Transnational Comparative Assessments in European Higher Education

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Measuring and Comparing Achievements of Learning Outcomes in Higher Education in Europe 2023

Measuring and Comparing Achievements of Learning Outcomes in Higher Education in Europe CALOHEE Phase 2

The CALOHEE Phase 2 Project has been supported by the European Commission through the Erasmus+ Programme, Action Forward Looking Projects, 2020-2023.
Project number: 2019-612892

Tuning Educational Structures in the World

The name TUNING was chosen for higher education projects and initiatives to reflect the idea that universities do not look for uniformity in their degree programmes or any sort of unified, prescriptive or definitive curricula but simply for points of reference, convergence and common understanding. The protection of the rich diversity of higher education in Europe and the world has been paramount in the Tuning initiative from its start in 2001 and in no way seeks to restrict the independence of academic and subject specialists, or undermine local and national academic authority.

Co-funded by the European Union

Funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Education and Culture Executive Agency (EACEA). Neither the European Union nor EACEA can be held responsible for them.

Publisher: International Tuning Academy, Universities of Deusto and Groningen
Bilbao and Groningen, 2023

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Introduction

The context of higher education has been changing during the last 25 years, as a result of rapid advances in digitalization and methods of communication, job market disruption, politics and recently COVID-19, disruptive conflicts and inflation. The need for change of higher education learning has become even more imperative. Awareness of these challenges go back to the 1990s and resulted in EU initiatives and the Sorbonne/Bologna Declarations. This led to the call for developing a European Higher Education Area (EHEA).

A cornerstone of developing a EHEA is trust and confidence. The Area was launched in the context of the Bologna Process. This was thought necessary to enhance the quality and relevance of higher education for individual development, employment opportunities, societal needs. Another aspect was and is to have instruments in place to facilitate large scale credit mobility and recognition. Towards this end four key instruments have been developed: the *European Standards and Guidelines for Quality Assurance*, the *European Credit Transfer and Accumulation System* and the *Lisbon Recognition Convention* as well as two parallel and overlapping qualifications frameworks, the *Qualifications Framework for the European Higher Education Area* (QF for the EHEA) and the *European Qualifications Framework for Lifelong Learning* (EQF). The first defined in the context of the Bologna Process and the second initiated by the European Commission. Both have been endorsed by national authorities.

Qualifications frameworks are the foundations of the other instruments. They offer the reference point for the academic structure (curriculum design and credentials), quality assurance and accreditation as well as recognition of (period of) studies. Qualifications Frameworks encompass all three cycles of higher education learning.

In parallel, two major initiatives were taken, namely, the development of the QAA-UK Benchmark papers and the *Tuning Guidelines and Reference points* at subject area (discipline) level. These proved to be pivotal for giving substance to develop and enhance degrees and to move from expert driven education toward student-centred and active learning. Both initiatives were developed by groups of academics, however, many academics have found it difficult to deal with this fundamental change of the learning paradigm. Lack of initial training and continuing professional development have continued to hinder large scale change. This has been exacerbated by the over-complex structures in place. That is having two European overarching frameworks and subject ones which are not fully aligned. This might have drained away full adoption of the instruments available.

To respond to this concern, a proposal has been made by the Tuning initiative, called *Measuring and Comparing Achievements of Learning Outcomes in Europe* (CALOHEE), to make a deep analysis of the strength and weaknesses of the existing models. This has resulted in *General Tuning-CALOHEE Qualifications Reference Frameworks* for all three cycles, as well as aligned reference frameworks on the level of subject areas. An important driver for developing these frameworks has been to make the implicit explicit.

These much more detailed frameworks, building on the existing ones, offer the opportunity to encompass present and future challenges. In addition, ten subject areas have been, and are, developing Subject Area Learning Outcomes Reference Frameworks. These offer a template and menu as to what can be learned in the context of a degree programme.

This resulting set of reference frameworks will reduce complexity, offer greater clarity and guidance for programme design, delivery and quality assurance.

However, qualifications reference frameworks are only part of process of change. As fundamental and as a consequence of the change of the paradigm of learning, is revisiting the way learning, teaching and assessment is designed and undertaken. This has been done too in the context of the CALOHEE initiative, supported by the European Commission.

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Preparing international comparative assessments

Mutual recognition and mobility go hand in hand and therefore need evidence of comparability of learning and teaching, but in particular assessment, which should obviously be aligned.

Although General Qualifications Reference Frameworks, Subject Area Qualifications Frameworks and related Subject Area Learning Outcomes / Assessment Reference Frameworks offer clarity regarding the levels of learning, they do not offer the evidence whether the related learning is actually achieved. To achieve the latter some form of assessment must take place, primarily to assure that across the spectrum of countries and institutions comparable learning in terms of its outcomes is taking place.

On the level of achievement, it is possible to make a distinction between the individual learner, the subject, the programme, the HE institution and the country (system level). The aim of the CALOHEE project has been to develop diagnostic international comparative assessments for five disciplinary fields, that is civil engineering, history, nursing, physics and teacher education.

These assessments provide a diagnostic tool to allow for a comparison to be made regarding the level of achievements of the different descriptors as included in the frameworks. The focus is here on the degree programmes in the context of the subject area. The results of the exercise will provide valuable evidence-based information for academic staff responsible for delivering the programme to allow for further enhancement.

The discussions among international groups of subject area experts show us that disciplines have their own requirements. There are obviously specific contextual settings, cultural and national conditions. For example, the field of history only allows for a high level of abstraction, whereas nursing, civil engineering and teacher education are usually regulated professions with all that that entails.

Assessment of students is perceived as a highly sensitive issue and the prime responsibility of the academic when the programme is purely theoretical. However, in professional and regulated programmes assessment of performance, the responsibility is shared with responsible professionals. Similarly, while academics are responsible for implementing a programme, they are required to involve relevant stakeholders. This requires coordination regarding programme design, delivery, evaluation and student-assessment and grading. This may influence academic freedom for regulated professions. Although all programmes will have their own profile, there should be common standards meeting international reference points. This approach intends to do justice to the EU motto, introduced in 2000, ‘unity in diversity’ which is clearly not standardisation.

In this context, the relation should be highlighted between the graduate profile and the learning outcomes of an individual programme and its units. This reflects the different missions of institutions and programmes, covering the full spectrum from research driven programmes to applied ones. This can be visualised in a spider web in which individual degree profiles, programme and unit learning outcomes are matched with the CALOHEE subject area qualifications refence frameworks for all three cycles, representing the graduate profile. These spiderwebs show varieties, which are both system and programme related.

Regarding the system level, although pursuing the EHEA, it has to be fully understood that we are dealing with national states which historically have their own educational philosophies, and in this instance, nursing philosophies, health beliefs, cultures and traditions. Regarding general education philosophies we can make a distinction between the Anglo-Saxon, Humboldtian, Napoleonic and Soviet models. These traditions are deeply rooted and have an ongoing impact on the way learning, teaching and assessments is constituted, although convergence is taking place. This convergence – implying international alignment at subject area / disciplinary level - is commended by global societal developments and needs, to which the higher education sector and its degree programmes are expected to respond. An exploration of how variances in health beliefs and nursing philosophies impact programme design and delivery is found later in Section 1.

At programme level, countries might still define conditions which have to be met and/or set limits regarding the autonomy of the professional. This has implications for the (transnational) assessments to design.

As a consequence, in valid transnational comparative assessment both communalities and differences should be taken into account, as they have been detailed above. In this setting, lessons have been learned from the OECD *Assessment of Higher Education Learning Outcomes* (AHELO) feasibility study, implemented in the period 2010-2013, which obtained severe criticism from policy makers as well as academics, because it did insufficiently recognise the wide range of system and programme differentiations.

The disciplinary experts, involved in this CALOHEE project, are fully aware of the diversity in the way learning, teaching and assessment is modelled, although at the same time agreeing on the descriptors as defined in their subject area qualifications reference frameworks and far more detailed learning outcomes / assessment reference frameworks. Finding common ground - doing justice to the differences - has taken considerable time, but proved to be conditional for developing useful (transnational) assessments.

Departing from the objectives of the Bologna Process and the EHEA that programmes should be outcome based, the assessments developed, intend to cover high level generic and subject specific competences, that is applying knowledge and skills in real life situations – work place and society – requiring 'autonomy' and 'authority'. Authority reflecting self-confidence to take position and act accordingly. In other words, the assessments should allow for evidencing a critical mindset in the context of a particular academic field by focussing on 'measuring' high level skills and competences in the context of the subject area and its domain of knowledge, such as critical thinking, analyzing and synthesizing, making and criticizing an argument, problem solving, observing and analyzing behavior, operating in conjunction with others. All perceived from two angles: the academic field involved and active societal participation. Relating to present and future needs of society, a much wider scope and approach than 'disciplinary knowledge and skills' and 'critical thinking' as had been tested in the global OECD-AHELO feasibility study.

This requires taking into account 'burning societal issues', for which in the context of the CALOHEE projects separate initial reference qualifications frameworks were prepared, meant to serve as sources of information and inspiration. Based on academic literature and policy documents, it identified five current topical issues, that is:

- Societies and Cultures: Interculturalism
- Processes of information and communication
- Processes of governance and decision making
- Ethics, norms, values and professional standards
- Sustainable development (climate change)

These topical issues should be integrated in the actual learning, teaching and assessment processes doing justice to the academic field involved and avoiding overload of learning.

From the start of the CALOHEE project to develop transnational assessments and testing, the aim has been mutual. The outcomes should allow for real testing to be applicable in different contexts, ranging from an individual HE education programme to transnational testing. Intended to be inspirational – offering new models of assessment – they should also be aspirational by covering topical issues.

As has been indicated already a distinction is made between the development of models of assessment and actual assessments and testing. Testing is defined here as the application of the assessments prepared, by asking groups of students to take a test. According to the project aim, actual testing was not foreseen in this phase. This project focussed instead on preparing the groundwork for testing whether of theory or in the workplace where this is relevant to the student programme.

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In the context of the CALOHEE Phase 2 project assessment models and assessments have been prepared for the following five subject areas: Civil Engineering, History, Nursing, Physics and Teacher Education, nearly covering the full range of academic fields.

The assessments have been developed to measure the achievements of generic and subject specific competences at the end of the bachelor / first cycle. In the case of Nursing also the second cycle has been covered.

Structure of the assessments

The five subject area groups have followed a comparable model and approach to implement their tasks. Due to the COVID-19 pandemic initially the meetings took place online. Because more fundamental discussions were needed to define common ground requiring deep intensive reflection over a longer time span, only limited results could be obtained. Three multi day face-to-face meetings were needed to come up with actual results. These meetings took place in the period April – September 2022 and were supported by an additional set of online meetings.

A first step has been to match individual degree programmes with the subject area qualifications reference framework published in 2018. A follow-up has been to re-visit their academic field making use of the 2018 edition of the brochure *Tuning Guidelines and Reference Points for the Design and Delivery of Degree Programmes* for their subject area. This proved to be a learning process in itself, developing partly new insights requiring accommodations of the materials prepared earlier.

The third step was to identify the (sub) descriptors included in the qualifications reference framework and learning outcomes / assessment reference framework, best suitable for developing transnational assessments, but also key to the subject area. This again required fundamental and deep reflections. The next step was to identify the most appropriate mode(s) of assessment and to decide on its feasibility. Independently of the mode of teaching and learning - class room, online, hybrid - different assessment formats were suggested to apply, e.g. scenario testing, observation, critically responding to arguments / texts, analyzing a problem and coming up with possible solutions, etc. This to be followed by describing / documenting the overview of items and approaches (independent of existing individual degree programmes) and the choices made. In practice, to:

- identify for each of these items the modalities for assessment: learning/teaching required, the best ways of assessment and the criteria for assessment.
- document the rationale for selecting a particular competence; describe the actual test
- constitute a set of assessments reflecting a key part of the descriptors as included in the qualifications reference framework. The result should be a variety of assessment formats for the competences identified.

The outcomes of the work established by the five subject area groups are presented in separate publications for each of the five subject areas involved in the CALOHEE Phase 2 project: Civil Engineering, History, Nursing, Physics and Teacher Education. The reports of these five disciplinary groups follow a comparable format, but each group has taken the freedom to make its own choices in presenting its findings in doing justice to the process of reflection and discussion. This brochure presents the work established by the Subject Area Group of Nursing, coordinated by prof. Mary Gobby, Emerita, Faculty of Health Sciences, University of Southampton – Southampton and prof. Marja Kaunonen, School of Health Sciences, Faculty of Social Sciences, Tampere University – Tampere.

CALOHEE Project Team
Groningen, 2023

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In addition, we would like to thank and acknowledge the support of the following who kindly provided good practice examples of assessments, answer guides and rubrics for level 6 and Level 7 programmes.

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1. Introduction to Nursing

1.1 Background and context

The impact of COVID-19 (2020 onwards) upon the Nursing Subject Area Group (SAG) has been substantial in that colleagues have been managing the consequences of the pandemic on the nursing workforce, education institutions and health services under significant strain. Each programme has been affected in a variety of ways, from education staff returning to practice, first year students either being withdrawn from practice or reallocated, final year students being returned prematurely to practice, etc. At each SAG meeting we shared the impact upon our respective countries. Each SAG member reported that students were struggling to fulfil the demands of the current Directive (Directive 2013/55/EU) due to the overwhelming shift in patient services due to COVID-19, the lack of available supervisors, the frequent reorganization of services and the backlog of care. Furthermore, where face to face academic tuition, required for the learning of practice and skills, could not be undertaken due to 'lockdown or other precautions' it meant that curricula needed realignment and revalidation from competent authorities (e.g, removal of first year students from practice for one year in 2020). There have been serious consequences on the subsequent curricular experience of the students with implications once graduated. More recently, there is evidence of the impact upon student well-being, mental health and burn out (e.g. Bliss, 2021; Rasmussen et al. 2021; Sveinsdóttir et al 2021).

In our review of the Tuning competences, we identified that the key competences for the pandemic were present, but they needed to be more specific and explicit. Also, while we had always identified ethical competence as the most important, given the impact of COVID- 19, this remains our most important generic and specific competence. Similarly, the insertion of pandemics and disasters into the prescribed content of Directive 2013/55/EU meant that these issues were within the Level 6 curricula. However, their proportion and relevance is now heightened.

One crucial plank of the Tuning project was the identification of points of reference for generic and subject specific competences at first, second and third cycle graduates in their respective disciplines. Nursing joined the Tuning project in 2003 as the first 'harmonised' healthcare regulated discipline to apply the methodology. We revised the original competences in 2018, but now realised that not only did the format of the competences need updating for both level 6 and Level 7, but there was some overlap that would enable reduction in the total number of competences. Accordingly, in this project we produce a 2023 revision of the Nursing Competences.

Nursing activity continues to vary across the European space in relation to the role of registered nurses in society, the organisation of the health and welfare systems, the legal authority and accountability afforded to nurses and the available national resources of the labour market and economy. Noticeable advances in the nursing scope of practice indicated in the previous edition are now more prevalent. For example: nurse prescribing, telenursing, advanced, specialist and consultant nurses. The rate of adoption of these roles of the nurse varies significantly from country to country, particularly at post qualification or post graduate level.

Pioneering and high-quality nursing research has established connections between nursing activity, level of education, workforce conditions and patient dependency, patient experience and outcomes (see Bridges et al.; 2019, Griffiths et al, 2017; Ball et al, 2016; Dall'ora et al, 2016; Aiken, et al. 2014). These studies have drawn attention to the importance of working conditions for the well-being of both patients, staff and by implication students.

For the purposes of the Tuning project, the first cycle competences were designed for the contemporary professional, first level registered nurse. At the SAG1 meeting in Athens 2003, the Tuning group adopted a *working* definition of the professional first cycle registered nurse, namely,

> *This registered nurse is a professional person achieving a competent standard of practice at first cycle level following successful completion of an approved academic and practical course. The registered nurse is a safe, caring, and competent decision maker willing to accept personal and professional accountability for his/her actions and continuous learning. The registered nurse practises within a statutory framework and code of ethics delivering nursing practice (care) that is appropriately based on research, evidence and critical thinking that effectively responds to the needs of individual clients (patients) and diverse populations.*

Higher Education Qualifications at First, Second or Third cycle levels may be awarded in Nursing Practice, Nursing Studies, Nursing Science or Humanities according to local custom. The title assigned to an academic nursing degree remains associated with where the nursing department is situated in the higher education institution. We continue to use our earlier definitions, where the use of the term 'nursing' alone is reserved for programmes where there are practice-based competences as a requirement of the programme award. To distinguish this type of degree from others, the term nursing science is used interchangeably with the term nursing studies. The use of the word 'science' is not meant to convey a commitment to a positivist model for nursing; rather this reflects common usage of this term in many parts of Europe. It is important to acknowledge that nursing is a practice-based profession at all levels of its education. In programmes where practice competences are a requirement of the award, then the clinical learning experience and supervision is crucial to the student's development. This applies equally to first or second cycle studies, whose typologies remain largely the same as in 2008.

In contrast, where the competences developed at Master's level in Tuning 2008 were for generic nursing competences, there has been a rapid expansion in some countries of not only Master's level in nursing practice, but advanced nurse practitioners since the Tuning 2018 revisions. This development has enabled us to revise the Level 7 competences for practice in a more detailed manner.

Before proceeding further, it its timely to recall that the Tuning competences are arranged within five dimensions, namely:

1. Professional values and the role of the nurse
2. Nursing practice and clinical decision making
3. Knowledge and cognition
4. Communication and interpersonal skills
5. Leadership, management, and team working.

The finalised 2023 versions of the competences are found In Appendix 1 (Level 6) and Appendix 2 (Level 7) with the 2018 versions in Appendix 3 and Appendix 4. Kindly note that the first surveys and tasks of the project were conducted with the 2018 Tuning competences.

1.2 Nurse Education and Professional Context

1.2.1 Country Profiles and Scope of Practice

The first task of the project was to survey our programmes and profile them with respect to the then Tuning 2018 competences. As there was an anticipated high degree of alignment, we revised the survey instruments to engage in exception reporting only. The outcomes of this survey are found in Table 1 below.

Recognition of academic and professional qualifications in nursing is based on trust in approved laws (e.g. Directive 2013/55/EU), voluntary guidance and compliance (European Higher Education Qualifications Framework, EQF) and /or reputation (local or ranking tables). The challenge of measuring and comparing nursing competences at programme, institutional or national level remains a contested issue, particularly where there is diversity of context, academic level, scope of practice and linguistic challenges in translation. The two nursing programmes selected for comparison were level 6 nursing qualifications that comply with Directive 2013/55/EU and level 7 qualifications with an associated practice component and competences. The programme learning outcomes were compared with those derived from the revised 2018 Tuning competences (Gobbi & Kaunonen, 2018).

Level 6 comparisons

At the beginning of this project (2020), we surveyed our programmes that were all at EQF level 6, although some countries reported separate programmes operating at level 5 outcomes for the registered nurse programme (e.g. Malta and Slovenia). The courses were full time with an ECTS credit range of 180-240 ECTS where one ECTS ranged from 25-30 hours. Programme duration was from 3- 4 years; however, this needs to be viewed in the context of different academic year duration. In November 2022, we reviewed the situation post pandemic and found that there were not any major changes in regulatory issues in Level 6 Bachelor's education in nursing.

Five Core Dimension comparisons

Unsurprisingly, as a minimum, each country could match the core dimensions of the Tuning Framework to their programme. The dimensions may be expressed differently (e.g., Flanders), and embedded within the programme outcomes, but the theme /content was within the national or local frameworks.

Competence comparisons

Given the requirements of the EU Directive; the international benchmarks at Bachelor's level, and the dissemination of the Tuning competences, there was significant harmonization between countries with respect to the Tuning competences. Certainly, there were competences, or elements of a competence, that participants considered could be made more explicit (e.g. Estonia) or phrased differently (Flanders, Finland). An illustration is competence No 12 when it refers to the element of technology use for communication. Two competences were developed at master's level/following the bachelor's programme in Flanders: (28 and 29). Similarly, the extent to which leadership competences and research/evidence-based practice is addressed, or made explicit, varied. Sometimes this was related to the developmental stage of the country concerned.

Where the programme outcomes did not provide a match at first inspection, the competences were often found in the module outcomes. This was specifically the case in Malta. This is a stylistic issue as to where the total outcomes for a programme can be found. This is inevitable and acceptable because

there are very few optional or elective modules at level 6 due to the legal requirements for programme achievement.

