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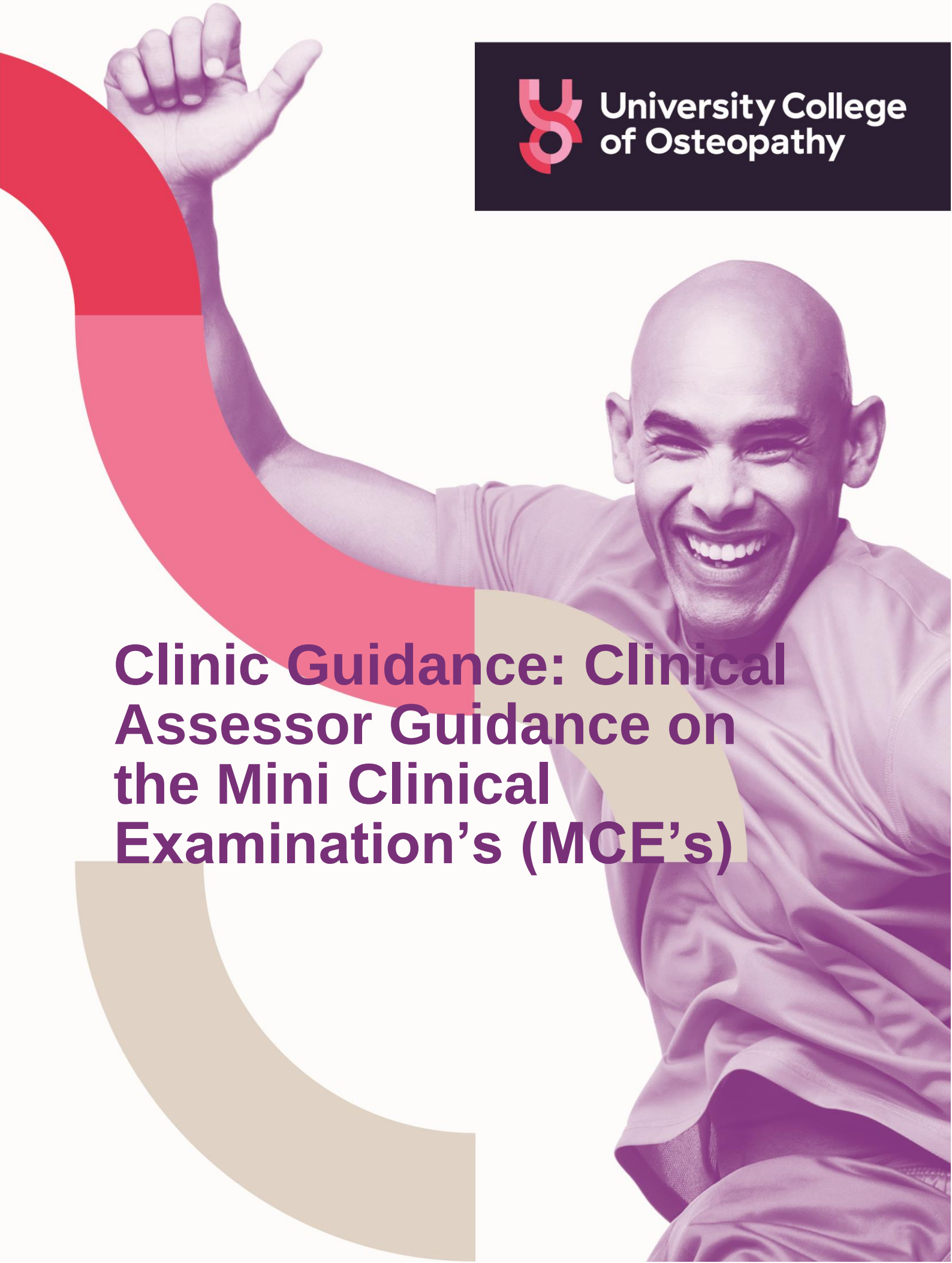

Clinic Guidance: Clinical Assessor Guidance on the Mini Clinical Examination's (MCE's)

University College of Osteopathy

Documentation Cover Page					
Clinic Guidance: **Clinical Assessor Guidance on the Mini Clinical Examination's (MCE's)**					
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Equality Impact	
Positive equality impact (i.e. the policy/procedure/guideline significantly reduces inequalities)	
Neutral equality impact (i.e. no significant effect)	X
Negative equality impact (i.e. increasing inequalities)	

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University College of Osteopathy

Clinic Guidance:

Assessor Guidance on Clinical Assessor Guidance on the Mini Clinical Examination's (MCE's)

Contents

1) USE OF THESE GUIDELINES

1.1 The following guidelines were initially developed from the General Osteopathic Council's (GOsC) "FCCA Guidelines for Assessors 2005" and work completed by Hilary Abbey at the British School of Osteopathy (now the University College of Osteopathy (UCO)) in 2006. They underwent a significant review in 2010 as we moved into the first year of the Clinical Competency Assessment (CCA) being assessed at M level and have since been reviewed regularly.

1.2 In 2016, these guidelines were further developed to include information on the Mini Clinical Examinations (MCE's) that are now part of the assessment profile of clinical assessments. A further review was undertaken in 2017 as clinic assessments moved to Mini Clinical Assessments for level 6 and 7, as opposed to Clinical Competency Assessments and Clinic Tutor Reports that were part of the assessment portfolio previously.

1.3 These guidelines are intended for all assessors of clinical assessments, whether this is part of a formative or summative process and whether as an assessor or reviewer, internal or external to the UCO or as an Assessment Co-ordinator. These guidelines may also be used for clinical staff development.

