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Assessing and developing students' English language proficiency prior to clinical placements: a pilot study

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As universities cater for increasing numbers of students from linguistically diverse backgrounds, there is a need to develop effective post-enrolment spoken language assessment and development programs to ensure students have adequate English language levels for clinical placements. This paper presents an evaluation of a pilot project that embedded a clinical communication strategy into the first year of a nursing degree to ensure students had a level of English language considered safe for clinical placement. The strategy consisted of an initial language screening task to identify students in need of development, a follow-up compulsory language program for those identified, and a post program language assessment task, in which students needed to achieve a threshold level, in order to proceed to clinical placements. The study was conducted in a large metropolitan university in Australia. Data collected included pre- and post-assessment results, survey data on students' evaluations, and student results from two clinical placements following the communication strategy. Descriptive statistics and thematic analysis were used to analyse data. The study found: the communication strategy was effective in identifying students in need of language development; the majority of students improved their communication skills during the language development program; and the threshold level of language used to determine whether students were ready to proceed to clinical placement seemed appropriate. The study suggests that combining initial and post-assessment with an intervention, all of which are systemically integrated into a degree program, results in a strategy with high educational impact.

Key Words: English as an additional language; post-enrolment language assessment; nursing; health communication; cultural and linguistic diversity.

1. Introduction

The linguistic diversity of nursing students entering undergraduate degrees has resulted in increased attention to issues of English language. Although universities have minimum entry language requirements, they are no guarantee of success (Craven, 2012), and many Australian universities undertake their own post-enrolment language screening assessments to identify students in need of further language development (e.g. Glew et al., 2015). Following screening, language development opportunities are offered to students, often on a voluntary basis. Much literature focuses on screening and development of academic language (e.g. Hillege, Catterall, Beale, &

Stewart, 2014; Müller, Arbon, & Gregoric, 2015). These initiatives have been shown to help students better understand the content of their subjects (San Miguel, Townsend, & Waters, 2013) and improve their academic writing (Hillege et al., 2014).

However, for nursing students, it may not suffice to screen and develop *academic* English. Nursing students often begin clinical placements early in their degree and language is commonly cited as contributing to stressful clinical experiences for both students and their supervisors (e.g. Mikkonen, 2016a, 2016b). The minimum language entry requirements for studying nursing are most commonly based on assessments of English for *academic* purposes tests such as the International English Language Testing System (IELTS), which are not intended to assess readiness for *clinical* placements. One recent study showed that the IELTS better predicts students' performance in academic rather than clinical topics (Müller & Daller, 2019). Sedgwick, Garner, and Vicente-Macia (2016) found that the IELTS does not test some of the language skills essential for clinical contexts, for example: initiating social conversations; switching between nursing terminology and everyday language; and requesting personal information from patients, including requests for clarification.

Another factor that contributes to the need to better screen and develop students' post-enrolment spoken language is that many students in Australia bypass formal language entry requirements altogether and enter university via a college pathway. The language of these students may not always equate to the minimum formal language requirements (Müller & Daller, 2019, p.9) and these students may be even less prepared for clinical placement than those who enter with formal language qualifications.

At the large metropolitan university where we work, clinical language programs are offered to students prior to clinical placements. Evaluations have shown that such programs can help students move from feeling excluded to a sense of belonging, based on increased confidence and knowledge of what to do and say during clinical practice (Rogan, San Miguel, Brown, & Kilstoff, 2006). However, despite the positive outcomes of the language program, anecdotal feedback from clinical placement providers, clinical facilitators and academic staff indicated a requirement for more rigorous processes of identifying students in need of language development, as well as mechanisms to ensure that students' language levels were adequate for clinical placement once students had completed the language development program. This anecdotal evidence was also underpinned by the requirement of the Australian Nursing and Midwifery Accreditation Council (2012) that students' English language proficiency is assessed before undertaking clinical placements. This paper presents an evaluation of a communication strategy that integrates initial post-entry oral language screening for nursing students, an intervention to develop identified students' clinical language prior to placement, and a final assessment post intervention to determine whether students' clinical English is sufficient to proceed to placement.