Tuning 2018 Competences deemed to have changed priority

No competences were considered to have changed priority. However, as discussed earlier, the importance of competence one was crucial during the pandemic. '*Demonstrates the ability to practise within the context of professional, ethical, regulatory and legal codes, recognising and responding to moral/ethical dilemmas and issues in daily practice and the public space'*. Indeed, the Irish Department of Health (2020) produced its own document for the pandemic. *Ethical Decision Making in a Pandemic.*

When the assessment framework from Calohe1 was analysed, exception reporting was conducted. The Table 1 below outlines where there was not a match or a reasonable match to the programme concerned. These present the participant countries EST= Estonia and Fla= Flanders. The grey highlight indicates that there is no match in the Tuning competences and the green highlight indicates a minor or partial match.

Table 1. Competences were there was no match or an imperfect match between the programme competences/module outcomes and the Assessment Framework

DIMENSION 1. KNOWLEDGE AND COGNITIVE COMPETENCES	**Nursing theories, knowledge and concepts of health, ill health, well-being, The humanities, arts and sciences necessary to understand human behaviour, body functioning and adaptive responses in different cultures and contexts.**	**The ability to evaluate evidence and apply this evidence to individual clients, populations and cultures so as to deliver effective nursing care in a timely manner.**	**Aware of the impact of globalisation, particularly with respect to migration of staff and patients and their health and well-being. Knows how to contribute in the public /civic space during emergency or disaster situations. FLA more in Level 7**
SUB-DIMENSION 5.2 CRITICALLY USE TOOLS TO EVALUATE AND AUDIT CARE ACCORDING TO RELEVANT QUALITY STANDARDS	Knows approaches, methods and processes of quality control, rating and development	Est NOT Is able to use, evaluate and audit care in accordance with current guidelines and professional standards	EST NOT Demonstrates a fundamental understanding of quality management in the health care system, its financial background FLA NOT and importance for patients care
SUB-DIMENSION 5.3 AWARENESS OF THE PRINCIPLES OF HEALTH/SOCIAL CARE FUNDING AND USES RESOURCES EFFECTIVELY	Understands theories of team working and personal development. Understands basic principles of local healthcare funding FLA NOT and access to resources	EST NOT demonstrates the ability to aim to achieve/support patient well-being through accessing/guiding (where appropriate) the combined resources and actions	Is committed to using resources effectively while appreciating how health/social care funding influences the organization and delivery of care FLA NOT

		of members of the health/social care team	

Level 7: with practice-based competences- either specialist or generic

The programmes studied were all at EQF level 7. With practice-based competences, except for the institution from Ireland. Ireland itself does have advanced practice level 7 programmes and we will review the national framework for this separately. Most courses were designed as full- time with an ECTS credit range of 60- 120 ECTS where one ECTS ranged from 25-30- hours. Full time programme duration was from 1.5- 2 years; however, this needs to be viewed in the context of different academic year duration. Flanders required students to undertake a one-year bridging programme following their bachelor's degree and then their full-time course was one year. The part time route could take 3 (Estonia)- 5 years (UK). Some programmes had a healthy part time option and reported that unsurprisingly most students were following the part time route as they were working as registered nurses. Many programmes offered different tracks/pathways in specialist areas of nursing/midwifery. In these cases, generic competences had been developed that were then demonstrated in the specialist setting (e.g. mental health, critical care, cancer care, rehabilitation). In some countries like Ireland and the United Kingdom, exit awards can be offered for sub cycle degrees. (See table 6)

Five Core Dimension comparisons

Unsurprisingly given the high degree of informal alignment due to international benchmarks, as a minimum, most countries could match the core dimensions of the Tuning Framework to their programme. The dimensions may be expressed differently, but the theme /content was within the national or local frameworks. Where countries did not have such a framework (Finland) the themes were still evident.

Tuning 2018 Competence comparisons

In comparison with the Level 6 competences, there was more diversity between the Level 7 competences. It was evident that this is connected to the specificity of some programmes which are specialist (emergency care for example), have general core competences and then different tracks /pathways according to clinical need. Participants provided details of these specialist tracks which indicated that such specialist programmes might be amenable to comparison. There is a widespread use of international Advanced Practice Nursing Competence Benchmarks (e.g Ireland, USA, UK). In countries with Advanced Practice these competences also form frameworks for comparison and analysis. The extent to which extended roles like nurse prescribing are within a country Scope of Practice also determines the presence of competences which may seem to be omitted as described within the Scope of Practice or Code of Conduct.

Table 2. Tuning 2018 Competences deemed not to be the same (but partly present or implicit)

Country	Tuning competence number
Estonia	11,14,21,30,39,42,44,45,48
Finland	2,4,20,27, 28, 38-44 52, 53, 55 These are covered at level 6 – 5,23,47, 34 is responsibility of employer
Flanders	1,2,3,4,9,13,14,24 These are general not specific- 25-31, 55,56 These are covered at level 6 – 5,23,47,

Ireland	All covered
Malta	Covered in modules, but not always explicit
Slovenia	Covered in elective modules: 23, 29-31, 39-42, 49-52 Different not a priority- 3,6, 29,32
UK	All covered

Table 3. Tuning 2018 Competences deemed to have changed priority

Country	Tuning competence number
Estonia	None
Finland	None- except overall changes re technology and critical care
Flanders	None
Ireland	None
Malta	None
Slovenia	None
UK	Post covid competence 1 is more relevant

Table 4. Tuning 2018 competences -omissions/additions

Country	Local additions	Omissions
Estonia	None	
Finland	Example from English programme Focused on emergency care for national need Ability to understand simulation-based education and how it can be used in CRM	38, 40, 45
Flanders	None	11`,16,17,41,52, 53 Some of the absent items are comprehensively covered in the bachelor competencies and are not specifically identified in the master's level PLO's (at Flemish or Institutional level). (18,19,20,21,22) E.g. holistic care, advocacy, use of technology etc Others are identified at the learning outcome level for specific courses. Furthermore there is an intensive bridging year that covers some of the items identified in the Tuning competencies but not addressed by the Flemish level DRL (PLO's) or KU Level OLRs. (see slide below)
Ireland	None	More extensive detail provided in sub sections of the regulator standards
Malta		See assessment framework
Slovenia	None	55
UK	None- use Royal College of Nursing standards and APRN	32-International not mentioned Assumed in the evidence base 41 Required by the NMC standards and Code of Practice- so tacit outcome.

Table 5. Assessment framework: criteria where there was not a match or reasonable match

Country	Comment
Estonia	Nil
Finland	Nil
Flanders	Nil
Ireland	Nil
Malta	NOT IN PROGRAMME OUTCOMES SUB-DIMENSIONS 1.2, 2.1, 2.2,2.4, 3.1 AND 4 NOT IN PROGRAMME OUTCOMES BUT IN COMPULSORY MODULE: 3.1 5.0, 5.1
Slovenia	Less emphasis on this statement *Has an advanced knowledge of nursing management and leadership theories and a comprehensive understanding of multidisciplinary work settings*
UK	*Within a global context, can identify future trends and challenges with respect to the professional, moral, ethical and/or legal principles, dilemmas and issues in day to day practice within a global context.* *Subsumed in evidence base not explicit*

Conclusion

Most of the Tuning 2018 competences or dimensions within the Assessment Frameworks (L6 and L7) appeared to be amenable to comparative assessment. However, they required analysis of the interpretation of the competences with respect to the Scope of Practice and the breadth of the curriculum. This was discussed in CALOHE1 by Gobbi and Kaunonen (2018). Further detailed work was required once competences for assessment had been identified for the assessment tools. The SAG wish to make it explicit that comparisons must take account of the role of practice competences and not give 'skewed' impressions based solely upon theoretical assessments.

In November 2022, the SAG reviewed all the country profiles to identify any significant changes since the Pandemic- and none were reported, although some revisions and consultations were in progress (Finland, Flanders).

Table 6. Level 7 comparative profile Level 7 nursing programme with practice competences.

All based on the Bologna Process etc

Country	Estonia	Finland	Flanders	Ireland	Italy	Malta	Slovenia	UK
Degree Title	Master of Science in Health Sciences (MSc) (options)	(MA in Nursing) / Master in Health Sciences Dual system	Master's in Nursing and Midwifery	Master's in Nursing	*Master's Degree in Nursing and Midwifery*	M.Sc. in Nursing	MSc (EU Postgraduate 2nd degree study programme Nursing Care – study field Emergency Situations In Health Care	MSc Advanced Clinical Practice (Advanced Nurse Practitioner) with specialist options
Duration years	**1.5**	1,5 / 2	1 year masters after mandatory 'bridging'	2 years; Clinical component 1 year; academic over 2 academic years	2 years	6 semesters 3 years	2	2- 5 years-
Are these full time years?[1]	**45**	45 week years / 45 week years	30-33 weeks	Part time	Full time	Part time	Full time (30 week)	Part time
ECTS number	**90**	90 / 120	60	60/120	120	90	120	90
1 ECTS = hours?	**26**	Appr 27 (27-30)	26-30	25	25 - +/- limit of 20 percent.	25	25 hours	25
Is this profile typical for the field of study as offered in your country? **Update 2020 accordingly to ICN guidelines to APN** **Update 11/2022**	**Yes**	Yes, both are typical; but MA in Nursing is always with practice competences	Yes	Yes	Yes	Only programme	Yes In 2020-21 started the first MSc APN programmes	Yes Changes in 2022 to community programmes

[1] **(45 week years or 30-33 week years)**

1.2.2 Overview Strategies for Learning, Teaching and Assessment in Nursing

This next section builds upon an earlier working paper by Dale, Gobbi, Jaccarini, and Hollos as part of the Tuning 2018 project. Here we have updated the paper to reflect the contemporary situation and further explored how concepts of learning and teaching influence assessments processes.

Since some seminal nurse education studies in the 1970s, there has been a well-established research and evidence based associated with the learning, teaching and assessment of nursing and nurses. Boyer's (1990) scholarship four component typology has been aptly applied to nursing namely the scholarship of: discovery/research, integration, application/service and that of teaching itself (see Oermann 2014).Nurse learners, whether before or after qualification, are adult learners undertaking an academic, professional/vocational programme of studies that includes both theoretical and practical knowledge, a range of subject areas and forms of knowing, behaviours, attitudes, personal characteristics, and the ability to perform in routine and unpredictable situations.

Since the late 1980s and certainly during the 1990s, debates concerning the development of competence-based education were already in process (see Eraut, 1994). The pedagogical knowledge base includes concepts and research associated with andragogy (Knowles et al., 2005), experiential learning (Boud, Cohen and Walker, 1993) and work-based learning and communities of practice (Gabbay and Le May, 2010; Gobbi, 2010, Boud and Middleton, 2003)) organisational cultures and learning, decision making, development of leadership skills, social psychology of learning, values, ethical and emotional literacy to name but a few. The different approaches to learning have all been included in the history of curriculum design and implementation, for example cognitive, behavioural, constructivist and post-modern approaches to nursing and nurse education. Theories of competence acquisition, clinical decision making, mentorship, expert practice (Benner 1984), tacit knowledge (Polanyi, 1958, 1961) and reflection (Bulman, Lathlean and Gobbi, 2013; Johns, 2004, 2009: Schon, 1983, 1987; and Gibbs, 1988) are well established. Theories or models that have been applied to nursing include Bloom's cognitive taxonomy of learning, (now updated by Krathwohl; 2002); Steinaker and Bell's (1976) experiential taxonomy; Dreyfus and Dreyfus (1986) and Benner's work on novice to expert development.

Many of these models have associated schema or criteria that have formed the basis for assessment rubrics in nursing practice and theory. Typically, knowledge assessment or knowledge application strategies have been influenced by first Bloom's taxonomy, but latterly by Kratwohl's (2002) revision This proposes that a two-dimensional framework Knowledge and Cognitive Processes. Readers will appreciate this bears similarity to one of the Tuning Nursing Competence Dimensions (Dimension 3). Here the linear hierarchy of achievement is represented by two axis the new Cognitive Processes comprising remembering understanding, applying, analysing, evaluating and creating. The second axis that is based on the original Bloom et al Taxonomy, comprises knowledge forms as factual, conceptual, procedural, and metacognitive knowledge. Numerous assessment rubrics have been derived from these and other cognitive models. Typically, knowledge and cognitive competence are assessed through taxonomies and employ strategies like:

- Multiple choice, innovative computer delivered selected response items, machine scorable questions that don't look like traditional multiple choice, essays, short answer questions, comprehension.
- However higher order critical thinking and judgement skills that are less amenable to some of these methods and the three 'S's have a role:

- Scenario based, Simulation, Situational Judgment.

Questions then arise with respect to the student's assessment literacy and the contested nature of interpretation and application of knowledge in increasingly complex health care practises. Furthermore, within the context of the profession, we are familiar with a range of forms of knowing, from Carper (1978) the empirics, ethics, personal knowing and the aesthetics; from White (1995) socio-political knowing; Gobbi (2005) embodied knowing and Chinn and Kramer (2008) Emancipatory knowing. These various typologies are schematically represented in Appendix 6.

Addressing the learning in, and of, practice leads us to two other illustrative models. First, there is Benner's (1984) seminal work that drew on the work of the Dreyfus brothers. From these studies on the nature of expertise and its development, it was realised that nurses went through stages that influenced their perception, focus and performance. Various rubrics have been developed based on this model and its characteristic features.

Benner 1984. Novice to Expert.- a developmental model

Benner conducted research using the Dreyfus Model (1981) which posits that the acquisition and development of a skill a student passes through 5 levels of proficiency

- novice
- advanced beginner
- competent
- proficient,
- expert

These stages reflect changes in 3 general aspects of skill performance

(1) Movement from the reliance on abstract principles to the use of past concrete experience as paradigms.

(2) From learning pieces to a complex whole with the ability to focus on relevant components at a time

(3) From detached observer to attached performer

The second model used to assess performance in the practice area focuses on different concepts of development, from beginner towards a state of being, is the Experiential Taxonomy (after Steinaker and Bell 1979). This model has five stages commencing with exposure (the student is introduced and orientated to the experience and context). Stage 2 (Participation) is where the student consciously participates in an aspect or part of the experience. In Stage 3 (Identification) the student identifies with the experience in an emotional and cognitive manner. Stage 4 (Internalisation) is particularly interesting because this is the phase when the experience (nursing in this case) begins to affect the way he or she conducts their life and, consequently may decide that the profession is not for them. Finally, in Stage 5 (Dissemination), the student now exhibits the behaviours of a nurse and shares this with others and advocates the role.

Broadly speaking, assessment strategies that measure performance in practice include: observation in clinical practice; simulation and technology assisted assessment, specific tools for tasks, proxy measures; indirect or direct assessments and evidence-based criteria associated with the clinical

situation or activity. The role of experiential learning, learning in the workplace, whether through real, virtual or simulated practice continues to play a critical role in competence development and there is an increasing research base in this field [see the ISPAD project accessed 20th February 2023]

The question remains as to how we can assess the knowledge, skills and personal qualities that nurses need to practise humanely, competently, with expertise, and focused on the client and safety.

2. Assessments

2.1 Key principles and Options

We have already emphasised the crucial importance of assessing not only theoretical competences and practice-based competences, but the interrelationships between the two. Specific examples of the assessment strategies that are suited to the different competence dimensions were outlined in Tuning (2018). In this project we have conducted further literature reviews with respect to the Five Dimensions and the best practice methods of assessment (see Appendix 5). We now outline some of the key principles of assessment that underpinned our approach.

First, we recall that in Tuning 2018, we stated that

> "The notion of *differentiation* is crucial to nursing to enable development, progression and achievement of safe, intelligent practice in the world of patients and their families/loved ones. Many typologies of learning do not accord value to the role of apprenticeship, craft knowledge and skill acquisition that are often fundamental to learning in a person - based practice" page 37.

Hence, it was crucial to acknowledge that to assess competences in all five dimensions of the Tuning 2023 competences, we must generate valid, reliable, relevant and timely assessments that can address the interrelated and complex nature of professional nursing practice. We therefore outlined some key principles that informed the choice of assessment strategies and tools, namely that:

1) Assessments should be
    a. aligned to the competences and programme or module learning outcomes in their entirety, not just in selected narrow aspects of professional practice.
    b. practical, equitable, reliable, feasible, professionally relevant, and defensible.
    c. reliable across nations and institutions.
    d. able to accommodate varying Scopes of Practice and Autonomy.
    e. in simple clear language that can be translated easily.
    f. evidence based in method and content.
    g. assessed by fair, transparent and well-constructed, valid and reliable rubrics.
    h. resource efficient, effective, and sustainable.
2) Most competences cannot be assessed solely by theoretical knowledge assessments.
3) Students should have sufficient Assessment Literacy- that is to be familiar with the method of assessment. For example, they should:
    a. Understand the rationale for the test.
    b. Know what competences are being assessed.
    c. Have had experience of the method of assessment.
    d. Understand how the results will be handled.
4) It should be clear who the assessors/examiners are:
    a. Who should carry out the assessments (theory, practice, simulation)?
    b. What expertise and training are needed for the assessors?
    c. What might be the observer effect on student performance in simulation, virtual reality or practice-based assessments?
    d. How will Inter-rater reliability be achieved?
    e. What resolution process is required in cases of disagreement between assessors?
5) The process for handling results should be transparent and accountable.

a) Consequences- for example if student passed all of institutions tests but fails the final test, professional consequence.

The group drew on the seminal work by Evans (2016, 2018 and 2020[2]) regarding the concepts of Assessment Literacy, Feedback and Design. While Evans's work is explicitly concerned with the student learning and achievement through Assessment, there are elements that will impact upon the students undergoing comparative cohort assessments. Of key importance here is Assessment Literacy, that is the extent to which students *understand* the requirements of the Assessment task. This is particularly relevant in an international comparative assessment context.

2.1.1 International Comparative Assessments

We have already indicated that for an assessment to be meaningful and relevant, for students and other stakeholders, (e.g., examiners/assessors, employers, clinicians, quality agencies, institutions), we need to ascertain the extent to which the relevant stakeholders share a common understanding of the assessment task, its associated competences, learning outcomes, metrics/rubrics, content and performance standard. That differences exist, is well known within the nursing field as we shall explore later with the competence 'safe administration of medicines'.

We need to establish the extent to which assessors/examiners and students from different countries share:

1) Familiarity with the various modes of assessment
   a) Simulation, higher order on line tests, situational awareness tests, orals,
2) Similar understandings as to what constitutes a 'pass'.
   a) For example, if a patient is 'killed' by the student response is this automatically a failure? for a component or the whole examination?
3) Have comparable criteria for patient management and treatment.
   a) Evidence based practice.
   b) Resource availability and its impact on patient management and technical assessments
4) Share common Codes of Practice
5) Develop the same competence standards at level 6 or level 7, before, or after registration.
6) Similar expectations concerning the tasks, roles, diagnostics, treatments, initiation, and engagement with the multidisciplinary team at the end of the relevant programme.

Given the wide variances, the assessment task may need to have 'layered' options to accommodate the differences between country cohorts. As we discussed with *Thomas Van Essen Executive Director Center for External Research Educational Testing Service during Calohe 1,* our assessment methods need to consider their degree of Authenticity and Fidelity to the nature of our profession – theoretical and practice based actions; have mechanisms for dealing with variability: Scope, context, culture, interpretation, evidence 'who's right?'; political dynamics, and address current competence versus capability. We have already stated our preference for current competence assessment and our intention to use integrated assessments to address subject specific competences in the context of generic competences and vice versa. Hence, in any future work the engagement of the key stake holding communities will be essential.

Following this overview of some of the key issues associated with developing and designing suitable assessment tasks for students, we now outline the process and results.

[2] Carol Evans (2016, 2018 and 2020) Enhancing assessment feedback practice in higher education: The EAT Framework Equity – Agency - Transparency

2.1.2 Assessment Design Process

Table 7 below summarises the process undertaken by the Nursing SAG to develop their final assessments. The team worked in small groups before synthesizing the data and working collaboratively on the final assessments.