1.4 These guidelines should be used in collaboration with the Clinic Tutor Handbook that can be found at: http://intranet.uco.ac.uk/guidelines_and_handbooks/

2) CLINICAL ASSESSMENTS

2.1 Clinical assessments consist of Mini Clinical Examinations (MCE's) at level 6 and level 7.

2.2 Mini Clinical Examinations (MCE's) at level 6:

a) These assessments are designed to assess students in the core knowledge, skills and attributes that are expected of a novice student at level 6. The emphasis of MCE's will be on the case history, communication skills, examination and osteopathic care of a patient.

b) MCE's at this level typically involve students seeing one ongoing patient (OP) or a new patient (NP) depending on their stage of progression through the course.

2.3 Mini Clinical Examinations (MCE's) at level 7:

a) MCE's at level 7 assess a candidates ability to be competent with the complexity and uncertainty of clinical practice, and to be safe, autonomous osteopaths capable of making reasoned professional judgments in the best interests of the patient.

b) Candidates are expected to integrate all aspects of their acquired skills in the process of osteopathic patient care and to develop individual treatment and management plans, critically informed by appropriate evidence. Osteopathic treatment is the candidates' responsibility and is applied in a justified manner in response to changes in the patient throughout their treatment and management. Further responsibilities include communicating with outside agencies and other practitioners where appropriate.

c) MCE's at level 7 typically involve a student undertaking a series of MCE's across the academic year. These MCE's would typically be with an OP or a NP, depending of their stage of progression through the course.

3) GRADE DESCRIPTORS

3.1 The UCO employs a 16 point grade descriptor scale for grading candidate performance in an assessment:

Grade	Signifies
A +	Excellent work. Fully achieves the learning outcomes in accordance with the level descriptors
A	
A -	
B +	Generally good work but with some minor defects. Ably achieves the learning outcomes in accordance with the level descriptors
B	
B -	
C +	Generally sound work, but with a small number of errors or omissions. Satisfactorily achieves the learning outcomes in accordance with the level descriptors
C	
C -	
D +	Adequate work but with a number of significant errors or omissions. Marginally achieves the learning outcomes in accordance with the level descriptors
D	
D -	
E + (Marginal Fail)	Unsatisfactory work with a significant number of serious errors and omissions. Marginally fails to achieve the learning outcomes according to the level descriptors.
E - (Fail)	
F (Fail)	Work of a very poor standard containing little discernible merit. Clearly fails to achieve the learning outcomes according to the level descriptors. No submission
G	Failure on grounds of safety (see definition of a G grade below)

3.2 Where there is appropriate evidence of a candidate's performance, the school encourages the use of all grade scales. The pass grade in pre-registration courses is A+ to D-.

A) Definition of the 'G' Grade

3.3 Across the institution a 'G' grade can be awarded when the following conditions apply:

a) In a practical assessment (including clinical assessments) the candidate makes a judgement or performs an action that is deemed to have a high risk of causing serious harm, unnecessarily high levels of discomfort to the patient, or fails to identify a clear need to act (including appropriate referral) to benefit the patient.

b) In a written or oral assessment, the candidate makes and defends a statement that, if applied clinically, is likely to cause serious harm either by omission or commission

B) Definition of a 'G' grade with respect to Clinical Assessments

3.4 This could, for example, include the following situations:

a) giving treatment to a patient who has already been identified as having a condition for which that treatment is contraindicated;

b) failing to take steps to modify a technique when there is evidence of significant patient discomfort;

c) a patient withdrawing their consent to treatment or examination (e.g. requesting a candidate to cease a technique or procedure) but the candidate continues against their wishes.

3.5 It is also possible to award a 'G' grade if it is deemed that a candidate's level of knowledge is deficient, i.e. their lack of knowledge or understanding of its application puts the patient at significant risk of suffering serious harm either through action or inaction by the candidate.

3.6 This could for example include the following situations:

a) the candidate not being able to recognise clinically evident signs and/or symptoms that contra-indicate treatment or require referral;

b) the candidate fails to recognise the need for or neglects to perform clinical examinations that, through their omission, place the patient at significant risk of serious harm.

3.7 In all cases, the awarding of a G grade will take place following further discussion of the evidence. In the case of MCE's, such discussions must involve the assessor and the assessment co-ordinator, plus a senior member of the clinic faculty team, who has been independent to the process up to this point.

3.8 When considering the awarding of a G grade, the purpose of the discussions is to relate the evidence to the regulations of the BSO and the definitions of the G grade. Clear evidence must be provided by the assessor and recorded on the assessment form. The decision to award a G grade must be agreed following discussion by all members of the review team, including the independent third party and should be based on the evidence presented.

4) LEVEL 6 AND LEVEL 7 CRITERIA

4.1 The Quality Assurance Agency (QAA) sets out the qualification criteria across different levels[1]; and these are set out below for Level 6 and Level 7, that are most pertinent to clinical assessments:

A) LEVEL 6

"Descriptor for a higher education qualification at Level 6: Bachelor's degree with honours: The descriptor provided for this level of the FHEQ is for any bachelor's degree with honours which should meet the descriptor in full. This qualification descriptor should also be used as a reference point for other qualifications at level 6 of the FHEQ, including bachelor's degrees, and graduate diplomas.

