The assessment of undergraduate bachelor of nursing students in the collaborative clusters education model: A qualitative descriptive design

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ABSTRACT

Background: Worldwide, undergraduate Bachelor of Nursing students are required to complete experiential learning placements in health care settings as part of the curriculum. There are a variety of facilitation models that support student learning and assessment on clinical placement. As workforce pressures increase globally, innovative approaches to clinical facilitation are required. In the Collaborative Clusters Education Model of clinical facilitation, hospital-employed clinical facilitators work collaboratively within peer groups (clusters) to collectively participate in a process of facilitating student learning and conducting assessment and moderation of student performance. The assessment process in this collaborative clinical facilitation model is not well described.
Aim: To describe how the assessment of undergraduate nursing students is achieved in the Collaborative Clusters Education Model.
Design: A qualitative descriptive approach was employed.
Methods: In March 2021 individual and group interviews were conducted with seven clinical facilitators working in the Collaborative Clusters Education Model in one health service in southeast Queensland, Australia. Content analysis of transcribed interviews was performed.
Results: Assessment was achieved through two processes, situational scoring and moderation. In the process of situational scoring, clinical facilitators balanced the students' perception of their role in assessment, accounted for the type of experiences available, considered multiple sources of evidence and used the Australian Nursing Standards Assessment Tool. In the process of moderation, clinical facilitators communicated with their cluster colleagues to determine a shared understanding of student history, considered data from multiple evidence sources and collaboratively evaluated the trustworthiness of student performance evaluation decisions.
Conclusions: In the Collaborative Clusters Education Model, the input of multiple assessors, working in a small team, ensured transparency in assessment processes. Furthermore, this transparency in assessment practices normalised on-going moderation, an in-built quality-check and, as such, an innovative component of assessment in the Collaborative Clusters Education Model. As nursing directors and managers seek to ameliorate the impact of nursing workforce pressures, this innovative model of collaborative assessment may serve as a valuable addition to nursing clinical assessment toolkits.
Tweetable abstract: The Collaborative Clusters Education Model of Clinical Facilitation enables transparency in assessment processes and normalises moderation.

1. Introduction

The World Health Organization (2022) reports a global shortfall of nurses, estimating a further nine million nurses will be required by 2030. To address this shortfall, competent nursing graduates will be needed. Innovative clinical education models are required to accommodate the

expected higher student numbers participating in clinical placement. One such innovative model, the Collaborative Clusters Education Model, is a model of clinical facilitation, where clinical facilitators, who have undertaken education in work-based learning, work in clusters of three or four to share the responsibility for the assessment of 35–50 learners across several clinical areas. The clinical facilitators are appointed by the hospital service, supported by funding from universities and they provide "leadership through supporting learners to be active participants and supporting clinical nurses to include learners into their complex workplace" (Grealish et al., 2018).

The Collaborative Clusters Education Model has been found to be an acceptable model to provide access to clinical placement experiences for larger groups of nursing students supported by a dedicated team of clinical facilitators (van de Mortel et al., 2020). The next step in evaluating this innovative model is to understand how assessment practices are enacted and moderated to ensure assessment rigour and competent graduates.

Processes of assessment in the workplace are increasingly complex. Various models for clinical placement have emerged to replace more traditional models of supervision and preceptorship (Bøe and Debesay, 2021). In the traditional models one person was responsible for assessment and drew on direct observation, for example students may be paired one-on-one with a registered nurse who may be responsible for the student's assessment, or they may be paired with a registered nurse with another nurse trained in assessment, being responsible for the student's grading (Hughes et al., 2018). Newer models such as the Dedicated Education Unit (Marcellus, Jantzen, Humble, Sawchuck and Gordon, 2021) and the Collaborative Clusters Education Model (Grealish et al., 2018), require collection of evidence from multiple sources to make a judgement about performance. How assessment is achieved in these emerging models requires further investigation (Cross et al., 2022; van de Mortel et al., 2020).

