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Practice-based assessment: strategies for mentors

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Summary

The reader is encouraged to investigate what is involved in the practice-based assessment of students and to consider how it might be improved. The author suggests that students should be assessed on their performance during episodes of care rather than by continuous assessment.

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decide how best to meet expectations associated with clinical learning environments. Practice-based assessment is complex and sophisticated and it is difficult to ensure that it is objectively managed (Carr 2004). Busy clinicians struggle to find adequate time to assess students and sometimes wonder whether they have interpreted assessment requirements correctly.

The aim of this article is to assist the reader to conduct a preliminary investigation of what practice-based assessment involves in consultation with university and clinically based colleagues, and to examine how assessment might be arranged or enhanced. A case is made for assessing students' performance during episodes of care and abandoning the more protracted, less objective and difficult to arrange continuous assessment.

After reading this article you should be able to:

- ▶ Explore your experiences of assessing students in practice and what is problematic about it.
- ▶ Identify what in current assessment arrangements can accentuate problems or encourage solutions.
- ▶ Clarify what assessment you are engaged in and to what purpose.
- ▶ Identify episodes of care or skills that are amenable to practice-based assessment.
- ▶ Together with colleagues examine other ways of improving practice-based assessment.

Introduction

Nurses consider their profession to be practice-based and work hard to ensure that a large part of learning and assessment takes place in the

Aims and intended learning outcomes

New expectations for the assessment of learning in practice have been set out by the Nursing and Midwifery Council (NMC) (2006). In many ways this emphasises the NMC's existing responsibilities but it also highlights the challenges for those who co-ordinate the mentorship of learners at all levels, for example, arranging consistent assessments in practice (Brady and Hyde 2002, Stuart 2003, McGaughey 2004), and dealing with the shortage of well-prepared, clinically based teachers or practice mentors.

Practice-based education is expensive to provide. Difficult compromises are encountered when mentorship programme designers decide what to include in the syllabus, or managers

clinical area. While it is recognised that important learning happens on campus, including the teaching of concepts, theory, critical thinking skills and research, these are best integrated with skills during carefully supervised practice placements (Stuart 2003). Skills can be learned using patient simulations (Tsai 2004), in skills laboratories and through approaches such as objective structured clinical examinations (Aithala 1998). However, the craft of nursing – that which happens when nurses combine practice observations, clinical experience, knowledge and skill, to a specific patient-centred purpose – is finally learned and assessed clinically.

There is well-established literature highlighting the challenges of assessing learning in practice. Discussing the assessment of clinical competency in senior house officers, Carr (2004) explains that it is difficult to agree what represents competency and, beyond that, to examine performance. It is noted that competency is what is demonstrated in a test situation, but that performance is what the practitioner demonstrates in clinical practice.

Knowing and showing are insufficient proof of performance, unless assessment is continued over time so that checks can be made on consistency of performance under different conditions. Performance involves combining different skills – cognitive (for example, reasoning), psychomotor (for example, touch), interpersonal (for example, communicating) and attitudinal (for example, showing empathy) – in ways that reflect the needs of a situation.

If Carr (2004) is right, any assessment of clinical achievement needs to deconstruct what has been accomplished in each component skill and to reconstruct that so we understand how the practitioner has combined the skills for the planned purpose. Deconstruction involves analysing how knowledge and decisions are combined. Reconstruction focuses on how the skill is then used to address specific clinical contexts and needs (Price 2007). The assessor asks what skills are used, whether they are used appropriately and how the nurse combines them to address the needs of the situation.

Dogra and Wass (2006) note that any assessment of clinical performance needs to accommodate the diversity of patients and their needs, so that performance is judged in terms of cultural sensitivity. The authors observe that few clinically based forms of teaching and assessment have addressed this. Care is, therefore, not simply technical but cultural too.

In the 1990s nurses wrote about the challenges of facilitating and assessing learning in practice (Lankshear 1990, Ashworth and Morrison 1991, Girot 1993). Chambers (1998) reviewed the literature on what represents competence and noted the difficulties posed by the objectivity, reliability and validity of assessments. Previous forms of assessment provided snapshots of student competence under contrived conditions and associated with specific tasks, such as the administration of medicines (the A, B, C and D assessments of the 1970s). At that time assessment was task-related, for example, administering medicines or completing an aseptic technique. While this approach set parameters for what was being assessed and what standards should be applied, it also disconnected nursing performance from the diversity and complexity of care requirements that nurses experienced routinely.