Table 7. Summary of the Nursing SAG workplan and process

6 Step Process
1 Analysis of Nursing Competences -Five dimensions: literature A literature review was conducted for each dimension and summarised in a literature table with annotated narrative. The evidence base was analysed for its strengths and weaknesses for both theoretical and practical assessment. Good practice examples were identified for each dimension.
2 Search for Validated Assessment tools (Dimension) Within each dimension, there was a search for any relevant validated and reliable assessment tools. These were critiqued for practicality, rigour, level, complexity of administration and depth
3 In depth analysis of two selected 2 competences within each dimension Two (sub) competences were selected from each dimension and a further search was made for any assessment tools that could be used to assess these competences in theory and/or practice across a range of countries. The literature and practice were critically reviewed for the reliability and validity and generalisability of any recommended assessment tools. Each SAG member sought country based good practice examples for each competence.
4. Scope of Practice analysis and Assessment literacy Each competence and assessment tool was then analysed to establish whether there were similar 'correct answers' for each competence and assessment. Particular attention focussed on potential differences due to Assessment Literacy, Scope of Practice and Nursing roles with respect to the assessment task and competences. We developed models /criteria to identify similarities and differences that could enable comparative assessments to be practicable, equitable, fair, reasonable, valid and reliable. Models /frameworks /tools included: Scope of Practice, Levels of Autonomy, and the necessity for developing a Country /Institution based profile before undertaking comparative assessments.
5. Development The SAG integrated all the evidence, experience, and analysis. The final decision was to develop the following products: • Scope of Practice profile using medicines management and wound care as examples • Worked examples for each dimension drawing upon the above work • Further Develop the Model of Enacted Competence and to support this with a schema representing the different forms of Knowing and Knowledge employed in the nursing profession • To develop integrated assessments were possible using Level 6 and Level 7 scenarios in similar competences to demonstrate the difference between the two levels Each assessment rubric, tool, and revised competences was analysed by each country member for their practicality, assessment literacy and ability to translate into the languages represented by the SAG.
6. Final Scenario Development Following an iterative process that engaged and refined the Scenarios, answer guides and assessment rubric, the two scenarios, one at level 6 and one at Level 7 were finalized.

2.2 Steps 1- 3 Analysis of the available knowledge

1) Analysis of Nursing Competences -Five dimensions: literature
2) Search for Validated Assessment tools (Dimension)
3) In depth analysis of two selected 2 competences within each dimension

Essentially in these three steps, we gathered evidence to determine two competences from each Dimension that might be amenable to international comparative assessment. From page 25 the selected competences are outlined commencing with a summary of the key literature, any validated tools and conclusions reached concerning the challenges of assessment in the relevant dimension. Three core nursing 'universal' competences were used for illustrative purposes, namely, wound care management, safe administration of medicines and pre-operative surgical preparation using the World Health Organisation Surgical Guidelines.

2.3. Step 4 Scope of Practice analysis and Assessment literacy Embodied Competence, Scope of Practice and Autonomy levels

In this step, significant attention was given to those factors that could generate variances and differences, particularly with respect to the role of the nurse and local contextual influencers. Gobbi and Kaunonen (2018, page 9) proposed the concept of 'enacted competence'. This refers to the way a competence may be enacted (performed) differently between and within countries. While there are three components to this, Scope of Practice; Governance and Regulation; Culture and Context, one can also add the formal and informal education and training and work-based learning that the individual has experienced.

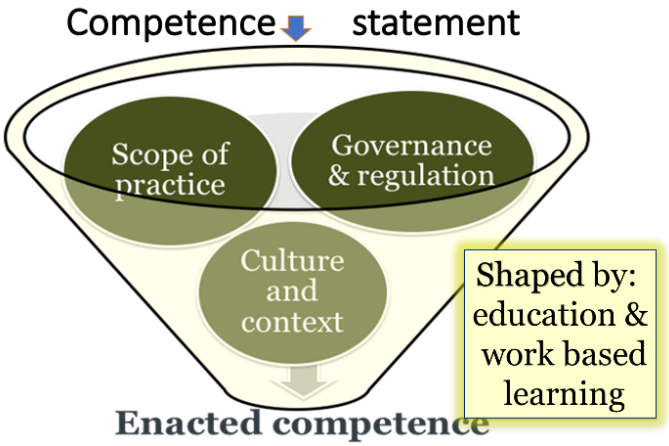

Figure 1. The concept of enacted competence

During the Thessaloniki meeting (June 2022) the group worked on this model to develop further this concept to make explicit, a set of factors or variables that may contribute to the enactment of the competence. In addition, the *way the competence may be performed* will also be shaped by the role undertaken by the nurse, specifically as researcher, practitioner, educator, and/or leader/manager.

It therefore became important to identify and analyse those factors that may influence the Enacted Competence at a cohort level, for that is the aim of the comparative assessments. These variances appeared to be clustered along the continua that are outlined in the matrix/schema Figure 2 below.

These factors may apply as a whole to the practitioner/student's practise, or specifically to the competence in question. For example, the expectations regarding what constitutes ethical practice versus the competence associated with a specific nursing intervention or skill.

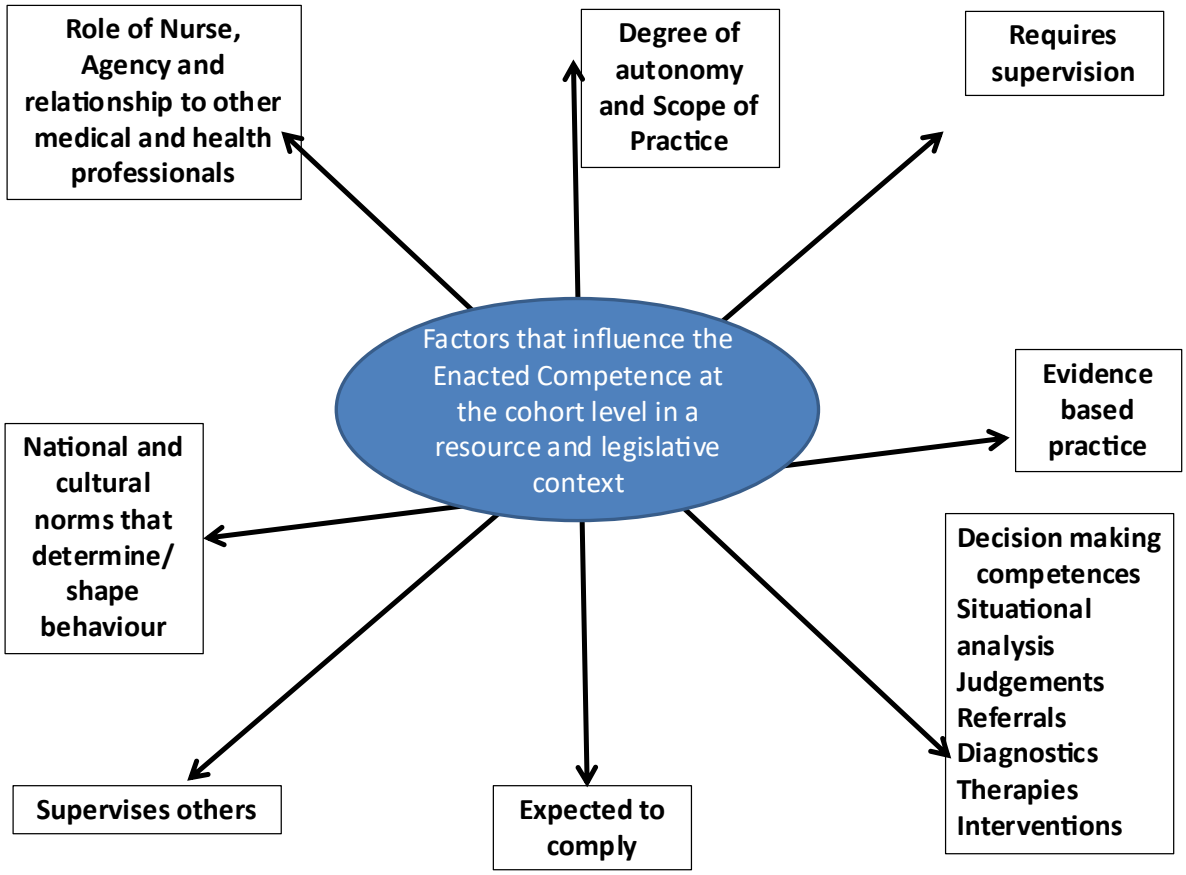

Figure 2. Schema to outline those factors that may influence the Enacted Competence at a cohort level.

The aim of the concept map/matrix is to make explicit those tacit influencers that shape and determine the nature of the enacted competence. We intend to illustrate these influencers through the analysis of our exemplar competences and sub domains. First however, we needed to explore the practical challenges of cohort variation and ethical aspects in international cohort comparative assessment. This builds upon the work of Evans mentioned earlier.

Cohort Variation, ethics and challenges

In CALOHEE1 we established that cohort variation would mean that an assessment strategy would need to accommodate variations in both assessment design and determination of the 'right' answer, particularly as in our case we are dealing with a regulated profession and patient safety. Unlike the assessment of individuals, with which we were all familiar, we need to turn our mind set to address *the profile* of a group of students- the cohort,- and not just an individual profile of a student. This meant the following questions arose-

1. *What is the cohort profile and how do we establish this? (i.e., on what and how can this cohort be tested?)*
2. *How can we make the assessment fair and relevant given that the enacted competence may not be the same for every country/ institution/cohort?*

3. *When conducting these assessments (for Calohe not for the institution) if it reveals a student who is highly likely to be unsafe to practice, where do the responsibilities lie?*

These three questions underpinned our approach. In the case of question three, we consider that this must be addressed before any comparative assessments are undertaken. A simple example of this interaction between the stated competence and the enacted competence is illustrated here with a common nursing practice, wound management. This will be explored further later in our final scenarios.

Example 1: Competence statement: Can safely and effectively manage wound care ***Apply these questions to each cohort involved in the comparative assessment***
Scope: the extent to which the nurses are expected to defer wound management decisions to medical staff. **Governance:** whether the nurses (all or some) have prescribing powers for wound products **Culture and context:** presence of other healers and beliefs about wounds (traditional practises) Hence the **Enacted competence**: is influenced by the above as well as the nurse's competence in their- a) Knowledge of wound healing and products b) Ability to use appropriate products *c)* Skills to manage beliefs and challenge others where necessary based on evidence yet being sensitive to tradition

In this example, we have shown that the enacted component may be higher or lower than the stated level of expected competence according to how these factors vary.

Enacted (assessed) competence *Higher performance standard*

Stated level of expected competence- no variation

Enacted (assessed) competence *Lower performance standard*

The group worked on this model because of its crucial importance to the country specific variations and how this may influence the stated and expected level of enacted competence at country or institutional level.

2.4. Step 5 and 6 Current Assessments

In this first example, we demonstrate how the competence 'safely administers medicines' involves the application of a range of other competences for it to be an enacted competence in practice, as well as three interrelate elements, a knowledge component, the application of knowledge, and a performance component. All three are influenced by the nurse's autonomy, responsibility, ability to delegate, and ethical and clinical decision making. These variances need to be elicited for each cohort to ascertain what can be tested and measured. This competence is essential to patient safety and drug errors are often the most common errors in patient safety.

Research has highlighted similarities, differences and learner performance outcomes in the context of medication knowledge, safe administration and errors. Gonzales (2012) noted the

> 'variation in how and when safe medication administration is assessed in the education setting. There is a need for a valid and reliable comprehensive assessment of safe medication administration in order to evaluate whether nursing students have the knowledge, skills and attitude to safely administrate medications.' Page 29.

Simonsen' et al. (2014) study of medications knowledge between experienced nurses and bachelor's students found a disturbingly high potential for error. While Gianetti, Dionisi, Stievano et al. (2021) provide evidence from a twelve-country study. We thus concluded that this was an important competence to address in our assessment strategy.

2.5 Good practice examples of Competence Assessments

In table 7 we find the analysis of the competence and its relationship to other competences or their component part(s).

Table 7. Example of Good Practice Safe Administration of Medicines

Example of Good Practice: Competence statement: Level 6 **Scope of Practice: Role of registered nurse** **Competence 13** Uses appropriately a range of nursing skills, medical devices/technologies, interventions/ activities to provide optimum care. For example: **13c *safely administers medicines and other therapies***
Taken from Dimension 1 The Professional Values and Role of the Nurse 1. Practices within the context of professional, ethical, regulatory, and legal codes, and responses appropriately to moral/ethical issues in day-to-day practice.
Taken from Dimension 2 Nursing Practice and Clinical Decision Making 7. Undertakes comprehensive and systematic patient assessments using appropriate tools/frameworks, while considering relevant physical, social, cultural, psychological, spiritual and environment factors. 8. Undertakes effective risk assessment and takes appropriate actions. 9. Recognises and interprets signs of normal and changing health/ill health, distress, or disability in the person.
Taken from Dimension 3 Knowledge and cognitive competences: 14. Can critically evaluate and apply current and relevant knowledge of the following. Has current and relevant knowledge of the following to nursing practice, patient care and situations of uncertainty: a. Theories of nursing and nursing practice b. Theories and views concerning the nature and challenges of professional practice c. **Natural and life sciences** **d. Social, health, and behavioural sciences** e. **Ethics, law,** and humanities f. Technology and health care informatics g. International and **national policies** h. Problem solving, **decision making** and managing tension or conflict i. Theories of personal and professional development 15. Appropriately applies and utilises understanding of research process to apply evidence to practice.
Taken from Dimension 4: Communication and interpersonal competences
16. Communicates effectively with patients, families, and social groups, including those with communication difficulties.

20. Accurately reports, records, and refers care using appropriate terminology, technology, and systems.

Next, we conducted an analysis of the possible cohort variances due to Scope of Practice (Autonomy), Knowledge and performance. In Table 8, we show how the statement 'safely administers medicines' can have a multiplicity of meanings.

Table 8. Example of the Scope of Practice and nursing autonomy

Safe administration of medicines (oral) – Levels of Autonomy what the nurse can do on his/her own.	
Increasing complexity of performance, autonomy and application of knowledge	Give tablets that someone else had selected and measured **Assists** patient to swallow pills- handed over by someone else Can **administer pills** from a named packet dispenser
	Can assess suitability of patient to take the pill (assessment skills) - knows action, can recognise side effects, can take measurements- but cannot omit medicine without referral to doctor/ pharmacist Decides whether to give the tablets the doctor has prescribed (has discretion) Can assess suitability, judge whether to give medicine, initiate other actions-has a protocol (initiation)
	Initiates assessment actions required by the patient prescribed a particular medicine Can initiate /adjust medicines according to a specified protocol- e.g., intensive care, care pathways, pain relief (judgment, discretion, and action)
	Can prescribe selected tablets to give to the patient (from a protocol) Able to prescribe from a limited formulary Able to prescribe from the total formulary Prescribes independently of the doctor
	Can mentor others and teach them to become prescribers

Following these two sets of analysis, a scenario-based assessment was designed to capture the different dimensions and competences that underpin 'safely administers medicines'. The example illustrated the knowledge content from other competences (health education role of the nurses in hospital and home settings).

Assessment examples (optional) using a scenario:
Example of a Level 6 Scenario

Mrs Smith, aged 45, has been prescribed sub cutaneous heparin following a venous thrombosis. She is to be discharged home in 48 hours and due to immobility, must continue with the heparin for at least 2 more weeks. Mrs Smith will be self-administering her heparin at home.

- Theoretical:
  - Oral exam: Explain and discuss various medicines and their clinical use and risks, - in this case heparin, discuss plan for safe discharge
  - Written exam: 1-hour long answer. One question- examples
    - Supported by evidence, explain the role and actions of the registered nurse to enable Mrs Smith to self-administer her heparin safely when she gets home (100%)
    - Critically discuss the role of the nurse in the safe administration of medicines, taking account of ethico- legal issues (100%).

- With respect to the following drugs, (a) briefly outline the side effects of the drug concerned and (b) discuss the nurse's role in patient education/health promotion
  - Steroids- oral (20%); Antibiotics- oral (20%); Heparin- self administration (20%); Insulin- self administration (20%)
  - Analgesics (20%)
- MCQ – single best answer. **3 stem questions on the key features of patient safety (paper based or online)**
  - Calculation questions; How drug X acts and works, side effects, how to assess; Questions related to scenario (s)
  - Online examinations like safe medicate

- Clinical Practice Assessment: Observation of a medicines round under supervision/administering medicines to patients in the community.
- Indirect Assessment /Representation of Practice
  - Objective Structure Clinical Examination (OSCE)
  - Simulation using a patient scenario

Example of a Level 7 scenario

Mrs Smith, aged 45, is paraplegic since an accident 5 years ago. Following a deep venous thrombosis, she is to be discharged home in 48 hours. Mrs Smith will self-administer her sub cutaneous heparin for another 2 weeks before commencing oral anticoagulants.

Theoretical:

- Written exam: 1 hour. Supported by evidence, design a holistic interdisciplinary plan of care for Mrs Smith over the next 4 weeks.

- Clinical Practice or Indirect Assessment: as above

References as accessed 16th January 2023

https://sciedu.ca/journal/index.php/jnep/article/viewFile/433/323 **NICE guidance** https://www.nice.org.uk/guidance/NG5

Safe medicate https://www.safemedicate.com/

https://www.councilofdeans.org.uk/case-study/safemedicate-computer-environment-for-medication-dosage-education/

NURSING

Example of Good Practice: Competence statement: Level 6 **Scope of Practice: Role of registered nurse** **Competence 13** Uses appropriately a range of nursing skills, medical devices/technologies, interventions/ activities to provide optimum care. For example: **13b *practice principles of health and safety, including moving and handling, infection control, essential first aid and emergency procedures***
Taken from Dimension 1 The Professional Values and Role of the Nurse 1. Practices within the context of professional, ethical, regulatory, and legal codes, and responses appropriately to moral/ethical issues in day-to-day practice.
Taken from Dimension 2 Nursing Practice and Clinical Decision Making 7. Undertakes comprehensive and systematic patient assessments using appropriate tools/frameworks, while considering relevant physical, social, cultural, psychological, spiritual and environment factors. 8. Undertakes effective risk assessment and takes appropriate actions. 9. Recognises and interprets signs of normal and changing health/ill health, distress, or disability in the person.
Taken from Dimension 3 Knowledge and cognitive competences: 14. Can critically evaluate and apply current and relevant knowledge of the following. Has current and relevant knowledge of the following to nursing practice, patient care and situations of uncertainty: a. Theories of nursing and nursing practice b. Theories and views concerning the nature and challenges of professional practice c. Natural and life sciences d. Social, health, and behavioural sciences e. Ethics, law, and humanities f. Technology and health care informatics g. International and national policies h. Problem solving, decision making and managing tension or conflict i. Theories of personal and professional development 15. Appropriately applies and utilises understanding of research process to apply evidence to practice.
Taken from Dimension 4: Communication and interpersonal competences
20. Accurately reports, records, and refers care using appropriate terminology, technology, and systems.

Assessment examples (optional) using a scenario:

Example of a Level 6 Scenario

Mr Smith, aged 62, presented to the Emergency Department with a history of palpitations of unknown duration. He was diagnosed with atrial fibrillation and admitted to the ward. Today, he is being brought to your theatre for an elective cardioversion.

- Theoretical:
  - Sample oral exam question: Explain and discuss the pre-procedural (intra-procedural, post-procedural) care of Mr Smith.
  - Sample written exam 1-hour long answer question: Supported by evidence, explain the role and actions of the registered nurse in caring for Mr Smith (in the pre/intro/post procedural phase) (100%).
  - Sample MCQ – single best answer:
    - What is a potential complication of cardioversion: A) Stroke B) Respiratory depression C) Hypoglycaemia D) Pruritis
- Clinical Practice Assessment example: Observation of a nurse completing pre-procedural checks with the patient
- Indirect Assessment /Representation of Practice
  - Objective Structure Clinical Examination (OSCE)
  - Simulation using a patient scenario

Example of a Level 7 scenario

Mr Smith, aged 62, presented to the Emergency Department with a history of palpitations of unknown duration. He was diagnosed with atrial fibrillation and admitted to the ward. Today, he is being brought to your theatre for an elective cardioversion. He has a history of diabetes and smokes 20 cigarettes a day.

- Theoretical:
  - Sample oral exam question: Explain and discuss the pre-procedural (intra-procedural, post-procedural) care of Mr Smith.
  - Sample written exam 1-hour long answer question: With reference to the recent relevant literature and potential complications of this procedure, critically discuss the perioperative management of this man (100%).
  - Sample MCQ – single best answer:
    - Which ECG finding would you expect to see in this man prior to the procedure: A) A fast regular rate with narrow QRS complexes Stroke B) A fast regular rate with wide QRS complexes C) A fast irregular rate with narrow QRS complexes D)A fast irregular rate with wide QRS complexes
- Clinical Practice Assessment example: Observation of a nurse identifying and preparing the necessary equipment for this procedure
- Indirect Assessment /Representation of Practice
  - Simulation using a patient scenario
  - Objective Structure Clinical Examination (OSCE)

References as accessed 16th January 2023

https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/algorithms
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2.6 Final Integrated Scenario Based Assessments for Level 6

Level 6 scenario for registered nurse. Assumes in EU that the programme has complied with EU Directive 2015

Example of a Level 6 scenario and assessment:

[3]Mr X[4] a 65-year-old gentleman, with no co-morbidities and a well-supported social environment[5] was admitted to your surgical ward yesterday and is due to undergo a hip replacement today. You are caring for Mr Smith and must prepare him for theatre. The patient's surgery is due at 1200.