2. Background

Australian nursing students undertake clinical placement in healthcare facilities during their undergraduate program, as a requirement for professional accreditation (Jackson, 2018). In 2016, one Queensland tertiary hospital service introduced the Collaborative Clusters Education Model to support and assess nursing students on clinical placement (Grealish et al., 2018). In this model, hospital-appointed registered nurses, known as clinical facilitators, work in clusters to share responsibility for the assessment of groups of learners across several clinical areas (Grealish et al., 2018). In the clinical areas the learners work alongside registered nurses, known as practice partners or preceptors (Grealish et al., 2018; Ranse et al., 2022).

Clinical placement experiences provide an opportunity for students to learn about practice and receive feedback from experienced nurses. Formal feedback, in the form of assessment, is considered necessary to ensure patient safety (Burden et al., 2018; Takashima et al., 2019). Reliable assessment against practice standards is crucial, but also complex (Almalkawi et al., 2021; Hughes et al., 2021). Assessing competence in nursing generally reflects three central concepts, knowledge, skills and attitude, with emphasis placed on integration of these for safe patient care (Burden et al., 2018). However, the assessment of student competence and what this means for the work readiness of newly qualified registered nurses, has been raised as an area for further investigation (Harrison et al., 2020; Missen et al., 2015).

Globally, there is variation in how undergraduate nursing students are assessed on clinical placement. Formative assessment helps students understand how they are progressing by providing feedback on their strengths and limitations (Jackson, 2018) and is normally completed during the placement to provide an opportunity for improvements in performance. Areas of student growth and development are the assessment focus (Jackson, 2018). Summative assessment is the overall assessment of student performance on placement, with grades provided

against criteria that contribute to the student's academic record (Almalkawi et al., 2021). Formative and summative assessment is usually conducted in person by hospital-based registered nurses, or clinical facilitators, with academic staff involved in the design, calibration and moderation process, usually at a distance.

According to Bloxham and colleagues (2016), assessment phases include design, calibration, judgement, external validation or comparison and evaluation. The registered nurse feedback contributes to the process and should be critical, providing information about what the student is doing well and what can be improved (Sherwin and Muir, 2011). In undergraduate nursing education, feedback should be provided for learning and development rather than compliance (Peach et al., 2014).

Worldwide, a limited number of valid and reliable assessment instruments cater for the diverse range of clinical settings (Almalkawi et al., 2021; Takashima et al., 2019). In Australia, the Australian Nursing Standards Assessment Tool (the ANSAT) is the only tool based on the national standards (Ossenberg et al., 2016). While predominantly used in undergraduate nursing programs, inter-rater reliability for the ANSAT has not been tested and there is ambiguity in relation to benchmarks across year groups (Grealish and Shaw, 2018; Takashima, 2019).

Different learning and clinical contexts and situations, assessor subjectivity and bias can contribute to disparity in assessment (Takashima et al., 2019). Human influences have an impact on assessors' experience of student performance with different notions of what is expected of students across the different year levels of the Bachelor of Nursing curriculum (Hughes et al., 2018). Additionally, the assessor's 'frame of reference is not always congruent with the program and professional standards' (Burden et al., 2018 p. 20) and assessors can form an impression that is moderated by their expectations of the ideal student depending on the clinical practice area (Hill et al., 2022). One way of addressing the problem of inter-rater reliability between assessors is moderation.

Moderation is a quality assurance approach allowing multiple assessors to agree performance (Bloxham, 2009). In a recent evaluation of the Clinical Clusters Education Model, moderation of the assessment of student performance on clinical placement was a source of tension, due to the involvement of multiple assessors (van de Mortel et al, 2020). Consensus moderation discussions are a part of the calibration and judgement stages of the assessment, where standards used to form judgements about student performance are agreed, assured and confirmed (Bloxham, 2009). The collaborative element of the model, particularly the assessment and moderation of student performance by a group of registered nurse experts, rather than singly, is innovative. The aim of this study is to describe how the assessment of undergraduate nursing students is achieved in the Collaborative Clusters Education Model of clinical placement.

3. Methods

3.1. Study design

A qualitative descriptive approach was adopted. Underpinned by a constructivist-interpretative paradigm, a qualitative descriptive study seeks to learn about a phenomenon through the perceptions and experiences of the participants, providing a rich report addressing context as well as processes (Thanh and Thanh, 2015). In this study, a rich report on how the assessment of nursing students is achieved in the Collaborative Clusters Education Model was required.