Bachelor's degrees with honours are awarded to students who have demonstrated:

a) a systematic understanding of key aspects of their field of study, including acquisition of coherent and detailed knowledge, at least some of which is at, or informed by, the forefront of defined aspects of a discipline

b) an ability to deploy accurately established techniques of analysis and enquiry within a discipline

c) conceptual understanding that enables the student:

   i. to devise and sustain arguments, and/or to solve problems, using ideas and techniques, some of which are at the forefront of a discipline

   ii. to describe and comment upon particular aspects of current research, or equivalent advanced scholarship, in the discipline

d) an appreciation of the uncertainty, ambiguity and limits of knowledge

e) the ability to manage their own learning, and to make use of scholarly reviews and primary sources (for example, refereed research articles and/or original materials appropriate to the discipline).

Typically, holders of the qualification will be able to:

a) apply the methods and techniques that they have learned to review, consolidate, extend and apply their knowledge and understanding, and to initiate and carry out projects

b) critically evaluate arguments, assumptions, abstract concepts and data (that may be incomplete), to make judgements, and to frame appropriate questions to achieve a solution - or identify a range of solutions - to a problem

c) communicate information, ideas, problems and solutions to both specialist and non-specialist audiences.

And holders will have:

a) the qualities and transferable skills necessary for employment requiring:

   i. the exercise of initiative and personal responsibility

[1] http://www.qaa.ac.uk/en/Publications/Documents/qualifications-frameworks.pdf

ii. decision-making in complex and unpredictable contexts

iii. the learning ability needed to undertake appropriate further training of a professional or equivalent nature."

B) LEVEL 7

"Descriptor for a higher education qualification at level 7: Master's degree

The descriptor provided for this level of the framework is for any master's degree which should meet the descriptor in full. This qualification descriptor can also be used as a reference point for other level 7 qualifications, including postgraduate certificates and postgraduate diplomas.

Master's degrees are awarded to students who have demonstrated:

a) a systematic understanding of knowledge, and a critical awareness of current problems and/or new insights, much of which is at, or informed by, the forefront of their academic discipline, field of study or area of professional practice

b) a comprehensive understanding of techniques applicable to their own research or advanced scholarship

c) originality in the application of knowledge, together with a practical understanding of how established techniques of research and enquiry are used to create and interpret knowledge in the discipline

d) conceptual understanding that enables the student:

i. to evaluate critically current research and advanced scholarship in the discipline

ii. to evaluate methodologies and develop critiques of them and, where appropriate, to propose new hypotheses.

Typically, holders of the qualification will be able to:

a) deal with complex issues both systematically and creatively, make sound judgements in the absence of complete data, and communicate their conclusions clearly to specialist and non-specialist audiences

b) demonstrate self-direction and originality in tackling and solving problems, and act autonomously in planning and implementing tasks at a professional or equivalent level

c) continue to advance their knowledge and understanding, and to develop new skills to a high level.

And holders will have:

a) the qualities and transferable skills necessary for employment requiring:

i. the exercise of initiative and personal responsibility

ii. decision-making in complex and unpredictable situations

iii. the independent learning ability required for continuing professional development."

5) Overview of Clinical Exams

5.1 It may be the case that some assessors will find themselves assessing candidates that they have tutored or know well. It is therefore important that assessors are aware of the need to conduct themselves in a professional manner and do not show bias towards or against particular candidates. Assessors should be aware of how their demeanour, actions and words may be perceived and should avoid saying or doing anything that undermines or devalues the candidates' experience of the examination process.

5.2 When assessors meet with candidates prior to their assessment, please note the following:

a) Many if not all candidates are likely to be nervous.

b) It is important to introduce yourself as the assessor, as candidates may not know all UCO staff.

c) That it may be helpful to remind candidates that with NP's, they can take a few minutes prior to each presentation (after the case history and after the examination) to gather their thoughts; candidates should let assessors know as and when they may need this time.

d) It may be useful to remind candidates to ask for questions to be re-phrased if they don't understand the assessor.

e) It may be helpful to encourage candidates to keep to time and to provide effective patient care, including hands on treatment where appropriate.

f) That if candidates have any concerns about sensitive issues in relation to the patient, to let their assessors know, so that these can be discussed outside the consultation room.

6) Results

6.1 It is imperative that assessors and any other member of staff involved in the process, do not discuss the performance of candidates with each other until the review meeting. This applies to formative and summative assessments and is aimed at improving the objectivity of the assessment and the use of the feedback. All discussions and decisions at any review meetings are confidential and assessors and any other staff involved MUST NOT disclose any results to other members of faculty or students.

6.2 As part of the MCE process, we aim to provide students time with the assessor for immediate feedback on the students overall performance.

6.3 The feedback provided as part of clinical assessments, should be used by students when they complete their action plan of their strengths, weaknesses and how they plan to proceed. This is typically completed at the end of each term. Hence the quality and the relevance of any feedback is an integral part for this to be successful (please also see the section below on feedback).

7) PROCEDURE FOR THE MCE

7.1 During the MCE, assessors will evaluate the core knowledge, skills and attributes, and practical abilities that are expected of a student at level 6 or level 7.

7.2 The aim of the MCE is to give candidates the opportunity to demonstrate their ability to deliver osteopathic patient care in a practice setting appropriate to their level of study.

7.3 The role of the assessor is to observe candidates' clinical performance, identify and evaluate evidence of the rationale for their actions by relevant questioning that is fair, efficient and searching and to provide constructive feedback on their progress to date that can then be used to inform their ongoing development. There is time built into the MCE so that any questioning of the student can be done after they have completed their consultation with the patient.

7.4 Feedback must be informed by assessment criteria and ideally should relate to specific examples or instances that illustrate how the assessor has measured the candidate so as to provide clear justification for any comments and grades given. It is also vital that any feedback given is balanced and illustrates strengths as well as areas for development from the candidate's performance.