Theoretical assessment

Oral exam	
	Discuss a named aspect of the WHO safe surgery checklist.
Written exam: an essay using an evidence-based approach (1 hour) One question	
Dimension 1: 1.4 Dimension 2: 2.8, 2.10 Dimension 3: 3.14 Dimension 4: 4.16, 4.19	• Explain the nursing care that is required for this patient until you handover the patient in theatre to the theatre staff. • Describe the role of the registered nurse in ensuring patient safety, dignity, and consent during the perioperative period for this operation. • How would you prepare Mr. X for a safe discharge? (Would include rehab)
Short answer questions to form 60 minutes	
Dimension 2: 2.7, 2.8, 2.10 Dimension 3: 3.14 Dimension 5: 5.21	• Which members of the interdisciplinary[6] team would be involved in the care of Mr X in his post-operative period and briefly describe their role? • What nursing history /further information would you require in order to safely discharge Mr X?
MCQ- to form 60 minutes	
Dimension 3: 3.14	• Which of the following vital signs indicate that Mr. X may be deteriorating following his surgery? • Which of the following signs indicate that Mr. X may have an incisional wound infection: • What would be your main priorities during the recovery period immediately post-op?

Practical assessment

Candidate to accurately and efficiently complete the checklist under supervision within the relevant context, simulation or real

- OSCE
- Simulation[7]

[3] The gender, age and ethnicity of the patient can be altered to change aspects of the scenario
[4] Use a common name of the country concerned that has no associated potential for bias
[5] The scenario can be altered by adding complexity to the social circumstances
[6] The answer would reflect the composition of the workforce in the country concerned
[7] This requires facilities in the institution concerned and scenarios can be task focussed with single or multiple intereventions

- Patient case (in clinical setting)

2.7 Final Integrated Scenario Based Assessments for Level 7 for a registered nurse with practice-based competences.

Example of a Level 7 scenario

all answers to be supported by appropriate evidence

Mr X *(use a name and surname that may indicate the person's cultural background as desired and is linguistically competent in the country's first language*) is a 65-year-old (*age may be varied according to aims of assessment*) man living alone with a history of Atrial Fibrillation and Type 2 Diabetes. He has arrived on your ward from the emergency department.

He requires a hip replacement because of a fall. He had been lying on the floor at home for 10 hours before he was found and brought to the hospital.

He is upset and anxious about undergoing the operation and does not fully understand what will happen during and after the operation.

You are conducting his assessment based on recent evidence-based practice.

Example of multiple-choice questions: 50 questions in 1 hour Focus on scientific and clinical knowledge	
Mapping to 2023 competences	Question and single-best answer- Illustrative questions
Dimension 3	Question: diabetes general Mr. X, a 65-year-old gentleman living with type 2 diabetes has suffered a hip fracture and is scheduled for surgery. His glucose control is good and normally takes 1g of Metformin slow release. Which of the following is **TRUE in relation to his preoperative care_**
	Option 1: Blood glucose must be controlled with continuous low-dose intravenous insulin and intravenous fluid, adjusted to the glucose levels.
	Option 2: Metformin must be stopped on the day of the surgery
	Option 3: Metformin should be replaced by Glibenclamide on the day of the surgery
	Option 4: Subcutaneous insulin should be administered on the basis of a sliding scale for the dosage of insulin based on glucose levels.
	Option 5: No change to his normal medication is required.
Dimension 3	Question: diabetes general What target glucose range would you apply in caring for Mr. X prior to surgery?
	Option 1: 3.0 -5.0 mmol/l
	Option 2: 4.0 - 6.2 mmol/l
	Option 3: 4.4 - 10 mmol/l
	Option 4: 12-14 mmol/l
	Option 5: There is no need to set a target blood glucose range for this patient.

Dimension 3	Question: Which surgical option is most likely to be used to treat a displaced intracapsular hip fracture?
	Option 1: Richard screws
	Option 2: Hemiarthroplasty*
	Option 3: Proximal femoral nail antirotation
	Option 4: Dynamic hip screw
	Option 5: Total hip replacement
	*as per NICE guidelines
Dimension 3	Question: Which ECG finding would you expect to see in this man?
	Option 1: A fast regular rate with narrow QRS complexes
	Option 2: A fast regular rate with wide QRS complexes
	Option 3: A fast irregular rate with narrow QRS complexes
	Option 4: A fast irregular rate with wide QRS complexes
	Option 5: A fast regularly irregular rate with narrow and wide QRS complexes
Dimension 3	Question: What of these medications is an anticoagulant that you might expect to see on Mr X medication chart? *Local products names would be used here*
	Option 1: Diltiazem
	Option 2: Amiodarone
	Option 3: Vernakalant
	Option 4: Rivaroxaban*
	Option 5: Atorvastatin
	*this is the only anticoagulant on the list
Example of a short answer question	
Mapping to 2023 competences	Question
Dimension 2 (2.9; 2.10; 2.12) Dimension 3 (3.14;3.15)	Based on the history and presentation, identify the key priorities for this gentleman following admission to the ward. Justify your rationale for choosing these priorities.* • On admission to ward** • In preparation for hip surgery • In the post-operative period • In preparation for discharge / rehabilitation *: priorities that the examiner may wish to assess might include pain, vital signs, glucose levels, anxiety, is he stable, ECG, initial assessment / admission to ward including investigations, use of screening tools (e.g., skin integrity) and history of the fall and risk factors, specific assessments, concurrent health conditions, specific surgery, general pre-op, family) See attached answer plans in relation to pre-existing conditions and in relation to hip surgery. Grading criteria should be updated regularly on the basis of the most current clinical guidelines and other available evidence **: using the same scenario, the focus of the assessment can be easily changed by focusing on different time periods.

Dimension 2 (2.10; 2.11) Dimension 5 (5.22)	Using a risk assessment format, prioritise the plan of care to be implemented by the nursing and interdisciplinary team.
Dimension 5 (5.22)	Critically outline the respective roles and responsibilities of different interdisciplinary team members.
Dimension 1 (1.4) Dimension 2 (2.10), Dimension 5 (5.22)	What informs your decision to delegate and/or refer (nursing) actions to other members of the team?
Example of long answer (essay) questions . 1 question to be attempted in 60 minutes	
Dimension 1	*With reference to the recent, relevant literature, critically discuss/describe the nurse's role within the interdisciplinary team in the holistic care of Mr X during the hospital stay including discharge home.*
Dimension 1 (1.1-1.4)	Critically discuss the role of the registered nurse in ensuring patient safety, dignity and consent during the perioperative period for this operation.
Dimension 4; (4.17) Dimension 5	You have a newly qualified nurse working on the shift, *how* would you explain to them the relevance of the patient's history to the plan of care including discharge home.

The above scenario was derived from the earlier work on the WHO Surgical check list that is listed below.

Competence statement: Level 6: Able to provide safe and effective nursing care for a patient undergoing elective surgery **Demonstrates ability to use the WHO check list (includes pre-operative preparation and patient journey)- theory and practice.** **Standard: World Health Organization Surgical Check List** Safe surgery (who.int) (accessed 16th January 2023) **Scope of Practice: Role of registered nurse**
Taken from Dimension 1 The Professional Values and Role of the Nurse. 1. Practices within the context of professional, ethical, regulatory, and legal codes, and responses appropriately to moral/ethical issues in day-to-day practice
Taken from Dimension 2: Nursing practice and clinical decision-making competences. 7. Undertakes comprehensive and systematic assessments using the tools/frameworks appropriate to the patient taking into account relevant physical, social, cultural, psychological, spiritual and environment factors. 8. Undertakes effective risk assessment and takes appropriate actions
Taken from Dimension 3: Knowledge and cognitive competences 14. Can critically evaluate and apply current and relevant knowledge of the following Has current and relevant knowledge of the following to nursing practice, patient care and situations of uncertainty: a. Theories of nursing and nursing practice b. Theories and views concerning the **nature and challenges of professional practice** c. **Natural and life sciences** d. **Social, health, and behavioural sciences** e. **Ethics, law**, and humanities f. Technology and health care informatics g. **International and national policies** h. Problem solving, **decision making** and managing tension or conflict i. Theories of personal and professional development

15. Appropriately applies and utilises understanding of research process to apply evidence to practice.
Taken from Dimension 4: Communication and interpersonal competences 16. Communicates effectively with patients, families, and social groups, including those with communication difficulties. 20. Accurately reports, records, and refers care using appropriate terminology, technology, and systems.

2.8 Assessment Rubrics Level 6 and 7

We recognise that due to the different Scopes of Practice, cultural and academic contexts of nurses and nursing practice, what may be a criterion for 'failure' may vary from country to country. Therefore, our assessment rubric comprises two Sections, Section 1 addresses the Scope, regulation, safety, and ethical aspects that may, in some countries or institutions, lead to automatic 'failure' in an assessment task. Section 2 examines the rest of the assessment task, with no measurement of factors addressed in Section 1. Where appropriate, this will be matched to the Country/Institutional Profile.

Section 1: Scope of Practice, Regulations, Safety and Ethics.

Please answer these questions first in your local and national context. Please write N/A [not applicable] if the question does not apply to this assessment/examination task. **Where appropriate, does the answer…..**	**YES or NO? Or N/A**
1. Comply with the Scope of Practice and national laws regulating nurses?	
2. Describe or represent safe practice for patients/ families/staff?	
3. Describe or represent ethical and/or caring practice?	
4. Comply with other relevant legislation (e.g. health and safety, safeguarding)?	
5. Comply with recommended local policies and procedures?	
Score number of 'Yes' answers	
Please explain here your reasons for stating 'No' to any question above.	

Once these questions have been answered, please mark the rest of the paper / assessment task on its content and level of academic achievement.

Section 2: Professional and academic competences

Pass criteria- Please refer to the answer guide for the expected typical content for the assessment task.

Please write N/A if the criterion does not apply to this assessment task, then change the rubric for the criteria that apply.

Answers must be aligned to the assignment task.
When a criterion has met the 'pass' descriptor, then please decide whether the answer meets the criteria for a 'good pass' or a 'very good pass' and tick the relevant box. When you have decided that a criterion has not been met, please provide a reason to support your decision at the end.

NURSING

Assessment Mark Sheet/Rubric/Criteria- based on the Level 6 competences.

Criteria for a Pass Minor omissions or errors may be present. Answers should be relevant and timely. The assessment task is addressed.	YES N/A NO?	Criteria for Good Pass Minor omissions only Confident answers addressing the assignment task. Reading wider than course list and some questioning of 'routine' practices. Clinical questions are individualised and holistic.	Criteria for Very Good Pass Comprehensive, detailed, analytical answers. Evidence of wide reading. Shows insight /innovation/evaluation and questions established practises. Clinical questions are individualised and holistic.
1. Demonstrates understanding of their responsibilities and role in the assessment task			
2. Shows evidence of self-reflection/ appraisal			
3. Sufficient and relevant clinical data are collected accurately			
4. Assessments are holistic: appropriate tools are used			
5. Clinical judgements are sound based on relevant data/evidence			
6. Plans of care are prioritised and responsive to changing circumstances			
7. Procedural knowledge and nursing interventions are described and briefly explained.			
8. Evaluation of practice is present.			
9. Knowledge content is accurate, sufficient, and relevant (see indicative content for the assessment task)			
10. Sources of knowledge and evidence are appraised and critically evaluated.			

11. Applies appropriate research and evidence.			
12. Answers/explanations are clear and easily understood.			
Criteria for a Pass **Minor omissions or errors are acceptable** **Answers should be relevant and timely- but they may not totally address the assignment task**	**YES** **N/A** **NO?**	**Criteria for Good Pass** **Minor omissions and errors only** **Confident answers addressing the assignment task**	**Criteria for Very Good Pass** **Comprehensive, detailed and analytical answers**
13. Language/Non-verbal communication is professional, appropriate, and respectful of others			
14. Language /communications are responsive to the needs of others (e.g. capacity, disability, culture).			
15. Language is technically accurate and logical			
16. Represents the 'voice' of patients and others when appropriate (e.g to other members of health care team).			
17. Shows understanding of the role of other health/social care professionals			
18. Takes account of available relevant resources			
19. Demonstrates role as supervisor/educator of others			

20. Shows insights into the role of clinical leaders and managers			
Total no Answers per descriptor, 'Pass' 'Good' or 'Very Good' Passes.			
Questions/Criteria that have not passed		**Reason for decision**	

We recognise that due to the different Scopes of Practice, cultural and academic contexts of nurses and nursing practice, what may be a criterion for 'failure' may vary from country to country. Therefore, our assessment rubric comprises two Sections, Section 1 addresses the Scope, regulation, safety, and ethical aspects that may, in some countries or institutions, lead to automatic 'failure' in an assessment task. Section 2 examines the rest of the assessment task, with no measurement of factors addressed in Section 1. Section 2 descriptors are enhanced from the Level 6 assessment rubric to reflect Level 7 competences, standards and levels. Where appropriate, this will be matched to the Country/Institutional Profile.

Section 1: Scope of Practice, Regulations, Safety and Ethics.

Please answer these questions first in your local and national context. Please write N/A [not applicable] if the question does not apply to this assessment/examination task. **Where appropriate, does the answer…..**	**YES or NO? Or N/A**
6. Comply with the Scope of Practice and national laws regulating nurses?	
7. Describe or represent safe practice for patients/ families/staff?	
8. Describe or represent ethical and/or caring practice?	
9. Comply with other relevant legislation (e.g. health and safety, safeguarding)?	
10. Comply with recommended local policies and procedures?	
Score number of 'Yes' answers	
Please explain here your reasons for stating 'No' to any question above.	

Once these questions have been answered, please mark the rest of the paper / assessment task on its content and level of academic achievement.

Section 2: Professional and academic competences

Pass criteria- Please refer to the answer guide for the expected typical content for the assessment task.

Please write N/A if the criterion does not apply to this assessment task, then change the rubric for the criteria that apply.

Answers must be aligned to the assignment task.
When a criterion has met the 'pass' descriptor, then please decide whether the answer meets the criteria is a 'good pass' or a 'very good pass' and tick the relevant box.

When you have decided that a criterion has not been met, please provide a reason to support your decision at the end.

Assessment Mark Sheet/Rubric/Criteria- based on the Level 7 competences.

Criteria for a Pass **Minor omissions and errors may be present.** **Answers should be relevant, timely: demonstrating criticality and evaluation.** **The assessment task is addressed.**	**YES** **N/A** **NO?**	**Criteria for Good Pass** **Minor omissions only** **Confident answers addressing the assignment task. Evidence sources are broad and appraised.** **Clinical questions are individualised, holistic and promote optimum practice.**	**Criteria for Very Good Pass** **Comprehensive, detailed, analytical answers. A wide variety of evidence sources provide innovative, challenging, and new insights into established practices or complex situations.** **Clinical questions are individualised, holistic and offer multiple perspectives on the situation**
21. Demonstrates a critical appreciation of their responsibilities and role in the assessment task.			
22. Evidence of critical or evaluative self-reflection/ appraisal.			
23. Decides which clinical data are required and then interprets, synthesises, and evaluates.			

24. Assessments are holistic: tools are critically evaluated for their relevance.			
25. Clinical judgements are defensible, and evidence based.			
26. Plans of care are prioritised and responsive to changing circumstances and complexity.			
27. Procedural knowledge and nursing interventions are systematically appraised for their relevance for the assessment task.			
28. Nursing interventions and practises are critically evaluated.			
29. A variety of sources of evidence and forms of Knowing /Knowledge are justified (see indicative content for the assessment task).			
30. Actively promotes, leads, and enhances the quality-of-care provision/systems.			
31. Audit, research, and evidence-based practise are used to improve care, quality standards, safety, efficiency and effectiveness.			
Criteria for a Pass **Minor omissions or errors may be present. Answers should be relevant, timely: demonstrating criticality and evaluation. The assessment task is addressed.**	**YES** **N/A** **NO?**	**Criteria for Good Pass** **Minor omissions only** **Confident answers addressing the assignment task. Evidence sources are broad and appraised.** **Clinical questions are individualised, holistic and promote optimum practice.**	**Criteria for Very Good Pass** **Comprehensive, detailed, analytical answers. A wide variety of evidence sources provide innovative, challenging, and new insights into established practices or complex situations.** **Clinical questions are individualised, holistic and offer multiple perspectives on the situation**
32. Answers/explanations are clear, easily understood, logical and defensible.			

33. Language/Non-verbal communication is professional, appropriate, respectful of others and responds to the complexity of the situation			
34. Language /communications show insight, anticipation and adaptability when meeting the needs of others (e.g., capacity, disability, culture).			
35. Language is technically accurate, logical, and confident.			
36. Represents and advocates for the 'voice' of patients and others when appropriate.			
37. Critically appraises the role of self and other health/social care professionals.			
38. Appraises available human and other resources to promote wellbeing, sustainability and effectiveness.			
39. Actively promotes the support, learning and development of others in the work environment.			
40. Shows a critical appreciation of the role of clinical leaders in the development of strategy/policy and procedures.			
Total no Answers per descriptor, 'Pass' ' Good' or 'Very Good' Passes.			
Questions/Criteria that have not passed		**Reason for decision**	

2.9 Thematic interdisciplinary task groups

The nursing group members were active participants in the cross disciplinary / thematic groups.

1) Interculturalism
2) Information and communication
3) Governance and decision making
4) Ethics, norms, values and professional standards
5) Sustainable development (climate change)-
6) Tuning-CALOHEE overarching / meta qualifications reference framework based on a merger of the EQF for LLL and the QF for the EHEA –

When sharing ideas from the interdisciplinary group work, it became clear, that many of those dimensions were already within the nursing framework, and were often equivalent to our five dimensions. In particular, the Ethics theme has been one of the most valued competences in nursing both level 6 and 7. Information and communication is one dimension in nursing competences as is also Nursing practice and clinical decision making. When the nursing competences were updated during the CALOHE2 project, the sustainable development was taken into consideration and the GREEN COMP and WHO guidelines were followed. The 2013 competences reflect these changes and refinements. For an example of the nature of ethics education in nursing see Cannaerts, Gastmans and Casterlé (2014).

3. Improved Future Assessments

This report has highlighted the multifaceted nature of international comparative assessment in nursing education. We have shown the importance of establishing the true nature of the enacted competence before conducting assessments so that they are fair and relevant to all stake holding groups, but most importantly to students. Two key areas are of course the issues of translation and ethical practice in assessment. Areas for future deliberation and quality improvement include the following issues.

3.1 Further Adoption of Technologies in assessment and in real world practice

We have shown how the availability of technology influences not only the interpretation and implementation of competences, but also the possibility for modes of assessment. Rather than paper based multiple choice or short answer questions, accessible digitalised formats in a range of languages become accessible and cost effective. There is a burgeoning literature concerning the use of high-fidelity technologies for assessments, ranging from highly expensive virtual reality platforms to the assessment of the use of technology in the clinical workplace (e.g. on line record keeping, interpretation of video based scenarios). The scalability of some modes of assessment is largely related to the costs of authentic assessments using digital platforms. Interactive simulations, situational analysis assessments and on-line short answer questions offer potential for the content and format of assessments as well as means to generate objective marking criteria. However, care should be taken to address issues like unconscious bias through variances in context, culture, and health care relationships. As technology develops, work that has been, or is, proof of concept will eventually become a reality. This will require the development of standards for the design, implementation, and evaluation of such modes of assessment.

3.2 Clarifying role of assessors and training needs

Whatever the assessment design and mode of delivery, future work needs to address the training needs of assessors/examiners. Such training should encompass ethical standards, security of the assessments, the modes of delivery, the nature and criteria for assessment, inter rater reliability, the use of rubrics, and the interpretation of results as a minimum. Collaborative design, equity and transparency of assessment as recommended by Evans (2020) could form a methodology to underpin the Assessment Literacy of the examiners.

3.3 Develop standards of assessment

Given the numerous possibilities for the assessment task, a range of standards for valid, reliable, authentic and meaningful international comparative assessments will need to be developed. An international language of assessment in the discipline will be required. This includes assessments undertaken in real world practice and simulations. In December 2020, a new set of international guidelines were published for clinical placements for health care trainees. These guidelines should provide a requirement for any comparative assessments undertaken in the clinical environment. They cover aspects such as mentorship, compliance obligations, risk management, partnerships and crucially for this project assessment. See ISO - IWA 35:2020 - Quality of learning environments for

students in healthcare professions — Requirements for healthcare education providers in care settings . New standards will also need to address the role of assessors, the assessment design, delivery, evaluation, interpretation, and dissemination of the results. They should also include the standards for ethical behaviours and the management of any 'unsafe' practises that might identify students who are a potential risk for safe practice. Conflict resolution processes should also be designed and procedures for dealing with breaches of the ethical conduct code. The integrity of the content of the assessment is likely to require an expert management group supported by country-based education, practice, and research teams.