3.2. Setting and sample

The study was set in a tertiary health service, consisting of two hospitals, outpatient and community-based programs, in southeast Queensland. Experienced registered nurses, employed as clinical facilitators in the Collaborative Clusters Education Model, were purposively

sampled (Palys, 2008) to share their specific experiences of assessment and moderation.

Purposive sampling ensured that clinical facilitators with experience in performing the assessment processes, that this study sought to describe, were targeted for recruitment (Miles et al., 2014). Additionally, a 'maximum variation' purposive sampling approach was used (Patton, 1990), in that all clinical facilitators employed in the Clinical Clusters Education Model, from across the entire health service, were invited to voluntarily participate. This focused, multisite sampling approach allows for a thorough description of practices and to identify variations in practices that may occur across different clinical areas, thereby laying the strongest foundations for transferability of the study findings (Galdas, 2017; Miles et al., 2014; Slevin and Sines, 1999). Potential participants were invited to participate via an email sent from a member of the administration staff in the education department of the health service organisation, she was not part of the research team. The email included study information and a consent form.

3.3. Data Collection

Individual and group interviews were conducted, over a three-week period in March 2021, either via MS TEAMS© or at the participant's workplace, depending on participants' preferences. Interviews were 25 min (individual) to 60 min (groups). One co-investigator (LDF) facilitated the group discussion and a second (KR) took field notes during the session. Both co-investigators were female Registered Nurses and Nursing Academics, experienced in the facilitation of groups for research purposes and were known to some group participants, one has a Masters and the other a PhD qualification. The incorporation of two experienced researchers in the data collection phase of this study facilitated researcher transparency and reflexivity in this study. Additionally, as the researchers were known to the participants, rapport and trust were easily built resulting in rich, personal descriptions of participant experiences (Charmaz, 2006).

Interview questions were derived from a review of the literature and informed by feedback from the previous feasibility study (reference withheld for review). Questions included describing the processes that were used in the clinical clusters to decide the final assessment outcomes for a student on clinical placement and identification of resources used (Table 1). Interviews were audio recorded, de-identified and professionally transcribed.

3.4. Ethical considerations

Ethics approval for this research was obtained from the health service (HRECLNR/2020/QGC/71836) and two universities Human Research Ethics Committees (GU Ref No: 2021/106; H21REA063). To ensure confidentiality, consent forms were stored in a different location to interview summaries. Furthermore, participants were informed that there would be no identifiers from the interview recordings ensuring confidentiality of data collected. Audio recordings were erased following transcript checking. Codes were used in place of names to preserve anonymity. Electronic data were stored on password-protected computers. During data-analysis, transcript hard copies were stored in a locked filing cabinet. Only de-identified data were used in research reporting.

The Principal Investigator was the line manager for participants and therefore not involved in recruitment or data collection to reduce any power differential. Participants were aware of the Principal Investigator's role.

3.5. Data analysis

Data were analysed using content analysis, which is commonly used to understand individual and group perspectives on a particular topic (Green and Thorogood, 2018). In content data analysis, codes are systematically applied and derived from data (Sandelowski, 2000). Transcripts were read several times before developing categories. Open coding was then undertaken in a continuous comparison method, comparing the emerging coding's clusters together to group them under higher order headings to organise the data and formulate a general description of the research being studied (Vaismoradi et al., 2013). Two researchers [BG, LDF] were involved in the initial open coding process performing this separately and then coming together to compare coding to ensure trustworthiness of the findings. A third researcher [LG] was involved in data integration, which involved using the higher-order concepts to rearrange data, keeping in mind the research question (Punch and Oancea, 2014).

Throughout this process, categories and themes were named to provide a direct representation of the content from these data and memos were written to capture ideas about the reason for code allocation and the relationship between the categories. Keeping memos helped the researchers identify emerging sub-themes and themes, in relation to the research question and make meaning of the information (Vaismoradi et al., 2013; Punch and Oancea, 2014). The outcome was a rich descriptive summary of the assessment practices categorised in higher order themes (Sandelowski, 2000). The 32-item Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007) was used to enhance transparency, rigour and credibility of the study reporting.

4. Results

Seven of the 21 invited clinical facilitators participated in interviews. All were female, five had postgraduate education and there was a wide range of experience as a registered nurse (1–40 years) and as a clinical facilitator (0–15 years). For three, this was their first year working as a clinical facilitator in the Collaborative Clusters Education Model (Table 2).