A) ON THE DAY

7.5 Students should arrive in good time prior to the start of their MCE so that they have plenty of time to get organised. Although all candidates typically have an assessment briefing session with their Unit Leader, there is typically a briefing session prior to the start of their assessment session, which all students are expected to attend. This assessment briefing session on the day of the MCE is led by the Assessment Co-ordinator.

7.6 All assessors should be ready to meet with the candidates 15 minutes before the start of the assessment. This allows assessors to be introduced, the process to be reviewed with the candidates and an opportunity for any questions or any clarification that is needed from the candidates.

7.7 Students will be examined by one assessor where they are seeing an OP for their MCE; when students are seeing a NP for their MCE, there will be a review meeting at the end of the session. The role of the reviewer is to provide an opportunity to consider the evidence from the assessor in light of the learning outcomes and level descriptors to ensure that the grade awarded is appropriate. Those involved in reviewing the evidence with assessors may also be able to contribute to the consistency of the process, within the parameters of a clinical assessment.

B) ONGOING PATIENT (OP)

7.8 The times allocated for an MCE with an ongoing patient (OP) is as follows:

a) Presentation of the case to the assessor = 10 mins
b) Entire consultation and appointment time with ongoing patient = 40 mins
c) Further questions/clarification with the assessor = maximum of 20 mins
d) Time for feedback/discussion with the candidate = approximately 5 – 10 mins

7.9 As part of the MCE with an OP, each candidate will initially provide a succinct presentation to the assessors of their OP. This should include the summary statement and summary of dysfunction of the patient, and the treatment and management plan that sets out the osteopathic care provided.

7.10 Assessors should bear in mind that some candidates may have had a limited choice when selecting their OP and so assessors should be mindful of the potential limitations this places on the student and the potential for assessor bias.

7.11 The process of summarizing the patient's case often proves a difficult task for candidates. Assessors should be wary of judging a candidate against what they themselves may or may not think is relevant simply from the summary presentation. There is time built into the assessment after the patient consultation so that assessors can explore the candidates understanding of their OP using the presentation as a basis for this. If an assessor considers that a candidate has omitted something from the summary that is of significance, the assessor should try to explore the candidate's reasoning for this. Assessors should try to look for evidence of a candidate's level of knowledge and understanding in relation to the context of the health of the patient and how this has informed the candidate's decision making.

7.12 Candidates will typically present the OP case to the assessor before the patient is collected from reception and there is time built into the schedule for this. Candidates are then able to continue with their examination and treatment of their OP. If the patient presents with a new symptom or other situation that requires further detailed investigation, then the candidate should act accordingly and let the assessors know of this situation.

7.13 Assessors should try to sample the candidate's interactions with their OP at different stages of the consultation to enable them to assess different aspects of the assessment criteria. There is time built into the MCE so that any questioning of the student can be done after they have completed their consultation with the patient.

7.14 The time an assessor spends with a candidate and their OP, and subsequent questioning, will depend upon the demands of an assessor elsewhere and the time restraints this presents.

C) FORMAT FOR THE NP

7.15 The times allocated for an MCE with an NP is as follows:

a) Entire consultation and appointment time with NP = 90 mins (although level 7 students should aim to work towards a consultation time of 80 – 85 mins – please see below).

b) This time can be broken down in the following way (although this is in part case dependent):

	Level 6	Level 7
Case history	30 minutes	20 – 25 minutes

Presentation 1	15 minutes	10 -15 minutes
Observation and examination	20 minutes	15 – 20 minutes
Presentation 2	15 minutes	10 – 15 minutes
Discuss with NP, consent, treatment if appropriate	10 minutes	10 – 15 minutes

7.16 PLEASE NOTE: Level 7 students would be expected to complete their case history in 20 - 25 minutes where appropriate, and refine other timings, which would enable the student to complete their notes and so be ready for their next patient at the correct time. This is a useful model to work towards in general clinic in preparation for clinical assessments, as well as practice life.

7.17 When assessors are examining the candidate with the NP, they should observe samples of the candidate at the different stages of the consultation. Assessors should try to sample each phase of the consultation for each candidate, bearing in mind the need to effectively manage time during that period. There is a danger of 'over examining' so please be mindful of seeing enough to make an informed and evidenced decision, but not so much as to be unfair on the candidate.

7.18 Each candidate will have their own discussion room. After the candidate has completed the case history they may wish to take a few minutes to gather their thoughts and this can be done in the discussion rooms. This is the opportunity for the assessor to introduce themselves to the NP and explain that they have overall clinical responsibility for the patient during this assessment and are the point of contact for the patient should they wish to ask any explanatory questions or raise any points of concern.

7.19 Phases of the NP consultation:

a) Case history taking

b) Presentation 1: Interpretation of the case history

c) Observation and Examination

d) Presentation 2: Osteopathic Evaluation

e) Management of the patient

f) Osteopathic care of the patient including Consent, benefits, risks and alternatives (including doing nothing)

These phases are set out on the assessment forms, including more detail on the criteria for each area.

7.20 Presentation 1: Interpretation of the case history

a) Following the case history, and any time the candidate may have needed to gather their thoughts, candidates should be asked to present a succinct summary of the main features of the case. This should lead onto the candidate using the

clinical temporal profile and other relevant information about the case, such as any relevant flags, to develop their understanding of the patient and the priorities for the patient at this time. This should lead onto their proposals for the next steps, which in most cases is likely to be the examination of the patient.

b) It is important that candidates can explain the rationale for their reasoning and clinical choices, and the means by which they will attempt to differentiate between potential areas of concern in their examination. At this stage, assessors may ask a few clarifying questions and/or hypothetical questions that link to the patient case, to enable a candidate to demonstrate the full range of their knowledge and understanding.

c) This section of presentation and questioning should not normally exceed 15 minutes and assessors should be mindful that candidates are not overly delayed at this stage.

