



Assessing students' English language proficiency during clinical placement: A qualitative evaluation of a language framework



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SUMMARY

The increase in nursing students for whom English is an additional language requires clinical facilitators to assess students' performance regarding clinical skills, nursing communication and English language. However, assessing language proficiency is a complex process that is often conflated with cultural norms and clinical skills, and facilitators may lack confidence in assessing English language. This paper discusses an evaluation of a set of guidelines developed in a large metropolitan Australian university to help clinical facilitators make decisions about students' English language proficiency. The study found that the guidelines were useful in helping facilitators assess English language. However, strategies to address identified language problems needed to be incorporated to enable the guidelines to also be used as a teaching tool. The study concludes that to be effective, such guidelines need embedding within a systematic approach that identifies and responds to students who may be underperforming due to a low level of English language proficiency.

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Introduction

The increase in linguistic diversity amongst nursing students has been widely documented over the last decade. In undergraduate nursing programmes in Australia, for example, the number of international students increased more than 500% from 2002 to 2011 ([Health Workforce Australia, 2013](#)). A linguistically and culturally diverse workforce helps provide culturally appropriate care for the diverse populations now typical in many western countries ([Donnelly et al., 2009](#)). However, concern is often expressed anecdotally amongst nursing academics and nursing staff about the language proficiency of students for whom English is an additional language (EAL). Whilst this concern has been raised in other discipline areas ([Birrell, 2006](#); [Bretag, 2007](#)), it is particularly relevant in nursing where effective communication is essential for patient safety.

The link between safety and English language is highlighted by the Nursing and Midwifery Board of Australia, which states that it is 'committed to best practice regulation that protects the public by ensuring nurses and midwives can communicate effectively in English to provide safe care to clients' ([NMBA, 2011 p. 1](#)). The assurance relies on mandatory English language testing prior to registration, not only for nurses

who have graduated from overseas universities but also for nursing students graduating from an Australian university with less than five years of education in English ([NMBA, 2011](#)). The importance of English language is also noted in nursing education standards leading to registration in Australia, where it is noted that students' English language proficiency needs to be assessed before undertaking workplace practice; and ongoing assessment of competencies, including communication in English is necessary throughout an undergraduate degree ([Australian Nursing and Midwifery Accreditation Council, 2012](#)). However, no guidelines are provided as to how language proficiency should be assessed.

English language proficiency is often interpreted differently by various stakeholders ([Dunworth, 2010](#)), and in the clinical environment can overlap with broader communication skills, clinical tasks and clinical knowledge ([Elder et al., 2012](#); [Woodward-Kron et al., 2012](#)). During clinical placements, students' language proficiency is often assessed by clinical facilitators (referred to henceforth as facilitators); the term used in this paper to refer to those responsible for supervising and assessing students while on clinical placement. However, it may be difficult for facilitators 'to disentangle language issues from content knowledge and other health-specific aspects of communication' ([Elder et al., 2012 p.417](#)). At the large, metropolitan university where the study reported in this paper was conducted, the University of Technology, Sydney (UTS), facilitators had previously assessed English language proficiency with a simple 'yes' or 'no' tick box on the clinical assessment form. Without guidelines as to what constituted 'yes' or 'no', the assessment process was challenging for facilitators and provided little feedback for students.

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In response to these issues, a framework was developed at the UTS to help facilitators identify and describe features of students' English language proficiency and make more nuanced assessments. This paper presents the results of a pilot evaluation of these guidelines, which are part of a larger programme addressing the English language development of EAL nursing students at this university.

Assessment of English language during clinical placement

Sophisticated communication skills and a high level of spoken and written English language are necessary in clinical environments (Pilotto et al., 2007). Clinical facilitators play a central role in students' learning and development of spoken language during their placements by encouraging them, providing feedback and debriefing on clinical events (Malthus and Lu, 2012). However, supervising EAL students can be challenging for facilitators who may have difficulties communicating with students and feel they lack strategies to effectively supervise EAL students (Jeong et al., 2011). Particularly challenging is the role facilitators play in assessing students' performance during clinical placement, ensuring they meet national competencies (NMBA, 2006), including effective communication. Assessing communication in the clinical setting requires consideration of multiple factors, including English proficiency, specific communication techniques appropriate to patient-centred care, cultural knowledge and appropriate clinical skills (Wette, 2011).