2. Background

One of the challenges facing universities is to design language initiatives that effectively ensure students' English language proficiency is adequate for clinical placements. A systematic review of assessments and interventions in relation to communication strategies for students who speak English as an additional language identified that a major limitation is the lack of integration between assessment and intervention (Chan, Purcell, & Power, 2016). That review found that although assessments were used to identify students in need of language development and to provide summative results, little feedback was provided to students, and referrals were not made to follow-up language development programs.

A second limitation found by Chan et al. (2016) concerns the language programs themselves. Many universities offer programs that focus on preparing students for clinical placement (e.g. Boughton, Halliday, & Brown, 2010; San Miguel & Rogan, 2009) by teaching them the language of typical clinical interactions. While Chan et al. (2016) found evidence to show that students

were mostly satisfied with programs, there was little evidence of actual changes to students' communication skills. Those authors attribute this limitation to, firstly, the fact that few programs had pre-testing and therefore it was not clear at what level students were operating before the interventions. Secondly, there were few interventions that measured students' end performance against the objectives of the programs. They conclude that there is a need for communication strategies that have a high educational impact. Achieving a high impact requires the use of assessment tools to provide feedback or to refer students to an intervention program, and program evaluation to ensure students are meeting objectives and improving specific communication skills (Chan et al., 2016).

A further challenge in language assessment is determining a threshold level of language where students are considered 'safe' to proceed to clinical placements. Here 'safe' refers to 'a threshold of proficiency below which communication is seriously compromised' (Elder et al., 2012, p. 416), which in a nursing setting could lead to adverse health outcomes for patients. There are, to our knowledge, no studies that investigate what that threshold might be.

The Faculty of Health at our university has used for a number of years a language screening tool to assess students' English language in a clinical context (San Miguel & Rogan, 2015) and has offered language development programs to develop students' clinical communication skills (San Miguel & Rogan, 2009). Referral to the language development program was based on tutors' assessments in the first four weeks of nursing laboratory classes. However, when faced with large class sizes, it was difficult for tutors to identify all students in need of language development. Furthermore, not all students referred to the program attended, and those who did not attend were still allowed to proceed to clinical placements. This lack of rigorous identification and attendance processes led to some students being identified in the workplace by their clinical facilitators or hospital staff as having inadequate language for safe practice during clinical placement.

A decision was made by the Faculty to increase the rigour of the assessment process by improving the identification of first year nursing students' language levels, making attendance at the language development program compulsory, and conducting post-program language assessments. The strategy was piloted with a cohort of first year students in their second semester who were undertaking a core clinical subject. They had already attended a one-week clinical placement in first semester. In this pilot project, we drew together established resources, that is a language framework and a face-to-face language development program, to develop a communication strategy.

3. The communication strategy

Initially, the spoken language skills of all students undertaking the identified core clinical subject were assessed. Students identified as needing language development were instructed to attend a compulsory 20 hour face-to-face clinical language program. On completion of the program, students were reassessed to determine if their language levels were safe to proceed to clinical placements. Once on clinical placement, all students were assessed using the same spoken language framework to determine their language proficiency. These components are described in more detail in the following section.

3.1. Initial language screening

The language framework used for the assessment process was adapted from one already used in the Faculty (San Miguel & Rogan, 2015), which described three levels of language (levels 1, 2 and 3). For initial screening purposes, an additional level was added (level 1.5). The framework was first used with a range of language educators and clinical facilitators to identify the reliability of the tool (this aspect of the project is not reported in this paper). In consultation with nursing academics and a language academic, the decision was made that students who received a level 1 or 1.5 were required to attend the 20 hour face-to-face clinical language program.

Clinical facilitators were employed to conduct the initial language screening, and a training session was held to establish consistency among markers in allocating language levels to students, and to provide some guidance in conducting spoken language assessments. In week three of the clinical subject, an assessor was situated in a side room and each student left the laboratory class for a brief interaction. Each student was given three questions to answer: a general question about their experience, a clinical communication question, and a question to assess if students would ask for clarification. An example of the three types of questions is:

- What kind of things did you learn during your last clinical placement?
- I am your patient. I would like you to take my blood pressure and talk to me as you would talk to a patient during clinical placement.
- Could you please go and get me a slipper pan?

Students were informed of results via email and those who received a language level of 1 or 1.5 were instructed to attend the language development program prior to placement.