7.21 Examination and observation:

a) The candidate should then return to the consultation room to discuss with the patient the proposed plan of examination and to proceed with this, if the patient consents. Assessors should aim to observe part of the examination of the patient by the candidate. Again this will be dependent on time and duties elsewhere. Following the examination, the candidate should step out of the consultation room, to the interview room and again may wish to take a few minutes to gather their thoughts. At this stage, the candidate should be in a position to discuss their examination findings and working hypothesis with the assessor before discussing this with patient. Presentation 2 is the second key opportunity for the assessor to ask the candidate relevant questions.

7.22 Presentation 2: Osteopathic Evaluation

a) Once the candidate is ready, he/she should be asked to present their findings and evaluation of the patient (summary of dysfunction). The assessor can then ask additional questions as needed to explore the level of the candidate in relation to the assessment criteria. Again, this phase should typically last no longer than 15 minutes. Time permitting, candidates should then proceed to treat the patient where appropriate and hopefully demonstrate their skills in managing a NP at this first consultation. Assessors again should be aiming to observe this.

b) If an assessor is unsure of the process at any point or would like clarification then they should speak to the assessment co-ordinator, whose role is to direct candidates and assessors as necessary and help with the smooth running of the examination process.

D) Review meeting

7.23 MCE's do not have a moderator who samples the assessment process, as has been done previously with CCA's. This is thought to be appropriate given the style of the assessment, the number of opportunities a candidate has and the weighting of the assessment. Typically, there is an assessment co-ordinator that assessors can speak to, if they have any concerns or queries, however there is no formal moderator.

7.24 Once assessors have completed their sampling of the candidates work at each stage of the consultation and there has been time for additional questions and discussion with the candidate, and time for initial feedback, then there is the opportunity for a review meeting. The purpose of the review meeting is to allow for any aspects of the candidates' observed performance to be reviewed and discussed, so that assessors are able to reflect on the candidates performance with a 3rd party. This helps to ensure that the grade awarded best reflects their overall performance on the day. Clinic co-ordinators would typically be involved in review meetings; it may be that other senior members of the clinic faculty would also be involved. Member of staff involved in this process have a responsibility to ensure that assessors are relating candidate performance to the assessment criteria and that detailed evidence is provided to support the grades awarded.

7.25 All assessors should have a sample of their assessments reviewed with the Assessment Co-ordinator (or appropriate other). However, the evidence should always be reviewed in the following circumstances:

a) When a candidate has been awarded a D (high, mid or low)

b) When a candidate has been awarded a fail grade (E high, E low or F)

c) When a candidate has been awarded a G grade based on safety concerns. In all cases, the awarding of a G grade will take place following further discussion of the evidence with the assessor and the assessment co-ordinator, plus a senior member of the clinic faculty team, who has been independent to the process up to this point. Please see section 3 for further details.

7.26 At the review meeting of an MCE, the assessor should present the grade they have awarded the candidate, along with the supportive evidence for this. Discussions should then take place that explore the evidence in light of the assessment criteria and level descriptors. Members of staff involved in review meetings are expected to challenge as appropriate, if it is felt that the grade awarded is not supported by the evidence. Discussions between the assessor and any other staff members at the review meeting, should then lead to a final grade being awarded, that is supported by the evidence gathered. Central to this process is the effective use of the grade descriptors and assessment criteria to ensure that candidates are being assessed appropriately and effectively.

7.27 An important element of the MCE's is time for candidates to have immediate feedback from the assessor and for the candidate to provide their own feedback and experience of the process. This feedback from the assessor will typically be one or two key areas that the candidate demonstrated good practice in and one or two areas where the candidate may be given constructive feedback on how to improve in these areas. The candidate is then able to provide their own feedback on the process and this can be recorded on the assessment form for consideration as part of a reflective cycle and further feedback, that typically takes place during the last week of each term.

8) CANDIDATES WITH DISABILITIES AND SPECIAL CIRCUMSTANCES

8.1 The Equality Act (2010) legally protects people from discrimination in the workplace and in wider society and as an educational establishment, we have a duty to adhere to this act.

8.2 It is important for academic and clinical staff to reflect and review their learning, teaching and assessment methods and materials in relation to delivering more inclusive practice. This legislation supports a mainstreaming approach to disability, often referred to as the 'social model of disability'. The social model recognises that the disadvantages and social exclusion experienced by many disabled people, for example in connection with employment or educational opportunities, are not the inevitable result of their impairments or medical conditions, but rather stem from attitudinal and environmental barriers which discriminate against disabled people and limit their life chances. The higher education sector can play a vital role in helping to eliminate these disadvantages, by ensuring that disabled candidates are not discriminated against through any policies and practices and can fulfil their educational potential.

8.3 To support a socially inclusive approach to disabled candidates, academic and clinical staff will need to be informed and supported to respond appropriately to the needs of disabled candidates.

8.4 This includes:

a) ensuring that staff have appropriate training to make their teaching and assessment practices accessible to disabled candidates
b) ensuring that staff understand their duties to make and adhere to reasonable adjustments
c) ensuring that staff are aware of the advice and support services which are available within the institution for disabled candidates.

8.5 The duty to make reasonable adjustments applies where a disabled person is placed at a substantial disadvantage in comparison with people who are not disabled. In these circumstances, the Higher Education Institute (HEI) must make reasonable adjustments, to remove that disadvantage. What is and is not reasonable depends on the circumstances of the individual and the resources of the HEI. It is also an important element of the duty to make anticipatory adjustments. This means that HEI's must think ahead about the type of adjustments that they may need to make to include students with a range of impairments.