As early as the 1960s efforts were made to develop more objective competency rating scales for nursing practice, for example, Slater (1967) and Hillegas and Valentine (1986); however, such assessment measures were questionable in their authenticity, although consistent in their approach. Nursing practice cannot readily be described as a series of tasks that are assessed according to their completeness and ordering. An authentic form of clinical assessment needs to include an appraisal of the ways in which nurses assess situations, make judgements about risk or need and decide how to proceed.

Spouse (2001) describes many of these problems in terms of the need to combine two forms of knowledge and to develop a framework that helps to describe learning and what we might assess in a given context.

Conceptual or formal knowledge is important. We may, for example, conceive of risk in abstract terms as a series of circumstances and threats which, when combined, tell us something about the nature or level of risk.

Craft knowledge is used in practice. Here knowledge is strongly founded on experience and a review of what worked or did not work in the past.

In teaching students to become knowledgeable doers, both sorts of knowledge are required and need to be assessed in combination and in application. Assessors need to understand how the student reads risk situations in practice and uses concepts, such as threat, to address practice requirements.

Educational debates on the right way to conduct assessments are important to practice mentors. Practice mentors have traditionally undertaken the bulk of assessment where the availability of qualified practice teachers is limited, and where link tutors have acknowledged concerns about sustaining clinical

credibility alongside their other duties. It quickly becomes apparent to mentors that assessment of learning under clinical conditions is challenging. Yet practice mentors have historically been served by, and will continue to be limited to, relatively short programmes of preparation.

Time out 1

Begin your investigation by evaluating the arguments that have been outlined. In your opinion are they well founded or not? Is it difficult to assess how learners combine and employ knowledge in practice? How realistic is it to continuously assess learning in a busy clinical environment?

Exploring assessment discomforts

To investigate what might be done to improve practice-based assessment it is important to clarify what seems taxing about assessment to mentors. While mentorship is generally challenging, assessing students seems especially complex. Intelligent, inquisitive, self-disciplined learners may be a joy to teach and assess, but a variety of problems are also encountered.

Time out 2

Consider what concerns you have had associated with the assessment of learners during practice placements. Make notes on what makes the process difficult. When you have completed your notes, compare your difficulties with those listed in Box 1.

We can divide assessment concerns into three areas:

- ▶ Preparation and competency of the mentor.
- ▶ The structure or purpose of the assessment.
- ▶ Achieving constructive learning in the clinical area.

Preparation and competency of the mentor

Mentorship programmes only have time to introduce the principles of supervision and assessment. Different programme and assessment requirements do not necessarily match the best practice taught on a mentorship course. The mentor may then have anxieties about educational terminology and how to accurately assess learning. Box 2 illustrates this problem as described by Anna, a mentor who was assessing a third year nursing student on clinical placement.

Structure or purpose of assessment Confusion may exist about whether the assessment is of

learning and permits a report on progress (for example, comparing the insights and abilities a student has on joining a ward with those he or she has on leaving it); or of performance, which presumes a clear set of parameters against which to judge achievement. This is illustrated in Box 3.

Achieving constructive learning in the clinical area

Where performance and competence have to be judged, questions can arise about the best way to do this. It is possible that students could become upset, angry and even aggressive if these duties are not discharged sensitively (Box 4).

Time out 3

Compare notes with colleagues to ascertain what types of problems occur in your practice setting. If problems of perceived competence predominate, raise this issue with the practice development lead in your organisation – both as a means of finding out what professional update might be available and as a way of reviewing what the course provider can realistically expect of assessment in your setting. If the issues are concerned mainly with the structure or purpose of assessment, alert your link tutor to these difficulties to examine what additional guidance or briefing might be sought from the university. If the problems are associated with giving feedback and reporting on performance, identify those charged with your professional development and request sessions that address your needs.

Exploring educational assumptions

To improve practice-based assessments it is necessary to consider how education has been arranged. Is it an expectation of the programme that learners on placement are continuously assessed? If so, is that assessment deemed to contribute incrementally to the final judgement on competence, or can some of the preliminary assessment be formative and designed more simply to alert students to their progress? Is there an opportunity in your practice area to designate some work to the supervision of learners, setting aside other episodes of care for assessment? Assessment in clinical practice needs a structure that is transparent and purposeful for mentors and students.