3.2. The language development program

The four consecutive day program covered key clinical skills and associated communication related to the core clinical subject material, for example, making small talk, establishing rapport with patients and staff, asking for clarification, demonstrating understanding, listening to handover, and undertaking pre-operative checklists and pain assessments. All materials for the program were developed collaboratively by language and nursing academics. The material was taught using role plays and interactive language activities, which formed the basis for the post-assessment.

3.3. Post- language program assessment

Post-assessments occurred on the day following completion of the language program and assessors were trained as described above. Students were placed in one of two assessment bays. Students who had demonstrated low levels of language during the face-to-face program were allocated to the same bay. For these students, a language educator sat behind a one-way mirror so that students could be double marked. The two assessors concurred once the assessment was complete. Similar to the initial screening, the students were provided with three questions, an opening question and two related to program objectives, for example:

- One of the things you might have to do during clinical placement is to carry out a pain assessment on a patient. What questions would you ask the patient and how would you ask them?

Students who achieved a language level of 2 or 3 proceeded to clinical placement. Students who achieved a language level of 1.5 were able to proceed to placement but were provided with a communication support plan constructed from post-assessment feedback. This plan ensured that their clinical facilitator was aware of the student's need for language development and was provided with information about specific areas which needed development. Students identified as level 1 for language were unable to proceed to placement. This outcome resulted in a fail grade for the clinical subject. These students were asked to meet with relevant Faculty staff to discuss a study plan and further language development strategies. Finally, all students who proceeded to clinical placement had their language levels assessed in the clinical setting by their clinical facilitators (see San Miguel & Rogan, 2015).

4. Method

This project aimed to evaluate the effectiveness of the communication strategy by drawing on quantitative and a limited amount of qualitative data to investigate the follow questions:

1. How effective is the use of the spoken language framework in a first-year clinical subject in identifying students in need of further language development?

2. How effective is the language development program in providing support to students who need language development?
3. How appropriate is the minimum threshold level of language for clinical placement?

All students who participated in the communication strategy were tracked from the initial language screening until the end of the second clinical placement following the language development program. We considered results from only the next two placements because "the more we move away in time and space from the actual assessment, the harder it is to say how the results of the assessment might have affected the students' study activity or their ability to meet the language demands of their degree courses" (Read, 2015, p. 231). Data were accessed from university databases where students' results were stored. Quantitative and qualitative data collected included: language levels students received in the initial language screening and in assessments conducted at the end of the language development program; language levels from the two clinical placements following the language program; and the results of an online survey requesting students' perceptions of the communication strategy.

Analysis consisted of three stages: stage one, the initial language screening; stage two, the effectiveness of the language development program; and stage three, the appropriateness of the threshold level. Quantitative data were analysed using descriptive statistics. Qualitative data were analysed using thematic analysis. As each stage involved different data collection methods, different numbers of participants, and different types of analysis, further details are provided in the relevant sections of the findings.

Ethical approval for the study was granted by the university's ethics committee. Student confidentiality was maintained by restricting data access to the two authors and by coding data for analysis. Once analysis was complete, all identifying features were removed from the data. The anonymous student survey was conducted on completion of the language development program. Students were advised that the survey was optional.

5. Results

5.1. Stage one: the initial language screening

A total of 570 students were screened from a cohort of 607. The missing students did not comply with requests to attend alternative screening times.

Data were cleaned by removing students who were repeating the clinical subject where language screening occurred, as the project was focusing on only first year students. All remaining data were for first year, second semester students who had only had one previous clinical placement. A total of 60 first year students were identified as having a language level of 1 or 1.5, requiring them to attend the language program. These students were mainly from China, with some from Cambodia, Korea and Nepal. Since three of these students did not attend the full program (they attended two days or less), they were removed from the data. However, it is worth noting that all three withdrew from their degree before completion.

In order to determine the effectiveness of the language framework in identifying students in need of language development, data were analysed in two ways. Firstly, we investigated how many students were reassessed on day one of the face-to-face program by the language educator and excused because their language level was considered high enough to proceed to clinical placement (i.e. they were at level 2 or 3). Of the 53 students, eleven were excused. All of these eleven students continued to progress through the following two clinical placements without any language issues. Secondly, we investigated whether any students who had not been identified by the initial language screening were removed from the clinical setting during the following two placements due to a low level of English language. No students initially screened as level 2 or 3 were removed due to low levels of language. On the basis of these results, the initial screening process was deemed to be quite effective.