3.4 Addressing resource gaps that influence methods of assessment

Inevitably assessments costs throughout the process shape and determine the possibilities for the mode of assessment and its delivery. Costs include- labour, time, materials, training needs, and political implications. Technological infrastructures will also determine the extent to which assessments can be conducted via digital platforms and the issue of equity then arises. Furthermore, the digital literacy of students and assessors may also be a limiting factor. Similarly, issues concerning personal data (capture, consent, storage and dissemination), security and confidentiality will need to be managed.

3.5 Further work on country profiles and their currency

Our work in this area is in its infancy and will need significant engagement with the stake-holding community. The further development of our metrics to elicit variances in Autonomy, Scope of Practice and local practises in assessment and nursing practice is essential. This is an area of potential high risk. As mentioned earlier, another area of risk is to ensure the scientific quality of the assessment content and assessment rubrics.

4. Future Testing – Practical Implications

4.1 Opportunities and Challenge

We have raised a number of risk factors throughout this report and advocated recommendations for good practice Assessment Design, Delivery and Evaluation. Given the global pressures within the national and international nursing and nurse education sector, the political risks and reputational consequences cannot be ignored. Within the European space, the role of the EU Directive is one aspect when the potential implications of data findings for both the Directive itself and countries participating in the project might be challenging.

Given the reality of international mobility of staff and patients, the ability to understand the reality of enacted competences and what this might mean for patient safety could be a huge benefit. Furthermore, valid assessments can provide meaningful and useful feedback to all concerned. At the simplest level, the country profiles should facilitate discussions concerning the appropriate orientation of new students and staff to the setting. Our simple SWOT analysis summarises some of the issues.

Strengths	**Weaknesses**
• Respect country/institution/discipline autonomy by offering variable /layered exit points to the assessment. • Provides a transparent framework to facilitate comparison and dialogue. • Between countries, institutions, students/teachers, and their achievements • Further refines and makes transparent definitions of learning outcomes (LO) and competences. • The extent to which different pathways and contexts lead to comparable LOs • Facilitates research and evaluation into comparative assessments.	• Insufficient account of context may invalidate the assessment results. • Risk that the language of assessment and assessment literacy is not aligned to country-based concepts and practises. • The effectiveness of translation • Deficiencies in the Assessment Design • Inter rater reliability.
Opportunities	**Threats**
• Creates dialogue concerning the similarities and differences in real world education and nursing practice • Stimulates programmes and institutions to articulate and discuss learning outcomes, curricula, goals of education and achieved, enacted competences of their graduates.	• Bureaucratisation, effort in demonstrating compliance rather than actualisation of concepts, items, dimensions • Context and complexity of the process • Different educational paths to nursing qualification that are too diverse. • Unethical practises, conflicts of interest • Lack of training and resources

• Shared language a starting point for comparison and learning from each other. • Implications for the mobility and support of the workforce • Implications for patient safety • Implications for policy makers	• Lack of engagement of stakeholder communities and resistance

4.2 Trends in the profession

This report commenced with an outline of the impact of COVID 19 on the profession and education. There is little doubt that significant forces are having detrimental effects on the nursing workforce and consequently nursing students before and after registration. The rapid expansion of technologies, and a huge workload, partly due to the back log of the pandemic, but more specifically the global workforce challenges means that it is likely that new ways of working and new roles will emerge in the next five years. These factors alone may require further revisions of the competences especially those associated with changes in Scope of Practice and Autonomy and the ratio of registered nurses to doctors, assistant grades and other healthcare professionals. Readers may wish to study Schokkaert, Aerts and Callens (2023) for some indication of likely trends. World Health Organization annual reports also provide relevant data together with the European Observatories for Health.

4.3 Summary

From a theoretical perspective, it appears that most of the Tuning competences or dimensions at both Level 6 and Level 7 are technically amenable to comparative assessment. We have shown however that effective assessments require analysis and interpretation of the competences with respect to the Scope of Practice, context, and the breadth of the curriculum in each participating country/institution. Further detailed work is required to translate our conceptual models and templates into real authentic assessments.

From a practical perspective, the SAG have not found the Assessment Framework designed at the end of CALOHE1 to be of any practical value. It has not contributed to our Design process due to the integrated nature of our competences. In fact, the framework became confusing when retrospectively analyzed in the latter part of the project. When reflecting upon this, the SAG realized that while we had complied with the request to design an Assessment Framework, the development of the framework had played no part in our conceptual process of Assessment Design and Literacy.

We therefore suggest that this needs further exploration for other similar subject areas who may have integrated competences and dimensions like ours. The SAG members all had educational qualifications and were well versed in competence-based curriculum design, and this may have been a contributing factor.

Diabetes answer plan for essay question

		Noted	Expanded
On admission to ward			
Key priorities	**Justification**		
Obtain HbA1c level if no test result is available for the past 3 months	To obtain information on preadmission glycaemic levels; these influence inpatient and discharge outcomes (ADA, 2022)		
Assess diabetes self-management and behaviour (obtain information from family or friends or during the post operative period if patient is not able to provide information at this stage).	To allow identification of diabetes self-management education needs prior to discharge (ADA, 2022)		
Assess for risk of pre-existing complications of diabetes using appropriate risk assessment tool e.g., ischaemic heart disease, autonomic neuropathy, renal failure. Alert surgeon and anaesthetist in the presence of such scenario.	Pre-existing complications of diabetes may be present which put the patient at higher risk of peri-operative complications.		
Assess normal diabetes regime for this patient and establish when medications were last taken			
Set target glycaemic levels for the patient. Target of 4.4–10.0 mmol/L) is recommendable in this scenario.	This is the target glycaemic range suitable for persons during the perioperatieve period. Hyperglycaemia increases the risk of negative post-surgical outcomes (ADA, 2022). Avoid stringent control of blood glucose levels due to the risk of hypoglycaemia (ADA, 2022).		
If/when patient is fasting initiate:	To achieve target blood glucose levels (ADA, 2022).		

• Blood glucose monitoring every 2-4 hours (ADA, 2022) • Basal insulin and/or basal plus bolus insulin if blood glucose is above target of 10 mmol/ml	To allow for control of blood glucose levels (ADA, 2022).		
Establish if on Metformin, normally withold Metformin on the day of surgery (ADA, 2022).	Metformin increases risk of lactic acidosis due to renal dysfunction in the perioperative period (Sudhakaran and Surani, 2015)		
SGLT2 inhibitors must be discontinued 3–4 days before surgery (if possible); in this scenario discontinue with immediate effect	Due to risk of dehydration (Preiser et al, 2020)		
Do not administer any other oral glucose lowering agents prior to surgery without clarification	To avoid risk of hypoglycaemia (ADA, 2022)		
Give half of intermediate acting insulin dose if patient was receiving insulin prior to surgery	To avoid risk of hypoglycaemia (ADA, 2022)		
Use clinical judgement with regards to continuation of GLP-1 receptor agonists or ultra-long-acting insulin analogs on glycaemic control	No evidence available to date on the effects of GLP-1 receptor agonists or ultra-long-acting insulin analogs on glycaemic control (ADA, 2022)		
Answer guide post op period			
Key priorities	**Justification**		
Maintain glycaemic target of 4.4–10.0 mmol/L	Whilst patient is still nil by mouth use basal insulin to control blood glucose levels (ADA, 2022)		

Avoid use of sliding scale insulin administration	Basal-bolus insulin has been shown to improve glycemic control and decrease complications compared to sliding scale (i.e., insulin adminstration in response to blood glucose level) in patients with type 2 diabetes undergoing surgery.		
Recommence usual diabetes management medications once the patient is able to eat.	To return to normal routine blood glucose management and achieve glucose control prior to discharge.		
Assess diabetes self-management and behaviour if not assessed in preoperative period.	To allow identification of diabetes self-management education needs prior to discharge (ADA, 2022)		
Answer guide Prior to discharge/rehabilitation			
Key priorities	**Justification**		
Provide structured information and ensure understanding by the patient and any family members or friends prior to discharge in relation to: • Follow-up needs must be communicated to the patients' diabetologist or diabetes specialist nurse. • Provide discharge note to the patient's general practitioner following discharge • Schedule follow-up appointments prior to discharge and communicate this to the patient and/or family	Increases likelihood that the patient will attend follow up visits on an outpatients basis (ADA, 2022). Structured patient education has been shown to provide improved behavioural outcomes and glycaemic control (APA, 2022). Providing transitional care and education has been shown to decrease the risk of readmission in persons living with diabetes (APA, 2022).		

members/primary carers.			
Review the following areas of patient knowledge and address them prior to discharge (APA, 2022): • The name of the health professional who will be following up the patient after discharge. • Level of understanding related to diabetes diagnosis, self-monitoring of blood glucose, target blood glucose levels. • When to seek professional help and how. • How to prevent, recognise and manage hyperglycemia and hypoglycemia. • How to make healthy food choices at home and referral to an outpatient registered dietitian nutritionist to guide individualization of the meal plan, if needed (refer	Social norms are important in providing support to the patient in making behavioural changes. Particular cultural and religious practices and social circumstances may challenge the ability to self-manage diabetes effectively and achieve glycaemic targets. This puts the person at risk of the complications of diabetes. Behavioural recommendations need to be peson-centred and take the individual's habits, resources and preferences into account		

to dietitian if needed). • Exercise in the context of the patient's physical abilities. • Involve immediate family in relation to behavioural change. • If relevant, when and how to take blood glucose–lowering medications, including insulin administration if appropriate. • Assess for particular needs if the patient belongs to a vulnerable group in relation to management of type 2 diabetes e.g. if the patient has a low income inhibiting appropriate dietary choices, lack of appropriate accomodation and availability of resources: Homeless individuals, persons in detention, persons living in migrant centres, persons with intellectual			

impariments, visual impairment, lack of social support systems. • Advice on local entitlements / benefits / social insurance. • Self amangement advice when feeling unwell • Proper use and disposal of needles, if using insulin. Assess for special educational needs of the patient based on cultural or religious background e.g. particular food preferences and cultural habits such as participating in festivities, fasting in persons with diabetes during Ramadan. Refer to available guidelines in relation to managing blood glucose in such contexts e.g. Hassanein et al. (2021).			

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NURSING

Answer guide for level 7 cardioversion question for the written exam long answer question

	Noted	Expanded

Types
- Pharmacological
- Electrical

Goals
- Disrupt the abnormal electrical impulses in the heart and to restore a normal heart beat.

DCC Definition
- Synchronized direct current electrical shock is delivered to the heart through the chest wall using special electrodes or paddles that are applied to the skin of the chest and back. DC electrical discharge is synchronised with the R or S (myocardial contraction) wave of the QRS complex.

Indications
- where cardiac arrhythmia is causing haemodynamic symptoms

Contraindications
- not anti-coagulated (if > 48 hours)
- unstable arrhythmia
- multiple previous cardioversion failures
- asymptomatic arrhythmia
- severe co-morbidities, digoxin toxicity, major atrial dilatation, severe electrolyte imbalance, untreated hyperthyroidism

Atrial Fibrillation
- Most frequently diagnosed arrhythmia
- Loss of organized atrial contraction
- S&S => asymptomatic, or palpitations, chest pain, dizziness, weakness, CCF, dyspnoea, breathlessness
- Causes / risk factors => ↑age, ↑BP, IHD/CVD, HF, ↑thyroid, ↓K, Mg, Ca, phaeo, drugs, C_2H_5OH, electrocution,
- Diagnosis => 12 lead ECG
- Complications => stroke, CCF

Anticoagulation
- If AF > 48hours => anticoagulation for min 3/52 before cardioversion +/- TOE

Preparation
- Equipment => monitors, defib&pads, cot side pads, suction, intubation equipment, emergency equipment, emergency drugs, room ready
- Patient => Meet & Greet, explanation/reassurance, answer questions, fasting, consent, bloods, ECG, TOE, pre-op checklist, IV line and fluids, t/f to anaesthetic room, baseline neuro obs and vital signs, ICD/pacemakers

Procedure
- Safe surgery checklist
- Apply monitors
- Defib pads & ECG from defib

- Defib set to “sync”, check markers on R wave
- IV access, IV fluids
- Short acting anaesthetic
- Supplemental O2 => remove for shock
- BVM / LMA when asleep
- Patient not touching anything
- Shock delivered at appropriate energy =ALL CLEAR
- Check patient, rhythm strip, pulse
- Resume ventilation / airway management
- Max 3 shocks if required following procedure above
- Remove pads, check skin

Post procedure

- Transfer to recovery / PACU
- ABC, ensure patient maintaining own airway
- Monitors - BP, ECG, SPO2
- Neuro-obs
- Documentation
- Specific post operative instructions
- ICD / pacemakers
- Return to ward when discharge criteria met
- (12 lead ECG on ward to confirm rhythm)

Potential Complications

- Embolic event (stroke). Monitor FAST, neurological observations, actions if stroke suspected
- Post-cardioversion cardiac dysrhythmias. VF/VT, asystole. ACLS protocol
- Respiratory Depression - associated with (short-acting) anaesthesia
- Electrical injuries to health care providers
- Soft tissue injury / burns. Treatment depending on severity: cold compress, cream, ointment, dressing. Incident form, notify team
- Pain
- Unsuccessful cardioversion

Miscellaneous

- References
- Evidence to support practice
- Relate theory to practice
- Overall attention to patient care
- Organisation of answer

NURSING

Example of Good Practice: Competence statement: Level 6 **State competence: PROFESSIONAL VALUES AND THE ROLE OF THE NURSE** **Standard: Scope of Practice: registered nurse** **Drawing on Reflective Practice Skills Competence 5**
Taken from Dimension 1: PROFESSIONAL VALUES AND THE ROLE OF THE NURSE
1. Practices within the context of professional, ethical, regulatory, and legal codes, and responds appropriately to moral/ethical issues in day-to-day practice. 2. Practices in a holistic, tolerant, non-judgmental, caring, and culturally sensitive manner, ensuring that the rights, beliefs and wishes of different individuals and groups are not compromised. 3. Educates, facilitates, supports, promotes, and encourages the health, well-being and comfort of populations, communities, groups, families, and individuals whose lives are affected by ill health, distress, disease, disability, or death. 4. Within the scope of their professional practice and accountability, is aware of the different roles, responsibilities, and functions of a nurse responding effectively to population/patient needs and challenging current systems when necessary and appropriate. 5. Accepts responsibility for their own professional development and learning, using evaluation to reflect and improve upon on their performance so as to enhance the quality of service delivery. 6. Justifies and articulates relevant evidence that underpins to their professional practice
Requires application of competencies: theoretically and practically
A theoretical example using a Case study approach: *Reflection on a positive event in clinical training* *Based on the experience in clinical practice, please describe and reflect ONE experience (event or situation) in detail and write a reflection on this experience (approx. 800 words).* **Guidelines:** Think about the many events and situations you have experienced or witnessed while performing clinical exercises and choose one (event, situation, moment while performing an activity) that particularly caught your attention, surprised you, or otherwise touched you, e.g. delighted you or aroused compassion, excitement, etc. It does not matter how big or important the event (situation) was, but it is important that the event (situation) touched you - as a student, future graduate nurse, or simply as a human being. Relive the selected event (situation, moment) in your mind and then prepare: a. Description: Briefly describe the event (situation), e.g. what happened, who was involved, what someone did (or should have done, but he did not), how it all ended. what were the consequences, etc.

b. Explanation: Write how you interpret an event or situation, e.g. how did you feel (or did others) feel about the event (situation), what emotions did you feel, what were your feelings, how did you experience the situation, how did the event affect you, what was most importantly, relevant, useful…) aspect of the event or situations in which the event (situation) was typical, whether it differed from other similar events (situations), etc.
c. Lessons learned: Write (based on 'a' and 'b') what lessons you have gained or what you have learned from the event (situation). What did you learn? What did you understand? What would you do if the event (situation) happened again?
Some tips and suggestions for writing a clinical study diary.
-Write regularly, preferably immediately after the experience. If you have very little time, write down key facts and information about the activity or. The event, which will help you write the rest of the entry later.
-When writing, focus on the experience (activity, event, situation) that you find most important for your learning in clinical practice or that in some way marked that hour the most. As a rule, start the entry with a short description of the activity or event, followed by your feelings, thoughts, and insights from/after the experience.
-Write as naturally as possible, be clear and specific, sentences should not be too long. Basically, writing a reflection is a kind of conversation with yourself based on the experience you have experienced. Write openly and be honest with yourself and others.

Practice based assessment:

Clinical supervisor assesses nursing students' application of Code of ethics – ethical and moral principles during clinical training using predetermined criteria:

- attitudes towards patients, their relatives and families
- honesty, reliability, punctuality, acceptance of responsibility
- ensuring patient safety

Clinical supervisors assess nursing students on a scale 1 (Insufficient) to 10 (Excellent) how he/she perceives nursing students' application of ethical principles in their practice. Assessment is a part of the clinical evaluation form which includes also other aspects (the assessment of interpersonal relations and communication skills and assessment of nursing activities).

Good practice example from University of Maribor Faculty of Health Sciences

Example of Reflection on positive event

Description: At the end of the meal sharing, nursing staff usually gather in the extended part of the hallway, chats and eats undistributed meals. At breakfast, I first helped feed the elderly who need help, but when I finished my work I joined the rest of the staff, however I didn't eat. All the patients had food distributed, and most of the staff had already had breakfast, only a few caregivers still provided assistance to the elderly. One of the nurses noticed that Mrs. who is usually eating alone, without help is not at her best. She asked me if I would be willing to help her. ***We could frame a question: What would you do next?*** *I immediately approached the elderly woman and asked her how she was feeling. She said that she is feeling weak, so I helped her take a position more suitable for feeding and lifted her up headboard. When I wanted to start feeding her, the old woman resisted, saying that she would do it on her own. I asked her if she was sure and that I could help her if she wasn't really feeling well today. Once again, she told me not to worry about*

her, that I should rather join the rest of the staff and also take something to eat. I assured her that I would be happy to help her, that this was my task after all, at the same time I reassured her not to worry about me, since I already had breakfast at home. When she heard my assurances that she was not a burden to me gratefully accepted my help. She thanked me many times for helping her. At the end of the feeding, she thanked me again for her help and because I was so patient and kind.

Explanation: My feelings at the event were mixed. I was pleased to feel useful, I made someone's morning easier and more beautiful, I was touched by the fact that the elderly woman was concerned of me. It seems to me that the caregivers are perceived by many as a piece of furniture, as a tool to meet their needs, and this elderly woman also saw me as a person who need care. At the same time, I was a little sad that the elderly woman refused my help at first, not because she wouldn't need it but because she felt like a burden. I was angry that she thanked me so many times, especially since I didn't offer her any great help, I just did my job. I was concerned that her excessive gratitude was the result of some negative previous experience, when staff did not treat her properly, did not help her, or were rude to her. Lessons learned: After thinking about the event, I realized that the elderly and nursing staff are very connected in an intimate and reciprocal way. Many have known each other for years and years, most nursing staff carefully observes person *he or she takes care and monitors their daily well-being. They know them so well to notice deviations in behaviour and respond to them. They are ready to help them before the elderly ask for it. At the same time, many elderly are cared for by staff. Together they are like an extended family with their rules and dynamics, they know they need each other and that with some understanding their day will be better. This is something I would like to integrate into my own as well in my future work.*

Example of Reflection on positive event

Description: Clinical exercises at the faculty reminded me of my first exercises in secondary school in the retirement home in Ljubljana. Feelings at the entrance and the meeting were similar, except that the second time there was no initial tremor when meeting with patients, the elderly. The second day of clinical exercises impressed me the most. In the morning I did care with nursing assistant, who was in charge while I was assisting her. I quietly participated and observed her way of working and how she relates to the elderly during work. Throughout the work, she was smiling, was cheerful and had positive towards the home residents. In the last room we were in, I was touched a little differently and I ponder on the situation a little then. Upon arriving at the room, she greeted the elderly man, took him by the shoulder and started talking to him, I had a feeling like they had known each other for many years and they were friends. During their short conversation, I stood by the door and just watched and thought about them. I thought about how we humans are generally superficial, fast, and often insensitive to certain things, both in health care and beyond. I notice that there is less and less empathy and genuine relationships in our work and that we look at people as numbers and not as beings similar to us and in need of attention. Every person would like and want to be independent and independent of others, but life and age change things, so health professionals should not judge. We should not be mostly difficult or rude to the elderly, or also closed in on our self's but on the contrary, we should not run away from our emotions and we should largely show our emotions to patients so they can feel the warmth, friendly human warmth, and not just to see a person in a uniform. I feel as if we (most) don't think the quality is important, but the quantity, how much we did and not how we did something ... I thought about this event for a few days after it and also wondered if we will ever achieve virtues of 'good person' and establish a new patient-staff relations. What I have seen is a rarity in healthcare but in my opinion it is the key to successful nursing with all other expertise and I am of the opinion that when we move this boundary we will also push the boundaries of overall nursing at the global level.