8.6 Candidates with disabilities will be given the opportunity to disclose their disability to the assessors prior to assessment through the Student Support Manager and student support team. The examining team will be made aware of the candidate's situation and any appropriate adjustments that have been made.

8.7 Examples of adjustments may include:

a) extra time
b) written aids to support the thought processes of candidates, such as time lines, mind maps etc.
c) breaks between patients

8.8 Although the Equality Act 2010 ensures that reasonable adjustments are made to an assessment process, where appropriate, this does not alter the competency standards that all candidates must reach. This means that the way in which competency standards may be assessed, may be different, but the standard must nonetheless be achieved.

A) Candidates with Dyslexia

8.9 In Higher Education the most common disability is the learning disability dyslexia and currently, here at the BSO about 95% of students who have declared a disability fall into this category. Dyslexia is a condition which affects many students, often in different ways. The most common symptoms are:

a) poor spelling – these students often spell phonetically and inconsistently;

b) reading/writing problems - reading and/or writing may show repetitions, transpositions, additions, omissions, substitutions and reversals in letters, words, and/or numbers;

c) slow processing skills – processing written information can take the student with dyslexia much longer;

d) motor dexterity - handwriting varies or is illegible in extreme situations; these students may confuse left/right and over/under;

e) language - difficulty putting thoughts into words; may stutter under stress, mispronounces long words or transposes phrases and words when speaking.

f) memory – poor working memory is common

B) Candidates with Other Disabilities

8.10 The Equality Act (2010) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. This could include a sensory impairment, visual or hearing, or perhaps a disease such as cancer or HIV.

8.11 A student from this group may request a number of reasonable adjustments to enable the assessment to be inclusive. For example:

a) A student with a visual impairment might request the use of technical equipment to write up a case history or extra time to read an ongoing patients case history.

b) A student with HIV may be taking medication which affects their thought processes and may require extra time to digest information.

8.12 In all cases; if a student requires a reasonable adjustment to any of their clinical assessments, they will need to meet with the Student Support Manager in order to provide documentary evidence to support their request and to discuss their situation with the Student Support Manager.

8.13 Reasonable adjustments will be made in accordance with the circumstances of the individual and the resources of the HEI.

8.14 The student will be asked to sign a disclosure form which permits all involved in their teaching and learning, and assessment to be made aware of their disability and what reasonable adjustments are to be put in place to accommodate them.

9) ROLE OF ASSESSOR

9.1 The role of the assessor is to gain sufficient evidence to make a judgement about the clinical competence of a candidate. This should be done in a manner which appreciates the daunting task that this will present for many if not all of the candidates.

9.2 The dress code for assessors is to be smartly dressed and without the need for a clinic coat.

9.3 Many of the areas discussed below may seem obvious to tutors and assessors who are familiar with the process of assessing candidates in the clinical environment or other assessments, as well as working as tutors. However we want to be clear in our aims as objective assessors, trying to create a fair environment for all candidates.

A) QUESTIONING

9.4 As with clinical tutoring, the style of questioning can affect the candidate's interpretation and ability to demonstrate their knowledge and understanding. Clearly, questions phrased simply and in 'bite-size' chunks are often better received by candidates, particularly at the beginning of a clinical assessment when candidates may feel more nervous. Long and complex phrasing can be very unsettling and time wasting. It is important that questioning is clinically relevant to the case at the time and does not become skewed towards a particular assessor's favourite topic or simply a barrage of questions to test their knowledge base alone.

9.5 Questions need to be asked that sample the candidate's underlying knowledge base and how this relates to their clinical reasoning skills but not to such an extent that the candidate's interaction with, and management of their patient, suffers. The clinical assessments need to look globally at the candidate's clinical practice. It needs to be balanced and not focus unduly on a specific topic. Questions also need to reflect the appropriate level criteria; exploring how candidates are making and justifying clinical decisions throughout the process.

9.6 With the structure of the MCE's, there is no need for assessors to question the candidate in front of the patients, as there is time built in for questions and discussions at the end of the assessment phase. Assessors are able to speak in the consultation room (say hello, check the patient is ok etc. etc.) otherwise the atmosphere may feel a little odd to all involved!

9.7 There are however occasional times when an assessor may want to ask a question of a candidate and this would typically be to promote a change. For example, if the positioning of the patient appeared to be awkward, the assessor may ask the candidate a question about this to encourage them to think about this, and hopefully make a change.

9.8 If assessors are concerned that the candidate may be approaching something that would potentially cause the patient harm (mentally, emotionally or physically), or that it could be dangerous, then they are duty bound to intervene and stop the process. At this point, assessors should ask the candidate to step out of the consultation room so that they can discuss this further. Assessors should at this point locate the assessment co-ordinator to meet with the assessor and the candidate. If needed, the

assessment co-ordinator can assign the patient to another practitioner and clinic tutor to follow up. Any actions should be decided by the assessor and the assessment co-ordinator.

9.9 When assessors are questions candidates, there should be progressively challenging but not aggressive questioning, tempered with the ability to recognise when a candidate is 'freezing' due to being nervous or just temporarily unsettled by direct questions. If a candidate is clearly having difficulties in replying to questions, it is better to move away from a particular line of questioning and return to it later, perhaps framing questions in a different way. Where appropriate, an assessor may ask the assessment co-coordinator for additional support and advice.