5.2. Stage two: the effectiveness of the language development program

The total number of students attending the language program full time was 42. These students were included in stage two of the tracking. In order to analyse the effectiveness of the language program, data were analysed to determine whether students improved in their language level from the initial screening to the final assessment (qualitative data related to this question are reported in Tables 4 and 5 and associated text.). Table 1 shows that of the 42 students attending the program, 31 students improved, nine remained at the same level, and two received a lower level in the final assessment. These results indicate that the program seemed to lead to improvements in clinical language for the majority of students.

Table 1. Comparison of initial screening and final language assessment.

Attended CS	Initial screening	Post- assessment	
Language level	Number of students	Language level	Number of students
Level 1	8	Level 1	1
		Level 1.5	2
		Level 2	5
Level 1.5	34	Level 1	2
		Level 1.5	8
		Level 2	24
TOTAL	42		42

5.3. Stage three: The appropriateness of the threshold level

The communication strategy determines that a language level 1 is too low to proceed to placement and that students who receive a language level 1.5 can proceed with language learning support. This third stage analyses the validity of this threshold.

Data were analysed to investigate the outcomes of students who had received a level 1 or 1.5 in their assessment. The three students who were not allowed to proceed to placement failed the subject overall, as placement is a requirement to pass the subject. Two of these students repeated the subject in the next teaching session and proceeded to placement. The third student repeated the subject and the language program the following year, after which he proceeded to placement with a learning support plan but failed placement due to a low language level. The three students continued to struggle in the following clinical subjects due to low levels of language.

Table 2 summarises the results for the remaining students who proceeded to clinical placement. In this table, ‘non-progression’ refers to students who failed to progress for reasons other than language; for example, failure in the theoretical component of the clinical subject meant students could not attend clinical placement. Of the 35 students who proceeded to placement either directly or with learning support, only one failed to progress after the first placement. Of the 32 students who proceeded to a second placement (three students failed to progress to a second placement for reasons other than language), one was given a level 1 assessment for language during the placement. However, on investigation it appeared that the clinical facilitator was drawing attention to her lack of critical thinking rather than her level of English language. That student progressed to following placements with no language problems. These results indicate that the threshold levels of language required to proceed to placement (level 1.5 with specific language learning support during placement, and level 2/3 with no specific language learning support) seem appropriate.

Table 2. Progression on clinical placement according to language level.

Post-assessment	First placement		Second placement	
Level 1.5 (10)	Level 1	1 (failed)	Non-progression	
*2 non-progression	Level 2	7	Level 2	4
			Level 3	3
Level 2 (29)	Level 2	9	Non-progression/Level 2	1
*2 non-progression			Level 3	8
	Level 3	18	Non-progression	1
			Level 1	1
			Level 2	7
			Level 3	9

5.4. Students' perceptions

In order to investigate the effectiveness of the language program from participants' perspectives, students were asked to complete a short evaluation survey at the end of the program, using an online survey tool. A total of 46 students completed the survey. This number of students is larger than the number in the tracking above (42 students), as students who completed only several days of the program also completed the survey. It was not possible to remove these from the data for purposes of analysis, as the survey was anonymous. This was not considered a significant issue, however, as it was only a small number of additional students.

The first three questions on the survey asked students to rate their response to a statement on a five-point scale of "strongly agree" to "strongly disagree". All the responses fell into the categories "strongly agree" and "agree". As can be seen in Table 3, students perceived the usefulness of the program in developing communication. Students also gave high ratings to the program overall.

Table 3. Students' perceptions of the effectiveness of the language program.

	Strongly agree	Agree		No response
The clinically speaking program was a useful learning experience	33	12		1
I improved my communication skills	27	19		
I developed skills needed by my profession	31	15		
Overall how would you rate the program?	Excellent	Good	Satisfactory	Poor
	32	11	3	0

The survey also contained two open-ended questions. Responses to each of these questions were analysed thematically. The first question asked students to comment on the communication strategy, including the language screening and post-program assessment. Responses were divided into positive and negative responses to the program. The majority of responses were positive. The negative responses were only partly negative; students did not like the language screening and assessment process but thought they had benefitted from the face-to-face language development program. These responses are summarised in Table 4 below.