One of the challenges in assessing spoken English during clinical placement seems to be the difficulty in differentiating between language use and cultural differences. An analysis of written comments made by facilitators on students' clinical assessment forms (San Miguel and Rogan, 2012) found that students were expected to have clear spoken and written communication, and a good bedside manner, including qualities such as being courteous, polite and respectful. These qualities contribute to 'professional demeanour' (Jette et al., 2007, p. 838), a broad term encompassing 'the way in which an individual speaks, asks and dresses', which is important in establishing rapport with patients and building effective relationships with registered nurses and facilitators. However, professional demeanour may be influenced by differing cultural norms, which may lead to misunderstandings related to cultural expectations.

The difficulty of assessing English language rather than cultural behaviours has been noted by Chur-Hansen and Vernon-Roberts (1998, p. 355) who, in a study of supervisors' written comments assessing undergraduate medical students' clinical performance, suggest that 'perhaps Asian students are regarded as having 'language problems' because they are not vocal and do not question their teachers, when in fact they are obeying cultural rules of respect'. These authors propose that clinical educators may 'make unsubstantiated judgements based upon fragmentary information, or upon factors not necessarily related to English language proficiency, such as personality or appearance'.

A second challenging issue in student assessment is making decisions about underperforming students. There may be an unwillingness to document communication weaknesses 'due to lack of ability to clearly describe the problem or for fear of being seen as racist or bigoted' (Cross and Smalldridge, 2011, p. e365) or 'because raters are uncertain about their judgment, or afraid to take responsibility for the negative consequences thereof' (De Haes et al., 2005, p. 588).

The Guidelines

In order to address some of these challenges, a set of language guidelines was developed to help facilitators make decisions about the English language component of the overall clinical assessment of students during clinical placement. The guidelines were developed collaboratively with nursing academics and a language academic based on 'intuitive' and empirical methods (Fulcher, 2003). Intuitive

methods included the professional expertise of facilitators, nursing academics and a language educator with expertise in clinical supervision or clinical language education. Empirical methods were based on previous research investigating facilitators' feedback comments regarding language, interpersonal skills and professional demeanour (San Miguel and Rogan, 2012).

The guidelines describe three 'levels' of English language performance, satisfactory (3), in need of development (2) and unsatisfactory (1), with each level containing an overall description and more detailed descriptors in four areas; pronunciation; vocabulary; asking for clarification and demonstrating understanding. These categories were identified as important elements of clinical communication in previous research (San Miguel and Rogan, 2012). The guidelines are generic enough to be used across all years of the undergraduate programme alongside the overall clinical assessment form, which provides assessment criteria specific to each placement. Importantly, the guidelines were designed to be used in any clinical context by facilitators who may have little or no formal knowledge of language issues.

Pilot Study

The guidelines were piloted by eight experienced facilitators across eight clinical settings. These facilitators were invited to participate by the Director of Clinical Practice who was familiar with their expertise and experience. Ethics approval was granted for the study by the university ethics committee. All participants signed informed consent. A briefing was held with the facilitators to introduce the guidelines for use in their next two-week placement with first year nursing students. Each facilitator supervised up to eight students per clinical group but only used the guidelines with EAL students. Facilitators were not given any information as to what level of language was acceptable for a first year.

After the clinical placement, facilitators were invited to attend one of two focus groups to provide feedback. Each focus group was attended by facilitators, the Director of Clinical Practice and the two researchers, one of whom is a nursing academic, and one a language education academic. The focus groups were audio recorded, transcribed and analysed for key themes. The researchers analysed the transcripts independently to interpret the facilitators' experiences in using the guidelines, creating themes which were then clustered into two major categories. The researchers compared their analyses until agreement on themes and categories was reached.

Findings

This section of the paper describes the two main categories identified from the focus group discussions. The first category relates to facilitators' views on assessing students' communication during clinical placement. The second category focuses on facilitators' evaluations and comments about the guidelines and includes: facilitators' perceptions of the purpose of the guidelines; the processes they adopted in using them; and their suggestion that the guidelines are 'a good start'.

Assessment of Communication

This category centres on facilitators' recognition of the complexities in assessing English language and their desire for guidance in doing so. They expressed confidence in assessing clinical skills and tasks but lacked confidence in assessing language because 'we're not language specialists'. They acknowledged the necessity of assessing English language as it was on the clinical assessment form but were challenged by this as 'a lot of us are finding our way ... so we'll always assess skills yep black and white they've got it, English language not so sure'.

