 5 4 1 1 1 1 C7 UNINTERESTED/UNINVOLVED
DEAL WITH PT, AS A WHOLE C8 4 5 4 2 1 1 1 C8 LACKING INSIGHT
EFFECTIVE COMMUNICATION C4 4 4 3 2 1 2 22 C4 WORKS IN ISOLATION
USE OF PRACTICAL SKILLS C1 4 4 3 4 3 2 11 C1 UNINFORMED APPROACH

ORGANISATION SKILLS C3 3 3 3 3 3 3 33 C3 DISORGANISED

***************

* * * * * * * * TREATING PTS.
* * * * * * * * ASSESSING PTS
* * * * * HOME VISITS
* * * * * * * * INTERACTION WITH PTS/STAFF
* * * * * REPORTING
* * * * MANAGEMENT
* * * * * * * * WRITTEN WORK
* * USE OF KNOWLEDGE

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CONSTRUCT POLE RATED - 1 -
E E E E E E E
7 2 3 6 4 8 5 1

-------------------------------
SOUND THEORY C1 1 1 1 2 5 5 5 5 * C1 LACK OF THEORY BASE
PRAC APPLICATION OF SKILLS C8 1 1 1 2 4 3 3 4 * C8 ILLOGICAL APPLICATION
UNDERSTANDING OF OT C5 1 1 1 1 3 3 3 3 * C5 CANT INTEGRATE ALL ASPECTS
PROFESSIONAL ATTITUDE C6 1 1 1 2 1 1 2 1 * C6 DEPENDENT ON SUPERVISOR
MANAGEMENT/RE-EVALUATION C2 3 1 1 2 2 1 1 3 * C2 LACK ORGANISATIONAL SKILLS
FORWARD PLANNING C3 2 2 1 2 1 1 1 5 * C3 ILLOGICAL APPROACH
EFFECTIVE USE OF TIME C4 2 2 2 1 1 1 1 5 * C4 INFLEXIBILITY

LACKS AWARENESS OF SELF RC7 5 4 4 1 1 3 4 5 * RC7 GOOD INTERACTIONAL SKILLS

*INTEGRATION WITH PTS/STAFF
*MANAGEMENT OF PTS
*SENSE OF RESPONSIBILITY
*MANAGEMENT OF SELF
*WRITTEN REPORTING/TR PLANS
*TR SKILLS/TECHS
*A assesment of PTS
*VERBAL REPORTING
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INTRODUCTION


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JOURNAL ABBREVIATIONS

B J O T British Journal of Occupational Therapy
A J O T American Journal of Occupational Therapy
C J O T Canadian Journal of Occupational Therapy