Three interviews were conducted. There were several people in groups 1 (CF1–3; 55 min) and 2 (CF4–6; 49 min), with one person interviewed alone (CF7; 26 min). Two processes of assessment were identified from the data: situational scoring and moderation (Table 3).

4.1. Process of situational scoring

In the process of situational scoring, there were four elements. Firstly, the clinical facilitators confirmed students' perception of their role in assessment. Secondly, they considered the types of experiences available to the student, which influenced learning and opportunities to demonstrate competence. Thirdly, evidence from multiple sources were gathered and recorded. Finally, the performance was judged as

Table 1
Interview Questions.

Process related questions
1. Please describe the process that you use, in your clinical clusters to decide the final assessment outcomes for a student on clinical placement?
2. We are interested to know about how you moderate. How do you come to an agreement within the clusters you have worked in?
3. What does it look like when moderation processes work well?
4. How do you explain this process to new members in your cluster?
Resource related questions
5. What resources do you use to help you come to assessment outcomes?
6. How do you decide what sources of information or evidence to use in your assessment of students?
General Questions
7. How does the practice context influence student assessment outcomes?
8. How do you think students see your work?
9. How do you consider student responses to your assessment, if at all?
10. Could you describe any barriers to an effective assessment and cmoderation process?
11. Could you describe any factors that help to make this process work well?
12. What might make the process work better?

Table 2
Summary of participants' demographic characteristics.

Demographic Characteristic	Number (n = 7)
Gender, female	7
Age, years	
25–34	3
35–44	0
45–54	3
55–65	1
Highest level of education, degree	
Undergraduate	2
Post-graduate	1
Master	4
Experience as a Registered Nurse	
1–10 years	3
11–20 years	1
21–30 years	1
31–40 years	2
Experience as a CF, years	
0–5	3
6–10	2
11–15	2
Experience as CF in CCEM, years	
0–1	3
1–2	2
3–4	1
5–6	1

Table 3
Major themes.

Theme	Sub-Themes	Categories
Process of situational scoring	Role definition	Confirm students' perception of the clinical facilitator role in relation to the assessment process
	Diverse experiences	Account for the type of experiences available
	Sources of evidence	Consider multiple sources of evidence
	Assessment tool	Score using the ANSAT tool
Process of moderation	Clarifying student history	Communicate with other clinical facilitators to develop a shared understanding of student history
	Evidence for scoring	Using evidence to improve trustworthiness of the scores
	Scoring consensus	Confirm scores through alignment of the evidence from multiple sources with the ANSAT instrument

competent (or not) using the scoring system prescribed in assessment instrument (the ANSAT).

Clinical facilitators recognised students had experienced other models of clinical education and confirmed with students their role in assessment:

> A lot of [students] come from the one to eight [supervision] model which they have at aged care, their first placement… I think that orientation week, part of that is educating them, that the [RN] buddies they're working with are the experts. Part of our role is assessing (CF5).

Facilitators were aware that students saw them as the assessors and worked to change that perception to incorporate feedback as an opportunity for learning, consistent with formative feedback:

> I think a lot of them see us as, oh lookout the assessors coming…but most of them build a rapport with at least one of us in the team, which is good (CF7).

Clinical facilitators accounted for the types of experiences that were available to the students. They were aware that access to learning experiences depended on (1) students' allocated ward and (2) on their personal clinical expertise. They understood that each clinical unit

presented different learning opportunities, which may result in variation in student performance required to achieve a pass grade across the cluster. They didn't see these differences in access to experiences as problematic in terms of assessment. Clinical facilitators consulted with ward staff to confirm patient complexity to establish an appropriate patient load for the student to demonstrate competence:

> When we go around and we see [ward staff], we make sure that when we talk to the [team leader] and also the practice partner, getting a gauge of what the section is like. (CF2).

Clinical facilitators had a range of clinical backgrounds and expertise. They perceived that when their clinical expertise aligned with the student's allocated ward, students had more access to meaningful learning experiences. Recognising that such access was important, clinical facilitators would consult with cluster colleagues trained in that specialty for specific information that could be beneficial to the student's experience:

> So, we generally know everybody's [clinical facilitators] clinical backgrounds so if you've got a question about the process within that area or what would you expect their knowledge to be or the staff member's knowledge to be able to teach something and get exposed to a certain skill or something like that, you can refer to your peers (CF 2).