The first complexity was assessing students' current use of English language in relation to the length of time it had taken students to reach that language level:

... because if they've been here for 5 years you're going to be harsher on your judgment than if they've just come and it's their 1st year because you think well perhaps with more time they'll get here but if they've done school here they should have more ability

The second complexity was the role of context in determining how well students performed with language and how important particular instances of language use were in determining patient safety. Facilitators argued that students might be assessed differently according to the situation; for example, talking individually to a facilitator was seen as less challenging than performing in a clinical setting with other healthcare workers. More broadly, the hospital site and the cultural and linguistic diversity of staff were seen to influence students' performance and attending clinical placements in hospitals with multilingual staff was considered beneficial and supportive as students '*felt comfortable and they could get clarification in their own language, it was supportive*'.

The final complexity was the extent to which English language proficiency influenced decisions as to whether a student's performance was satisfactory or not. It seemed students could pass their clinical even if they had communication problems because '*clinically they're getting it and then when we pull them aside one to one they're not quite there on their language but clinically they've done enough to perform*'. Clinical tasks seemed to be prioritised over communication with students deemed satisfactory if *task oriented [they] are very good ... and the one things missing is actually the communication they can go in and take the BPs and make the bed and do the showers and do them 100%*.

What became clear was facilitators were making judgements about language according to whether the consequences of miscommunication or lack of communication caused harm to patients. So, for one facilitator:

[it] doesn't say to me it's unsafe practice being told something and going doing something totally different ... if you said go and get me a bed pan and they bring back something totally different because of the nature of that it's not critical for the patient so then it's not deemed as unsafe, it's just that they've misunderstood but [if the instruction is not to go and give that injection], and then they go and give the injection that's an unsafe practice ...

Facilitators looked for patterns of behaviour from students. Whereas a miscommunication regarded as unsafe might result in immediate removal from clinical placement, miscommunications that were regarded as harmless would be less significant. 'Safe' incidents of miscommunication were only problematic if they occurred regularly. One facilitator explained it was not so much whether students understood everything but rather if they were confident enough to ask for clarification:

you've got to assess if they've got the confidence to say I don't know about this as that's a big thing when they're still shy and finding their feet that makes its sort of a gauge as whether they're safe or ...

This category suggests assessing students' clinical communication is a complex and challenging process. Factors that influence facilitators' assessments include the context, length of time the student has been in the country and the student's competence in clinical skills. However, patient safety appears a fundamental factor in the assessment. The consequences of miscommunication, the presence (or not) of a pattern of miscommunication and the student's ability to ask for clarification are deciding factors in facilitators' decisions about assessment. These challenges support facilitators' need for specific guidance to ensure judgements are reasonable and made with confidence

The Guidelines

This second category focuses on the facilitators' perceptions of the purposes of the guidelines and the processes they adopted in using them. This category also includes facilitators' overall conclusion that the guidelines are a 'good start'.

Facilitators saw four different purposes for the guidelines: an assessment tool to help them assess students; a tool to help facilitators give feedback to students; a feedback tool for hospital staff to give feedback on students' performance; and a learning tool for students.

The first purpose was as an assessment tool for facilitators. The guidelines were useful because facilitators had not '*had a tool before to guide us and I think anything that can guide us is beneficial*'. Several comments were made about the guidelines making language assessment more objective and supporting facilitators to explain a student's language assessment. The guidelines *take away a bit of that subjectivity to give you the support as a facilitator if you do fail so to say this this and this is what you need to be doing*'. In this sense the guidelines were '*protection*' from potential negative consequences of failing students due to English language proficiency.

The guidelines helped make explicit facilitators' tacit expectations when assessing students and provided a vocabulary to discuss these expectations. The guidelines were not providing new information to facilitators as they '*usually look at these overall things, but it's good to have that guide there*'. Rather the guidelines *put[s] it in words what you're actually looking for*'. In particular, the guidelines helped make explicit what the facilitators' expectations were in terms of when students should pass, that is, facilitators saw level 2 on the guidelines as '*the unofficial benchmark—level 2*'.

A second purpose of the guidelines and the one that was seen to be most important to the facilitators was a teaching tool to provide students with feedback about how to further develop English language. In particular, facilitators wanted not only descriptors at the three levels but also strategies that they could use to help students improve their English. They wanted to use the guidelines '*as a bit of a plan ... to give feedback and identify strategies to help students*'. The desire for the inclusion of strategies in the guidelines is also related to a level of discomfort facilitators felt in assigning students a level. One concern was how to grade students if the facilitator felt they were sitting across different levels. A second concern regarded the consequences of assigning a particular level, as they were not sure what the university's expectations were in terms of language, and particularly in transitioning from one year to the next. However, most of the discussion in this theme related to facilitators wanting to focus more on teaching rather than assessing as '*it's more important for us not to get too hung up on giving them a category, giving them a grading ... I think having your strategies of things to do is really more the important tool rather than trying to classify students into a box because then you'll know whether they've been able to achieve, whether they've got there or not*'.