Table 4. Students' perceptions of the communication strategy.

	Number	Sample comments
Positive		
Comments on the program and assessment	7	*At the beginning I was reject this program. However, after those few days, I have change my mind. This program is very useful. If the program has change, I hope it may open in the next year for 2nd or 3rd years student.*
		It is a good process which want me to come to study and not even want me to skip even on day as whole weeks they teach important things which give me a lot of advantages.
		It does assess my English skills effectively. And every parts of clinical speaking are helpful and useful.
Comments on the program without reference to the assessment	5	*I love attending* [name of program] *program. Please run this workshop for second year students!!!!!*
		It will be very useful in my next placement.
Negative		
Comments on the assessment process	7	*I would be very happy to attend such class again only if is not before the exams period and no assessment*
		The result of assessment is not really correct but I enjoy to be in the [name of program] *class*
		In week 3 I felt nervous to talk with the assessor and I didn't prepare before. It case poor performance in my speaking

The second question was a two-part question which asked students what they had enjoyed about the program and what they would like to change. There were 46 responses to this question, all of which contained positive comments. One main theme was the teaching style. Students commented on the way in which they were encouraged to speak through learning activities, including role plays and language games. Within this theme they also commented on the interpersonal qualities of teaching staff. Students felt that the teaching style and the teachers' attitudes helped them to learn. A second theme was the content. Students appreciated the relevance of the content including medical terminology and communication associated with specific skills. A final theme was resources. Students commented that they would like the program to be longer and for more resources to be provided. These themes and sample comments are summarised in Table 5 below.

Table 5. Students' perceptions of the face-to-face language development program.

What students liked		
Teaching style	Encouragement to speak	*teacher push us to communicate with them and encourage us to learn English*
		Students are always encouraged to speak English in this program
	Fun and interesting activities	*We had lots of role play and it were so interesting*
		I really like the "guess words" part, I have learnt useful abbreviations in these activities
	Interpersonal qualities of teachers	*I love to work with an English teacher because it feels safe when I speak*
		[the teachers] are pretty nice and likely to share their knowledge with us. They helped me a lot
Content	*Practice handover and pain assessment*	
	Learning the terminology and use it in the practice.	
	I prefer to learn the clinical medical words and how to ask the clarification.	
	Practice handover and pain assessment	
What students would change		
Resources	*Actually， it is a short class and just have 4 days*😒	
	I want [the program] *is also open in year 2*	
	Giving more resource and showing the resource in the class	

6. Discussion

The evaluation of the communication strategy aimed to investigate the effectiveness of a language framework to identify students in need of language development, and of a follow-up language development program. A further aim was to assess whether the minimum threshold level of language students needed to achieve to progress to clinical placement was appropriate. The study shows that the three elements of the communication strategy, that is, the pre- and post-language assessment tasks and the face-to-face program result in what Chan et al. (2016) refer to as a high impact model, where assessment is integrated with interventions resulting in educational change. Figure 1 illustrates how the communication strategy aligns with Chan et al.'s (2016, p. 907) design model for clinical communication programs; Chan et al.'s (2016) recommendations are highlighted in bold font.