Clinical facilitators collected and considered multiple sources of evidence from direct observation of student performance as well as their conversations with the students:

> We ask questions to see how their mind works … to be able to do critical thinking…sometimes we have to question them as well to get the information that we need for the gaps we pick up with covert and overt observations (CF4).

Clinical facilitators would also discuss students' performance with several practice partners to obtain specific performance feedback to inform scoring decisions:

> Some [practice partners] will say oh, yeah, they're great, they're really great and not give a reason why. But if they can tell me specifically why they're so great and specifically what they've done that's different to what I would expect, then that helps a lot as well in the decision (CF 6).

Registered nurse practice partners, team leaders, Nurse Unit Managers and patients on the clinical units were also important sources of information about student performance:

> I also talk to the patients about the students to see how they feel like they are being treated. You can read their body language to see how the student leaves them feeling and whether they feel like their problems are dealt with and heard (CF4).

Each student has an electronic file that could be accessed by clinical facilitators who were members of that cluster. The files documented clinical facilitator observations and any student feedback, as well specific feedback provided to the student:

> We have a column for where we write down … how well they're doing in reference to the standards … Then we have a column of areas of improvement…what method of delivery of nursing practice they need to polish up or what areas of critical thinking they're missing and why are they missing that (CF4).

The files are a team communication tool:

> It is a way of kind of doing their ANSATs [scoring] on the roll, as they happen, so that we can give independent or individualised examples of how they're meeting the standard (CF4).

The ability to gather evidence from multiple sources depends on placement duration. For example, clinical facilitators were more

conservative on the midway score in a two-week placement:

> …I don't have evidence to say that they're excelling in such a way but I also don't have the evidence to say that they're not (CF6).

Clinical facilitators preferred to consider multiple sources of evidence to support their scoring, shorter two-week placements limited availability of evidence. Collecting adequate evidence was easier in a four-week placements:

> I think that the four-week placements, they do better in the midways, because …they've had longer to find their feet and we've had longer to collect information on them to assess them properly (CF7).

When making judgements about student performance, the clinical facilitators used the ANSAT in several ways to assess students' performance. Firstly, they used the ANSAT resource manual (2018) as a guide for scoring, referring to the descriptors provided in the manual:

> I use the ANSAT book manual… It's got the one page where it says what is a '3', what is a '4', what is a '5'. We use it a lot with our new people so they can see why we're getting the particular score (CF 3).

There was a consensus that a score of '3' was required to be safe and work within students' scope of practice:

> …where they need to be. A '3' is not a 50 per cent; it's the expectation (CF 6).

Others referred to their own experience as a student when describing their expectations of students:

> I remember in second year, we were very skills based and learning about the different disease processes and conditions, but a lot of it was, this is how you prime a line, this is how you give an injection. So, higher level critical thinking didn't really come until third year and so when they're out on placement, I guess in the back of my mind that's what I'm thinking I should expect to see (CF 6).

Clinical facilitators also mentioned that they also consider the type and number of placements the student has had when describing their expected standard:

> I've got third years who are at the beginning of their third year which is different to the end of third year. So, a third year is not a third year, they've all had different journeys, different placements where they've come from. So, we take this into consideration as well. Because some might need extra help (CF3).

In relation to scoring, clinical facilitators raised factors like safety, how much independence was demonstrated, how much prompting was required and consistency:

> …that they've been able to demonstrate that standard or that substandard point consistently at a high level with virtual independence. So, they've been able to for that bit, independently be doing that within their year level (CF2).

They discussed how the ANSAT was used to incorporate the different year levels of students being assessed and whether this was measured against newly qualified nurse performance or current year level of practice:

> …often for second years a lot of them are just at satisfactory for their first placement. But not necessarily all of them… So, looking at each student individually, they could score higher in one of the criteria depending on what is observed, your assessment of them (CF3).

> …we've got to look at the level of education they're at and what they've covered. Otherwise, second years would never get fives (CF4).