Limitations of continuous assessment There are some significant limitations to what can be achieved in continuous assessment by mentors in busy and complex clinical settings. It is stressful for students to feel that they are continuously assessed across the whole placement, especially when this happens in front of patients, relatives and other clinicians. Just as the researcher

accumulates information during a project, the mentor accumulates information about the student's progress during his or her placement. However, it can be difficult to judge the overall performance. Do we 'average out' the performances witnessed over time and make

allowances for weaker performance at the start of the placement? If so, what sorts of improvement are considered to be satisfactory over the following days or weeks?

Mentors may feel that they can monitor learners, helping them to avoid making important mistakes, but observe that it is doubtful whether they have the capacity to combine educational judgements with clinical practice and student support on a continuous basis.

BOX 1

Assessment anxieties experienced by mentors

Anxiety	Explanatory notes
Understanding what to assess: competency, proficiency and professionalism. Terms vary according to educational programme and learners from different programmes may share practice placements. If terms are not clearly defined in a given context, this can mean we are assessing different things.	A student might prove to be competent in a specific skill, proficient in getting a set amount of work done on time and yet remain unprofessional in the attitude he or she adopts with patients or colleagues. Not only are there challenges in judging each of these at different stages or levels during a course, but we also have to decide how to combine them when judging performance.
Deciding the parameters on which to base assessment.	While students join clinical placements with clear objectives and module learning outcomes, these may not be expressed well or be appropriate for the clinical learning opportunities. When assessing performance, context and changing clinical conditions also need to be considered.
Understanding the purpose of assessment (formative or summative).	Mentors are engaged in both forms of assessment. Formative assessment is designed to guide the student on their progress while summative assessment is designed to judge the performance and to either pass or fail this as part of course requirements. However, it is not always clear when we should use each of these.
Deciding what to include in the assessment.	Assessors need to decide the boundaries of the assessment. This could be in terms of time or, for example, the whole placement or performances after a settling-in period. Decisions are made about whether an average performance is assessed across the placement or whether certain performances or skills are deemed critical.
Deciding how to judge complex clinical skills.	Many practice skills are composite, that is, they combine knowledge, skills and attitudes. How do we decide which of these are most important? For example, if the right thing is done for the wrong reason, does this constitute failure?
Justifying judgement on performance.	The Nursing and Midwifery Council (2006) will make provision for a 'sign off' mentor with effect from September 2007, but most assessments are consultative. So how do we use informed opinions to arrive at the final judgement?
Managing feedback to the learner.	Because judgements on clinical practice examine student knowledge, skill and attitudes combined, they can seem more powerful to students, judging their worth in ways that an assessment of a more discrete skill might not. So how is this managed in a professional and empathetic way?
Clarifying what I feel confident to assess.	Changes in the curriculum, the level at which a student learns or adjustments in practice protocols, may leave the mentor feeling less competent to assess some areas. So how is this handled with senior colleagues?
Deciding when it is equitable to assess.	Is the student ready to be assessed? Compassionate, health or other circumstances might not preclude clinical placement, but they could distract the student from focusing attention on that which is to be assessed.

BOX 2

Competent to assess (Anna)

I was panic struck. The student showed me new learning outcomes that I had not seen before and I did not understand what these meant in this clinical setting. My sympathetic student tried to explain what 'metacognition' meant, referring to reflection, but I wondered how I would decide what level of reflection had been achieved.

BOX 3

Purposeful assessment (John)

We had monitored the student's progress over two weeks and agreed that not only was conflict management part of the interpersonal skills the student had to demonstrate, but also that this was a routine part of being a registered nurse in this setting. Patients or relatives can be anxious or angry; however, the student lacked insight into why this might be so. She lacked some flexibility in addressing patients' and relatives' needs and readiness to refer the query to a more experienced colleague. We realised that this was difficult to measure and that we needed help to decide what would be an adequate performance for this stage in her education.

Time out 4

Do you continuously assess students in practice? Do students reflect positively on how you arrange teaching and assessment in practice, for example, what do they say in their evaluation of clinical placements? If you do not know, consider discussing this with your link tutor. What measures do you put in place to manage difficulties?