9.10 If direct questioning becomes too protracted there is a possibility of distracting and undermining the confidence of the candidate, which may impact on the rest of the assessment, particularly in relation to timekeeping. This is particularly so if there is intensive questioning early in the assessment before the candidate has settled. It is often necessary to 'ease into' questioning, covering some of the more basic concepts before building up to more challenging questions.

9.11 If candidates appear not to understand particular questions then it is necessary to re-phrase them. Assessors should also be aware of the time taken for questioning so that this does not delay the candidates significantly or affect the ability of the assessor to spend time with other candidates.

9.12 It is important that candidates are encouraged to be specific and accurate in their replies, especially where differential diagnosis and the osteopathic evaluation are concerned. It is not uncommon for candidates to state vague diagnoses, such as a 'muscle tension' or 'heart problems'. In such cases the assessor needs to ask the candidate "to explain in more detail" what they are considering.

B) PERSONALITY

9.13 Assessors need to reflect on their own personality and how this may come across to a candidate who is likely to be in a heightened state of anxiety, even in a formative exam. This is not an attempt to make assessors into automatons but is just recognising the potential for misinterpretation by candidates in a stressful situation.

9.14 It is desirable that assessors do not enter into a situation where there may be a clash of personalities and should therefore adopt, as far as is reasonable, a neutral approach. Candidates who are under stress may behave in a wide range of different ways. Some become very quiet, some aggressive and others panic. It is necessary to be sensitive to this and to reflect on why a candidate may be reacting in a certain way. Often some reassurance about the exam process may be helpful.

9.15 Some candidates may initially seem aggressive or argumentative, which may be their response to a stressful situation. It is important the assessors respond appropriately to this, which may be to not pursue further questioning at this time but resume this at a later time. The over-riding consideration should be to give the candidate 'the benefit of the doubt' to a point until such behaviour becomes protracted, unreasonable or unprofessional. If in doubt, assessors should ask the Assessment Co-ordinator for guidance.

9.16 Candidates who are behaving in a timid fashion may also be reacting to the stress of the situation. Assessors should look past their initial impressions to seek evidence of the candidate's ability as it is difficult for some people who are normally confident and competent to display this in an assessment situation.

9.17 It is important to remember that assessors are in a much more 'powerful' position in the dynamics of this assessment. This brings with it the responsibility to create the conditions, as far as is possible, for individual candidates with varying personalities and approaches to perform to their highest potential.

C) Assumptions

9.18 Assessors need to be aware of their own biases and preconceived ideas. Assessors should not discuss a candidate's usual clinical ability with other members of staff who may know the candidate better, either before or during any clinical assessment. This may lead to assumptions being made, either positive or negative, about the likely performance of a candidate and may colour perceptions of what is actually observed on the day. Obviously, it will be difficult to be completely neutral about candidates who are well known to a tutor but judgements must be made on the performance on the day.

9.19 Being guided by the assessment criteria will help assessors to remain neutral. Candidates who have been assumed to be poor in clinic may not have been given sufficient opportunity to prove otherwise, while positive assumptions about other candidates may lead to assessors not adequately sampling their underlying knowledge base, skills or rationale.

D) 'On the Day' Performances

9.20 Sometimes candidates who have had consistently poor or borderline performances in normal clinical practice may excel on the day of their clinical assessment. Conversely, candidates who have performed consistently well in clinic may under perform in a clinical assessment. This is one of the reasons that the UCO now uses a range of clinical assessments which are combined with appropriate weighting. This is aimed to reduce the incidence of unexpected passes or an overall fail that can happen in a single 'snap-shot' assessment. One of the aims of formative clinical assessments, is to identify candidates who suffer from extreme 'exam nerves' so that they can develop strategies for coping more effectively in subsequent examinations. Assessors need to be aware that some candidates may give superficial responses to questioning that may require further challenging, to ascertain whether their underlying clinical reasoning is sound and based on evidence about their particular patient.

E) Decisions of the Assessors

9.21 Formative assessors are able to give a little more guidance to candidates in very complex cases or where the candidate seems completely stuck at one stage of the consultation. Feedback would later highlight where this help was needed and explain what consequences this could have in the later summative exams.

9.22 The aims of the summative assessments are to make judgements about the safety and competence of candidates with assessors taking a 'hands-off' approach to the

process that is commensurate with the level of the candidate being assessed. This is of particular importance at level 7 where it allows candidates to demonstrate themselves as autonomous practitioners.

9.23 Assessor's decisions need to be fair and considered and there needs to be an appreciation of the complexity of the clinical practice process. Some candidates may cope well with complex and challenging patients which should be taken into account. Conversely candidates who see patients with relatively simple cases should still be able to demonstrate a wide range of skills to enable them to gain higher grades if appropriate. The complexity or simplicity of the case should not be a barrier to attaining a higher grade.

9.24 All decisions made by assessors need to be rational and based on clear evidence thus enabling an accurate grade to be given. Assessors need to look at the candidate's overall performance and not be unduly influenced by discrete areas of good or poor performance, especially if this relates to an assessor's favourite subject area. Assessors should not judge candidates by what they would do themselves, since candidates have been influenced by many different sources during their training. The important point is that the candidate has a reasoned rationale for the conclusions they arrive at and what they then decide to do. Assessors should also be aware of the limitations of the candidates' experience to date and not expect the decisions of candidates to compare equally with their own.

F) Clinical Responsibility and Risk

9.25 Whilst the candidate and assessor are responsible for patient care, overall clinical responsibility for the patient lies with the assessor. This is further supported by the clinical responsibility that is taken by the BSO, where patient safety is paramount.