> I think it would be good to have, like, this is where a second year should be. This is where a third year should be and this is the

standard of an exemplary second year. It's not an RN because they can't be an RN (CF 6).

In summary, clinical facilitators clarified their role as assessors early in the placement, accounted for the type of experiences available and used multiple sources of evidence to support decisions about student assessment scores made using the ANSAT.

4.2. Process of Moderation

The moderation process was done in parallel to situational scoring. The process of moderation began early in the students' clinical placement and required communication with others, adequate evidence to ensure trustworthiness of student assessment scores and alignment of multiple data sources and the ANSAT to produce midway and final scores.

The process of moderation was conducted through regular communication between clinical facilitators in the cluster. It is initiated with the recording of evidence about student performance in the electronic journals. Information recorded throughout the placement is used to validate judgements about scores:

> So, you would go okay, let's bring up the journal for this one and we can go yeah, there's our example, okay. Yeah, that supports there, why they're saying that's a five or that's why they're saying that's a three there because of that example. Then you can take that into consideration when you're moderating (CF 2).

In addition to written communication about student performance in electronic journals, regular verbal communication between clinical facilitators in each cluster supported moderation:

> …because the moderation is sort of towards the critical points, like the midways and the end, I think by that time, because we've seen them a few times already and discussed them at handover, we already have an idea of who we need to keep an eye on, who may not be meeting an expected standard and who, based on the information that they've provided to us, that we've gathered from their practice partners and we've shared in hand over, we all seem to have a unanimous view already that they're actually doing well (CF 6).

Clinical facilitators communicated daily about students' progress to develop a shared understanding about each student's history:

> Yeah, it's all a conversation. It's not like we wait until moderation day to moderate. We do it daily almost because we are handing over and it's like a constant this is where they're progressing. So, like even if you haven't seen somebody in four days, you still sort of know a generalised where they're tracking with their progress. So when you go and see them, it's yes, I know this is the feedback that they've been given it's not by me but I know what they've been given because we've handed that over (CF2).

As the evidence is gathered, clinical facilitators confirm the trustworthiness of assessment scores through the collection of consistent reports over time, although more recent reports were more highly valued to support a score:

> Then we'd almost get to the point where it's just like this is what I observed and then the next person would be like okay, well I saw them a couple of days later, they were able to take on feedback that you had given. We saw implementation of that improvement in their practice (CF2).

The trustworthiness of data was also related to clinical facilitators trusting colleagues' judgements about student performance:

> I think a lot of it is about trusting your colleagues as well.…we work so closely together that you know you can trust their judgement in aspects of this as well (CF6).

As the clinical facilitators gathered information about each student's progress, they sought to align evidence from multiple sources with the ANSAT to confirm the allocated scores.

For example, some clinical facilitators would also seek an independent assessment from colleagues outside of their cluster to confirm their assessment:

> I think it's always a good idea to get another facilitator to assess a student if you have some concerns. I think it's a real advantage, just ask them to have a look at them but don't tell them your concerns so that they can go over it with fresh eyes and make their own judgement (CF5).

Clinical facilitators accepted that sometime there were gaps in the evidence that they collected and would also consider evidence presented by the student:

> Because they [the student] might say actually, 'I'm doing so much better in this, how come I'm not a five?'… They could then give us examples [as] to how they've met that and that's an open discussion. We would normally take that back to the team, we might change the scores depending on that (CF 1).

Conversations between the clinical facilitators in a cluster produced moderation of student assessment:

> Sometimes we have hearty discussions too, around a student for what we've seen, observed, the kind of data we've collected to help us get to that decision and sometimes we bandy it around a little bit in the handovers while we're doing moderation and we'll give points or reason as to why they should be a three, four or five (CF4).

The ANSAT manual (ANSAT resource manual, 2018) was described as an additional resource to secure alignment during moderation:

> We really had to nail down how many times she had been prompted and how frequently that is occurring, to be able to make a decision as to whether she wasn't meeting the standard. It turned out after we looked at the descriptors, she wasn't meeting that standard and she went on a learning plan (CF6).

In summary, moderation was continuous, requiring communication with others, the availability of evidence to improve trustworthiness of student assessment scores and alignment of multiple data sources and the ANSAT instrument to produce midway and final scores. When student placements were shorter, or clinical facilitators did not have clinical expertise for an area, the evidence for trustworthiness and alignment to support scores may be inadequate. In these cases, further information is sought but sometimes a score of 'three' was provided.