Educationalists have sometimes made spurious divisions between learning and training. Flanagan *et al* (2000) identify that while education has been associated with learning outcomes and performance testing is associated with training, mentors are expected to determine whether learners are competent to practise as well as advising them on their progress.

Assessing performance It is, therefore, necessary for educators and service providers to meet and agree exactly what type of assessments are being undertaken in the clinical area and for what purpose. Some assessments of performance – used to describe the student's ability to combine skills purposefully, sensitively, appropriately, effectively and knowledgeably in practice – may be agreed as formative for students at the start of their programme, but as summative for learners returning to the area in a later module or at a higher level of study. Different performances may therefore be assessed in different ways as the student accumulates knowledge and experience

and proceeds through his or her programme. It is important to agree with educators just what is meant by a performance. While module learning outcomes are described in different areas, for example, cognitive, psychomotor and attitudinal, clinical performances involve combining such skills to strategic purpose. Box 5 gives an example of one such performance to which mentors and educators might then determine what counts as competent with regard to component skills and the performance as a whole. A performance then constitutes the matching of skills to an episode of care. It involves explaining decisions as well as delivering care. Typical episodes of care in the clinical area – those that can be practised and repeated – provide the best opportunities to assess a student's performances and what has been learned during the module.

Time out 5

In your practice area are there any episodes of care that could be used as the basis for assessing learners' performance and their abilities to combine and apply different sorts of knowledge? The ideal performances:

- ▶ Combine the need for reasoning, doing something, working with others and proceeding in a sensitive way.
- ▶ Provide opportunity for students to rehearse aloud why they are proceeding as they do.
- ▶ Involve episodes of care that frequently occur in your area.
- ▶ Draw on the experience of mentors and the wisdom that they have to share.
- ▶ Contribute to one or more of the student's module learning outcomes.

How will we know what standard the student has reached and what seems the most valid and objective means of doing this? In clinical areas the use of objective structured clinical examinations is cumbersome and probably

BOX 4

Combining learning and assessment (Raymet)

I had worked hard with the student during her placement and faced certain difficulties when I and others reluctantly concluded that she had not met the placement objectives. We all knew that this could either lengthen her studies or even lead to a student being discontinued. We agonised over whether we had provided the best opportunities for her to learn. I had to break the bad news to her: first asking her to rehearse her own evaluation of performance and then listing the shortfalls we had acknowledged. It was not easy because the student seemed to have little insight into her own difficulties.

inappropriate. It requires time, money and considerable skill to devise tests that consistently examine students' competence which might not completely represent the circumstances of practice. Ethical objections are likely to be raised if we ask patients to simulate their problems for the purposes of educating or assessing learners (Tsai 2004). Patients, after all, are in the care of nurses for their own benefit and not the advancement of nursing science.

The observation of a student's performance has long been the basis for judgements made on progress and the substance of reports written about them as they leave the clinical placement. Observation, though, has a number of limitations and it is necessary to consider how these can be overcome (Box 6).

BOX 5

An example of assessment of performance

The reception and preliminary assessment of a patient whose diagnosis and needs are initially unclear requires the nurse to demonstrate interpersonal skills associated with the care relationship, history-taking, first observations and preliminary assessment of risk or need. Where risk is an important consideration it allows for an appropriate referral to another colleague so that the preliminary assessment can be checked and/or urgent action taken. The performance enables the student to demonstrate initiative, prioritisation of care and selection of investigations in clinical practice.

The relevant module concepts are: risk assessment, risk management, psychological support and anxiety management.

Time out 6

Consider your own practice setting and the use of observation for student assessment purposes. In what ways do you focus observation so that it is more objective? Have you discovered ways to deal with the problems of tiredness and possible bias? Students sometimes comment on the handling of observation as part of assessment, for example, they may highlight inconsistencies. Make some notes on what you have learned from student feedback.