A third suggestion facilitators made was to show the guidelines to healthcare staff when seeking feedback about students' performance. Students work alongside a registered nurse when on clinical placement and facilitators thought the guidelines would enable these nurses to give more specific feedback about students' English language.

A final purpose, but one that was least mentioned in the focus group was that it would be useful for students to use the guidelines to self-assess and as a learning tool as it would *[put] the onus back on them 'cause we can only do so much as a facilitator, they've got to do it themselves as well*.

Facilitators also discussed the process of using the guidelines, focusing on two main issues; accurate assessment of students' language takes time and the guidelines should not be used in front of students. The facilitators suggested that EAL students need time to adjust to the clinical placement, and students' performance would change during the placement as they adjusted. It was important therefore not to make hasty judgements about students' language proficiency. Facilitators were

aware of the anxiety students often feel on clinical placement and suggested that using the guidelines in front of students might contribute to that anxiety as *'it's intimidating, having paperwork in front of you when, you know, they're talking and you're busy'*. Some facilitators chose not to use the guidelines in front of students.

Overall facilitators felt the guidelines were a 'good start'. They considered the guidelines useful in *'getting people to start looking at what issues we need to focus on'* but they were also clear that there was a need to *'develop the next step as to what to do with them'*. The next step included what they called local strategies and university strategies; the local strategies referred to those facilitators could use with students during clinical placement to help them develop their communication skills; the university strategies referred to initiatives the university needed to adopt, for example, ensuring that facilitators were aware of university language programmes and developing systems to monitor students in need of language development.

The 'good start' was also conditional on ensuring facilitators adopted a flexible approach in using the guidelines, taking into account the context of the clinical situation and the influence of the particular linguistic and cultural make up of the ward. A further condition was the need to take time to make judgements so that hasty decisions about students' performance were not made. On this matter, facilitators discussed the need to consult with the Clinical Director at the university before making decisions that might result in students failing a clinical placement. A final factor mentioned by facilitators was the importance of the facilitator's experience in working with international students.

Discussion

This small pilot study highlights facilitators' recognition of the complexity of assessing EAL students' English language in the workplace. This complexity arises from the interdependency of language, cultural practices and complex, busy clinical environments. Elder et al. (2012) found health professionals rarely commented on students' language proficiency in the health setting and tentatively suggest that health professionals may feel that commenting on language is beyond their competence or that it is not relevant. The feedback from facilitators in this study shows that they think it is relevant and they carefully consider language assessment. However, it also shows language assessment is challenging because language is 'vague' and not 'black and white' like clinical skills. In the absence of guidelines, they have intuitively developed some ways of making assessments about English language, including judging students' language performance based on the length of time they have spent in Australia and whether students' miscommunications are potentially unsafe to patients. Relying on intuition, however, may not be enough for facilitators who may be unsure about the judgements they are making, reluctant to deal with the consequences of making such judgements (De Haes, Oort, & Hulsman 2005); and/or are concerned of being accused of discriminatory practice (Cross and Smallbridge, 2011), all of which can lead to a reluctance to identify underperforming students. In this study, the guidelines were perceived as an external framework which helped facilitators feel it was legitimate to comment on language, and to do so in a way that did not make them feel they were discriminating against students, in their words, the guidelines offered 'protection'. Furthermore, in providing facilitators with the vocabulary to talk about language the guidelines may help address the facilitators' perceived 'vagueness' of language and help them articulate and feel more confident about their decisions regarding students' English language proficiency within a given clinical context. In particular the guidelines help facilitators know **how** to talk about language, they *'put [s] it in words what you're actually looking [for]'* by providing the vocabulary. These benefits may help facilitators make decisions about underperforming students, which is important not only to maintain patient safety but also to enable students to undertake steps to improve their language proficiency from an early stage in their degree.