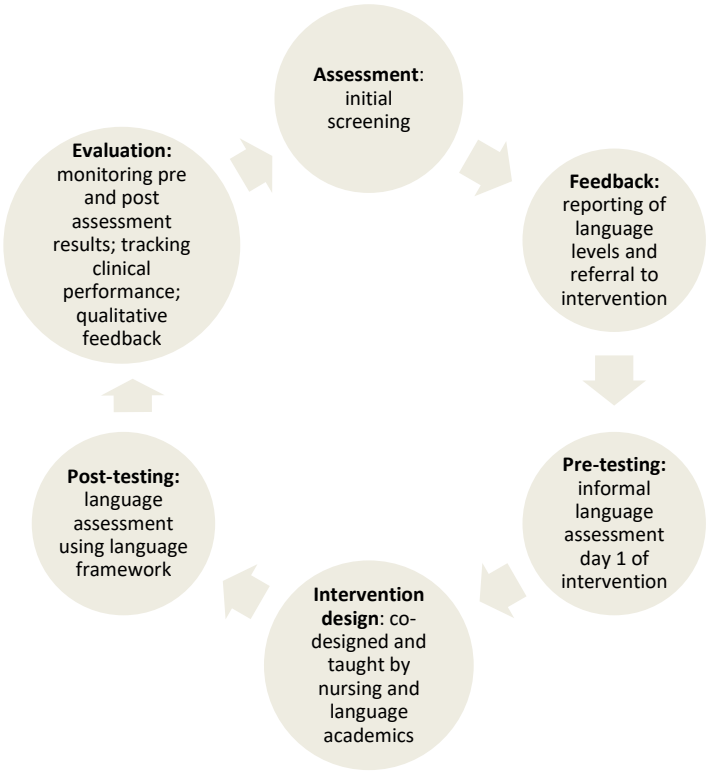

Figure 1. Communication strategy design model (based on Chan et al., 2016).

The clinical communication strategy is a model that links assessments with interventions. The informal language assessment on day one of the intervention measures students' baseline clinical communication skills according to the intended outcomes of the program. The post-assessment measures outcomes gained during the face-to-face program. The evaluation of the program includes not only the post-assessment language results, but also tracks students' performance during follow-up clinical placements. The final stage of Chan et al.'s (2016) model, institutional impact, is indicated by the way in which the clinical communication strategy is embedded within the nursing discipline. It is a core part of clinical subjects in students' first year. A further impact of the program is that the Faculty has also employed a part-time English language officer (a nursing academic with experience working with EAL students) to oversee the communication strategy, teach on the face-to-face program, then monitor students' performance during clinical placements.

The study demonstrates that trained clinical facilitators and nursing academic staff can, with a short professional development session, effectively identify students in need of language development using the language framework. There was a tendency to underestimate rather than overestimate students' language proficiency in the pre-screening language task. However, the informal assessment on day one of the face-to-face program means students who may have been incorrectly assessed can be removed from the program. Nevertheless, there is a need to maintain training in use of the language assessment tasks and language framework to ensure reliability amongst assessors so that, as far as possible, only students in need of language development are referred to the face-to-face program.

As in Chan et al.'s (2016) recommendations for program design, the collaboration between language and nursing academics resulted in a program that develops students' communication skills in a clinical context. The post-program language assessment data indicates that the majority of students can improve in specific areas with a 20-hour face-to-face program.

The qualitative results from the student surveys demonstrate that the majority of students felt that they had improved in their clinical communication skills. Given that this was the first iteration of the language program that involved compulsory attendance and assessments, with the high stakes consequence of failing the subject if students did not achieve the required language level, it was expected that there might be some resistance from students to the communication strategy. However, the majority of student comments were positive in regard to the usefulness of what they learned. Students' attitudes to the assessment components were more varied. For some students, assessment acted as a motivator, whereas for others it increased stress levels. Further work is needed to investigate how we might reduce and/or best respond to students' stress regarding the assessments.

As this study investigated only one cohort of students, conclusions drawn about the validity of the threshold level can only be tentative. However, based on these findings, it appears that the minimum language threshold level established for progression to clinical placements is valid. However, it must be noted that students who proceeded to clinical placement with a language level of 1.5 did so with the support of a learning contract which incorporated feedback from the post-assessment, and that these students were supported by clinical facilitators during their clinical placement to continue to improve their communication skills. Without this level of support, it may be that level 1.5 is too low to proceed to placement. Although the numbers in this study were extremely small, it also seems that students with a language level of 1 after the intervention will continue to find it difficult to make progress in the degree.

7. Conclusion

The study suggests that the combination of pre- and post-language assessments and interventions that are embedded into a nursing degree can help students develop the language required for their following clinical placements. Furthermore, the use of the language framework and the establishment of a threshold level of language required for clinical placement can help ensure that students only proceed to placement if their level of English is considered safe for practice. However, given that this was a pilot study and followed only one group of students, further studies are needed with new cohorts of students to confirm these findings.

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