Explanation: I continued to behave similarly to nursing assistants when I continued to work, and above all I was impressed by the fact that during the work I felt positive energy, which was also felt by the patients I cared for. I am glad that I was inspired and that it led to my friendly relationship. The whole staff surprised me as I saw how well they work together and how most of them pay attention to the elderly, but I was extremely pleased with myself as I am aware that I was a great help to them. It seems important to me or it is useful that I have experienced this and that it has touched me, as the experience I have gained will come in handy in the future when I do this work myself. In my opinion, in addition to compassion for patients, compassion for their colleagues is also important. In order to perform the work better, it is necessary to meet several factors, such as; good positive energy, good relationship between the team, friendly warm attitude towards patients and above all tidy work space and precision in performing work and especially affection for the patient, to be kind and simply be human. The experience is a bit special or a bit atypical in a positive sense, as it is not necessary that there is always positive energy and such kindness to the patient, which should be almost everyday.
Lessons learned: Each clinical training brings something of its own and from each exercise and each encounter I learn something new and carry it with me forward into my future practice and work. Empathy, kindness is something I carry within me as a person and I also try to transfer that into my work. The situation that happened to me during the clinical exercises definitely impressed me and let me know how beautiful and important the above written qualities are in our work, both for us and for the sick and in need of help. I will always try to remember that when I have a bad day, I don't need to be in a bad mood.

Technical content indicators/criteria/ tools: NPVS-R (Weis & Shank, 2009) or NPVS-3 (Weis & Shank, 2017) could be used.
Students can also use one of several 'Reflective Practice' Models to frame their answers (Gibbs, Boud etc). This is adaptable for both Level 6 and Level 7 studies at nursing student and post graduate level.

References

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Literature on Reflective Practice- especially in Nursing.

Example of Good Practice: Competence statement: Level 6
Scope of Practice: role of registered nurse
Dimension 2 Nursing Practice and Clinical Decision Making
(includes Knowledge and Cognitive Competences Dimension 3)

Competence 9. Recognises and interprets signs of normal and changing health/ill health, distress, or disability in the person (assessment/diagnosis).

14 Can critically evaluate and apply current and relevant knowledge of the following and can appropriately apply this knowledge to nursing practice, patient care, and situations of uncertainty:

a) Theories of nursing and nursing practice
b) Theories and views concerning the nature and challenges of Professional practice
c) Natural and life sciences
d) Social, health and behavioural sciences
e) Ethics, law and humanities
f) Technology and health care informatics
g) International and national policies
h) Problem solving, decision making and managing tension or conflict
i) Theories of personal and professional development

15. Appropriately applies and utilises understanding of the research to apply evidence to practice.

Requires application of aspects of Dimension 1 Professional Values and the Role of the Nurse:
Competence 2 Practices in a holistic, tolerant, non-judgmental, caring, and culturally sensitive manner, ensuring that the rights, beliefs, and wishes of different individuals and groups are not compromised.
Requires application of aspects of Dimension 4 Communication and interpersonal competences:
Competence 16- Communicates effectively with patients, families, and social groups, including those with communication difficulties.
Competence 20: Accurately reports, records, and refers care using appropriate terminology, technology and systems.
Requires application of aspects of Dimension 2 Knowledge and cognition – as above

Requires application of aspects of Dimension 2 Nursing Practice and Clinical Decision Making :
Competence 7: Undertakes comprehensive and systematic patient assessments using appropriate tools/frameworks, while considering relevant physical, social, cultural, psychological, spiritual and environmental factors

Theoretical assessment examples using a scenario :

1) **Examination Essay: of 1 hour**.
2) **Case study approach:** Simulation laboratory with patient case
   - How to assess the scenario case
   - Relate to scenario

Practice based assessment: Observation of interaction with patient in clinical setting

Good practice example from Tampere University of Applied Sciences

Emergency center gives a task D774. Address XXX. Additional information in the screen: Homecare nurse has call additional help to evaluate the condition of the client. She is a 85 years of woman. She lives alone and the home care nurse feels that she is not well. Situation: home care nurse opens the door and ask for evaluation. She tells that the Mrs is more tired than before. It is 21.05 and the nurse should be with the next client in 10 minutes time. Mrs is laying in bed. She tells when asked that she does not have any pain and she is feeling ok. She has DM2 and Alzheimers.

Technical content indicators/criteria/ tools

National assessment tool for nurse paramedics (in Finnish) Based on Walter Tavares et al. *Global Rating Scale for the Assessment of Paramedic Clinical Competence 2012*, Society for Prehospital Educators of Canada

References

Bjørk I T & Hamilton GA (2011) Clinical Decision Making of Nurses Working in Hospital Settings. Nursing Research and Practice, Article ID 524918. Doi: 10.1155/2011/524918

Carvalho EC, Oliveira-Kumakura ARS, Morais SCRV (2017) Clinical reasoning in nursing: teaching strategies and assessment tools. Rev Bras Enferm 70(3) 662-668. Doi:10.1590/0034-7167-2016-0509

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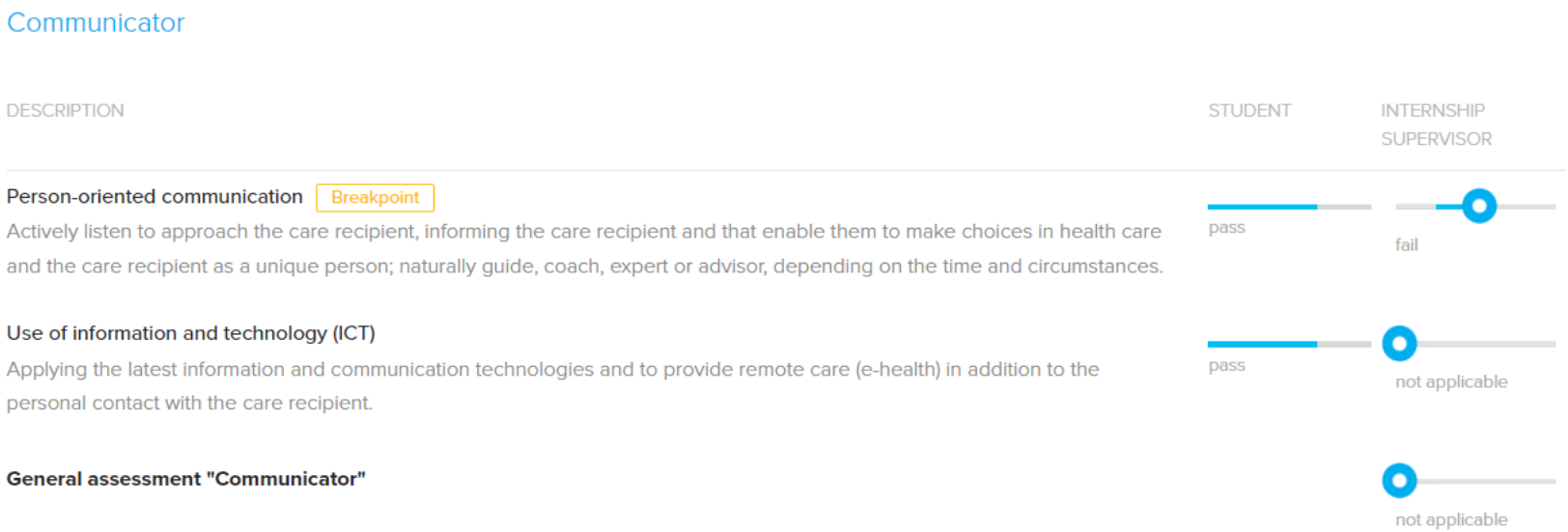
Example of Good Practice: Competence statement: Level 6 Scope of Practice: role of registered nurse
Taken from Dimension 4: Communication and interpersonal competences
16. Communicates effectively with patients, families, and social groups, including those with communication difficulties.
17. Enables patients and their carers to express their concerns and worries and responds according to their emotional, social, psychological, spiritual, cultural, or physical needs.
18. Within the context of relevant legislation, appropriately represents the patient's perspective and acts to prevent harm and abuse.
19. Uses a range of communication techniques to promote patient well-being. For example the ability to appropriately: a a) identify and manage challenging behaviour b) recognise and manage anxiety, stress and depression; c) give emotional support and identify when specialist counselling or other interventions are needed d) identify opportunities for health promotion and health education activities
20. Accurately reports, records, and refers care using appropriate terminology, technology and classification systems.
Requires application (e.g. Bloom's taxonomy level 3 min) should be assessed theoretically and in practice.
Theoretical assessment examples using a scenario: **Examination Essay: of 1 hour assessing competences 16, 17, 19** Mrs X, aged 72 with early stages of dementia is admitted to the hospital unit for elective surgery (hip replacement) due to (osteoarthritis). You are on duty from 0730 until 1700 and **responsible for preparing the patient for her operation at 1200**. Using an evidence-based approach, explain what you would say and how you would communicate the pre-op requirements to Mrs. X for her surgery at 1200. Which techniques will you use and what are the specific points of attention required in her case? **Case study approach: assessing competences 16, 18 and 20** Following your surgical placement, write a critical evaluation of a day surgical patient's journey from admission to safe discharge home. **Select a patient that was anxious or had a barrier to communication**. Explain this barrier and how it affected your communication with the patient. What was the impact on patient experience and patient safety? Any pre-admission assessments to be included (2000 words or annotated care plan).
Practice based assessment:
Observation in practice/assessment by clinical teacher/mentor including student self-assessment.

E.g. Assessing students **communication in practice** (with thanks to the department of Nurse Education, Faculty of Health, Odisee University College, Belgium). **Competence 16**, **17**, **18**, and **20**



The student, the mentor and placement supervisor score the student on each aspect (person-oriented communication and ICT) and the supervisor gives a global score for communicator. The options are

- not applicable
- extremely weak
- fail
- pass
- excellent

For an N/A, weak or fail a comment is mandatory
This is assessed at midpoint and the end of the placement.

Assessing skills of therapeutic communication techniques - simulation centre (with thanks to the Faculty of Health Sciences, university of Maribor)
These scenarios can be augmented by adding other details concerning the patient and their background/health status

Scenario A (In the nursing home in two-bedroom): **Competences 16, 17, 19 and 20**

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The 72-year old man is napping in bed in a sitting position. The lunch tray is intact on the nightstand. The nurse comes into the room and says, "Didn't you eat anything?"
The patient's first response is: "Oh, there is no need to bother with me. I have nothing to live for, anyway."
Your task is to respond to the patient therapeutically. After the conversation note what you would document in the patient file including a plan for further action?

Lecturers assess skills: active listening, responding, paraphrasing, directing the conversation, summarizing (avoid false reassurance, shutting the patient down etc)
Lecturers assess nonverbal skills: therapeutic touch, silence, reducing physical distance
Lecturers assess what is noted in the patient chart: clear description, non-judgemental language, nursing diagnosis, referals/plan

Scenario B (hospital, oncological ward)
53-year old woman is admitted to the hospital. She is diagnosed with stage 1 breast cancer. The doctor explains that her treatment will comprise surgery followed by radiotherapy. In the waiting room before going home, she becomes visibly upset. You are the nurse running the clinic and you notice that she looks uncertain. You take her to a private room and start a conversation using therapeutic communication skills. The woman says she is not sure if these are the right approaches to treat her. How do you proceed?

Lecturers assess skills: active listening, restating, paraphrasing, directing the conversation, focusing, accepting, seeking clarification, giving broad openings, encouraging the patient to express feelings, respecting the patient's personal values, beliefs, using open-ended questions, summarizing.
Lecturers assess nonverbal skills: therapeutic touch, silence, reducing physical distance, facial expressions, body language, eye contact

A standardised tool 'the ICAS Interpersonal Communication Assessment Scale (Klakovich & De la Cruz 2006) is a possible tool to use for assessment of scenarios

Scenario 3 in the NURSKit developed by the iSPAD (Innovative - Simulation Pedagogy for Academic Development) project was developed by educators from 10 European countries. The scenario is aimed at graduating students and tests complex communication amongst other aspects. This could be used for other dimensions too. The scenario is broad and designed also as a teaching tool but could be adapted to demonstrate competence in an OSCE type scenario. Link to NURS-kit: 3 Complex Care in the end of life facilitator's guide available at.
https://www.um.edu.mt/projects/ispad/wp-content/uploads/2019/08/NURS-Kit-3.2.pdf

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ICASExam version.pdf

Examination Copy Only—Do not duplicate

In **column 1** below are listed the interpersonal communication behaviors expected of undergraduate and graduate nursing students.

In **column 2**, please circle the number that reflects the level of effectiveness of your student's interpersonal communication behavior by using the following scale: ***1 = seldom, 2 = often, 3 = usually, 4 = almost always***

COLUMN 1	COLUMN 2
Interpersonal Communication Behaviors	**Effectiveness**
1. Gives clear instructions on management of condition.	1 2 3 4
2. Uses behavioral descriptions instead of judgments about the patient/family to give feedback.	1 2 3 4
3. Encourages patient/family members to express reactions to care and treatments.	1 2 3 4
4. Provides referrals when necessary.	1 2 3 4
5. Uses specific questions to gather detail about a potential problem area.	1 2 3 4
6. Demonstrates behaviors (such as eye contact, touching) when communicating if appropriate to situation and acceptable to the other person's cultural background.	1 2 3 4
7. Asks for confirmation of own perceptions.	1 2 3 4
8. States discrepancies in information provided by patient and family during interview.	1 2 3 4
9. Asks for clarification.	1 2 3 4
10. Detects inconsistency between verbal and non-verbal communication.	1 2 3 4
11. Invites patient and family to explore discrepancies of information.	1 2 3 4
12. Prepares patient/family for procedures by explaining the process and reasons before occurrence.	1 2 3 4
13. Gives descriptive feedback indicating broad observations of content, feelings, and process.	1 2 3 4
14. Acknowledges concerns of patient and family members as important.	1 2 3 4
15. Requests consultation when needed.	1 2 3 4
16. Identifies indications of patient/family member need for emotional support.	1 2 3 4
17. Teaches and promotes preventive health care.	1 2 3 4
18. Explains to patient/family varied treatment options.	1 2 3 4
19. Spends time with patient and family members to listen to their concerns and problems.	1 2 3 4
20. Questions decision not to take needed action or to discontinue needed treatment.	1 2 3 4
21. Facial expressions match the context of the conversation.	1 2 3 4
22. Maintains distance and space suitable to the other person's cultural background while talking with patient/family members.	1 2 3 4
23. Initiates a conversation with patient/family member who is usually silent.	1 2 3 4

Dimension 5: Leadership, management and team competences

Dimension 5 focuses on leadership, management and team competences. These integrated competences focus on: 1) development and achievement; 2) the ability to guide and direct, motivate and empower others in interdisciplinary co-operation; 3) critical, strategic, innovative and financial thinking; 4) ethics and professionalism; 5) policy and advocacy.

A number of different tools and strategies for assessment of these different areas have been developed and are available for use. The various assessment tools which focus on leadership, management and team competences are summarised in table 5.1. A review of this table indicates that the strategies used include team Objective Structured Clinical Examinations (e.g. Marshall et al. 2008; Curran et al., 2011; Lie et al. 2015), practice-based assessments which include peer and self-assessment (e.g. Hayward et al. 2014, Humphries et al. 2018), the use of role-play in simulated settings (e.g. Gonzalez-Marcos et al. 2016) and the use of a self-rating scale (e.g. Mann et al. 2021). The use of self-assessment or scoring is the most widely available strategy available for assessment of leadership, management and teamwork (e.g. Sakai et al. 2017; Shillam 2018; Bryant et al. 2021).

The content focus of these assessment tools include competence in relation to the components of interprofessional collaboration and team work (e.g. Curran et al.; Lie et al., 2015; Marshall et al., 2008; Humphrey's et al. 2018; Sakai et al. 2017), the ability to motivate, assist in the development of others, negotiate and resolve conflict (e.g. Humphrey's et al. 2018; Gonzalez-Marcos et al. 2016) as well as other characteristics of leadership including integrity, the ability to influence others and authenticity (Shillam et al. 2018; Bryant et al. 2021; Mann et al. 2021). Whilst these assessment tools cover a variety of leadership and management characteristics, the characteristics which receive most importance in these assessment scales, are interprofessional collaboration and effective communication.

In view of the different content and strategies proposed by these assessment tools, it is recommended that individual educational institutions should use different tools of different content and utilising different assessment strategies to obtain a comprehensive assessment of students as they develop their leadership, management and team competence over their years of studies. This choice will also require an evaluation of the resource availability in the different institutions as some assessment methods, such as the team objective structured clinical evaluates are more resource intensive than others, such as self-assessment scales. It must be remembered however that self-assessment scales may not be reliable and therefore the use of concurrent peer assessment may be the most recommendable method to assess this Dimension.

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Table 5.1 Summary of Assessment Tools for Leadership, Management and Team Competences.

Reference	**Assessment methods for theoretical/practical learning**	**Validated tools?** **Reliability?** **Specific competence/skill?**	**What to avoid?**	**Comments-** e.g. cost effectiveness, user friendly Requires high level of assessor training
Curran et al. 2011 Curran ICAR	Team Objective Structured Clinical Examination (TOSCE)	**Interprofessional Collaborator Assessment Rubric** has been developed for usage across different health professional education programs. <u>Subdimensions of Core competence:</u> 1. Communication 2. Collaboration 3. Roles and Responsibility 4. Collaborative Patient/Client-Family Centred Approach 5. Team Functioning 6. Conflict Management/Resolution	The relative standing of students may vary from evaluator to evaluator. Requires higher number of examiners per station.	TOSCE format is quite feasible For interprofessional collaborative competencies of learners at both formative and summative levels. Both interprofessional groups (medical, nursing, social work students) and uni-professional groups (role-play the roles of other team members). The methodology is logistically challenging, resource-intensive, both time-consuming and human resources
Lie et al. 2015 Marshall et al. 2008		Modified McMaster-Ottawa scale for rating individual students, with instructions for 3-point scoring (below expected, at expected, above expected) Interprofessional team-work - reliability and validity data demonstrate the effectiveness of this evaluation methodology. Both students and evaluators (79–100%) agreed or strongly agreed that the TOSCE format was feasible	The relative standing of students may vary from rater to rater.	
Hayward et al. (2014)	ICAR in Multi-source feedback (MSF)	360-degree assessment for workplace-based assessment. Self-assessment and evidence on performance in the workplace can be collected from multiple sources (colleagues, peers, different healthcare workers and patients)		Prefer for formative assessment. Less used for nurses, more for doctors

Humphreys et al. 2018	Trainee Perceived Leadership Competence (TPLC) Self-assessment *On the example of* ***Maternal and Child Health (MCH)***	Collaboration and leadership within interdisciplinary teams. Full description of the development of the Specialist Leadership Competencies are needed. MCH Leadership Competencies Self-Assessment measure based on the 72 skills, which LEND trainees complete as a process measure at multiple time points during the training year <u>Leadership Competences areas conceptual framework</u> **Self:** 1) special needs knowledge base; 2) Self-reflection; 3) Ethics and professionalism; 4) Critical thinking. **Others:** 1) Communication—working with others; 2) Negotiation and conflict resolution; 3) Cultural competence;4) Family-centered services and supports; 5) Developing others through teaching and mentoring; 6) Interdisciplinary team building. **Wider community**: 1) Working with communities and systems; 2) Policy and advocacy.	Is criticized for a lack of accuracy and bias towards positive self-portrayals	The basis for preparing MCH competencies is the Leadership Education in Neurodevelopmental Disabilities (LEND) programs. Trainees are required to complete a minimum of 300 h of didactic instruction, clinical training, and leadership skill development over a 9-month academic year.
Gonzalez-Marcos et al. 2016	Role play in project management - self-assessment and peer-assessment during learning process (on a process level) in a simulation environment	**Specific competences:** negotiation; results orientation and motivation; leadership and teamwork; communication; resources and quality assessment, risk and opportunity assessment and some more. Numerical assessment of competence level in different roles and different weights for different competence clusters. The method increases decision criteria transparency because of the specific forms and tools that are used.	Depends on the ICT environment	Specific tools and forms that are well integrated and competence-centric help students learning. Used in a learning environment with different levels of degrees (bachelor's and master's)
Sakai et al. 2017	The Chiba Interprofessional Competency Scale (CICS29) Self-evaluation scale used in IPE	Competence for interprofessional collaboration consists of six domains: 1) respecting patient, 2) team management, 3) professional role, 4) attitudes and beliefs as a profession, 5) attitudes which improve the cohesion of the team, 6) actions for accomplishing team goals. Self-assessment scale allows to evaluate collaborative awareness and activities through 29 items.	A certain subjectivity of self-evaluation must be taken into account	Allows to evaluate collaboration among all health professionals, is not limited to specific professionals.