However, providing guidelines to help facilitators describe problems is only an initial step as this study shows that even with guidelines, facilitators may still be uneasy about assigning levels of proficiency to students. The guidelines, as presented to facilitators offered descriptions as to the kind of language used at each level and asked facilitators to give students a level during formative and summative assessment sessions with students during clinical placement. It seems the facilitators in this study were not fully comfortable with assigning a level for several reasons. Firstly, it was not enough to give facilitators some guidance on how to talk about language; they also wanted strategies to help students improve their English language. Secondly, some facilitators were not sure what to do if students did not fall clearly into one level. Finally, facilitators wanted clarification about what the expected level of English language was from the university at each stage of the degree. This feedback indicates the guidelines are only a starting point and need to be situated within a broader systematic approach to addressing issues of English language throughout students' degrees.

In response to this feedback, the guidelines were amended and embedded in a broader systematic framework that addresses issues of English language proficiency. A workshop was held with clinical facilitators to discuss the kind of language strategies they used on clinical placement with students and these strategies were then included in an amended set of guidelines. The guidelines are now as much a feedback and learning tool as an assessment tool (see Table 1). A student version of the guidelines was also developed so students are aware of the framework facilitators use to give them a level of English language proficiency, and to allow them to talk about language with clinical facilitators using a shared vocabulary.

To foster familiarity with the guidelines, tutors and students use them in nursing laboratory classes during the first semester of the first year Bachelor of Nursing degree to identify students who need language development. These students participate in an intensive one-week clinical language programme prior to the first clinical placement to prepare them for the clinical environment. This programme has been discussed elsewhere (Rogan et al., 2006; San Miguel et al., 2006). The first clinical placement that students undertake is now a formative placement, with a purpose of orienting students to the clinical setting and is also a second opportunity to identify students who need language development and who may not have already been identified by university tutors. Students identified by clinical facilitators using the guidelines during their clinical placement are referred to an intensive one-week clinical language programme in second semester.

At a broader level, the guidelines have brought about discussion amongst Faculty staff to determine the appropriate level of language for students at the end of each year. As a result, the guidelines are used throughout the three years of the degree to refer students in second and third year who need language development to the Clinical Director, who develops learning goals with students.

Although facilitators found the guidelines useful, there are some areas that need further exploration. This was a pilot study and further evaluation needs to be undertaken, including assessment benchmarking activities with groups of facilitators to investigate the reliability of the guidelines when used by multiple assessors. Other areas raised in this study that need further research include the extent to which good performance on clinical tasks overrides underperformance in English language proficiency; and the extent to which the consequences of miscommunication influence clinical facilitators decisions about language proficiency. Finally, clinical facilitators noted that these guidelines were only useful for spoken language and expressed a need for similar guidelines for assessing written English language.

Conclusion

Despite the limitations of the guidelines being trialled by only a small number of clinical facilitators with a small group of students, the study offered important insights into facilitators' perceptions of their

Table 1

A facilitator's framework for assessing and giving feedback on spoken English during clinical placement.

The framework focuses on aspects of English that Clinical Facilitators think are important. Students' English language usually improves during the clinical placement as EAL students often take time to adjust to the placement and to gain confidence. How students perform in the first few days may be very different from how they perform towards the end of the placement and, hence, it takes time to make an assessment of students' English. Some suggestions for using the framework are:

How to use this framework?	Talk to students about the framework—tell them you will be using it to help assess their English and give them feedback	Use the framework to point out some of the important expectations during placement, e.g. that students need to ask for clarification and show they understand	Ask students to assess themselves, talk to you about it, and plan activities they can do during and after clinical placement to help them improve (see the strategies below)
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Levels 1, 2 & 3 what do they mean?

The levels are a guide as to how well students communicate in English during clinical placement. This framework only focuses on language and you will need to use it in conjunction with the Clinical Assessment Form, which focuses on the clinical and communication skills expected at each year of the degree.

You might find that some students cross two different levels or perform at different levels when undertaking different clinical tasks. For example, students may perform better when talking with only one person than they do when talking with a group. They may perform better when taking a patient's blood pressure than they do when moving a patient from a bed to a chair. You will need to use the guidelines alongside the objectives for the students' clinical and take into consideration what year the student is in and how they are expected to perform at that level.