Imagining ways forward

Exploration of educational assumptions about learning and assessment assists mentors and colleagues to identify ways to achieve more valid and reliable assessment that is feasible and educationally sound. Solutions will vary in different contexts, but certain principles are likely to apply widely:

- ▶ It is best to assess less behaviour but to have a clear purpose about what we choose to focus on. Focusing on a performance with two to three skills enables the mentor to do this.
- ▶ Distinguish between supervision that is used to support safe practice or ongoing learning and assessment that is used to judge competency.
- ▶ Characterise learning opportunities (performances) that are possible in your area so that coherent assessment can be planned.
- ▶ Be honest about assessment capacity and ability (competences may already be assessed elsewhere or educators may be able to move

BOX 6

Limitations of observation as a performance assessment technique

Limitations	Possible remedies
Captures behaviour rather than reasoning.	Back up with open questions that help students rehearse aloud how they are reasoning at key points. For example: 'So what prompts you to explore the symptoms in that way with this patient?'
Open to bias or error if conducted by one individual.	Where multiple observers are unrealistic, arrange for multiple performance observations, preferably by different mentors.
Could be unfocused, eclectic or lack reliability.	Work with agreed performances that state clear standards of competence. Update regularly on how these relate to module learning outcomes or placement objectives.
Time consuming and/or tiring.	Accept that much learning work is supervisory with the student. Assess for limited periods of time, signalling the performance of interest.
Involves moral dilemmas.	Indicate in advance where you will intervene or advise as part of patient safety. Decide whether this then constitutes an assessment fail or an assessment aborted.
Requires a balanced record.	Record notes in the student records, alongside the student's self-evaluation.

some assessments to other, more appropriate, settings).

- ▶ Allow time to understand module learning requirements – it can help to prioritise practice-based assessment later.

In the future there may be different ways of assessing learning in clinical practice. Flanagan *et al* (2000), for example, view learning and assessment as part of work-based learning. In this approach the student and mentors collaborate on the configuration of the clinical work and assessment. Such an approach appeals to mature students, who may either be studying for a higher level qualification or have a considerable depth of life experience and self-insight as a professional.

It is possible to start more modestly using some of the lessons learned through the process of examining assessment concerns and educational assumptions. Practice performances (Box 5) can be used as the basis of assessment and linked to

the relevant module learning outcomes. It is then important to arrange periods of supervision and assessment, during which performances are considered. Arranging assessment in this way enables learners to feel that their practice-based assessment is transparent and equitable. Box 7 illustrates one such schedule which relates to a five-week clinical placement, but which could be adjusted to other periods of experiential learning.

Time out 7

Referring to Box 5 describe a performance from your clinical setting and discuss it with a colleague. Identify what level of learner might be asked to complete the assessment and prepare a description of what will count as competent here. Show this to your link tutor to get his or her opinion on the clarity and comprehensiveness of your assessment guide.

BOX 7

An example of a clinical assessment schedule

Assessment week and focus	Notes
Week 1 Induction and training in key clinical protocols. Close supervision to avoid unsafe practice. Performances are selected that are appropriate for the module learning outcomes and which are likely to be available during the placement.	Students are able to estimate the challenge ahead. Mentors are able to establish parameters for assessment that are realisable and equitable given the nature of clinical situations available in the clinical area.
Week 2 One or more performances are targeted during this week and assessed formatively. The mentor provides verbal feedback to the student on achievements and plans for adjusted practice are noted in the student passport.	Students perceive forthcoming assessments as equitable. Skills have been evaluated and guidance offered.
Week 3 Two or three performances are now completed for the purposes of competency assessment. Each performance is likely to last long enough to show how care is arranged and sequenced, and to provide opportunity to demonstrate reasoning.	Stress levels are minimised for learners and assessors can focus their assessment accurately. The perceived authenticity of assessment is high. The first performances are likely to be those explored before – helping students to develop confidence.
Week 4 More complex performances might be used, depending on placement objectives and student seniority. These are discussed, rehearsed, while the mentor rehearses aloud his or her own performance, that is, describes the reasoning for care decisions and actions demonstrated.	The mentor has the scope to be the guide and advisor – there is no ambiguity between assessment and making learning easier.
Week 5 The more complex performances are assessed for competency this week, achievements, strengths and limitations are discussed. Placement ends with a review of all performances, identification of learning left to do and results shared on whether placement objectives or learning outcomes have been met.	Feedback is on distinctive areas of practice and the student gains incremental information on his or her performance. The focus on areas of learning enables the student to concentrate and improve his or her practice. There are no final interview surprises about achievements.