Tonarelli et al. 2020 Soemantri et al. 2019	Italian version of CICS29 Indonesian version of the CICS29	Reliability and construct validity has been confirmed. Reliability of the sub-constructs varied from .66 and .77. (Sakai et al. 2017) '*The Italian version of CICS29 has a satisfactory level of reliability and validity and it is recommended for measuring interprofessional collaboration of the health professionals*' (Tonarelli et al. 2020). Reliability of the sub-constructs varied from .62 and .78		Scale is short enough, easy to understand and full.
Shillam et al. 2018	Development of the Leadership Influence Self- Assessment (LISA©) instrument	80 items in 4 factors: *Status* (18 items, Cronbach's alpha = 0.932), *Authority* (25 items, Cronbach's alpha = 0.938), *Strategy* (14 items Cronbach's alpha = 0.916), and *Integrity* (23 items, Cronbach's alpha = 0.912).	Caution required due to self-assessment	Based on self-assessment; good validity and internal reliability
Bryant et al. 2021	Self-assessment tool designed to evaluate leaders' self-assessed ability to influence.	Leadership Influence Self-Assessment (LISA©) instrument (Shillam et al., 2018).		Suitable for aspiring, emerging and middle level leaders
Mann et al. 2021	Resilience at Work Leader 180 Scale provides insight into leader behaviours that foster or detract from employee resilience	Self-rating and rating by direct report employees 40 item scale divided into 22 subgroupings in 7 components: • Living authentically • Finding your calling • Maintaining perspective • Managing stress • Interacting cooperatively • Staying Healthy • Building Networks Content validity tested		Difference identified between self-report and report from others.

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Appendix 1. Revised Subject Area Specific Competences – Nursing Level 6

Bachelors Level including practice-based competences version 2023

Please note the term 'patient' is used as an inclusive term to refer to the child, adult or older person

Competences 2023
Dimension 1: The professional values and the role of the nurse
1. Practices within the context of professional, ethical, regulatory, and legal codes, and responds appropriately to moral/ethical issues in day-to-day practice. 2. Practices in a holistic, tolerant, non-judgmental, caring, and culturally sensitive manner, ensuring that the rights, beliefs and wishes of different individuals and groups are not compromised. 3. Educates, facilitates, supports, promotes, and encourages the health, well-being and comfort of populations, communities, groups, families, and individuals whose lives are affected by ill health, distress, disease, disability, or death. 4. Within the scope of their professional practice and accountability, is aware of the different roles, responsibilities, and functions of a nurse responding effectively to population/patient needs and challenging current systems when necessary and appropriate. 5. Accepts responsibility for their own professional development and learning, using evaluation to reflect and improve upon on their performance so as to enhance the quality of service delivery. 6. Justifies and articulates relevant evidence that underpins to their professional practice
Dimension 2: Nursing practice and clinical decision making
7. Undertakes comprehensive and systematic patient assessments using appropriate tools/frameworks, while considering relevant physical, social, cultural, psychological, spiritual and environment factors. 8. Undertakes effective risk assessment and takes appropriate actions. 9. Recognises and interprets signs of normal and changing health/ill health, distress, or disability in the person. 10. Responds to patient needs by planning, delivering, and evaluating appropriate and individualised care working in partnership with the patient, carers, families, and other health/social workers. 11.Ensures quality standards are critically evaluated and evidence based to enhance practice. 12. Uses technology to assess and respond appropriately to patient need. 13. Uses appropriately a range of nursing skills, medical devices/technologies, interventions/ activities to provide optimum care. For example: a. maintains patient dignity, privacy and confidentiality. b. practise principles of health and safety, including moving and handling, infection control; essential first aid and emergency procedures. c. safely administers medicines and other therapies. d. considers emotional, physical and personal care, including meeting the need for comfort, nutrition, personal hygiene and enabling the person to maintain the activities necessary for daily life. e. responds to individuals needs through the life span and health/illness experience e.g., pain, life choices, revalidation, invalidity or when dying. f. informs, educates, and supervise patient/carers and their families.
Dimension 3: Knowledge and cognitive competences

14. Can critically evaluate and apply current and relevant knowledge of the following. Has current and relevant knowledge of the following to nursing practice, patient care and situations of uncertainty: a. Theories of nursing and nursing practice b. Theories and views concerning the nature and challenges of professional practice c. Natural and life sciences d. Social, health, and behavioural sciences e. Ethics, law, and humanities f. Technology and health care informatics g. International and national policies h. Problem solving, decision making and managing tension or conflict i. Theories of personal and professional development 15. Appropriately applies and utilises understanding of research process to apply evidence to practice.
Dimension 4: Communication and interpersonal competences
16. Communicates effectively with patients, families, and social groups, including those with communication difficulties. 17. Enables patients and their carers to express their concerns and worries and responds according to their emotional, social, psychological, spiritual, cultural, or physical needs. 18. Within the context of relevant legislation, appropriately represents the patient's perspective and acts to prevent harm and abuse. 19. Uses a range of communication techniques to promote patient well-being. For example, the ability to appropriately: a. identify and manage challenging behaviour; b. recognise and manage anxiety, stress and depression; c. give emotional support and identify when specialist counselling or other interventions are needed d. identify opportunities for health promotion and health education activities 20. Accurately reports, records, and refers care using appropriate terminology, technology, and systems.
Dimension 5: Leadership, management, and team competences
21. Effectively contributes to the health/social care team, and can lead a team, delegating care appropriately and meaningfully. 22. Assesses risk and actively promotes the well-being, security and safety of self and others in the working environment. 23. Improves patient outcomes and experience of care through the critical use of relevant data. 24. Educates, facilitates, supervises, and assesses nursing students and other learners in the working environment. 25. Takes account of the impact of resources upon the well-being of people, sustainability, and environment

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Appendix 2 Revised Subject Area Specific Competences – Nursing Level 7

Masters Level including practice-based competences version 2023

Please note the term 'patient' is used as an inclusive term to refer to the child, adult or older person

Competences 2023
Dimension 1: The professional values and the role of the nurse
1.Practises within the context of professional, ethical, regulatory, and legal codes, and responding to moral/ethical dilemmas and issues in daily practice and the public space.
2. Practises in a holistic, tolerant, non-judgmental, caring, and sensitive manner, ensuring that the rights, beliefs and wishes of different individuals and groups are not compromised.
3. Educates, facilitates, supports, promotes, and encourages the health, well-being and comfort of populations, communities, groups, families, and individuals whose lives are affected by ill health, distress, disease, disability, or death.
4. Demonstrates a critical appreciation of the contemporary, emerging and diverse roles, responsibilities, and functions of a nurse responding effectively to population/patient needs and challenging current systems when necessary and appropriate.
5. Takes responsibility for their own professional development and learning so as to enhance the quality-of-service delivery and patient outcomes.
6. Analyses complex issues from an academic and/or professional nursing perspective.
7. Demonstrates practical insight into the implications and applications of research and evidence-based practice to underpin practice for patient benefit (research ethics, governance, audit).
Dimension 2: Nursing practice and clinical decision-making competences
8. Undertakes comprehensive, holistic, and systematic patient assessments.
9. Initiates, completes, evaluates, and/or supervises complex risk assessments, taking appropriate and timely actions.
10. Plans, delivers, and evaluates care in partnership with the patient, carers, families, and other health/social workers.
11. Critically questions, evaluates, interprets, and synthesises complex information and data sources to facilitate nursing practice and clinical decision-making.
12. Utilises quality standards, relevant theories, and evidence-based practice to inform clinical judgments and actions.
13. Effectively and efficiently utilises an appropriate range of nursing and other skills, medical devices, technologies, interventions, and/or activities to provide optimum care and outcomes for diverse patients across the lifespan.
Dimension 3: Knowledge and cognitive competences
14. Critically appraises and applies contemporary bodies of knowledge that inform nursing practice, including but not limited to: a. Nursing practice and nursing science b. Perspectives on the nature and challenges of professional practice c. Natural, life, social, health, and behavioural sciences d. Ethics, law, and humanities e. Digital health and technology f. International and national policies, trends, and crises g. Problem solving and decision making h. Leadership, change, innovation, and conflict management i. Personal and professional development

15. Develops and maintains detailed, evidence-based, contemporaneous, and comprehensive knowledge and cognitive competencies related to their field of practice and/or patient group.
Dimension 4: Communication and interpersonal competences (including technology for communication)
16. Communicates effectively with patients, families, and groups, including those with complicated communication and intellectual difficulties to ensure optimum care and outcomes.
17. Communicates complex professional and /or and academic issues in nursing and nursing science to specialists, other professional colleagues, and lay people in a clear and unambiguous manner.
18. Effectively employs a range of communication / therapeutic skills for patient well-being and health promotion.
19. Communicates appropriately with patients and carers to sensitively anticipate, and respond to, their concerns, worries, and risks taking account of their emotional, social, psychological, spiritual, cultural, linguistic, or physical needs. For example, patients with: a. challenging behaviour b. anxiety, stress, and depression c. risk factors for or early signs of neglect or abuse d. a need for specialist counselling or other interventions e. a need for health promotion and health education
20. Effectively employs a range of communication skills for patient and staff advocacy and representation.
21. Effectively employs and evaluates a range of communication techniques and digital technologies to comprehensively document, report and/or refer care in the interdisciplinary context
Dimension 5: Leadership, management and team competences
22. Leads the nursing and/or interdisciplinary team, working collaboratively and effectively with nurses, health professionals, policy makers, and, where appropriate, policy makers and other actors in the public space.
23. Contributes to/leads strategy and policy development.
24. Promotes the well-being, security and safety of self and others in the working environment.
25. Promotes quality standards, the safety and well-being of people and the environment through effective and sustainable management of human and other resources.
26. Critically assesses, develops, and uses relevant guidelines, quality standards, tools/data to evaluate and audit care and resources to optimize patient experience and outcomes.
27. Actively promotes a learning organization and environment, supporting students, learners and staff in their professional development.

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Appendix 3. Revised Subject Area Specific Competences – Nursing Level 6 -

Comparison of Subject specific competences: Bachelors Level including practice-based competences version 2023 and 2018

Please note the term 'patient' is used as an inclusive term to refer to the child, adult or older person.

Competences 2023 **Final version**	**Competences 2018**
Dimension 1: The professional values and the role of the nurse 1. Practices within the context of professional, ethical, regulatory, and legal codes, and responds appropriately to moral/ethical issues in day-to-day practice. 2. Practices in a holistic, tolerant, non-judgmental, caring, and culturally sensitive manner, ensuring that the rights, beliefs and wishes of different individuals and groups are not compromised. 3. Educates, facilitates, supports, promotes, and encourages the health, well-being and comfort of populations, communities, groups, families, and individuals whose lives are affected by ill health, distress, disease, disability, or death. 4. Within the scope of their professional practice and accountability, is aware of the different roles, responsibilities, and functions of a nurse responding effectively to population/patient needs and challenging current systems when necessary and appropriate. 5. Accepts responsibility for their own professional development and learning, using evaluation to reflect and improve upon on their performance so as to enhance the quality of service delivery. 6. Justifies and articulates relevant evidence that underpins to their professional practice	**Dimension 1: The professional values and the role of the nurse associated competences** **1** Practices within the context of professional, ethical, regulatory and legal codes, recognising and responding to moral/ethical dilemmas and issues in day to day practice. 2.Practices in a holistic, tolerant, non-judgmental, caring and sensitive manner, ensuring that the rights, beliefs and wishes of different individuals and groups are not compromised. 3. Educates, facilitates, supports, promotes and encourages the health, well-being and comfort of populations, communities, groups, families and individuals whose lives are affected by ill health, distress, disease, disability or death. 4. Within the scope of his/her professional practice and accountability, is aware of the different roles, responsibilities and functions of a nurse, and is able to adjust his/her role to respond effectively to population/patient needs. Where necessary and appropriate is able to challenge current systems to meet population/patient needs. 5. Accepts responsibility for his/her own professional development and learning, using evaluation as a way to reflect and improve upon on his/her performance and to enhance the quality of service delivery. 6. Is able to justify and articulate the relevant theoretical and research underpinnings to their professional practice
Dimension 2: Nursing practice and clinical decision making 7. Undertakes comprehensive and systematic patient assessments using appropriate tools/frameworks, while considering relevant physical, social, cultural, psychological, spiritual and environment factors. 8. Undertakes effective risk assessment and takes appropriate actions.	**Dimension 2: Nursing practice and clinical decision making competences.** 7. Undertakes comprehensive and systematic assessments using the tools/frameworks appropriate to the patient taking into account relevant physical, social, cultural, psychological, spiritual and environment factors. 8. Able to undertake an effective risk assessment and take appropriate actions

9. Recognises and interprets signs of normal and changing health/ill health, distress, or disability in the person. 10. Responds to patient needs by planning, delivering, and evaluating appropriate and individualised care working in partnership with the patient, carers, families, and other health/social workers. 11.Ensures quality standards are critically evaluated and evidence based to enhance practice. 12. Uses technology to assess and respond appropriately to patient need. 13. Uses appropriately a range of nursing skills, medical devices/technologies, interventions/ activities to provide optimum care. For example: a. maintains patient dignity, privacy and confidentiality. b. practise principles of health and safety, including moving and handling, infection control; essential first aid and emergency procedures. c. safely administers medicines and other therapies. d. considers emotional, physical and personal care, including meeting the need for comfort, nutrition, personal hygiene and enabling the person to maintain the activities necessary for daily life. e. responds to individuals needs through the life span and health/illness experience e.g., pain, life choices, revalidation, invalidity or when dying. f. informs, educates, and supervise patient/carers and their families.	9. Able to recognise and interpret signs of normal and changing health/ill health, distress, or disability in the person (assessment/diagnosis). 10. Responds to patient needs by planning, delivering and evaluating appropriate and individualised programmes of care working in partnership with the patient, their carers, families and other health/social workers. 11. Able to critically question, evaluate, interpret and synthesis a range of information and data sources to facilitate patient choice, and to make sound clinical judgments to ensure quality standards are met and practice is evidence based. 12. Able to use modern technologies to assess and respond appropriately to client need (for example through telenursing, multimedia and web based resources) 13. Able to appropriately use a range of nursing skills, medical devices, interventions/activities to provide optimum care. For example: a) maintains patient dignity, privacy and confidentiality; b) practise principles of health and safety, including moving and handling, infection control; essential first aid and emergency procedures; c) safely administers medicines and other therapies; d) considers emotional, physical and personal care, including meeting the need for comfort, nutrition, personal hygiene and enabling the person to maintain the activities necessary for daily life; e) responds to individuals needs through the life span and health/illness experience e.g. pain, life choices, revalidation, invalidity or when dying; f) informs, educates and supervise patient/carers and their families.
Dimension 3: Knowledge and cognitive competences 14. Can critically evaluate and apply current and relevant knowledge of the following Has current and relevant knowledge of the following to nursing practice, patient care and situations of uncertainty:	**Dimension 3: Knowledge and cognitive competences** **14.** Has current and relevant knowledge of the following and can appropriately apply this knowledge to nursing practice, patient care and situations of uncertainty: g) Theories of nursing and nursing practice

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a. Theories of nursing and nursing practice b. Theories and views concerning the nature and challenges of professional practice c. Natural and life sciences d. Social, health, and behavioural sciences e. Ethics, law, and humanities f. Technology and health care informatics g. International and national policies h. Problem solving, decision making and managing tension or conflict i. Theories of personal and professional development 15. Appropriately applies and utilises understanding of research process to apply evidence to practice.	h) Theories and views concerning the nature and challenges of Professional practice i) Natural and life sciences j) Social, health and behavioural sciences k) Ethics, law and humanities l) Technology and health care informatics m) International and national policies n) Problem solving, decision making and managing tension or conflict o) Theories of personal and professional development 15. To have sufficient knowledge of the Research Process and current nursing research, so as to be able to apply this knowledge to clinical practice and other nursing activities and therefore provide nursing care which is rigorous and evidence based.
Dimension 4: Communication and interpersonal competences 16. Communicates effectively with patients, families, and social groups, including those with communication difficulties. 17. Enables patients and their carers to express their concerns and worries and responds according to their emotional, social, psychological, spiritual, cultural, or physical needs. 18. Within the context of relevant legislation, appropriately represents the patient's perspective and acts to prevent harm and abuse. 19. Uses a range of communication techniques to promote patient well-being. For example, the ability to appropriately: a. identify and manage challenging behaviour; b. recognise and manage anxiety, stress and depression; c. give emotional support and identify when specialist counselling or other interventions are needed d. identify opportunities for health promotion and health education activities 20. Accurately reports, records, and refers care using appropriate terminology, technology, and systems.	**Dimension 4: Communication and interpersonal competences (including technology for communication)** **16.** Able to communicate effectively (including the use of new technologies): with patients, families and social groups, including those with communication difficulties. 17. Enables patients and their carers to express their concerns and worries and can respond appropriately e.g. emotional, social, psychological, spiritual or physical. 18. Able to appropriately represent the patient's perspective and act to prevent abuse. 19. Can use a range of communication techniques to promote patient well-being. For example the ability to appropriately: p) use counselling skills; q) identify and manage challenging behaviour; r) recognise and manage anxiety, stress and depression; s) give emotional support and identify when specialist counselling or other interventions are needed identify opportunities for health promotion and health education activities 20. Able to accurately report, record, document and refer care using appropriate technologies.

Dimension 5: Leadership, management, and team competences 21. Effectively contributes to the health/social care team, and can lead a team, delegating care appropriately and meaningfully. 22. Assesses risk and actively promotes the well-being, security and safety of self and others in the working environment. 23. Improves patient outcomes and experience of care through the critical use of relevant data. 24. Educates, facilitates, supervises, and assesses nursing students and other learners in the working environment. 25. Takes account of the impact of resources upon the well-being of people, sustainability, and environment	**Dimension 5: Leadership, management and team competences** **21.** Realises that patient well-being is achieved through the combined resources and collaborative actions of all members of the health/social care team, and is able to lead and co-ordinate a team, delegating care appropriately and meaningfully. **22.** Able to work and communicate collaboratively and effectively with other nurses in the best interests of the patient 23. Able to work and communicate collaboratively and effectively with other members of the interprofessional team in the best interests of the patient. 24. Able to work and communicate collaboratively and effectively with all support staff to prioritise and manage time effectively while quality standards are met. **25.** Able to assess risk and actively promote the well-being, security and safety of all people in the working environment (including themselves). **26** Critically uses tools to evaluate and audit care according to relevant quality standards. 27. Within the clinical context, demonstrates the ability to educate, facilitate, supervise and support nursing students and other health/social care students / workers. **28.** Is aware of the principles of health/social care funding and uses resources effectively**.**

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Appendix 4 : Revised Subject Area Specific Competences – Nursing Level 7 -

Comparison of Subject specific competences: Masters Level including practice-based competences version 2023 and 2018

The term 'patient' is used as an inclusive term to refer to the child, adult or older person.