As a guide

- By the end of students' first year, they should be at level 2
- By the end of students' second year, they should be at level 3
- N.B. level 1 is a very low level of English. Some students may be this level at the beginning of their first placement until they gain confidence. Students' language may get worse when they are stressed

	Overall	Vocabulary	Pronunciation	Asking for clarification	Demonstrating understanding
Level 1 Unsatisfactory	<ul style="list-style-type: none"> – Often not clear what student is saying due to lack of appropriate vocabulary, pronunciation or incorrect grammar – Struggles to clarify meaning and does not always ask when s/he has not understood – Not always clear if student understands what is being said by patients and facilitators as student does not often show they have understood by responding with verbal or non verbal language – Rarely initiates conversations with patients and staff 	<ul style="list-style-type: none"> – Does not know many of the words for everyday hospital items – Only knows some of the nursing/medical terms studied previously at university – Finds it difficult to find the right word when talking 	<ul style="list-style-type: none"> – Often difficult to understand due to pronunciation – Listener frequently needs to ask for repetition and clarification 	<ul style="list-style-type: none"> – Rarely asks for clarification but becomes clear that the student often has not understood what was said 	<ul style="list-style-type: none"> – Rarely demonstrates understanding so speaker often unable to judge whether has understood or not – Little use of non-verbal/verbal communication to show listening and understanding
Level 2 Needs development	<ul style="list-style-type: none"> – Most of time can be understood but listener needs to listen carefully as intonation or pronunciation of some words may cause difficulties – May be pauses in conversation as student thinks of a response or needs time to process ideas – Mostly understands patients and facilitators but often needs to ask for clarification or repetition or for speaker to speak more slowly 	<ul style="list-style-type: none"> – Unfamiliar with much hospital and Australian slang – Does not know some vocabulary of equipment and everyday items – Familiar with some medical/nursing terminology but needs to ask for clarification for many words 	<ul style="list-style-type: none"> – Can mostly be understood but listener may need to concentrate more than with a speaker at Level 1 3 (below) – May sometimes seem abrupt because of the intonation used 	<ul style="list-style-type: none"> – Often asks for clarification when not understood but may need to be prompted to do so 	<ul style="list-style-type: none"> – Sometimes demonstrates understanding—usually non-verbally – May need to be asked at times if s/he has understood
Level 3 Satisfactory	<ul style="list-style-type: none"> – Usually clear what student is saying (accent not a problem if what student is saying is clear) – Usually understands facilitators, nurses and patients or asks for clarification if doesn't understand – Uses appropriate body language (smiling, eye contact) – May find it difficult to understand patients who do not speak clearly or who use a lot of slang but student nearly always asks for clarification 	<ul style="list-style-type: none"> – May not understand a lot of Australian slang e.g. crook but can ask for clarification – Familiar with nursing/medical terminology of subjects studied but may not know other nursing/medical terminology 	<ul style="list-style-type: none"> – Easy to understand – May make mistakes in pronouncing some medical/nursing terminology or unfamiliar words 	<ul style="list-style-type: none"> – Nearly always asks for clarification when does not understand 	<ul style="list-style-type: none"> – Nearly always shows s/he has understood by using appropriate non-verbal and verbal communication e.g. repeats key words, gives feedback such as okay, confirms details

Strategies

Overall	Vocabulary	Pronunciation	Asking For clarification	Demonstrating understanding
<ul style="list-style-type: none"> – Ask students to give you handover of patient. Ask questions about patient – Get students in briefing to practise small talk with each other. Set context, e.g. a) Imagine one of you is the patient and one the nurse and you are meeting for the first time b) You have just met the RN you will be working with on this clinical placement. – Model interactions for students – Give students tasks of talking to patients while they are carrying out a nursing skill e.g. talk to patients when washing them – Spend time developing rapport with students 	<ul style="list-style-type: none"> – Make sure students know where resources are to look up words (MIMS; dictionary) – Encourage students to ask patients and RNs if they do not understand – Role play how they could ask—e.g. could you explain what [insert word] means – Go through handover sheets with students and teach abbreviations and terminology 	<ul style="list-style-type: none"> – Ask student to present about something they did that day. Ask listener to ask for clarification if they don't understand – Listen carefully to students – Give students feedback on their 'tone' e.g. if student says 'you have a shower now'—explain effect of tone and teach phrases like 'would you like to have a shower now' 	<ul style="list-style-type: none"> – Build students confidence so they feel comfortable asking if they are unsure – Give students permission 'not to know' but tell them they need to ask to find 	<ul style="list-style-type: none"> – Ask students to rephrase something you have asked them to do – Ask students to report back their task or instructions – Ask students to document things e.g. in nursing notes. By documenting they are demonstrating their understanding. If they can't document and they don't ask for clarification, teach them how to ask

role and the challenges they face in assessing students' English language proficiency. The complexity in assessing students' English language was clear to these facilitators and the guidelines helped address some of the challenges facilitators face in commenting on language. This pilot project was a 'first step' in creating a systematic approach to help clinical facilitators assess students' English language proficiency in clinical placements.

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