9.26 If a candidate seems to be working in a manner that appears to endanger a patient, it is the assessor's duty to intervene and stop the candidate. The candidate should then be asked to leave the room with the assessor for discussion of the incident along with the assessment co-ordinator (or appropriate other) who will observe the discussion and question the candidate further if necessary.

9.27 If assessors feel that a candidate is really unable to cope with a particular patient, and/or situation, even following significant prompting and/or advice, it may be necessary to stop their assessment and alert a clinic tutor so that the patient can be cared for in the general clinic.

G) Recording

9.28 Assessors must ensure that they accurately record their evidence for all parts of the clinical encounter that they have observed. This evidence forms the basis for the assessor's decision about a particular candidate and will be used as reference during the review meetings to justify an assessor's views on a candidate's level of competence in relation to the assessment criteria. Assessors are reminded that all assessment forms will be scanned and emailed to candidates and therefore need to ensure that they are in an acceptable format.

H) Feedback

9.29 Assessors are expected to provide written feedback on a candidate's performance, so that candidates can use this for the next stages of their development.

9.30 The feedback given should include strengths and weaknesses of a candidate's performance but should also reflect their overall performance and the grade they received. Feedback should give clear and specific examples that highlight different aspects of the candidate's skills (strengths and weaknesses) and how these may be modified so that the candidate can use the feedback as part of a development plan and help them to better understand the process of the clinical assessment and its requirements. Candidates who have failed should have very clear feedback, detailing the reasons for their fail with relevant examples which again can be used as part of their action plan.

9.31 Candidates are asked not to approach any assessor to seek direct feedback at the time of the assessment or until the results are released. If after this time a candidate wishes to approach an assessor (who is a clinic tutor) for additional feedback, it is at the discretion of the assessor should they wish to give additional one to one feedback. Once scanned, all clinical assessments are available via Firstclass for clinic tutors to view.

10) Role of the Assessment Co-Ordinator

10.1 The assessment co-ordinator is responsible for the administration and smooth running of the assessment on the day.

10.2 More specifically, assessment co-ordinators are expected to:

a) At the beginning of the session

i. Brief all the candidates who have an assessment that session – this will either be at 8.30am for an AM session or 1.30pm for a PM session and should be held in the teaching room at the end of clinic

ii. Brief all assessors

iii. Ensure that assessors have all the relevant paperwork

iv. Ensure that consultation rooms and interview rooms have been appropriately allocated and are clearly identified

v. During the session

vi. Liaise with the reception team with regards to any changes during the session

vii. Be available for assessors or candidates during the session, so that any queries, questions or issues can be dealt with

viii. If a candidate wishes to continue treatment/management of their NP outside of the assessment time frame, to organise tutors to supervise student led patient care

b) At the end of the session

i. Be available to review assessor evidence and grades awarded

ii. Allocate additional clinic staff to review evidence and grades, if needed

iii. Gather all the relevant paperwork, including assessment forms and return to the Head of Clinical Practice office

iv. Ensure that all case histories are completed and that it is recorded that this was part of an MCE; assessment co-ordinators can then sign these off

v. Feedback to the Head of Clinical Practice on the assessment process, any areas of good practice and any areas for improvement

11) Role of The External Examiner

11.1 The UCO's current External Examiners for the clinical assessments are as follows:

	Level 6	Level 7
FT	Marianne Bennison	Marianne Bennison
PT	Ross Johnston	Ross Johnson
MScPR1	N/A	Marianne Bennison

11.2 The External Examiner samples the clinical assessment process to ensure, on behalf of the British School of Osteopathy, that the assessment is run appropriately. The External Examiner is not involved with the assessment of candidates, but is likely to sample the assessment process and observe during the review meetings.

11.3 For further information of the role of external examiners at the UCO, please see the Academic Quality Framework at: http://intranet.uco.ac.uk/Academic_Quality/

12) Current Assessment Criteria

12.1 Some or all of the following assessment criteria are used across the clinical assessments, with different expectations, depending on whether the candidate is Level 6 or Level 7.

Learning Outcomes	Grading (for this stage of the course)						
1: Case history & communication skills	Grade	A	B	C	D	E	F
Questioning (relevant/logical/methodical/fluid)							
Patient rapport (empathetic, responsive)							
Evident lines differential enquiry							
Listening/responding with clinical curiosity							
Professionalism (language, timing, legibility)							

2. Presentation 1: Interpretation of the case history	Grade	A	B	C	D	E	F
Presentation skills (relevant/structured/coherent)							
'Flag' recognition & discussion							
Justification/Reasoning of case history (CTP, hypotheses)							
Diagnostic reasoning (VINDICATE)							
3: Observation and examination	Grade	A	B	C	D	E	F
Examination skill (right test/right time)							
Patient communication							
Performance (effectiveness, competence)							
Palpation (application and integration)							
4: Presentation 2: Osteopathic evaluation	Grade	A	B	C	D	E	F
Responsibility for decision making							
Application of knowledge (functional, conceptual)							
Reasoned interpretation of findings/critical consideration							
Osteopathic evaluation (summary statements)							
5: Management of the patient	Grade	A	B	C	D	E	F
Integration of relevant guidelines to care							
Use of advice and exercise based care							
Management planning (relevant/patient centered)							
Meeting & managing Pt expectations							
Prognosis/monitoring outcomes/managing uncertainty							
6: Osteopathic care of the patient	Grade	A	B	C	D	E	F
Care of patient and self							
Application of knowledge base							
Modification of techniques							
Discussing benefits, risks, alternatives (including nothing), & gaining informed consent							
7: Professional Standards	Grade	A	B	C	D	E	F
Professional patient care							