5. Discussion

In the Collaborative Clusters Education Model, the process of assessment involves a continuous process, with moderation continually undertaken through alignment of multiple and emerging sources of evidence and with the formal assessment instrument, in this case the ANSAT. The relationship of these processes are further exemplified in Fig. 1.

Clinical facilitators clarified expectations in the context of situational circumstances, used a range of sophisticated communication strategies and possessed an openness to reviewing scores as emergent evidence was aligned with the ANSAT.

Clinical facilitators were continually reporting on and consulting with, their cluster peers on individual student progress. Through these discussions, they also learned more about assessment. Clinical assessment is highly specialised work, in a 2016 systematic review into assessment, researchers reported that training can have a positive impact on assessment quality (Helminen et al., 2016). The cluster format of assessors may provide an advantage in terms of training and development of clinical facilitators' assessment and moderation skills.

Clinical facilitators clarified expectations in the context of situational circumstances, firstly with students and then their cluster group, developing a shared understanding of students' expected performance levels against the ANSAT. Clear expectations have been linked to better outcomes for students (Cross et al., 2022), whereas lack of clarity around expectations can be compounded by high levels of stress that students are known to experience on placement (Lavoie-Tremblay et al., 2022). The practice of clarifying expectations with students in the orientation is recommended (Helminen et al., 2016). The establishment of expectations in the Collaborative Clusters Education Model reflects good practice.

Clinical facilitators indicated that they had different student performance expectations according to student year level, or timing of the placement within each year level and that they score each student according to their progression in the program, using the ANSAT. These expectations appear to be consistent with those of the internalised 'ideal student' found in a study of how mentors form judgements about student nurse performance (Burden et al., 2018). In reviews of assessment practices on clinical placement, these personal expectations of performance are considered problematic (Almalkawi et al., 2018; Helminen et al., 2016; Immonen et al., 2019). Inconsistency in assessment is attributed to personal characteristics of the nursing student, nurse mentor and assessor, as well as diverse placement settings (Helminen et al., 2016; Takashima et al., 2019). In the clusters, the clinical facilitators made their personal expectations of students explicit through a range of sophisticated communication techniques.

The clinical facilitators described gathering evidence from multiple sources to inform assessment. This practice is consistent with good
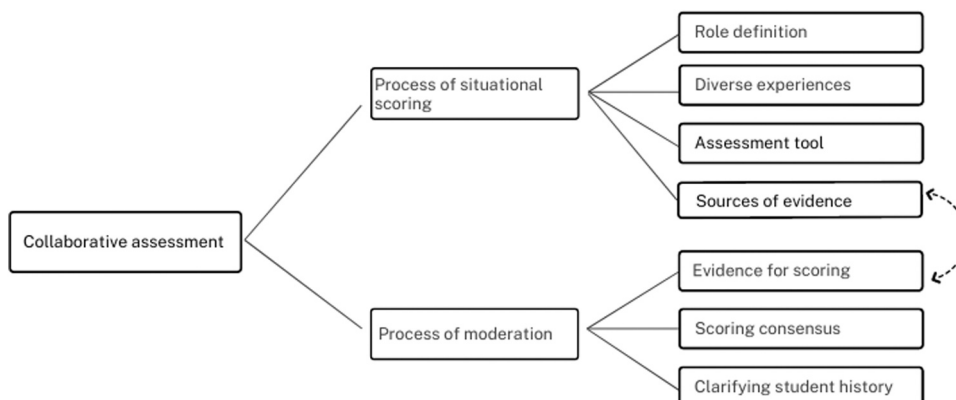

Fig. 1. Collaborative assessment in the Clinical Clusters Education Model.

clinical assessment (Bloxham et al., 2016, Takashima et al., 2019). Gathering information from the multiple practice partners that may work with an individual student is supported by questioning the student directly, consistent with other reports of student assessment (Hunter and Arthur, 2016). Information gathered in these conversations was recorded in a password protected, electronic journal accessible by clinical facilitators only, so that a history of the student's progress can be monitored over time.