Conclusion

In the interests of arranging equitable and high quality education, it is necessary to examine the arrangements for practice-based assessment. We cannot overestimate the complexity of this work, even though it is accepted that the clinical area remains the most appropriate place to assess students' achievements. Working incrementally, it is possible to identify the most difficult areas for the student and to focus on what might be changed. Work, then, focuses on deciding what should be assessed: when, how and to what standard.

In this article a case has been made for the assessment of performances. These are larger and more integrated examples of work associated with carefully chosen care episodes. They have the benefit of being more realistic than continuous assessment, and more authentic

than task-orientated assessment. Mentors have limited capacity to assess effectively and accurately for long periods. This is especially true because practice-based assessment relies heavily on observation. Open questions need to be used to assess the student's knowledge base. Work on learning outcome statements may have helped to clarify what to assess, but they have not assisted colleagues to decide how much to assess. Where learning outcomes are written in conceptual terms and fail to integrate practice 'knowhow', they will not assist the mentor in addressing the challenges outlined in this article. Assessing competency is necessary and important in a profession that puts the safety and wellbeing of patients first **NS**

Time out 8

Now that you have completed the article, you might like to write a practice profile. Guidelines to help you are on page 60.

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Practice-based assessment

TEST YOUR KNOWLEDGE AND WIN A £50 BOOK TOKEN

HOW TO USE THIS ASSESSMENT

This self-assessment questionnaire (SAQ) will help you to test your knowledge. Each week you will find **ten multiple-choice questions which are broadly linked to the learning zone article.**

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Ways to use this assessment

- ▶ You could test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- ▶ You might like to read the article to update yourself before attempting the questions.

The answers will be published in *Nursing Standard* two weeks after the article appears.

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Ensure you include your name and address and the SAQ number. This is SAQ No 392. Entries must be received by 10am on Tuesday May 29 2007.

When you have completed your self-assessment, cut out this page and add it to your professional portfolio. You can record the amount of time it has taken you. Space has been provided for comments and additional reading. You might like to consider writing a practice profile, see page 59.

- b) Capturing behaviour ☐
- c) Lack of focus ☐
- d) Unreliability ☐

9. Assessing competency is important for:

- a) Student education ☐
- b) The curriculum ☐
- c) Patient safety and wellbeing ☐
- d) Gaining a qualification ☐

10. In a five-week clinical assessment more complex performances should be undertaken in what week?

- a) One ☐
- b) Two ☐
- c) Four ☐
- d) Five ☐

This self-assessment questionnaire was compiled by Christine Walker

1. Clinical assessment includes:

- a) A patient-centred approach ☐
- b) Clinical experience ☐
- c) Practice observations ☐
- d) All of the above ☐

2. Assessment should cover:

- a) Competency ☐
- b) Proficiency ☐
- c) Professionalism ☐
- d) All of the above ☐

3. Students usually join clinical placements with what?

- a) Clinical proficiency ☐
- b) Excellent clinical skills ☐
- c) Objectives and module outcomes ☐
- d) Performance proficiency ☐

4. A moral dilemma that can arise when using observation as an assessment technique is:

- a) Assessing for limited periods ☐
- b) Deciding when to intervene if patient safety is potentially at risk ☐
- c) Accepting that learning work is supervisory ☐
- d) Using multiple mentors ☐

5. Assessing performance in a clinical episode should consider:

- a) Context and changing clinical conditions ☐
- b) Module outcomes ☐
- c) Objectives ☐
- d) The time of day ☐

6. Constant stress and difficulty in judging overall performance are particular weaknesses with:

- a) Assessment in general ☐
- b) Continuous assessment ☐
- c) Performance assessment ☐
- d) Practice-based assessment ☐

7. Performances are best chosen by considering what in particular?

- a) Untypical episodes of care ☐
- b) Intuition ☐
- c) Prioritisation of care ☐
- d) Typical episodes of care and potential learned module concepts ☐

8. The limitations of observation as a performance technique do not include:

- a) An opportunity to assess students ☐

Report back

This activity has taken me ____ hours to complete.

Other comments:

Now that I have read this article and completed this assessment, I think my knowledge is:

- Excellent ☐
- Good ☐
- Satisfactory ☐
- Unsatisfactory ☐
- Poor ☐

As a result of this I intend to:

Answers

Answers to SAQ no. 390

1. d 2. c 3. d 4. c 5. d
6. b 7. a 8. c 9. b 10. a