Competences 2023 Final version	**Competences 2018**
Dimension 1: The professional values and the role of the nurse	**Dimension 1: The professional values and the role of the nurse associated competences**
1.Practices within the context of professional, ethical, regulatory, and legal codes, and responding to moral/ethical dilemmas and issues in daily practice and the public space.	1. Demonstrates the ability to practise within the context of professional, ethical, regulatory and legal codes, recognising and responding to moral/ethical dilemmas and issues in daily practice and the public space.
2. Practices in a holistic, tolerant, non-judgmental, caring, and sensitive manner, ensuring that the rights, beliefs and wishes of different individuals and groups are not compromised.	2. Demonstrates the ability to practise in a holistic, tolerant, non-judgmental, caring and sensitive manner, ensuring that the rights, beliefs and wishes of different individuals and groups are not compromised.
3. Educates, facilitates, supports, promotes, and encourages the health, well-being and comfort of populations, communities, groups, families, and individuals whose lives are affected by ill health, distress, disease, disability, or death.	3. Demonstrates the ability to educate, facilitate, promote, support and encourage the health, wellbeing and comfort of populations, communities, groups and individuals whose lives are affected by, ill death, distress, disease, disability or death.
4. Demonstrates a critical appreciation of the contemporary, emerging and diverse roles, responsibilities, and functions of a nurse responding effectively to population/patient needs and challenging current systems when necessary and appropriate.	4. Demonstrates advanced understanding of the different roles, responsibilities and functions of a nurse, and is able to evaluate and, if appropriate, adjust their role to respond effectively to population/patient needs within the scope of his/her professional practice and accountability.
5. Takes responsibility for their own professional development and learning so as to enhance the quality-of-service delivery and patient outcomes.	5. Demonstrates the ability to accept responsibility for his/her own professional development and learning, using evaluation as a way to reflect and improve upon his/her performance to enhance the quality of service delivery and patient outcomes.
6. Analyses complex issues from an academic and/or professional nursing perspective.	6. Demonstrates the ability to critically evaluate the appropriateness of various methods of analysis and complex issues in nursing and nursing science from an academic and advanced professional nursing perspective
7. Demonstrates practical insight into the implications and applications of research and evidence-based practice to underpin practice for patient benefit (research ethics, governance, audit).	7. Demonstrates specialist understanding that extends academic and professional knowledge and competences gained through Bachelor degree
	8. Demonstrates comprehensive understanding of research work in nursing science and therefore be capable of participating in research.
	9. Demonstrates practical insight into the implications and applications of research and evidence based

	practice to underpin practice for patient benefit (research ethics, governance, audit).
Dimension 2: Nursing practice and clinical decision-making competences	**Dimension 2: Nursing practice and clinical decision making competences**
8. Undertakes comprehensive, holistic, and systematic patient assessments.	10. Demonstrates the ability to undertake advanced and systematic assessments using the tools/frameworks appropriate to the patient taking into account relevant physical, social, cultural, psychological, spiritual and environment factors.
9. Initiates, completes, evaluates, and/or supervises complex risk assessments, taking appropriate and timely actions.	11. Demonstrates the ability to initiate, complete and/or supervise an effective risk assessment and take appropriate actions safely and efficiently at an advanced level.
10. Plans, delivers, and evaluates care in partnership with the patient, carers, families, and other health/social workers.	12. Demonstrates the ability to recognise and interpret signs of normal and changing health/ ill health, distress, or disability in the person (assessment/diagnosis) and take appropriate action safely and efficiently.
11. Critically questions, evaluates, interprets, and synthesises complex information and data sources to facilitate nursing practice and clinical decision-making.	13. Demonstrates the ability to manage patient needs by planning, delivering and evaluating appropriate and individualised programmes of care working in partnership with the patient, their carers, families and other health/social care professionals.
12. Utilises quality standards, relevant theories, and evidence-based practice to inform clinical judgments and actions.	14. Demonstrates the ability to critically question, evaluate, interpret and synthesise complex information and data sources to facilitate patient choice.
13. Effectively and efficiently utilises an appropriate range of nursing and other skills, medical devices, technologies, interventions, and/or activities to provide optimum care and outcomes for diverse patients across the lifespan.	15. Demonstrates the ability to make evidence based clinical judgements to ensure optimum care and outcomes for patients
	16. Demonstrates the ability to use modern technologies to assess, manage and respond appropriately to patient need (for example through telenursing, multimedia and web resources).
	17. Demonstrates the ability to use effectively and efficiently a range of nurse skills, medical devices and interventions/activities to ensure optimum care and outcomes for patients.
	18. Demonstrates the ability to maintain and promote patient dignity, advocacy and confidentiality, using nursing skills, medical devices and interventions/activities to provide optimum patient care,
	19. Demonstrates the ability to practice and promote principles of health and safety for self and others to ensure optimum care, including moving and handling, infection control; essential first aid and emergency procedures,

	20. Demonstrates the ability to safely administer medicines and other therapies effectively while promoting patient compliance.
	21. Demonstrates the ability to assess and manage the emotional, physical and personal care needs of patients, including meeting the need for comfort, nutrition, personal hygiene and enabling the person to maintain the activities necessary for daily life.
	22. Demonstrates the ability to assess and manage patient need throughout the life span and health/illness experience e.g. pain, life choices, revalidation, invalidity or when dying.
	23. Demonstrates the ability to inform, educate and supervise patient/carers and their families to ensure optimum care and outcomes.
	24. Demonstrates the ability to make and justify decisions reflecting on social and ethical responsibilities as well as nursing and nursing science issues and, where appropriate, carry out analysis that results in an adequate basis for decision-making
	25. Demonstrates the ability to comprehend, analyse and evaluate development work based on scholarly, theoretical and / or experimental methods in nursing and nursing science
Dimension 3: Knowledge and cognitive competences	**Dimension 3: Knowledge and cognitive competences**
14. Critically appraises and applies contemporary bodies of knowledge that inform nursing practice, including but not limited to: a. Nursing practice and nursing science b. Perspectives on the nature and challenges of professional practice c. Natural, life, social, health, and behavioural sciences d. Ethics, law, and humanities e. Digital health and technology f. International and national policies, trends, and crises g. Problem solving and decision making h. Leadership, change, innovation, and conflict management i. Personal and professional development	27. Demonstrates advanced knowledge and understanding of the theories of nursing and nursing science that can be appropriately applied to nursing practice, patient care and situations of uncertainty.
15. Develops and maintains detailed, evidence-based, contemporaneous, and comprehensive knowledge and cognitive competencies related to their field of practice and/or patient group.	28. Demonstrates advanced knowledge and understanding of theories concerning the nature and challenge of professional practice that can be appropriately applied to nursing practice, patient care and situations of uncertainty.
	29. Demonstrates the ability to analyse, synthesise and evaluate the natural and life sciences that can be

	appropriately applied to nursing practice, patient care and situations of uncertainty.
	30. Demonstrates the ability to analyse, synthesise and evaluate the social, health and behavioural sciences that can be appropriately applied to nursing practice, patient care and situations of uncertainty.
	31. Demonstrates advanced knowledge and understanding of ethical theory, law and humanities that can be appropriately applied to nursing practice, patient care and situations of uncertainty.
	32. Demonstrates the ability to analyse, synthesise and evaluate use of technology and health care informatics that can be appropriately applied to nursing practice, patient care and situations of uncertainty.
	33. Demonstrates advanced knowledge and understanding of international and national policies that can be appropriately applied to nursing practice, patient care and situations of uncertainty.
	34. Demonstrates the ability to analyse, synthesise and evaluate advanced knowledge and understanding of problem solving, decision making and conflict theories that can be appropriately applied to nursing practice, patient care and situations of uncertainty.
	35. Demonstrates advanced knowledge and understanding of theories related to personal and professional development to enhance own professional practice.
	36. Demonstrates advanced knowledge and understanding of the research process and current nursing research that can be appropriately applied to nursing practice, patient care and situations of uncertainty.
	37. Demonstrates the ability to communicate complex professional and academic issues in nursing and nursing science to both specialists and lay people in a clear and unambiguous manner.
	38. Demonstrates the ability to formulate and analyse complex scholarly issues in nursing and nursing science independently, systematically and critically in the relevant specialisation
	39. Demonstrates the ability to continue own competency development and specialisation in a manner that may be largely self-directed or autonomous
Dimension 4: Communication and interpersonal competences (including technology for communication)	**Dimension 4: Communication and interpersonal competences (including technology for communication)**
16. Communicates effectively with patients, families, and groups, including those with complicated communication and intellectual	40. Demonstrates the ability to communicate effectively (including the use of new technologies) with patients, families and social groups, including those

difficulties to ensure optimum care and outcomes.	with communication difficulties to ensure optimum care and outcomes for patients.
17. Communicates complex professional and /or and academic issues in nursing and nursing science to specialists, other professional colleagues, and lay people in a clear and unambiguous manner.	41. Demonstrates the ability to enable patients and their carers to express their concerns and worries and respond appropriately and collaboratively (e.g. emotional, social, psychological, spiritual or physical worries) to ensure optimum care and outcomes for patients.
18. Effectively employs a range of communication / therapeutic skills for patient well-being and health promotion.	42. Demonstrates the ability to appropriately identify and represent the patient's perspective and act to prevent abuse to ensure optimum care and outcomes for patients.
19. Communicates appropriately with patients and carers to sensitively anticipate, and respond to, their concerns, worries, and risks taking account of their emotional, social, psychological, spiritual, cultural, linguistic, or physical needs. For example, patients with: a. challenging behaviour b. anxiety, stress, and depression c. risk factors for or early signs of neglect or abuse d. a need for specialist counselling or other interventions e. a need for health promotion and health education	43. Demonstrates the ability to appropriately use advanced counselling skills to promote patient wellbeing to ensure optimum care and outcomes for patients.
20. Effectively employs a range of communication skills for patient and staff advocacy and representation.	44. Demonstrates the ability to identify and manage challenging behaviour (using advanced communication techniques to promote patient wellbeing) to ensure optimum care and outcomes for patients.
21. Effectively employs and evaluates a range of communication techniques and digital technologies to comprehensively document, report and/or refer care in the interdisciplinary context	45. Demonstrates the ability to recognise and manage appropriately anxiety, stress and depression (using advanced communication techniques to promote patient wellbeing) to ensure optimum care and outcomes for patients.
	46. Demonstrates the ability to give effective emotional support and identify when specialist counselling or other interventions are needed to ensure optimum care and outcomes for patients.
	47. Demonstrates the ability to identify and use opportunities for health promotion and health education activities at an advanced level to ensure optimum outcomes for patients.
	48. Demonstrates the ability to accurately report, record and document care using appropriate advanced technologies and make referrals when needed to ensure optimum care and outcomes for patients.
Dimension 5: Leadership, management and team competences	**Dimension 5: Leadership, management and team competences**
22. Leads the nursing and/or interdisciplinary team, working collaboratively and effectively with nurses, health professionals, policy makers,	49. Demonstrates the ability to collaborate effectively with all members of the health/social care team to ensure optimum care and outcomes for patients.

and, where appropriate, policy makers and other actors in the public space.	
23. Contributes to/leads strategy and policy development.	50. Demonstrates the ability to lead, adapt and co-ordinate team, delegating appropriately and meaningfully to ensure optimum care and outcomes for patients.
24. Promotes the well-being, security and safety of self and others in the working environment.	51. Demonstrates the ability to work, influence and communicate collaboratively and effectively with other nurses, health professionals, policy makers, and other actors in the public space, to ensure optimum care and outcomes for patients.
25. Promotes quality standards, the safety and well-being of people and the environment through effective and sustainable management of human and other resources.	52. Demonstrates ability to work and communicate collaboratively with all support staff to manage resources effectively while maintaining quality standards to ensure optimum care and outcomes for patients.
26. Critically assesses, develops, and uses relevant guidelines, quality standards, tools/data to evaluate and audit care and resources to optimize patient experience and outcomes.	53. Demonstrates the ability to assess risk and actively promote the well-being, security and safety of all people in the working environment (including themselves).
27. Actively promotes a learning organization and environment, supporting students, learners and staff in their professional development.	54. Demonstrates the ability to critically assess, develops and use tools to evaluate and audit care according to relevant clinical guidelines and quality standards.
	55. Demonstrates the ability to educate, facilitate, supervise and support nursing students and other health/social care students or workers in the clinical environment.
	56. Demonstrates the ability to apply and influence of health/social care funding streams and use resources effectively.

Appendix 5. Assessment Rubrics - Nursing Level 7

We recognise that due to the different Scopes of Practice, cultural and academic contexts of nurses and nursing practice, what may be a criterion for 'failure' may vary from country to country. Therefore, our assessment rubric comprises two Sections, Section 1 addresses the Scope, regulation, safety, and ethical aspects that may, in some countries or institutions, lead to automatic 'failure' in an assessment task. Section 2 examines the rest of the assessment task, with no measurement of factors addressed in Section 1. Section 2 descriptors are enhanced from the Level 6 assessment rubric to reflect Level 7 competences, standards and levels. Where appropriate, this will be matched to the Country/Institutional Profile.

Section 1: Scope of Practice, Regulations, Safety and Ethics.

Please answer these questions first in your local and national context. Please write N/A [not applicable] if the question does not apply to this assessment/examination task. **Where appropriate, does the answer…..**	**YES or NO? Or N/A**
11. Comply with the Scope of Practice and national laws regulating nurses?	
12. Describe or represent safe practice for patients/ families/staff?	
13. Describe or represent ethical and/or caring practice?	
14. Comply with other relevant legislation (e.g. health and safety, safeguarding)?	
15. Comply with recommended local policies and procedures?	
Score number of 'Yes' answers	
Please explain here your reasons for stating 'No' to any question above.	

Once these questions have been answered, please mark the rest of the paper / assessment task on its content and level of academic achievement.

Section 2: Professional and academic competences

Pass criteria- Please refer to the answer guide for the expected typical content for the assessment task.

Please write N/A if the criterion does not apply to this assessment task, then change the rubric for the criteria that apply.

Answers must be aligned to the assignment task.
When a criterion has met the 'pass' descriptor, then please decide whether the answer meets the criteria is a 'good pass' or a 'very good pass' and tick the relevant box.

When you have decided that a criterion has not been met, please provide a reason to support your decision at the end.

Assessment Mark Sheet/Rubric/Criteria- based on the Level 7 competences.

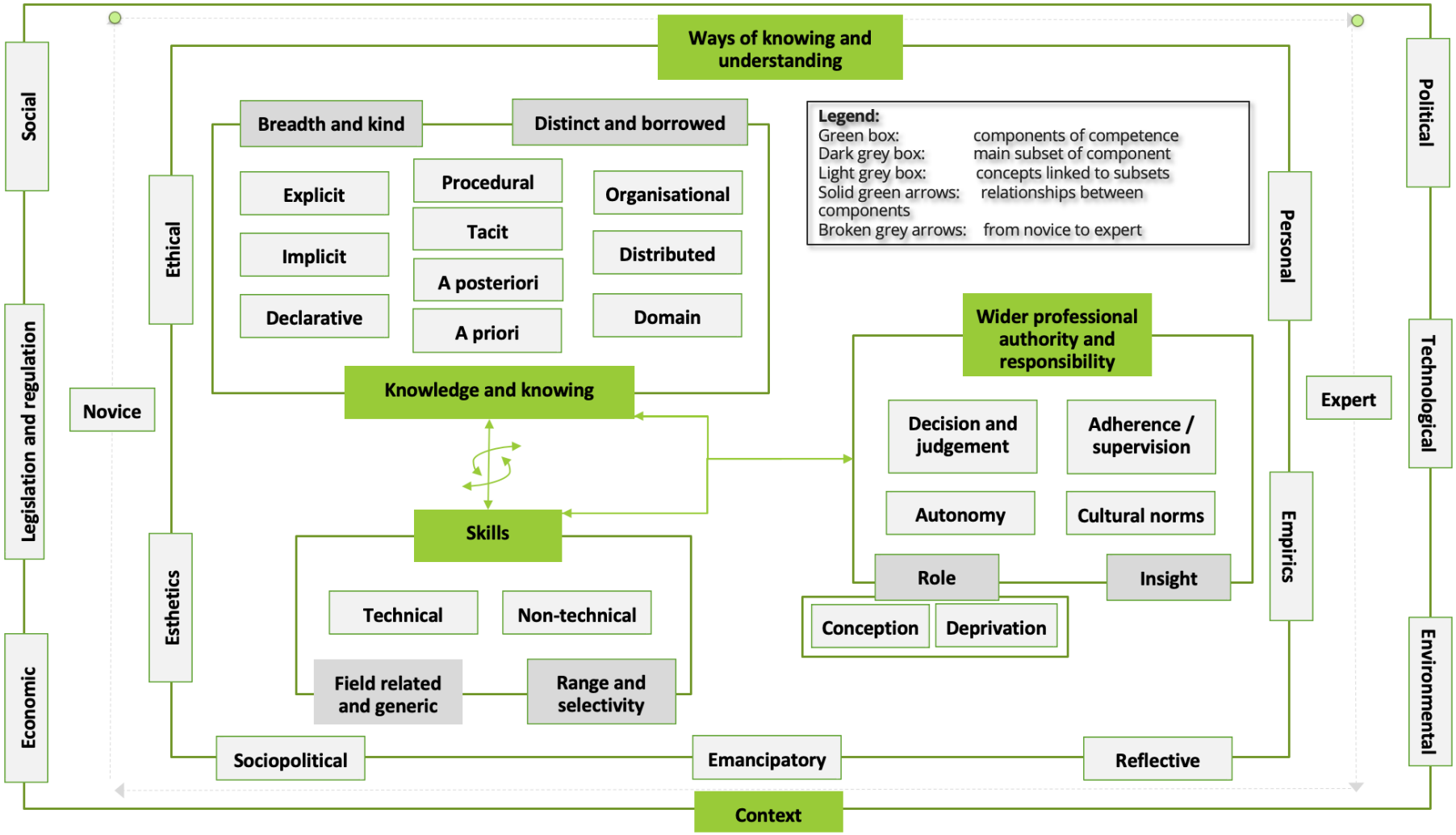
Criteria for a Pass **Minor omissions and errors may be present. Answers should be relevant, timely: demonstrating criticality and evaluation.**	**YES** **N/A** **NO?**	**Criteria for Good Pass** **Minor omissions only Confident answers addressing the assignment task.**	**Criteria for Very Good Pass** **Comprehensive, detailed, analytical answers. A wide variety of evidence sources provide**

The assessment task is addressed.		Evidence sources are broad and appraised. Clinical questions are individualised, holistic and promote optimum practice.	innovative, challenging, and new insights into established practices or complex situations. Clinical questions are individualised, holistic and offer multiple perspectives on the situation
41. Demonstrates a critical appreciation of their responsibilities and role in the assessment task.			
42. Evidence of critical or evaluative self-reflection/ appraisal.			
43. Decides which clinical data are required and then interprets, synthesises, and evaluates.			
44. Assessments are holistic: tools are critically evaluated for their relevance.			
45. Clinical judgements are defensible, and evidence based.			
46. Plans of care are prioritised and responsive to changing circumstances and complexity.			
47. Procedural knowledge and nursing interventions are systematically appraised for their relevance for the assessment task.			
48. Nursing interventions and practises are critically evaluated.			
49. A variety of sources of evidence and forms of Knowing /Knowledge are justified (see indicative content for the assessment task).			
50. Actively promotes, leads, and enhances the quality-of-care provision/systems.			
51. Audit, research, and evidence-based practise are used to improve care, quality			

standards, safety, efficiency and effectiveness.			
Criteria for a Pass **Minor omissions or errors may be present. Answers should be relevant, timel: demonstrating criticality and evaluation.** **The assessment task is addressed.**	**YES** **N/A** **NO?**	**Criteria for Good Pass** **Minor omissions only** **Confident answers addressing the assignment task.** **Evidence sources are broad and appraised.** **Clinical questions are individualised, holistic and promote optimum practice.**	**Criteria for Very Good Pass** **Comprehensive, detailed, analytical answers. A wide variety of evidence sources provide innovative, challenging, and new insights into established practices or complex situations.** **Clinical questions are individualised, holistic and offer multiple perspectives on the situation**
52. Answers/explanations are clear, easily understood, logical and defensible.			
53. Language/Non-verbal communication is professional, appropriate, respectful of others and responds to the complexity of the situation			
54. Language /communications show insight, anticipation and adaptability when meeting the needs of others (e.g., capacity, disability, culture).			
55. Language is technically accurate, logical, and confident.			
56. Represents and advocates for the 'voice' of patients and others when appropriate.			
57. Critically appraises the role of self and other health/social care professionals.			
58. Appraises available human and other resources to promote wellbeing, sustainability and effectiveness.			
59. Actively promotes the support, learning and development of others in the work environment.			

60. Shows a critical appreciation of the role of clinical leaders in the development of strategy/policy and procedures.			
Total no Answers per descriptor, 'Pass' ' Good' or 'Very Good' Passes.			
Questions/Criteria that have not passed		**Reason for decision**	

Appendix 6. Schema of Forms of Knowing and Knowledge that underpin enacted competence, model 2023 for future development



Role: 'A role is a set of expectations about how a person in a given position in a particular social system should act and how the individual in a reciprocal position should act' (Kramer, 1974, p.52). It involves an observable action component - role behaviour, and an internal cognitive component – role conception.

Role conception: is derived from a composite of internal values such as service role conception, professional role conception, or bureaucratic role conception.

Role deprivation: is a subjective report of the degree to which situational determinants permit the nurse to enact their role as they conceptualise it. It is the disparity between idealised role conception and that which is found operable and sanctioned in the work situation (Kramer, 1974).