Clinical facilitators communicated with each other to get shared understanding of their colleague's interactions with students and judgement of progress. They described participating in daily cluster handover to get up to date information on students' progress, using electronic methods, such as a shared journal and emails, to share their interpretations of performance over time and seeking performance review by an assessor external to the cluster. This process of establishing a shared student progress history among assessors appears to be unique to the Collaborative Clusters Education Model.

Using this numerous communication strategies, clinical facilitators retained transparency about their judgements in a systematic way, as recommended by researchers who conducted a systematic review of systematic reviews into assessment practices (Immonen et al., 2019). The transparent nature of recorded interactions and judgements in the journals may reduce the risk of bias, which is considered one of the key challenges of assessment on clinical placements (Almalkawi et al., 2018; Hughes et al., 2018; Jackson, 2018; Takashima et al., 2019). Future research into assessment in the Collaborative Clusters Education Model could explore whether the shared electronic journal acts like an assessment rubric, as defined by Almalkawi and colleagues (2018).

Clinical facilitators demonstrated an openness to reviewing scores as emergent evidence was aligned with the ANSAT, an important element of continuous moderation. Clear assessment criteria are considered critical to good clinical assessment practice (Immonen et al., 2019). Later in the assessment period, clinical facilitators described how they considered additional evidence from students and the process of validating this evidence with practice partners and then discussing with co-members of the cluster.

Working in small clusters provides the opportunity for clinical facilitators to consider multiple sources of evidence in a transparent way and to make a collective judgement on the evidence consolidated in the electronic journal and subsequent scoring in alignment with the ANSAT, thereby normalising moderation practices. This practice of discussing with other members of the cluster is a form of consensus moderation, with clinical facilitators holding each other to account by requiring evidence on a student's performance, aligned with the ANSAT parameters, to achieve a fair conclusion (Bloxham et al., 2016). Through these shared moderation conversations, clinical facilitators may be building communities of shared practice (Bloxham et al., 2016), which can nurture skill development in those new to assessment work.

In this study, clinical facilitators found shorter, usually two-week, placements provided inadequate time to collect the evidence to draw conclusions about student performance. Shorter placements limited trustworthiness of the assessments, reflecting earlier study findings (Hunter and Arthur, 2016; Hughes et al., 2018). Shorter placements also reduced opportunities for the discussions necessary for moderation. Similar to the findings in other studies of clinical assessment (Helminen et al., 2016; Hughes et al., 2019), clinical facilitators would practice leniency bias and provide a favourable assessment so that students can progress in the program. A review of the minimum length of clinical placements may assist with the identified challenge of ensuring graduates are competent (Missen et al., 2015).

5.1. Methodological strengths and limitations

This study set out to describe how assessment is achieved in a relatively new model of clinical education, the Collaborative Clusters Education Model. The descriptive qualitative method provided a rich description of assessment and moderation practices in this model and, although the sample was small, insights from this study may be transferable to similar clinical assessment contexts (Galdas, 2017; Miles et al., 2014; Slevin and Sines, 1999). Further research into the assessment practices that focus on key elements such as clarification of expectations, communication strategies between multiple assessors and alignment of multiple and sometimes emergent sources of evidence with clear assessment criteria would be beneficial.

6. Conclusions

This descriptive qualitative study outlines a model of collaborative assessment, of undergraduate Bachelor of Nursing students, used in the Collaborative Clusters Education Model of clinical placement. The Collaborative Clusters Education Model provides opportunities for larger groups of students to undertake clinical placement. The assessment processes within this model meet the good practice standards for clarifying student expectations early in the placement, gathering evidence from multiple sources, using an assessment instrument and peer review of judgements about performance.

The collaborative approach to assessment and moderation may offer additional benefits in terms of rigour and quality. The collaborative element of the model, particularly the assessment and moderation of student performance by a group of registered nurse experts (clinical facilitators), rather than a single assessor, is innovative.

As health services worldwide grapple with the impact of nursing workforce pressures, this innovative model of collaborative assessment may serve as a valuable addition to nursing clinical assessment toolkits. Further research into the value of the model for developing clinical facilitators' assessment skills is recommended. The possibility of an assessment rubric emerging from the e-journals shared by clinical facilitators could also be explored.

Declaration of Competing Interest

none.

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